

CDC 4C051N

Mental Health Journeyman

Volume 1. Common Mental Health Journeyman Experiences



**Extension Course Program (A4L)
Air University
Air Education and Training Command**

**4C051N 01 0903, Edit Code 03
AFSC 4C051**

Author: MSgt Jeff L. Johnson
383d Training Squadron
US Air Force School of Health Sciences (AETC)
383 TRS/TRR
939 Missile Road
Sheppard Air Force Base, Texas 76311-2363
DSN: 736-1965
E-mail address: jeff.johnson@sheppard.af.mil

Instructional Systems

Specialist: Steve McCarver

Editor: Geri W. Lang

Extension Course Program (A4L)
Air University (AETC)
Maxwell-Gunter Air Force Base, Alabama 36118-5643

IN THIS FIRST volume of CDC 4C051N, *Mental Health Journeyman*, you will study many of the basic tasks associated with being a mental health journeyman. These basic concepts and procedures will provide a launching pad for you to further your knowledge base into the patient care arena. These basic concepts are very important and will need to be recalled often as you begin your journey as a mental health paraprofessional.

Unit 1 begins with the single most important lesson of any of your career development courses (CDC). Professional standards of ethics are a guide for building a respectable and proper relationship not only with the patients but also with your peers and coworkers. This unit calls for mature and responsible stewardship of the unique task you have at hand.

Unit 2 delves into all aspects of the safety program. You will be guided on safety issues as they relate to the medical treatment facility (MTF) and your specific role in the program. The end of the unit focuses on crisis management as well as restrictive and protective measures.

Unit 3 will cover the subject of cultural diversity. This is designed for you to understand not only the perceptions your clients/patients may have about you and the medical community as a whole, but also, what perceptions you may bring to the counseling session as well. Spend some time in this unit examining the variety of beliefs by comparing them with your own.

Unit 4 gives you an overview of some of the prevention, education, and key personnel briefings you can expect to organize, direct, and conduct.

Unit 5 covers records maintenance and budgeting. They are vital to providing documentation as evidence of your work. Remember, you are the guardian of the taxpayer's money—do not waste or frivolously spend.

Unit 6 will conclude this volume with mental health readiness. This unit will provide you with basic care for combat and crisis as well as information on the aerovac program and how you fit into the process.

Volumes 2, 3, and 4 will prepare you for the responsibilities commensurate with being a 4C051 in today's Air Force. Specifically, volume 2 will provide an in-depth look at theories of development and abnormal psychology. You will also learn about the characteristics of specific mental disorders, psychopharmacological drugs, and family maltreatment.

Volume 3 will focus primarily on evaluation of patients in both an outpatient interview setting as well as prepare you to conduct psychometric examinations.

Volume 4 will conclude this set of CDCs. This volume will review treatment planning and introduce you to selected psychotherapeutic interventions. You will also learn the necessary requirements for your anticipated Certified Alcohol and Drug Abuse Counselor (CADAC) certification.

A glossary of abbreviations and acronyms used in this course is included at the end of this volume.

Code numbers on figures are for preparing agency identification only.

The use of a name of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force.

To get a response to your questions concerning subject matter in this course, or to point out technical errors in the text, unit review exercises, or course examination, call or write the author using the contact information on the inside front cover of this volume.

NOTE: Do not use the IDEA Program to submit corrections for printing or typographical errors.

Consult your education officer, training officer, or NCOIC if you have questions on course enrollment, administration, or irregularities (possible scoring errors, printing errors, etc.) on the unit review exercises or course examination. For these and other administrative issues, you may also access the Air University e-Campus Support Center (helpdesk) at <http://www.auecampussupport.com> and do a search for your course number. You may find your question has already been answered. If not, submit a new question or request, and you will receive a response in 4 days or less.

This volume is valued at 18 hours and 6 points.

WE NEED YOUR FEEDBACK! When you finish this course, please complete the student survey on the Internet at this site: <http://www.maxwell.af.mil/au/afiadl/>. Click on Student Info and choose **CDC Student Satisfaction Feedback**.

NOTE:

In this volume, the subject matter is divided into self-contained units. A unit menu begins each unit, identifying the lesson headings and numbers. After reading the unit menu page and unit introduction, study the section, answer the self-test questions, and compare your answers with those given at the end of the unit. Then do the unit review exercises.

	<i>Page</i>
Unit 1. Mental Health Standards of Practice	1-1
1-1. Professional Standards of Ethics	1-1
1-2. Legal Aspects of Patient Care	1-13
Unit 2. Safety and Health Measures	2-1
2-1. Aseptic Measures	2-1
2-2. Making the Mental Health Environment Safe.....	2-14
2-3. Crisis Management, Restrictive and Protective Measures	2-20
Unit 3. Cultural Diversity and the Counselor	3-1
3-1. Understanding Ethnic and Racial Issues	3-1
3-2. Understanding Age and Gender Issues	3-10
Unit 4. Client Education and Key Briefings	4-1
Unit 5. Administrative Tasks	5-1
5-1. Records Maintenance	5-1
5-2. Clinical Administrative Management	5-12
Unit 6. Mental Health Readiness	6-1
6-1. Combat/Disaster Casualty Management	6-1
6-2. Air Evacuation Classification Codes, Movement Precedence, and Responsibilities.....	6-27
 <i>Glossary</i>	 <i>G-1</i>

Please read the menu for Unit 1 and begin →

Unit 1. Mental Health Standards of Practice

1–1. Professional Standards of Ethics.....	1–1
001. Demonstrating high ethical standards.....	1–1
002. Mental health journeyman standards of conduct	1–3
003. Identify attributes of professional relationships.....	1–7
004. Identify attributes of therapeutic relationships	1–10
1–2. Legal Aspects of Patient Care	1–13
005. Legal responsibilities in patient care	1–13
006. State laws and patient rights	1–17
007. Joint Commission and inspections.....	1–21

YOU are about to embark on what I believe will be a training experience you will carry with you through the rest of your career. The lessons provided in your career development courses (CDC) will prepare you for practical application in your clinic/unit.

Our expectations of you are high. We will expect no more of you than we, your supervisors, expect of ourselves—our very best! Winston Churchill once said,

“To every man there comes in his lifetime that special moment when he is figuratively tapped on the shoulder and asked to do a very special thing—unique to him and his talents. What a tragedy if that moment finds him unprepared or unqualified for that work?”

Now is your time. Having studied and prepared for your opportunity to take the reins, you will not be unprepared or unqualified.

Before you begin examining any aspect of patient care, you must first examine the standard of conduct known as a code of ethics that you are expected to adhere to.

1–1. Professional Standards of Ethics

A common customized code of ethics guides every professional society, corporation, government, and academic institution. Yours is no different. The medical community is perhaps the most prolific in instituting codes of ethics, and with good reason; it is the most trusted of institutions by the populace at large. Use the information presented in this lesson as your guide to uphold the code of standards and ethical conduct established for your profession.

001. Demonstrating high ethical standards

Ethics are principles or standards that govern proper conduct. Simply stated, ethics are the rules dealing with what’s good or bad, or in another sense conformance to society’s moral standards in relation to duty or profession. It involves making choices or judgments about what should or should not be done. The following discussion will help you decide what to do in situations that may have ethical consequences. The Air Force core values are an excellent launching platform when you begin decision making: *Integrity First*, *Service Before Self*, and *Excellence In All We Do*.

Ethical standards

The Golden Rule is frequently used as a basic ethical standard. To treat others as you would have them treat you has always been a good rule to follow. To understand the concept of ethics, you must understand how ethics is defined. The following definitions will provide insight:

- *Morality*—personal belief system derived from family, school, religion, environment.
- *Professional ethics*—commonly held (and written down) values that guide professional behavior.

The following are a couple of concepts that will give you guidance.

Hippocratic Oath

Ethical standards developed by the early members of the medical profession are still with us today. The Hippocratic Oath was first used by the medical profession in the fourth century BC. Many parts of the oath are as applicable today as then—accountability, confidentiality, and good moral character. One concept that came from the oath was that the physician should be accountable for his or her work. Another was that the physician should have good moral character. A third, still with us, is—patients’ problems and treatments are confidential.

Florence Nightingale

Florence Nightingale had a significant influence on the development of medical ethics. She believed that nurses should completely devote themselves to their profession and never knowingly harm a patient. She also believed in keeping the patient’s care confidential and doing everything possible to elevate the standards of the nursing profession. You’ll find these concepts in the current codes of conduct used by nurses and members of other medical professions.

Basic ethical foundations

The following five areas form the foundation of trust that you are charged to exercise.

Basic Ethical Foundations	
Autonomy	Autonomy exists for the client’s participation in his or her own care. In other words, the clients are expected to have ownership of most aspects of their care and you, the technician, should respect differences. This doesn’t mean you must agree with the client/patient, but you must respect his or her opinions.
Beneficence	This encompasses the notion that you will make ethical decisions in good faith based upon the good of the client first.
Nonmaleficence	This foundation of trust is in the belief that you will do no harm. You will not intentionally harm the patient through malice or incompetence.
Justice	This assures clients there is recourse in the event they feel they are treated unfairly or unjustly. Clients should be made aware of this process.
Confidentiality	This foundation of trust reassures the patient that his or her medical information will be protected and he or she should expect a right to privacy.

Ethical behavior

You may be asking yourself, “Now that I have an idea of what ethics are, what can I do to show good ethical standards?” If you’ll adhere to the following principles when dealing with patients, you’ll be exhibiting the ethics that are expected of you.

Competence

You must continually assess your strengths, limitations, biases, and effectiveness. Do not engage in treatment activities that you are not qualified for or trained to perform. Know, and voice your limitations. You are expected to know the consequences of treatments you give the patient, and refrain from doing anything that may be harmful to the patient. You should also refrain from doing anything that you have not been trained to do. The fact that the person who ordered the treatment or medication is both an officer, and a doctor, does not make the treatment correct. Tell the doctor why you can’t do the treatment, and if he or she still insists that you do so, inform your supervisor or your section superintendent. Correct any conditions that threaten the patient’s health or safety. This could be as simple as talking to your supervisor about a co-worker who persists in performing unsafe or poor nursing care. The patient’s health is more important than possible loss of friendships.

Professional relationships

You must not engage in any activity that could be construed as exploitation for personal gain, be it sexual, financial, or social—i.e., intramural sports teams, self-help groups, base clubs, business interactions, etc. Having personal restraint and clear boundaries is paramount in this area. We will discuss this topic at length later in this lesson.

Individual care

This ethical standard is closely related to respecting the patient's dignity. Treating each patient as an individual means that you should avoid stereotyping them. All old people are senile, is one example of a stereotype. How many elderly people do you know who are actually senile? You should strive to learn as much as possible about each patient's likes and dislikes, and try to accommodate these likes and dislikes as much as possible. Treating the patient as an individual also involves respecting the customs and beliefs of the patient. The Air Force operates medical treatment facilities (MTF) all over the world. You may be exposed to many different customs and beliefs. Learn the customs and show each the same respect that you expect for your own beliefs.

Integrity

Trust is the basic therapeutic element in the technician/patient relationship. Keep in mind that your personal ethical standards aren't governed by Air Force regulations; they're governed by your conscience. While this may seem idealistic, you must remember that you're being entrusted with the care and welfare of a fellow human being. The very definition of integrity defines this area well; doing the right thing when no one is looking.

Privacy/confidentiality

In many areas the Air Force operates on a strict need-to-know basis. One of your primary obligations is to protect and respect the confidentiality of information obtained in the course of your work. As far as you are concerned, the only people who need-to-know anything about a patient's condition and treatments are those who are helping you care for that patient. All other inquiries should be referred to the patient's mental health provider. Remember, it is not your job to satisfy everyone's curiosity or bolster your image with sensitive information.

Respect

You should respect the rights and opinions of all clients and staff and treat them with dignity. You will not harass or discriminate based upon age, color, national origin, race, ethnic group, religion, gender, grade, sexual preference, or handicap. (**NOTE:** Sexual preference refers to civilian clients only. Established Air Force policy continues to denote homosexuality as incompatible with military service). Respect also means you will do no harm either physically or psychologically, nor will you allow others to endanger patients in any manner.

Role modeling

Lead by example! You are expected to project an image that compliments the behavioral health community. Public or private displays of substance abuse or misuse or behaviors that will bring discredit upon your duty section, peers, or the mental health career field will not be tolerated.

Duty to report

This obligates you to report any violations of ethical standards through the appropriate channels. Violations of ethical standards are a serious matter and it is not the time to demonstrate a loyalty to friendship—our clients deserve better. Failure to report known violations of ethical behavior can lead to disciplinary action against you as well.

002. Mental health journeyman standards of conduct

Standards are guidelines for providing care and criteria for evaluating care. As a member of the military, as well as the medical and mental health services, you have a dual responsibility for

maintaining high standards of conduct. When standards are clearly defined, patients can be assured that they are receiving high-quality care and that you know what is necessary to promote, maintain, and advocate fitness for duty. The standards of conduct discussed here are guidelines you can use in becoming an effective mental health journeyman.

Standards of conduct

Conduct yourself as a health care professional. To do this, always display the same ethical standards, conduct, and behavior towards patients that you'd expect of someone treating you. Be of good character and strive to uphold the honor and dignity of the position to which you're assigned. This means you should always conduct yourself with propriety. You are not only an ambassador of the Air Force, but also the mental health enlisted career field. Your actions reflect directly upon all of us. Make us proud!

In addition to common courtesy, the following actions are ways that you can display a professional conduct response towards patients, peers, and professional staff.

Do not evade laws

In addition to the obvious laws and regulations for which there are judicial penalties, observe the rules and regulations established to keep your clinic/unit running smoothly. All clinics/units have established Standard Operating Procedures (SOP) or Operating Instructions (OI) that you must know and follow. "I didn't know" is not an acceptable excuse for wrongdoing when clear guidance is available. One of the best ways to orient yourself to a new clinic/unit is to review the SOP/OI book. This will give you clear guidance about procedures in your work area. Your supervisor or your NCOIC should be able to point you in the right direction regarding SOP/OI books. As always, if you don't know how to complete a task, ask for assistance!

Do all of your duty

No matter how minimal the task may appear, if it's left undone, you may jeopardize the welfare and well-being of patients. Cooperate and assist your coworkers in all facets of patient care. Be sensitive to peers' inconvenience; by this I mean; avoid last minute requests when you can. Be observant; offer to help before being asked. This will help you fit in even though you are a new arrival at your clinic/unit. Be responsible and reliable! Reliability is extremely important. This builds confidence faster with both clients and supervisors—perhaps faster than anything else you do. The confidence of knowing a task will be accomplished because you promised it would be speaks volumes for your character. Be a part of the solution! Everyone has complaints, but what are you doing to help solve a problem?

In addition, consider it your duty to treat all patients and coworkers courteously and respectfully. Be aware of good interpersonal relationships at all times. Some sections are smaller than others and where you work may become like a second family for you. While you all may not agree on every issue, it is important that everyone works together in a courteous manner.

Display a positive approach

Convey a genuine interest in meeting the needs of the patients at all times. The patients' expectations for their improvement are affected by your interest and attitude. Always work to allay the patients' fears. They will almost always be apprehensive and uncomfortable entering your work section. Start the encounter off right with a positive attitude and a smile.

One of the principles of communication is to know its impact on the receiver. The results of a University of Wisconsin-Milwaukee study on what people remember from interactions is helpful. According to the study, people remember:

- 10% of what they read.
- 20% of what they hear.

- 30% of what they see.
- 40% of what they hear and see.

Inappropriate relationships with patients

You must know what appropriate versus inappropriate interactions between staff and patients are. This area—perhaps more than any other in the 4C0 career field—can cause problems or even have legal ramifications. As you may have recognized, there are patients who can be obnoxious, intimidating, and rude. On the other hand you will encounter patients who are equally as charming, cunning, and flirtatious! You may find patients that have much in common with you—i.e. same geographical region of origin, like values and interests, etc. However much you might have in common, you must maintain a professional relationship with all of your patients at all times.

There must be clarity regarding the appropriate relationship boundaries between staff (including all volunteers, students, interns, providers, technicians, secretaries) and patients (including former patients and patients' families). All patients by virtue of their need for treatment are especially vulnerable to exploitation in a relationship where an imbalance of power exists. The risk of damage to the patient is heightened when the relationship between staff and patient becomes ambiguous. Dual relationships can endanger the well-being of both staff and patients and can negatively impact the facility's ability to provide care.

Appropriate relationships with clear boundaries between staff and patients are necessary for accomplishing the mission. When a relationship becomes poorly defined, blurred, or compromised by outside interests, relationship boundaries may be violated. A conflictual, dual relationship exists when the parties involved in the relationship interact socially, romantically, or in business matters. Who initiated the relationship is irrelevant; as the technician you are responsible for exercising sound judgment and are accountable for your actions.

Inappropriate Relationships With Patients	
Type	Description
Romantic relationships	Romantic or sexual relationships of any type between staff and patient are unacceptable.
Business relationships	A business relationship between staff and patient can include direct monetary transactions, gifts, or something of tangible benefit to either the staff member or the patient.
Social relationships	An unacceptable social relationship occurs beyond the incidental run-ins at the Base Exchange (BX) or Commissary. Social relationships include taking a patient to a social event, inviting a patient to the staff member's home or dorm room, a staff member visiting a patient's home, or seeking the patient out for social interaction to name a few. Does this mean you can never engage in a nontherapeutic relationship with a patient? Is there a time frame when it is acceptable to engage in a nontherapeutic relationship? Anytime during the entire course of the patient's treatment it is unacceptable. Generally, anytime there is a differential in power between the staff and the patient it is unacceptable as well. As always, if you are ever in doubt, ask your supervisor.
Do not discuss personal problems with patients	Patients often look at the staff technicians as role models; someone they might pattern their lifestyles after to better effect a resolution of their current crises. If you, as a staff member, discuss crises of your life that you can't resolve, you may lower the patients' confidence in the staff as a whole. Patients visiting the clinic and hospitals are there to work on their own difficulties; patients attempting to resolve your conflict distracts from that process.

Inappropriate Relationships With Patients	
Type	Description
Avoid financial dealings with patients	<p>Do not have financial dealings with patients. To do otherwise will leave you, the team, the hospital, and the Air Force open to criticism. Also, it is unethical for you to advise a patient about financial matters. Soliciting money from clients for charities, donations, gifts, etc. is also prohibited.</p> <p>When I was an Airman First Class (A1C) and working on the inpatient psychiatric unit at Travis AFB, a long term patient gave me a birthday card and 20 dollars. This patient was very high functioning and close to discharge from the facility, but I knew that it was ethically wrong to accept the gift. I immediately returned the money and informed her that I appreciated the gesture, but it was inappropriate. I also immediately told my supervisor about the interaction.</p> <p>Regardless of how mentally intact the patient is; it will appear to individuals outside the unit that you took advantage of the patient who was mentally incompetent. Additionally, the patient can manipulate you by using a financial obligation as a lever.</p>
Avoid sharing religious values with patients	<p>Be careful to respect the patients' religious beliefs or absence of beliefs. It's okay for you to have religious beliefs. However, you are not a chaplain. Preaching or evangelizing to patients is unethical.</p>
Avoid unethical sexual activity	<p>When the American Psychiatric Association (APA) established its code of ethics, it adopted, for the most part, the ethical code of the American Medical Association (AMA). One area that the APA included and was very clear in stating was—<i>Sexual activities with patients are unethical</i>. The importance and concern for this area within the health care system is critical.</p> <p>Let the following negatives also be a guide:</p> <ul style="list-style-type: none"> • Don't date patients or engage in social contact during treatment. • Don't flirt with a patient. • Don't request sexual favors. • Don't cultivate an emotional dependence on you. • Don't tolerate unsolicited physical contact of a sexual nature. <p>As a member of the mental health care team, you're expected to follow this code. Keep in mind the problems encountered in one-to-one therapy—transference, counter transference, reaction formations, etc. You may come closer to this area of compromise than you realize. One of the major problems in dealing with any patient is the patient's tendency to become very dependent on the care provider. In many instances, you become the <i>primary care provider</i> in terms of time spent with the patient. Take special note of the patient's vulnerability and be sure not to gratify his or her needs by exploiting this personal and, sometimes intensely, emotional relationship.</p>
Avoid gossip	<p>Gossip and rumors are some of the most disruptive forces in a mental health treatment unit. Whether it relates to an individual, a staff member, appointment scheduling, test results, treatment plans for a patient, or reorganization of the mental health service, it causes stress and anxiety for the staff. Working with the additional stress rumors cause hinders your effectiveness with patients. Take positive action to see that gossip or rumors are reduced to their factual content. You can do this by discussing it with your peers or noncommissioned officer in charge (NCOIC) or in team or staff meetings.</p>

Be willing to accept change

Change is not always easy; and it is not always bad. Accepting change is easier said than done. With the turnover of personnel in the Air Force change is inevitable. New personnel bring new ideas about operations, treatment modes, treatment goals, etc. The stress that accompanies change is caused by

fear of the unknown. Going from a known, proven, and familiar treatment modality to one that is unknown is a very anxiety-producing experience. A team meeting is probably sufficient to discuss individual treatment changes, but the entire staff should meet to discuss major changes in treatment modalities. Meetings afford everyone concerned the opportunity to discuss the unknown factors of the change. Once these factors have been discussed and a decision to make the change has been made, do your utmost to effectively enact the change. Improvements in patient care are brought about by changes.

Some of the areas we've discussed include ethical considerations and the expected standards of conduct. If your daily activities exhibit the professionalism and the ethical characteristics we have just discussed, patients and staff members will respect your efforts and that respect will make your job easier. Remember the Air Force Core Values.

003. Identify attributes of professional relationships

An environment of trust is an essential component to the care we provide. The patient's perception of the quality of care he or she receives is created by his or her interactions with members of the health care team. You are a member of that team. It is important to establish a professional relationship with your patients, the patient's family, co-workers, and volunteers. In this lesson, you'll learn the basics about professional relationship that you need to exist between you, your patients, and other members of the medical team.

Developing professional relationships

The following paragraphs give you some guidance for developing professional relationships with others. Basically, we'll just expand and integrate the concepts of ethics and professionalism that we discussed earlier. Your attitude, behavior, and basic demeanor are important to the patient's well-being. When a patient feels comfortable in a situation or environment, he or she is more likely to be receptive to treatment; thereby resulting in a more conducive environment for a positive treatment outcome.

Appearance

Integral to any facility's standards of excellence are the professional appearance of every member contributing, directly or indirectly, to the care of the patient. Present a clean, neat appearance at all times. Wear a clean uniform every day, keep your shoes clean and polished, and avoid wearing excessive jewelry and cosmetics. More often than not, patients form their first impression of you based on how you look. Your sharp appearance establishes an air of confidence and respect. If your personal appearance is less than desirable, the impression you leave with them will be as well. Remember, you only get one chance to make a good first impression—so look sharp and do it right the first time.

Attitude

Be positive! Maintain a positive attitude towards your patients and coworkers. Be cheerful, respectful, and professional—it is contagious. Avoid distractions; focus on one thing at a time. Smile! Stay alert, be calm, do good work, and keep smiling. Remember your purpose and why you are there; if there are no patients (customers) there is no reason for you to be there either. Show concern for all patients—let each one know that his or her welfare is important to you. It would not be true if I said that you would completely dislike all of your patients, or that you would totally like all of your patients. You must behave in a professional manner!

Don't neglect or ignore your patient

Pay 100 percent attention to patients with your eyes, words, and body language. Your patients may be frightened and confused. Never neglect or ignore your patients, it only adds to the frustrations. "Good morning, Sergeant Gonzalez! Is all of your information correct in AHLTA? I see you are here today for an MMPI, BDI, MCMI..." Did you understand all of that? You may have, but the client may be

feeling completely lost, overwhelmed, and intimidated. Speak in terms the patient will understand. If working on an inpatient unit, circulate among your patients when you finish your routine duties. It's impossible to provide mental health care from the break room. Your patient may just need someone to talk to. If you spend a little time listening, the patient often feels more at ease and you may learn something. Try to get to know your patient as an individual, and learn as much as possible about the patient's illnesses, likes, and dislikes. The outcome is that the patient learns that you are genuinely concerned about his or her well-being and your work becomes more interesting.

Don't burden your patient with your problems

As a mental health technician most patients think that you know how to react to and handle life's problems as they come your way. The fact is, we all have personal problems, but we need to leave them outside and keep them away from our interaction with patients. Never burden your patient with your problems. Do not take your frustrations out on your patient or your co-workers. Do not share internal struggles with staff members or air "dirty laundry" with patients. Just as clients are sometimes merely looking for someone to listen, you too may need to stop from time to time and attend to your own well-being. If your problems have reached the point where you can't control them, talk to your supervisor. If your supervisor can't help, he or she will be able to refer you to someone who can.

Make teamwork your byword

Don't find fault, find a remedy! Another good word to use to sum up your relationship with other medical personnel is *teamwork*. You are part of a team and the team is concerned with helping the patient reach his or her own best physical and mental well-being. Be observant of your co-workers. Offer to help before being asked. A patient's life may depend on how good the teamwork is. Treat your co-workers with courtesy and respect and maintain a professional atmosphere. Remember, co-workers can also be your customer and visa versa. Set the pace and the example for peers. Use what I'll refer to as the "Spaghetti Theory of Leadership:" It's easier to pull a limp piece of spaghetti into a straight line than it is to push it. The same is true of people; leading by example is easier than pushing people to do the right thing!

Maturity

Maturity is a must. You are held to a higher standard not only on duty but off duty as well. You will be privy to and deal with enormously sensitive information that requires the utmost in responsible mature conduct. Horseplay and idle chatter have no place in a professional environment. Horseplay is an unsafe practice anytime, and idle chatter tells the patients that you are not concerned about them. Avoid using first names when talking to any officer—commissioned, non-commissioned, peers, or civilian personnel. Over-familiarity and professionalism are incompatible concepts. You may be friends, but it detracts from your professionalism when you are overly familiar in front of the patients. Never do anything to belittle your co-workers in front of the patients. If a co-worker is having a problem or improperly performing care, be discreet. Try to correct the situation yourself, but do not hesitate to involve your supervisor if necessary. Keep public areas free of private behavior. As we said earlier, the patient's welfare is more important than hurt feelings or the loss of a friend.

Empathy

Empathy is the ability to experience or understand the thoughts and feelings of others. It's the ability to feel and share the pain and joy with someone else. You must remember that too little empathy is ineffective and that you can never display too much empathy. Be aware of your own thoughts and feelings and remain objective. Empathy is sometimes confused with sympathy. But sympathy contains pity and condolence, and suggests a parallel feeling between you and the patient. With sympathy the feelings are close and objectivity is lost; therefore an inaccurate assessment of the patient's feelings may take place. Be aware that sometimes a mental health journeyman can be manipulated by a patient in an attempt to demonstrate empathy. Allowing patients to exceed

limitations isn't helpful to them and really doesn't demonstrate empathy. Empathy suggests a genuine understanding, but an understanding that allows objective appraisal.

Privacy

There are many kinds of privacy as it relates to patients; we will focus on two—personal and physical.

Patient Privacy	
Type	Discussion
Personal privacy	<p>Personal privacy means that you do not reveal anything about the patient or the patient's care to anyone who is not working with that patient—including fellow medical service technicians who work in another clinic. Personal information relating to a patient is on a "need-to-know" basis. This means only team members with a "need-to-know" about the patient's treatment or progress should be involved in the discussion of personal client information. Information that seems trivial to you may be very important to the patient. Never discuss the patient jokingly or casually; it is an unprofessional practice that must be avoided. Be mindful of where you are when discussing patient issues with appropriate staff members. A clinic lunch at a local restaurant is not the best place to discuss a patient's marital issues. Should the actual patient overhear, you lose the rapport you worked to build. If another patient or anyone else who does not work in the clinic overhears the conversation, your clinical credibility and reputation might be in jeopardy.</p> <p>Never peruse patients' charts for the purpose of curiosity. This is unprofessional and an unwarranted invasion of the patients' privacy.</p>
Physical privacy	<p>Physical privacy means never touching the patient unnecessarily. Think how you would feel if a stranger came up and started touching you with no respect for your dignity or person. Think about it for a minute, and understand how the patient feels. You are a stranger to your patients and they do not automatically understand everything you are doing. Explain what you are doing before you start. If you are performing a procedure that will require a patient of the opposite sex to disrobe in any manner, ensure you have a chaperone of the patient's sex in the room with you.</p>

Communication

Communicate with your patient in a friendly and respectful manner. Address clients by their rank or title (Mr, Mrs, etc.) and last name. Do not address your adult patients by their first name. Address your adult patients by their first names only when they specifically request it; then, be respectful. Juveniles usually will be more cooperative if they are addressed and treated as adults. Ask the parents about the child's name preference because children sometimes have a nickname they respond to. Never use terms of endearment (i.e., honey, sweetie, baby, etc.) when addressing a patient or co-worker. You are in a unique position as a mental health journeyman. You will be directing patients of all ranks and positions. If you expect to succeed at your work, remember the rules of military courtesy. Being overly familiar or abusive to a superior, or a person of any rank for that matter, will cause you to lose the patients' respect, plus get you into serious trouble. Military members, both active and retired, should be addressed by their titles. That is a right they have worked hard to earn.

Not only is it important to use proper names and titles when talking with your patients, but it is just as important to use effective communication techniques when providing quality patient care. Books have been written to teach people how to communicate effectively. Let's briefly cover some of these skills.

Principles of communication

Communicating is a difficult task. It is the act of giving or exchanging information. Although this is a simple definition, communication takes place only if the message being sent is received accurately. Here are five principles to remember:

1. Communication requires a sender, a message, and a receiver. The sender puts thoughts into words; then transmits these ideas in the form of a message to the receiver who tries to understand the thoughts.
2. Channels of communication are verbal, nonverbal, or written.
3. The goal is to obtain information, inform, explore problems, or release tension.
4. The degree of effectiveness is determined by the setting and attitudes of those involved in the communication process. Our emotional state affects listening.
5. Know what you're going to say and say what you mean.

Effective communication techniques

Speaking correctly and listening are also important. The ten effective communication techniques to remember are:

1. Look people in their eyes.
2. Concentrate on what is being said and listen patiently. This is known as attending.
3. Think of the feelings behind the words.
4. Look for a hidden message.
5. Occasionally repeat what is being said. This is known as reflecting.
6. Ask questions if you do not understand the message.
7. Be conscious of nonverbal signs—a smile, frown, blank look, fidgeting, toe tapping, etc.
8. Use silence effectively; this can convey care and compassion.
9. Offering of self. For example, “I will stay with you” or “Let me help you”.
10. Be empathetic. Empathy is placing yourself in the patient's position (e.g., “It must be difficult to be away from your family.”).

Now you know several ways to establish good professional relationships and to communicate with your patients and co-workers. If you think about it, all these rules and ethics are nothing more than common sense and decency. An easy way to keep these common courtesies at the forefront of your daily routine is to think of the mnemonic C.A.R.E—Courtesy, Appearance, Respect, and Empowerment. Periodically reflecting on this mnemonic will help remind you of what is expected of you even on the difficult days. In mental health, and the medical community in general, these rules were formalized to create a standard of care upon which the various professions were founded. The standard of care became both a statement of the purpose of the profession and guidelines to control the members of the profession.

004. Identify attributes of therapeutic relationships

The social structure of a medical facility and the interpersonal interactions among its staff and patients are major factors in the treatment of all patients. It is believed that what heals the patient is people, and that the interpersonal relationships the patient has with the staff and other patients directly affects behavior and recovery. Therefore, be aware and understand that your attitude when interacting with others is extremely important in developing and maintaining a therapeutic environment. Your behavior towards the patient, co-workers, and professional staff influences the patient's assessment of treatment worth and the overall success of a treatment program. When attempting to develop a therapeutic relationship with patients, you must maintain certain attitudes.

Attitudes

Some attitudes, when perceived by patients, have a detrimental and non-therapeutic effect on your relationship with them. Review the previous section regarding projecting a positive attitude. Being aware of your attitudes and feelings toward patients and their behavior is a major step in the development of sound therapeutic relationships.

Acceptance

Acceptance of the patients' behavior doesn't mean that you condone or approve of the behavior. This may well be one of the more difficult tasks for the newly trained mental health journeyman. Acts of child or spouse abuse, irresponsible drunkenness, promiscuity, philandering, and many other aberrant acts may leave you wanting to pass judgment. Blatant illegal acts are obvious and can be difficult for you to manage. Moral issues that are not compatible with your own morals will also present themselves. There are many issues that immediately draw definitive lines based on personal beliefs. It means that you acknowledge that patients have the right to act as they do, within limits. This doesn't convey resignation. Acceptance is an active process, a series of positive behaviors that convey respect for the patient as an individual. Many times acceptance of a patient's behavior is very hard. The patient's symptoms usually occur in an area where the average individual is used to making moral or value judgments. Guard against personal reactions to the patient's behavior. Feelings of shock when patients use vulgar or offensive language aren't wrong, but to make the patients feel that they should be punished for using the language is wrong. Make every effort to separate the act from the actor. Disapprove of the behavior but not the patient. Now that you have a better understanding of why acceptance of patients is so important, you may be wondering how you can demonstrate this acceptance. The following practices are methods that demonstrate acceptance to the patients.

Be aware of judgmental feelings

Judgmental feelings are a lifelong process and result from evolving values. Strive to be aware of judgmental feelings and recognize your responses toward patients that may stem from your feelings.

Use a nonpunitive approach

Allow patients to express their feelings and don't, directly or indirectly, punish them. Develop skills in recognizing how retaliation can be expressed so that you can avoid it.

Retaliation	Retaliation includes such things as: <ul style="list-style-type: none"> • Avoiding patients. • Calling attention to the patient's defects. • Reducing the patient to a diagnosis. • Laughing at the patient's fears. • Acting condescending and superior to the patient. • Saying one thing but allowing your facial expression to say something else.
Threats	Other punitive acts on an inpatient unit might be the threat of withholding medication or increasing the medication, canceling a pass, or seclusion. In an outpatient setting it could be the threat of delaying a security clearance, making public personal information, etc.

Show interest

You can show an interest in your patient not only by reading charts and texts but also by seeking out the patient and developing an awareness of his or her likes and dislikes. Don't brush aside his or her comments and complaints; deal with them realistically. Do not discount or treat his or her fears lightly.

Staying with a patient

Staying with a patient on an inpatient unit is a method of demonstrating acceptance and is easily overlooked. Your continued presence with a patient who is using objectionable behavior conveys acceptance of the patient, not necessarily the behavior.

Recognize the feeling expressed

Many times patients are unsure how far they may go in expressing their feelings. To be an effective sounding board for patients, you must be able to accept their expressions of emotion without retaliation. If you can understand the feeling expressed, you can reflect that feeling back to the patient. If you're in doubt about the feeling, paraphrase the words back to the patient for clarification. Cultural differences sometime prevent patients from expressing their feelings. We will look at that aspect of care in Unit 3 of this volume.

Consistency

Demonstrate the same attitude towards patients day after day. The patients gain a sense of security by being able to predict your behavior. The entire staff should be consistent; it lessens the patient's anxiety by simplifying their decision making.

The basis for your effectiveness as a mental health journeyman is your ability to establish and maintain strong, interpersonal, therapeutic relationships with the patients, peers, and other medical personnel. This is easier for some than others. But it does require a conscientious effort by all. Keep in mind the practices we've just discussed and know that you can increase your ability to establish these relationships.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

001. Demonstrating high ethical standards

1. What is the definition of morality?
2. What is the definition of professional ethics?
3. Identify the five areas that form the foundation of trust.

002. Mental health journeyman standards of conduct

1. When can you engage in a nontherapeutic relationship with a patient?
2. What is the American Medical Association's stance regarding sexual activities with patients?

003. Identify attributes of professional relationships

1. What is the patient's perception of the quality of care based upon?
2. What are the five principles of communication?

004. Identify attributes of therapeutic relationships

1. What influences the patient's assessment of treatment worth and the overall success of a treatment program?

2. Define acceptance.

3. What should you do if you're in doubt about a feeling the patient has expressed?

1-2. Legal Aspects of Patient Care

With lawsuits being brought against hospitals and health care workers, it's imperative that you understand the laws connected with patient care. As a mental health journeyman, you will often be in situations where you must decide what should or should not be done or what you can or cannot do. These questions may require an ethical application, or they may be of a legal nature. The information in this section will help clarify and guide you toward knowing what you need to do in these and other situations.

005. Legal responsibilities in patient care

To what extent can you, as a mental health journeyman, expect to be held responsible for negligent behavior? You know that you have legal responsibilities regarding patient care. Many terms applied to the law and to legal actions are unlike those terms used in the medical profession. In this lesson, you'll learn the terms and the legal responsibilities that apply to patient care and your profession.

Legal liabilities

All persons working in MTFs are held accountable for their actions by criminal, administrative, and civil tort legal liabilities.

Legal Liabilities	
Type	Description
Criminal liability	Criminal liability involves government prosecution of criminal offenses for the punishment of wrongdoers and deterrence of others.
Administrative liability	Administrative liability is nonpunitive. It involves an employer's right to direct the actions of its employees. While there is no direct financial liability, such as a fine, there can be financial repression from the loss of rank or discharge. This protects accountability of the patients and the Air Force.
Civil tort liability	Civil tort liability involves a civil wrong that injures a person, or property of another person. This liability involves a personal lawsuit and money damages. A tort is a lesser form of a crime and usually is prosecuted in a civil court by individuals or corporations rather than the government. In extreme cases, a wrong committed against a patient may be considered a crime and prosecuted in criminal court. The government may also institute a civil action in cases with significant public interest.

Intentional torts

Intentional torts attach a personal financial liability. There are several types of intentional torts—assault, battery, false imprisonment, misrepresentation, wrongful invasion of privacy, defamation of character, and constitutional torts. The following table provides a basic understanding of these legal concepts.

Intentional Torts	
Type	Description
Assault	<p>Assault is a threat of physical harm that creates a fear of imminent bodily injury or an apprehension of unwanted touching. It is an intentional, not accidental, act and no actual touching is required. If you threaten to hit, hold, or tie down a patient and the patient takes you seriously, you have assaulted your patient.</p> <p>Assault in the patient care environment happens most often when medical personnel are trying to work with an uncooperative patient. Remember that a patient does have the right to refuse treatment. What you should do in these situations is to remain calm and inform the patient's mental health provider, who can discuss the consequences of the refusal with the patient.</p>
Battery	<p>Battery is actual offensive touching of a person without that person's consent. The best way to avoid being accused of assault and/or battery is to always explain procedures to patients. This protects you and the Air Force, reassures the patient, and improves patient and staff rapport.</p>
False imprisonment	<p>False imprisonment is wrongfully restraining or restricting a person against his or her will. If you tie down the patient you were threatening, you have assaulted and battered your patient, and falsely imprisoned.</p> <p>If you have to restrain a mental health patient against his or her will, there must be a sound medical reason, and you must have permission from a physician. There is very clear guidance regarding when this is appropriate and the procedures to follow. Again, if you are unsure, ask!</p>
Misrepresentation	<p>Misrepresentation is a false statement of material fact that has caused detrimental reliance to the patient. For example, if you were to guarantee the outcome of a treatment and it was not achieved, this is misrepresentation. Fraud and deceit fall in the category of misrepresentation. A good example of fraud and deceit is the administering of a battery of unnecessary psychological tests.</p>
Wrongful invasion of privacy	<p>Patients have a right to expect their privacy to be respected. You must educate yourself and be aware of how you could violate the patients' privacy. The following are examples:</p> <ul style="list-style-type: none"> • The release of patients' medical records without their consent or proper authority is an invasion of privacy. • If you discuss a patient's medical condition or care with people having no need to know (e.g., your friends), you are guilty of wrongful invasion of privacy. • The use of a patient's name or photo in any form without consent is an invasion of privacy. <p>Another type of privacy invasion is of a physical nature. This includes eavesdropping, recording patient's conversation, or showing filmed procedures for training purposes without the patient's consent.</p>
Defamation of character	<p>Your reputation is like your credit rating—something you want to keep spotless. Libel and slander are two types of defamation. When someone says something false about you, it could be considered slander. Libel is generally written or printed defamation. Defamation of character is communication, which injures a person's reputation.</p> <p>The legal definition is: "a false derogatory statement communicated to a third person that injures the victim's reputation by exposing the victim to hatred, contempt, ridicule, aversion, or lower public opinion." These statements may be oral (verbal), which is called slander, or written (visual), which is termed libel.</p> <p>For example, if you tell a friend that one of your patients has AIDS, and it's not true, you have defamed your patient. Avoid this problem by not gossiping. On the other hand, if you suspect child or spouse abuse, you are obligated to report it. Even if the accused is found not guilty, that person cannot sue you for defamation of character.</p>

Constitutional torts

Constitutional tort is a violation of a patient's civil rights by a government employee. The Civil Court system provides a mechanism for individuals to recover damages when a tort (French for 'wrong') is committed against a person(s) or property.

Some Civil wrongs (or torts) are defined in state statutes; however, most tort cases are brought claiming negligence, which has its basis primarily in common law. Medical malpractice (which is defined as professional negligence in a medical setting) cases are heard in the Civil Court system.

An example of this is failure to obtain a warrant before searching a patient's belongings for criminal evidence.

Intentional infliction of emotional distress

Intentional infliction of emotional distress involves outrageous conduct causing severe emotional shock or trauma. If you show respect for your patients and follow the guidelines you learned earlier, you will have no problem with this or any other intentional torts.

Negligence and malpractice

Negligence and malpractice have essentially the same definition—performing an act that a reasonable individual with the same training and experience and in similar circumstances would not do. Or not performing an act that a reasonable individual with the same training and experience and in similar circumstances would do. *Negligence* is an event that could have resulted in harm. *Malpractice* is an event that has resulted in an injury or damage to the patient. Malpractice is a term generally used when referring to the actions of professional people. Although you are a member of a profession, you are not licensed as a doctor or nurse, so for legal purposes you are considered to be a paraprofessional.

Duty to patients—the standard of care

This is the duty to act as a reasonable person, with similar training, would have acted under similar circumstances. Skilled professionals must use the degree of skill normally used by other skilled practitioners in the same field of practice, under the same circumstances.

Failure to meet standards of care—breach of duty

Breach of duty requires a deviation from standard practice or acceptable alternatives. A bad result alone is not breach of duty. Negligence can occur in many ways in a patient care setting.

Breach of Duty	
Type	Description
Failure to inform	If you diagnose a patient's illness and fail to inform the mental health provider, you have committed a breach of the standard of care.
Failure to consult	If you diagnose a condition and institute treatment without consulting a credentialed mental health provider, you have also breached the standard of care.
Causation	This is an instance where the technician caused harm or his or her actions could be anticipated to cause harm to the patient.
Damages	This is the actual damage suffered by the patient. It could be a compilation of things including physical, emotional, loss of wages etc.

Diagnosing and treating

Diagnosing disorders and ordering treatment is the responsibility of a credentialed health care provider or physician, not a mental health technician. The best way to prevent negligent acts from occurring is to be conscientious in your work and act within the limits of your training.

Federal Tort Claims Act

There was a time when suing the government was unheard of; this is no longer the case. In 1946, Congress enacted the Federal Tort Claims Act (FTCA). It is a limited waiver of the United States government's sovereign immunity.

Liability

The general rule is that the federal government is liable for injuries caused by a federal employee, including *active duty military*, where the employee was acting within the scope of employment, and the state laws where the act occurred would render a private citizen liable for negligence under the same circumstances. The FTCA applies to all injuries caused by federal employees acting in the scope of their employment, not just medical malpractice.

Who sues

Civilians, dependents, and retired military are entitled to sue; however, *active duty military members are not entitled to sue*. A lawsuit against the federal government is justified if a federal employee, acting within the scope of employment, commits an act of negligence while on duty. In other words, if you are performing duties in an Air Force medical facility and you are negligent, only the Air Force can be sued.

However, failure to maintain any part of your responsibility is negligence. If this negligence results in a lawsuit and the judgment is against the government, the government pays the judgment. If the claim is not for negligence, but for an intentional tort, you pay for the judgment. You are accountable to the Air Force for any substandard patient care. You will be reprimanded. If you are guilty of gross negligence, you can be convicted and sentenced by a court-martial.

Exceptions to liability

There are some exceptions to the FTCA liability.

Exceptions to Liability	
Exception	Description
Military Claims Act	Injuries that occur in a foreign country are covered by the Military Claims Act, which, unlike the FTCA, does not permit lawsuits.
Intentional and outside of employment	Injuries resulting from intentional acts of misconduct and acts committed outside the scope of employment.
The Feres Doctrine	Under the Feres Doctrine (<i>Feres v. United States</i> —U. S. Supreme Court, 1950) active duty military personnel may not sue for injuries received arising out of or incidental to their military service. Also, it bars derivative claims of the family members of injured or killed active duty personnel. Injuries to active duty military personnel in MTFs are considered incidental to the service; therefore, recovery under FTCA is barred by Feres.

Good-Samaritan laws

Good-Samaritan laws are designed to protect medical personnel from liability due to simple negligence when they render noncompensated medical aid in good faith at the scene of an emergency. Each state has a Good-Samaritan law, but it varies from state to state and country to country. Your best protection is to act within the limits of your training and use common sense. Check for the wording of the Good-Samaritan laws where you are assigned.

Informed consent

Adults of sound mind have the right to decide what shall be done with their bodies. Patients must be mentally competent to give their consent. They must be able to understand and appreciate the risks and benefits of treatment, and they cannot be under the influence of drugs or alcohol at the time of

giving consent. Minors are considered incompetent to give consent except in certain circumstances. Such exceptions include: minors on active military duty, married minors, emancipated minors, and mature minors. Minors are permitted to consent to treatment for certain categories of care (e.g., pregnancy, birth control counseling (not in all states), venereal disease, drug and alcohol abuse, and medical emergencies). Furthermore, without the minor's consent parents and guardians access to the minors care in the aforementioned areas is limited. The type of treatment and age of consent for minors varies from state to state and overseas. Educate yourself on the laws for each location when you have a new assignment because they will vary.

006. State laws and patient rights

How does the law affect the admission of a patient to a mental health unit? Eventually you'll be involved in the care and treatment of more than just active duty personnel. The chances are very good that retired personnel or dependents will be seen and admitted to your facility. Unlike active duty personnel, these patients can't be required to follow Air Force instructions. A variety of factors enters into the legal aspects of patient care, especially with respect to admission or transfer of such patients to civilian mental health facilities. You already know the laws vary from state to state, so we'll only touch on a few general areas affecting admissions. Keep in mind that this information relates to admission to state or local civilian facilities, *not* Air Force treatment facilities.

Emergency

Most state laws allow for the hospitalization of people who can't exercise sound mental judgment, control, or are a danger to themselves or others. However, some states that don't have applicable laws usually confine these people in jails—a practice that mental health personnel find unacceptable. Emergency hospitalization has very limited goals—to suppress or prevent conduct that might be harmful to the individual or others. Admission usually requires application. Who may make application is usually designated in the state statutes. Some states require a judicial decision—others require a medical decision that is not necessarily limited to a psychiatrist.

Voluntary

Of all the types of admission, voluntary is the most desirable because it reduces the unfavorable reaction associated with involuntary admission. The patient may request the admission, or a relative/guardian may make the request. In a voluntary admission, the individual recognizes the illness and is willing to participate in the treatment.

Involuntary

Involuntary admission usually occurs when the patients are too ill to recognize the illness or when they can't act on their own behalf to protect their interests. Some states require a court order for involuntary admission. This usually occurs in three steps.

Steps in Involuntary Admission	
Step	Description
Application	Application is step one. The individual responsible for application for involuntary admission procedures varies from state to state. It can be a spouse, relative, physician(s), or in some cases a guardian or public official, such as a judge.
Examination	Examination is step two. The statutes that define involuntary admission specify the time limit within which an examination must be performed. They also list the qualifications required of the examining physician. The determination of required hospitalization may be done by a court, tribunal, or a group of physicians. This is determined by each state.
Detention in the hospital	Detention in the hospital is the third and final step in the involuntary admission process.

Temporary involuntary

Temporary involuntary admission is usually done for observation, diagnosis, or short-term treatment. It's *not* the same as an emergency admission. Instead, it's for a specified period of time, anywhere

from 60 days to 6 months. At the end of the specified period of time, the patient is either released or involuntarily hospitalized.

Formal (court) commitment

Court commitment is a formal judicial hearing where doctors, nurses, psychologists, and social workers who provide care may be asked for testimony. Any non-active duty patient may force a court hearing through *habeas corpus* proceedings, during which the cause of confinement must be clearly shown by those who detain the patient. In addition to the individual rights discussed above, areas related to keeping the patient's family informed, the maintenance of confidentiality, continuous training for staff, and patient work programs are also explained.

Know the local, state, and community laws that deal with the detention of patients. You'll be more comfortable in your interaction with resistive patients when you're sure of your legal stance.

Involuntary admission of active duty personnel

When a military member requires involuntary hospitalization for psychiatric reasons he or she may be ordered into the care of the MTF. This is not to say the military member has no rights. There are stringent procedural guidelines dictating timelines for a review of the appropriateness of the admission. The involuntary admission of active duty or reserve/guard personnel on active duty is governed by AFI 44-109, *Mental Health, Confidentiality, and Military Law*.

Risk evaluation

If the risk for imminent dangerousness cannot be ruled out the member may be admitted for up to 24 hours for observation and to coordinate an opportunity for an evaluation to be conducted.

If the risk for imminent dangerousness can be ascertained and there indeed exists a risk, the member may be admitted for up to 72 hours.

Review of admission

While the member cannot refuse admission, he or she is afforded an independent review prior to the end of the 72-hour period. The commander of the MTF responsible for the involuntary inpatient psychiatric care appoints a medical officer to conduct a review of the admission. The reviewing officer will provide the MTF commander, or if the MTF commander was the referring commander, his/her superior, with a letter detailing the reasons for continued admission or release. If the member who was involuntarily admitted feels his or her admission was inappropriate, the member may seek an investigation by the Inspector General IAW AFI 90-301, *Inspector General Complaints*.

Patient confidentiality

By now you surely have heard this sentence; "I probably should talk to someone, but I don't want it to affect my career". Reducing the stigma of seeking mental health treatment is tough enough without having individuals worrying about how a mental health visit might look on their "record". Keeping a patient's confidentiality is extremely important for developing strong rapport.

Ethical issues regarding confidentiality

The Surgeon General put it best. "Each profession that provides mental health treatment embraces confidentiality as a core ethical principle." While we can all relate that the value of confidentiality is high, we must remember that confidentiality is not an absolute value. The American Medical Association (AMA) released a statement in 1996 proclaiming that confidentiality should be protected "within the restraints of the law".

Federal confidentiality laws

Confidentiality laws applicable to health care professionals working with mental health or substance abuse clients differ depending on whether they are state or federal laws. Currently, there is no national standard of confidentiality for health care or mental health information in general. Each state

establishes its own laws to determine confidentiality rules and exceptions. Stricter confidentiality laws were created to help protect substance abusers who seek treatment without risk of being prosecuted. You might see something similar if someone underage self-refers to your ADAPT clinic. Although the crime of drinking underage may have been committed, your first priority is to determine whether or not the person had an issue with substances—not to try to prosecute them.

A few states apply and enforce a general law for all health care information. In other states, the mental health confidentiality statute applies only to information gathered when a state facility provides treatment. Others consider any mental health treatment confidential. The laws get even murkier when mental health information is disseminated to a third party.

Exceptions to Confidentiality

Most experts state the best way to “break” confidentiality is to ensure that the client is completely aware of what the health care provider is trying to do. As you can see in the following table, there are times when state laws allow a variety of disclosures without the client’s consent.

Exceptions To Confidentiality	
Type	Description
Disclosure to third party collections	Many states mental health confidentiality laws permit disclosure of otherwise confidential information as necessary to obtain reimbursement or other financial assistance for the person in treatment. Most of these statutes were written before the emergence of managed care and third-party utilization review. Therefore, most state laws that create this exception to confidentiality impose few, if any, limitations on the type or amount of information that can be disclosed to obtain reimbursement, and most do not explicitly require consent prior to disclosure.
Disclosure of information to families	An issue of some controversy in mental health is whether families should be provided information regarding their adult child in certain circumstances. As a general rule, parents or the legal guardian of a minor child are provided access to information until the child attains either the age of majority or the age at which state law permits the child to make his or her own treatment decisions.
Disclosure to law enforcement agencies	<p>Many state laws limit law enforcement officials access to information concerning people with mental illness to situations in which a hospitalized individual has left the hospital and not returned, or to situations in which a crime has been committed on the grounds of a treatment facility. A handful of state laws provide access for the purpose of investigating health care fraud.</p> <p>In contrast, most of the reform proposals designed to create a national standard provide comparatively broad access by law enforcement officials. Others would limit discovery to situations in which law enforcement could demonstrate, usually by clear and convincing evidence, that disclosure is necessary.</p> <p>The idea of information being disclosed to law enforcement agencies is a controversial issue.</p>
Disclosure to protect third parties	<p>In 1976, the California Supreme Court ruled that a mental health professional has an obligation to take steps to protect identified third parties whom the professional reasonably believes might be endangered by a client (<i>Tarasoff v. Regents</i>, 1976). A number of groups, including the American Psychiatric Association and the American Psychological Association, criticized the decision on the grounds that it required mental health professionals to perform a task for which they were ill-suited (that is, assess future risk) and that it would compromise confidentiality. Since the court’s decision, many states, either through statute or judicial decision, have addressed this topic.</p> <p>The majority of states that have done so through statute provide that a mental health professional who concludes that his or her client represents an imminent danger to an identified third party may take steps, including notifying the individual or law enforcement officials, to protect the third party without becoming liable for a breach of confidentiality. These states also typically provide that the clinician will not be liable if he or she decides not to act—rather, the statutes give the clinician discretion in deciding how to proceed.</p>

There are many reasons why an individual with a mental illness may decide *not* to get treatment. The reasons might be financial (a civilian having to miss work) or they may not want to face the stigma of going to see mental health. In the attempt to reduce the stigma, confidentiality is an important matter with both ethical and legal concerns.

Patient rights

The law protects a patient's privacy to the extent that violations involving irresponsible actions on the part of mental health personnel are the cause of serious legal problems. You have a fundamental right not only to protect patients' rights but also to educate and inform them of the rights they may have. A patient has many legal rights. For the most part, these rights are an extension of the rights of an ordinary citizen. However, due to the somewhat submissive position patients place themselves in when they enter the hospital, they become subject to conditions that are ordinarily considered a violation of their rights.

The United States Congress, and the Joint Commission (formerly, Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), have both spelled out some very specific rights regarding mental health patients. These rights are guidelines for MTFs to follow when establishing and providing health care to mentally ill patients.

Congress

In 1980 Congress passed the Mental Health Systems Act. This act primarily protects patients in mental health facilities and provides a launching platform for states developing or revising patient rights statutes. Unfortunately, budget restrictions negated funding for most of the provisions dealing with protection and advocacy. Within this act, however, a Bill of Rights remained intact and is being followed in varying degrees by many states.

The Joint Commission patient's bill of rights

As pressure built to recognize patient rights, other organizations began to develop their own criterion. One such organization was the Joint Commission. The Joint Commission is the organization that provides accreditation for all aspects of medical care nationwide including USAF MTFs. The Joint Commission's list of Individual Rights is periodically updated and you will be inspected on these items when your unit's accreditation is initiated, reviewed, or renewed. Review each and ask if you, as part of the clinic team, are meeting the element of performance and can you produce evidence of meeting the standard. Please review the *Comprehensive Accreditation Manual for Behavioral Health Care*, focusing on the elements of performance to ensure you are meeting the requirements.

Joint Commission Patient's Individual Rights	
The organization respects the rights of clients.	The organization addresses the resolution of complaints from clients and their families.
Clients receive information about their rights.	The organization respects the needs of clients for confidentiality, privacy, and security.
Clients are involved in decisions about care, treatment, and services provided.	Clients have a right to an environment that preserves dignity and contributes to a positive self-image.
Informed consent is obtained.	Clients have the right to be free from mental, physical, sexual, and verbal abuse, neglect and exploitation.
Consent is obtained for recordings or filming made for purposes other than the identification, diagnosis, or treatment of the clients.	Clients have the right to pain management.
Clients receive adequate information about the person(s) responsible for the delivery of their care, treatment, and services	Clients have a right to access protective and advocacy services.
Clients have the right to refuse care, treatment, and services in accordance with law and regulation.	The organization protects research subjects and respects their rights during research, investigation, and clinical trials involving human subjects. Applicable to organizations participating in research.

Joint Commission Patient's Individual Rights	
Clients and, when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes.	In organizations that provide opportunities for work, a defined policy addresses situations in which clients work.
The organization respects the client's right to and need for effective communication.	Clients have a right to exercise citizenship privileges.

Legal vs. ethical

Not all the rights listed here are legal rights—that is, they are not enforceable under the law. However, all of these rights do come under the ethical codes of conduct that all medical personnel follow. Without these ethics and patients' rights, medical care will become depersonalized and mechanical. Your patients will be the victims rather than the recipients of good professional care. Without any ethical controls, unscrupulous medical personnel are free to experiment and mistreat patients.

In summary, there's another important factor to remember: illness is a frightening and undesirable state for most patients, and their behaviors and attitudes are very much modified by their state of illness or well-being. Knowledge about therapeutics, no matter the depth, is useless unless it can be translated into specific health-seeking services for those patients in need of your help.

Patient obligations

Shouldn't your client expect to notice some alleviation from his or her original presenting symptoms? The answer is yes, BUT, it requires work on the client's part as well. Your client has an obligation to assist in his or her own recovery or wellness. When you enter into a contract, there are expectations that both parties will fulfill their obligation. Treatment is no different. Despite all your efforts, guidance, suggestions and hours spent formulating treatment plans, the client is doomed to failure unless he or she is a vested stakeholder in the outcome. This involves the client assuming responsibility for his or her care. Understanding this complementary relationship between provider and client will save you countless hours of worry and eventual burnout due to self flagellation.

007. Joint Commission and inspections

In the previous lesson, you learned about the Joint Commission's Patient Bill of Rights. Now we'll take a brief look at the Joint Commission in general and how you interact with it in a clinical setting. Joint Commission accreditation is recognized nationwide as a "seal of approval" which indicates a facility meets certain performance standards. The Joint Commission helps facilities improve their performance and patient outcomes as well as demonstrate accountability in managed care and the rapidly changing health care marketplace. We will also look at the process the commission uses to determine if a hospital is worthy of accreditation.

The Joint Commission evaluates all aspects of health care services provided by an organization against the applicable standards. The evaluation results in an accreditation decision and survey report. The survey is shaped to reflect the services offered by the facility. The Joint Commission has standards for and conducts surveys for the following organizations:

- Hospitals.
- Health care networks.
- Home care organizations.
- Long-term care organizations.
- Ambulatory care organizations.
- Pathology and clinical laboratory services.
- Behavioral health care organizations, including community mental health centers, freestanding chemical dependency care providers, and organizations that serve persons with mental retardation or other developmental disabilities.

Once again, the cliché of “if it isn’t documented it didn’t happen” is particularly applicable. You must be prepared to provide evidence of compliance with each applicable standard.

You may be wondering what the Joint Commission could possibly expect from a 4C051. You have an important role in the success of the survey the Joint Commission conducts. Is the Joint Commission interested in talking to the Commander, Chief Nurse, or Hospital Administrator?. No, they want to talk with you. Their concern is with such questions as: How are you actually conducting your daily operations? How is patient care occurring at the basic levels of care? No one else knows this better than you. This is why it is important to educate yourself about the Joint Commission compliance standards behavioral health and how they apply to you.

Joint Commission definition of standards

During an accreditation survey, the Joint Commission evaluates an organization’s performance of functions and processes aimed at continuously improving patient outcomes. This evaluation is based on a set of standards developed by the Joint Commission. According to the Joint Commission, a “standard” is defined as: “A statement of expectation concerning a degree or level of requirement, excellence, or attainment in quality of performance.” A standard may be used as a criterion or acknowledged measure of comparison for quantitative or qualitative value.

Survey process

During an accreditation survey, the Joint Commission evaluates an organization’s performance of functions and processes aimed at continuously improving patient outcomes. The survey process begins when the organization applies for an accreditation survey or is due for its triennial survey. Much preparation is conducted with the Joint Commission’s liaison prior to the survey personnel arriving at your facility. When the surveyor arrives your role might include orienting the surveyor to your area’s approach to performance improvement. This is your opportunity to showcase your organization’s program to measure, assess, and improve its performance of functions addressed by the standards. The surveyors will interact with every aspect of the organizations population including staff, patients, and community.

At the conclusion of the survey, the team members meet to integrate their findings. This yields a preliminary findings report that has potential impact on the accreditation decision for the organization under review. Upon completion of the survey, the preliminary report forms the basis for an exit conference the survey team members conduct with organizational leadership.

Following the survey, certain on-site findings are reviewed at the Joint Commission central office. Findings that raise specific issues impacting accreditation are reviewed by the Joint Commission’s Accreditation Committee—a committee of the Joint Commission’s Board of Commissioners responsible for accreditation decisions. In such cases, the Joint Commission Accreditation Committee makes a final accreditation decision.

Preparing for facility inspections

The Air Force Inspection Agency conducts health services inspections (HSI) to provide Air Force leaders with independent assessments to improve the readiness, discipline, and efficiency of their unit. The HSI ensures compliance with laws, directives, and standards of practice by examining processes and outcomes. They also assist staff when needed. Specifically, these inspections have the following functions.

- Evaluate the preparedness of active duty and reserve component medical units to fulfill their readiness mission
- Provide an objective appraisal of management and make recommendations for improvement to commanders and higher headquarters
- Identify instances of fraud, waste, and abuse
- Evaluate the effectiveness and efficiency with which health care resources are managed

You should always be ready for an inspection. However, realistically, most units will need to “ramp up” before an HSI or Joint Commission inspection. Not to worry, you will know about a forthcoming inspection well ahead of time and be provided with either a checklist or guidelines to use in preparation. Facility inspections are conducted approximately every 3 years according to AFI 90-201, *Inspector General Activities*.

Documents used to prepare for facility inspections

A variety of documents can provide guidance as you prepare for an inspection:

Preparation Documents for Facility Inspections	
Document	Description
Health Services Assessment Guide	The Health Services Assessment Guide or HSI Guide is designed as a tool for inspectors to use while performing inspections. Still, you will find this document useful to prepare for your inspection as it does focus on common problem areas.
Joint Commission Manual	A Joint Commission Manual contains hospital standards, intent statements, and accreditation policies and procedures. You will want to compare your processes and procedures to these established standards.
Air Force directives and policy letters	Of course, an HSI checks for compliance with all directives that apply to your operations. Refer to and maintain Air Force directives and policy letters to be sure you are in compliance—odds are your inspector will.
Documents from previous inspections	You will use documents from previous inspections to check on your status. Reports from other bases are also very helpful, especially if they are recent. Some sources include. <ul style="list-style-type: none"> • IG - (HSI quarterly newsletter published by AFIA/SG). • Staff assistance reports. • Joint Commission surveys.

Other sources to draw from are articles in *Medical Service Digest*, articles in *TIG Briefs*, *Mental Health Services Operating Instructions*, and commander’s newsletters. Also, do not forget your own self-inspection program. Use all of these tools to prepare and you will ensure that you have a program that meets or exceeds the mission.

So the long awaited day arrives and the inspection begins. Here are some procedural steps that you may need to accomplish.

1. Conduct an in-briefing for the team.
2. Introduce your key personnel.
3. Familiarize the team with the facility.
4. Make yourself available to the inspectors but don’t follow them around.
5. Expect executive feedback conferences to be conducted every morning of the inspection period.

Final report

The final report from the inspection team includes a Composite Facility Score and a Field Memorandum Report. These items identify your organizational strengths and any areas needing improvement. The basic tenet for the HSI scoring process is based on the unit goal of meeting mission requirements. Each of your key processes or elements receives a score. The following table explains the elements scored:

Element	Definition
Criteria met	Identified deficiencies were minor, primarily administrative in nature and unlikely to compromise either mission support or patient care.
Some, but not all, criteria were met	Program outcomes may be adversely affected.
Few criteria were met	Adverse mission impact was expected to occur.
There was noncompliance with standards	The medical unit failed to meet the minimum provisions of the elements.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

005. Legal responsibilities in patient care

1. Describe a civil tort liability.

2. Define assault.

3. Define the two types of defamation of character.

4. What are some examples of negligence that can occur in a patient setting?

5. Who is responsible for diagnosing disorders or ordering treatment?

6. What medical care is a minor allowed to consent for treatment?

006. State laws and patient rights

1. Describe the conditions under which an involuntary admission usually occurs.

2. When an active duty member is involuntarily admitted, what is the time period for an independent review?

3. What did the Surgeon General say concerning ethical issues concerning confidentiality?

4. What organization besides Congress has spelled out very specific patients rights?

5. What can occur in the medical community without ethical controls?

007. Joint Commission and inspections

1. Joint Commission is most interested in speaking to whom during an inspection?
2. What is the definition of a Joint Commission standard?
3. What does the Joint Commission team do at the conclusion of their inspection?
4. Who makes the final decision regarding Joint Commission accreditation?
5. What are the specific functions of the HSI?
6. What is the basic tenet of the HSI scoring process?

Answers to Self-Test Questions**001**

1. Morality—personal belief system derived from family, school, religion, environment.
2. Professional ethics—commonly held (and written down) values that guide professional behavior.
3. Autonomy, beneficence, nonmaleficence, justice, confidentiality.

002

1. Generally, anytime there is a differential in power between the staff and the patient it is unacceptable.
2. Sexual activities with patients are unethical.

003

1. It is created by his or her interactions with members of the health care team.
2. (1) Communication requires a sender, a message, and a receiver.
(2) Channels of communication are verbal, nonverbal, or written.
(3) The goal is to obtain information, inform, explore problems, or release tension.
(4) The degree of effectiveness is determined by the setting and attitudes of those involved in the communication process.
(5) Know what you're going to say and say what you mean.

004

1. Your behavior towards the patient, co-workers, and professional staff.
2. An active process, a series of positive behaviors that convey respect for the patient as an individual.
3. Paraphrase the words back to the patient for clarification.

005

1. Civil tort liability involves a civil wrong that injures a person, or property of another person. This liability involves a personal lawsuit and money damages.
2. Assault is a threat of physical harm that creates a fear of imminent bodily injury or an apprehension or unwanted touching.
3. Libel is generally written or printed defamation. Slander is when someone says something false about you.
4. Failure to inform, failure to consult, causation, damages.
5. Diagnosing disorders and ordering treatment is the responsibility of a credentialed health care provider or physician, not a mental health technician.
6. Minors are permitted to consent to treatment for certain categories of care (e.g. pregnancy, birth control counseling (not in all states), venereal disease, drug and alcohol abuse, and medical emergencies).

006

1. Involuntary admission usually occurs when the patients are too ill to recognize the illness or when they can't act on their own behalf to protect their interests.
2. 72 hours.
3. Each profession that provides mental health treatment embraces confidentiality as a core ethical principle.
4. The Joint Commission.
5. Without any ethical controls, unscrupulous medical personnel are free to experiment and mistreat patients.

007

1. They want to talk with you.
2. A statement of expectation concerning a degree or level of requirement, excellence, or attainment in quality of performance.
3. Integrate their findings and produce a preliminary report of these findings and the potential impact on the organizations accreditation decision.
4. Joint Commission Accreditation Committee
5. Evaluate the preparedness of active duty and reserve component medical units to fulfill their readiness mission; Provide an objective appraisal of management and make recommendations for improvement to commanders and higher headquarters; Identify instances of fraud, waste, and abuse; Evaluate the effectiveness and efficiency with which health care resources are managed.
6. The basic tenet for the HSI scoring process is based on the unit goal of meeting mission requirements.

Do the unit review exercises before going to the next unit.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter. When you have completed all unit review exercises, transfer your answers to ECI (AFIADL) Form 34, Field Scoring Answer Sheet.

Do not return your answer sheet to the Extension Course Program (A4L).

1. (001) Which area is *not* a basic ethical foundation of trust you must exercise as a mental health technician?
 - a. Respect.
 - b. Autonomy.
 - c. Beneficence.
 - d. Nonmaleficence.
2. (001) Which ethical behavior is closely related to respecting the patient's dignity?
 - a. Professional relationships.
 - b. Individual care.
 - c. Role modeling.
 - d. Competence.
3. (002) Which aspect of *doing all of your duty* is considered extremely important?
 - a. Sensitivity.
 - b. Observant.
 - c. Reliability.
 - d. Confidence.
4. (002) Who is held accountable if a journeyman engages in an *inappropriate relationship* with a patient?
 - a. Patient.
 - b. Technician.
 - c. Licensed provider.
 - d. Noncommissioned officer in charge.
5. (003) If you touch a patient *unnecessarily* you are *violating*
 - a. physical privacy.
 - b. personal privacy.
 - c. the Hippocratic oath.
 - d. the mental health technician code of ethics.
6. (003) Which of the following is *not an example* of *effective communication*?
 - a. Being conscious of nonverbal signs.
 - b. Looking people in their eyes.
 - c. Being sympathetic.
 - d. Being empathetic.
7. (004) Which of the following is *not an example* of *retaliation towards a patient*?
 - a. Reducing the patient to a diagnosis.
 - b. Laughing at a patient's fears.
 - c. Withholding medication.
 - d. Avoiding patients.

8. (004) Which attribute allows the patient to gain a feeling of security by being able to predict your behavior?
 - a. Attitude.
 - b. Acceptance.
 - c. Consistency.
 - d. Show interest.
9. (005) Which legal liability is considered *non-punitive*?
 - a. Administrative.
 - b. Criminal.
 - c. Civil tort.
 - d. General.
10. (005) Which liability protects the accountability of the patient and the Air Force?
 - a. Legal.
 - b. Criminal.
 - c. Administrative.
 - d. Civil tort.
11. (005) Which of these is *not* considered an *intentional tort*?
 - a. False imprisonment.
 - b. Misrepresentation.
 - c. Negligence.
 - d. Assault.
12. (005) A *constitutional tort* is a violation of
 - a. a spouse's civil rights by her husband.
 - b. a patient's civil rights by a civilian provider.
 - c. an employee's civil rights by his or her employer.
 - d. a patient's civil rights by a government employee.
13. (006) What type of patient admission reduces unfavorable reactions and is the *most desirable*?
 - a. Voluntary.
 - b. Emergency.
 - c. Involuntary.
 - d. Temporary involuntary.
14. (006) What act passed by Congress in 1980 created a Mental Health Bill of Rights?
 - a. Mental Health Systems Act.
 - b. Mental Health Privacy Act.
 - c. Mental Health Services Act.
 - d. Mental Health Confidentiality Act.
15. (006) What organization has very specific patient's rights guidelines that all military and civilian medical or treatment facilities *must* adhere to?
 - a. Occupational, Safety and Health Administration.
 - b. American Psychological Association.
 - c. Health Services Inspection.
 - d. Joint Commission.
16. (007) Accreditation findings that raise specific issues are *reviewed by* the
 - a. Joint commission's accreditation committee.
 - b. Joint commission's board of commissioners.
 - c. Joint commission's board of accreditation.
 - d. Hospital commander.

17. (007) Who conducts Health Services Inspections?
- a. Emergency Evaluation Team.
 - b. Air Force Inspection Agency.
 - c. Hospital Services Inspection Team.
 - d. Air Force Medical Treatment Facility Team.
18. (007) Which of these is *not* used to prepare for health services inspections?
- a. Joint commission manual.
 - b. Health services questionnaire.
 - c. Documents from previous inspections.
 - d. Air Force directives and policy letters.

Student Notes

Unit 2. Safety and Health Measures

2-1. Aseptic Measures	2-1
008. Infection control precautions and procedures.....	2-1
009. Medical asepsis techniques.....	2-10
010. Identify structure and function of the neurological body system.....	2-12
2-2. Making the Mental Health Environment Safe	2-14
011. Risks and Safety Procedures.....	2-14
012. Reporting accidents, incidents, and hazards.....	2-19
2-3. Crisis Management, Restrictive and Protective Measures	2-20
013. Crisis management.....	2-21
014. Restrictive measures.....	2-23
015. Seclusion measures.....	2-25
016. Physical response techniques for protection.....	2-26
017. Control and transport holds.....	2-35
018. Identify chemical/psychopharmacological restraints.....	2-40

AS A mental health journeyman your work is not confined to a desk. You may be assigned to inpatient units or substance abuse treatment units with patients who, in addition to psychological illnesses, may be stricken with a physiological illness or disease as well. Your expertise may require you to conduct interviews, counseling, or crisis intervention on medical units, emergency rooms, or to a deployed location.

2-1. Aseptic Measures

In this section we discuss various infection control methods and special procedures carried out in the Air Force medical treatment facilities (MTF) to stop or control infections from spreading. The lessons in this section also include guidelines for you as you conduct your daily routine.

008. Infection control precautions and procedures

Eliminating and controlling the spread of infection in health care facilities is one of greatest health challenges. Whether in an outpatient mental health clinic or an inpatient mental health unit you will be interacting with people who have or who are potential candidates for infections. Your responsibility is not only to ensure a clean noninfectious environment in which to provide the best possible care for your patients, but it is also equally important to protect yourself and coworkers from exposure to infectious conditions which could render you unable to provide care. You must do everything you can to prevent nosocomial infections. In order to do this you must know and use the precautionary measures that prevent the spread of these infections.

Before we begin, let's take a look at the key terms chart. The chart defines frequently used terms you will encounter throughout this lesson. Be sure that you understand any terms you are not already familiar with.

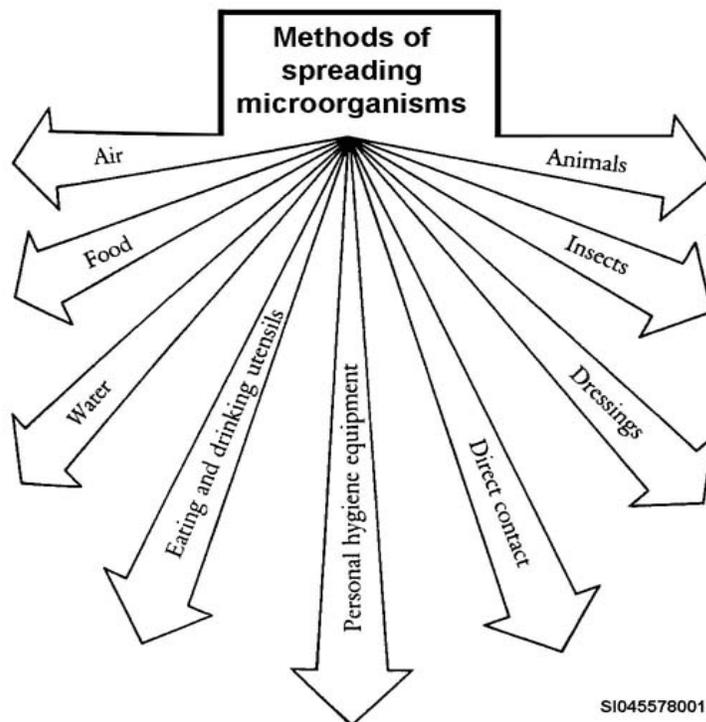
Infection Control Key Terms	
Asepsis	Absence of germs or microorganisms.
Contamination	The process by which an object or area becomes unclean or unsterile.
Infection	A disease state that results from invasion and growth of microorganisms in the body.
Isolation techniques	The practice that limits the spread of pathogens by setting up barriers that prevent the escape of the pathogen.

Infection Control Key Terms	
Microorganism	A small, living plant or animal that cannot be seen without the aid of a microscope; a microbe.
Nosocomial	Originating in a hospital.
Pathogens	A microorganism that is harmful and capable of causing an infection.
Sterile	The absence of all microorganisms both pathogenic and nonpathogenic.
Virus	An extremely small microscopic organism that grows in living cells.

Motivated by the spread of the Human Immunodeficiency Virus (HIV) which eventually leads to Acquired Immunodeficiency Syndromes (AIDS), the Centers for Disease Control (CDC) issued universal precautions to be used by all health care workers in all health care facilities. Universal precautions were developed in 1985 as a means to prevent both health care workers and patients from spreading HIV/AIDS. HIV is spread through contact with the infected person's blood. HIV, hepatitis B, and other blood infections are sometimes undiagnosed. In 1987 another preventative measure called body substance isolation (BSI) was introduced. BSI is the practice of isolating all body substances (blood, urine, feces, tears, etc.) of individuals undergoing medical treatment, particularly emergency medical treatment. Its purpose is to reduce as much as possible the chances of transmitting illness by those who might be infected with HIV or hepatitis. While BSI is similar to universal precautions, it goes further by isolating substances *not currently known* to carry HIV.

As a mental health journeyman, the chances of you having to insert needles in a patient or draw blood for laboratory workups are unlikely. However, there are many situations in which you could become exposed to a patient's blood or body fluid. For example, the patient's clothes or linen could become soiled with blood, body fluid, etc. A patient can be nicked when shaving or participating in physical training. There may also be blood in urine, feces, vomit, or respiratory or vaginal secretions.

Disease and infectious contamination are spread through a variety of venues and are constantly seeking a host. Figure 2-1 provides an example of the many methods of spreading microorganisms.



SI045578001

Figure 2-1. Hosts for the process of infection.

Standard precautions

Standard precautions represent a system of barrier precautions recommended by the CDC and implemented universally throughout the Air Force. It is to be used by all personnel when in contact with blood, all body fluids, secretions, excretions, non-intact skin, and mucous membranes. These standard precautions apply to ALL patients regardless of diagnosis. AFI 44-108, *Infection Control Program*, implements the program and provides additional information for all personnel.

General rules and procedures

Standard precautions are considered the “standard of care” and combine the concepts of “universal precautions” and “body substance isolation”. The primary focus of standard precautions is on reducing the risk of microorganism transmission. This is achieved by using barriers that vary with the level of potential contact with body substances. Maintaining an infection-free environment is very difficult and may require using many different techniques. While the techniques or polices used by your MTF may differ from those we discuss in this unit, the goal is the same.

All medical facilities have an Infection Control Committee (ICC). Among the many responsibilities the committee has are collecting data on all infections acquired within the facility, investigating the causes of any breakout of infections in the facility, and, most important of all, educating all personnel of current concepts in prevention and infection control. You should support medical facility ICC actions by actively employing its infection control procedures and recommendations.

Many pathogenic microorganisms are present in the hospital and surgical environment. To better understand infection control activities in the operating room and central supply, you should be familiar with some of the more common “bugs” that cause infections and disease. The following table(s) list some common pathogens and the diseases or infections they are associated with.

Microorganism	Commonly Found In (On)	Infection or Disease
1. Staphylococci (non-spore-forming bacteria) Staphylococcus aureus	Skin Hair Respiratory tract Urinary tract	Wound infection Boils (skin infections) Pneumonia Urinary tract infection Enterocolitis Septicemia
2. Streptococci (non-spore-forming bacteria) Streptococcus pyogenes	Nose Nasopharynx	Wound infection Cellulitis Urinary tract infection
Streptococcus pneumoniae (pneumococci)	Nose Nasopharynx Oropharynx	Lobar pneumonia Sinusitis Parotitis Conjunctivitis Peritonitis
Streptococcus viridans	Upper respiratory tract Intestinal tract	Localized gum/mouth sores abdominal abscess pulmonary abscess

Microorganism	Commonly Found In (On)	Infection or Disease
3. Neisseria (non-spore-forming bacteria) Neisseria catarrhalis Neisseria sicca Neisseria gonorrhoeae (gonococci) Neisseria meningitides (meningococci)	Nasopharynx	Respiratory infection
	Respiratory tract	Kidney infection
	Genitourinary tract Rectum Mouth Eye	Gonorrhea Gonorrheal vulvovaginitis Pelvic inflammatory disease Conjunctivitis
	Nose Oropharynx	Meningitis Pneumonia
4. Enteric (coliform) (non-spore-forming bacteria) Salmonella typhosa Shigella sonnei Salmonella (others) Escherichia coli Proteus vulgaris Pseudomonas aeruginosa	Intestinal tract	Typhoid fever Dysentery Enteric fever Gastroenteritis Septicemia
	Large intestine Perineum	Peritonitis
	Intestinal tract	Cystitis
	Soil Skin Intestinal tract	Wound infection Urinary tract infection Burn infection
5. Clostridium (spore-forming bacteria) Clostridium tetani Clostridium perfringens Clostridium novyi Clostridium histolyticum Clostridium septicum Clostridium botulinum	Soil Dust Feces	Tetanus (Lockjaw) Surgical tetanus
	Soil	Gas gangrene
	Dust	Food poisoning
	Manure	Uterine infection
	Feces (human)	Gastrointestinal infection
	Vagina	Genito-urinary infection Biliary infection
	Respiratory tract Urine Lymph nodes	Tuberculosis Peritonitis Meningitis Infection of almost any tissue, including: skin, bones, kidney, lymph nodes, and fallopian tubes
6. Mycobacterium tuberculosis (non-spore-forming bacteria)		
7. Candida albicans (fungi)	Respiratory tract Gastrointestinal tract Genital tract (female)	Thrush Skin infection Respiratory tract infection Vaginitis Endocarditis (rare)

Microorganism	Commonly Found In (On)	Infection or Disease
8. Viruses Hepatitis A	Blood and urine from infected persons Sewage/contaminated water Contaminated shellfish Food handled by infected person practicing poor hygiene	Infectious hepatitis
Hepatitis B	Blood Saliva Other body fluids Feces	Serum hepatitis
Hepatitis C	Blood Blood products	Non-A, non-B, transfusion associated hepatitis
Hepatitis D	Co-exists with Hepatitis B in some patients	Superinfects liver, leads to necrotizing liver disease and death.
Herpes virus	Lesions and body fluids of infected patients	Localized eruptions on borders of lips, in mouth, in nose (cold sores) Localized eruptions on genitalia or anal region Conjunctivitis Meningoencephalitis
Human Immunodeficiency virus (HIV)	Blood Semen Other body fluids	Acquired Immunodeficiency Syndrome (AIDS)

Pyogenic bacteria

The bacteria that causes wound infections is called pyogens. These bacteria cause wound inflammation leading to pus-forming (suppurative) infections. If the bacterial growth is not stopped at the wound or entry site, the infection can spread to the blood stream and then to other parts of the body. Pyogenic bacteria include most coccal (sphere-shaped) bacteria, and the enteric, or coliform, bacteria.

Staphylococci

This group of bacteria is responsible for a variety of infections. Commonly called “staph” infections, they are the most common type of postoperative wound infections. They range from relatively simple skin and mucous membrane inflammation, to more serious diseases such as pneumonia, septicemia, meningitis, or osteomyelitis. Many staphylococcal wound infections start as localized abscesses and pustules. Spread via the vascular system, they cause serious infections of the lungs (pneumonia), urinary tract, nerve tissue (meningitis), and bones (osteomyelitis). They are non-spore-forming, facultative anaerobes (they grow with or without oxygen), and are commonly found on the surface of the skin and mucous membranes of the nose and throat. Two types of staphylococci are usually associated with surgical wound infections—*Staphylococcus aureus* and *Staphylococcus epidermidis*.

Streptococci

These microorganisms cause such diseases as septic sore throat (“strep” throat), scarlet fever, impetigo, bacterial endocarditis, rheumatic fever, neonatal meningitis, and pulmonary infections such

as lobar pneumonia. These infections often appear as watery, blood-stained abscesses. “Strep” infections are often more harmful than staphylococci because the streptococcal bacteria usually cause widespread tissue damage without localized infection. Like staphylococci, most streptococci are non-spore-forming, facultative anaerobes. Three types of streptococci are of particular concern to MTF personnel because of their ability to cause severe infections and diseases:—the *Streptococcus pyogenes* group, *Streptococcus viridans* group, and *Streptococcus pneumoniae* (diplococci or pneumococci).

Streptococci are spread via direct contact or by inhalation of air containing bacterially contaminated moisture droplets and dust. Since many strains of streptococci are carried in the upper respiratory tract, they are easily transmitted when an infected person sneezes, coughs, talks, or laughs. Streptococcal bacteria spread is prevented by using strict aseptic technique.

Gonococci (Neisseria gonorrhoeae)

Gonococcal (*Neisseria gonorrhoeae*) microorganisms cause the sexually transmitted disease gonorrhea by invading the mucous membranes of the genitourinary tract. Gonococci also cause conjunctivitis of the eyes when transferred from the perineum. Long-term gonococcal infection spreads to the reproductive system and causes sterility. When gonococci enter the circulatory system, severe septicemia may result. *Neisseria gonorrhoeae* may also infect the eyes of newborn infants during passage through the birth canal; if untreated, it can result in permanent blindness. Gonorrhea is usually transmitted by direct sexual contact, but may be transmitted by contact with bedding, clothing, and other contaminated items. Control of this disease is accomplished through stringent sanitation methods and drug therapy for infected persons.

Meningococci (Neisseria meningitidis)

Meningococci are normally found in the nasopharynx, but may cause meningitis in people who are susceptible to the disease. It may be fatal, particularly when the patient is a child. It is transmitted primarily through droplet inhalation or from direct contact with the source. Meningitis can cause an epidemic when many people are crowded together in confined spaces.

Enteric (coliform) bacilli

Enteric bacilli are non-spore-forming, facultative anaerobes normally found in the intestinal tracts of humans and animals. Normally, enteric bacilli are harmless—as long as they remain in their normal habitat. When introduced into other areas of the body, they can cause severe suppurative infections. For example, when an inflamed appendix ruptures, fecal material containing enteric bacilli is introduced into the abdominal cavity; these bacilli can cause severe peritonitis. Enteric bacilli that migrate from the perineal region are a common cause of urinary tract infections. Three of the more common types of enteric bacilli are *Escherichia coli* (*E. coli*), *Proteus mirabilis*, and *Proteus vulgaris*. *Escherichia coli* is by far the most common enteric bacillus found in the intestinal tract. *Proteus mirabilis* and *P. vulgaris* are primarily found free-living in water, soil, and sewage, but are also frequently found in fecal specimens from healthy individuals.

Another enteric bacilli is *Pseudomonas aeruginosa*. This aerobic bacteria is commonly found in soil, water, sewage, and air. Occasionally, it is also found on the skin or in the intestinal tract. It was once thought to be nonpathogenic, but is now considered a pathogen—especially when introduced into an area with no normal defenses. *Pseudomonas* is often present in mixed bacteriological infections, and also attacks the tissues of debilitated persons (particularly burn victims).

Spirochetes

The most significant spiral shaped bacilli, or spirochete, is *Treponema pallidum*. This microorganism causes another common sexually transmitted disease—syphilis. *Treponema pallidum* is an anaerobic spirochete that is transmitted through intimate contact, usually sexual. Syphilis may also be transmitted indirectly by contact with contaminated articles such as drinking cups and towels. However, indirect transmittal can occur only when the time frame between the object’s contamination

and the contact with a carrier is very short. Any item used by, or coming in contact with, a person with open infected lesions is considered highly contagious.

Treponema pallidum enters the skin or mucous membranes through breaks in the tissue. Initially, the spirochetes remain at the infection site and cause a sore (chancre) to form. This stage of the infection is called primary syphilis and may last from 1 to 5 weeks. Within 2 to 12 weeks after the primary chancre heals, a generalized skin rash usually appears. This stage of the disease is referred to as secondary syphilis. The third and final stage of the disease is known as *tertiary syphilis*. This late stage is characterized by infection of numerous organs and tissues including skin, bones, joints, cardiovascular system, and the central nervous system. If left untreated, syphilis is eventually fatal.

Anaerobic bacteria

The anaerobic (grow without oxygen) bacteria most commonly encountered are the Clostridia. Clostridia are spore-forming bacilli—the most difficult type to destroy. Fortunately, most spore-forming bacteria are nonpathogenic, but some strains of Clostridia produce potent toxins and are pathogenic. Clostridia are always present in soil and in the intestinal tracts of humans and animals; they help decompose organic matter. When introduced into a surgical wound however, severe infections develop. Two types of Clostridia that cause severe wound infections are *Clostridium tetani* and *Clostridium perfringens (welchii)*.

Clostridium tetani

When introduced into a wound, *Clostridium tetani* causes the disease known as tetanus or “lockjaw.” This disease follows the introduction of tetanus spores (from soil or feces) into puncture wounds, burns, surgical sutures, or traumatic injuries. If anaerobic conditions exist in the wound, *Clostridium tetani* spores return to their vegetative state and begin secreting a powerful toxin. This toxin attacks the tissue of the spinal cord and peripheral motor nerve endings. The damaged nerve tissue causes muscle spasms near the infection site and in the muscles of the neck and jaw; hence the name “lockjaw.” As the disease spreads, the spasms become more widespread and severe, resulting in convulsions and eventual death.

Clostridium perfringens (welchii)

This bacteria causes a severe infection of muscle tissue, commonly referred to as gas gangrene (properly known as clostridial myonecrosis). Gas gangrene may be a complication of severe traumatic injuries. Lacerated wounds exposed to soil and accompanied by a compound bone fracture are particularly susceptible. In this type of injury, the blood supply to the muscle tissue near the injury may be damaged or destroyed, causing tissue necrosis (tissue death). This dead and dying tissue, rich in bacterial nutrients, provides an ideal anaerobic environment for clostridial spores, transferred from the soil, to grow and multiply. As the bacteria multiply, they secrete powerful toxins and enzymes that destroy the surrounding tissue. They also produce gas as the result of metabolizing tissue carbohydrates. Absorption of the gas results in further tissue death, providing continuous nutrition for *Clostridium perfringens* to thrive on. Infections caused by Clostridia are usually mixed infections involving the presence of other types of anaerobic bacteria, not just *Clostridium perfringens* alone.

Mycobacterium tuberculosis

This bacteria is an aerobic, non-spore-forming bacillus (rod-shaped bacteria). It has a wax-like protective coating surrounding the cell which makes tubercle bacilli nearly as hard to destroy as the spore-forming bacteria. *Mycobacterium tuberculosis* is responsible for causing the disease tuberculosis (TB), which can infect virtually every tissue in the body. The bacteria is spread through the lymphatic and vascular systems, and causes dense nodules or tubercles to form in the tissue it infects. Even though most deaths caused by TB stem from infection of the lungs, the tubercle bacillus can cause infections in bone, joints, lymph nodes, spleen, liver, kidneys, and the gastrointestinal tract. This microorganism is transmitted primarily by inhalation of contaminated dust or droplets discharged by an infected person through sneezing, coughing, or kissing. Effective infection control

for TB includes rigid housekeeping, immediate sterilization or disinfection of contaminated items, and strict isolation of individuals with active forms of the disease.

Viruses

Viruses are responsible for many of the most common infectious diseases. Viruses are parasites that attack specific types of living cells. They reproduce by taking over the host cell and causing it to reproduce more viruses. In an infected person viral diseases are caused by the rearrangement or modification of normal cell functions. You may have had, or been immunized against, many viral diseases, often referred to as childhood diseases. Many viral diseases are controlled through immunization programs, but others pose serious health problems for society and are of special concern to hospital personnel. Viruses of most concern in the hospital environment include rhinoviruses, influenza viruses, herpes viruses, hepatitis viruses, and, one of the most notorious viruses of all, HIV which causes AIDS.

Rhinoviruses and influenza viruses

The diseases we call the “common cold” are caused by numerous rhinoviruses. The rhinoviruses primarily attack the respiratory system and can cause severe inflammation of the nose and throat. Young children are particularly susceptible to “colds” caused by these viruses, and pneumonia is always a possible complication.

Influenza viruses affect not only the respiratory system, but can also affect other body systems (particularly the gastrointestinal system). Chills, fever, body and joint aches, swollen glands, and general malaise characterize diseases caused by influenza viruses. Recovery is slower than with rhinoviruses. Because of the body’s weakened state, bacterial pneumonia can easily develop.

Because there are numerous types of rhinoviruses and influenza viruses, it is impossible to develop vaccines to inoculate against all of them. The “flu-shot” you get every year is intended to inoculate you from the influenza strains epidemiologists believe will be most virulent during the season; it does not protect you from all forms of influenza. Surgical patients are particularly susceptible to viral infections because their bodies are already weakened by disease or injury. The additional trauma caused by surgery further weakens their natural defense mechanisms to the point where infection by “cold” or “flu” viruses can cause numerous complications. A simple cold or case of the flu that a healthy person would recover from in a few days can do serious harm to, and potentially kill, a surgical patient.

Besides being highly virulent to patients with weakened immune systems, rhinoviruses and influenza viruses are highly contagious and easily transmitted from person to person. Even when wearing a clean surgical mask, these viruses are easily spread via aerosol droplets that blow through the masks when you sneeze, cough, talk, or laugh. The viruses can find their way into open wounds. Other staff members breathe the contaminated air and become infected. As a result, not only are patients infected, but a mini epidemic results among clinic/inpatient personnel. Overall, patient care suffers because there are fewer healthy staff members to provide direct patient care. Also, those infected personnel who remain on duty perform at less than peak proficiency because they simply do not feel well.

The best way to combat rhinoviruses and influenza viruses is to keep yourself healthy. If you do come down with a cold or the flu, report it to your supervisor so you can go to sick call and be kept away from direct patient care activities. Being a “martyr” and trying to work while you have a viral infection does more harm than good.

Herpes viruses

Many diseases are caused by different strains of herpes viruses including cold sores, chicken pox in children, and shingles (painful nerve disease) in adults. The type of herpes virus we are most concerned with is Herpes virus hominis, the virus that causes cold sores, fever blisters, genital sores, and inflammation of the cornea of the eye (disease conditions collectively known as herpes simplex).

This highly contagious virus is usually transmitted through direct intimate contact with infected persons or contact with virally contaminated items. Transmission of this virus can be effectively controlled by adhering to strict aseptic technique standards and using stringent environmental housekeeping for cases involving patients infected with herpes. Usually, a special effort is made to alert all staff members on an inpatient unit to any patients afflicted with contagious diseases, such as herpes simplex, to ensure all necessary precautions are taken to reduce the risk of cross-contamination.

Hepatitis viruses

The hepatitis viruses specifically attack the liver and cause reactions ranging from slight jaundice with a full recovery to complete destruction of liver tissue resulting in death. We used to believe there were only two types of hepatitis virus, type A and type B. We now know there are many hepatitis viruses, including type C (formerly called non-A, non-B), type D (the delta agent), and type E (enteric). As researchers continue their investigations of viral diseases, other types may be discovered.

Hepatitis types A and E cause symptoms commonly known as infectious hepatitis. This type of hepatitis is usually transmitted by ingestion. Contaminated food, milk, and shellfish infected by sewage-polluted waters are common sources of the A virus. Contaminated water is the primary source of the E virus. Type A and type E hepatitis is found worldwide, and is particularly prevalent in countries with poor sanitation. Symptoms include fever, nausea, gastrointestinal upset, liver enlargement and tenderness, and jaundice. The disease caused by type A usually lasts from 3 to 8 weeks (sometimes longer) and is seldom fatal. Type E hepatitis is not fully understood, but appears particularly lethal for pregnant women. A short-term vaccine is available to protect against Hepatitis A from 3 to 6 months; you may receive it if you are being deployed to a high-risk area.

Hepatitis types B, C, and D, cause diseases commonly known as serum hepatitis; they are transmitted solely by contact with infected blood or body fluids. The symptoms are similar to those of infectious hepatitis, but the disease is more prolonged and more likely to cause permanent damage or death. Type B hepatitis primarily affects young adults in high-risk groups (such as medical personnel); adults generally recover, but the disease is usually fatal in infected newborns. Type D hepatitis is found only in combination with type B; it intensifies the effects of the disease and is the type most likely to result in death. Type C accounts for as much as 90% of hepatitis found in post-transfusion patients.

Serum hepatitis is of special concern to MTF personnel because of the frequent exposure to blood and body fluids, combined with the inherent risks presented by the numerous sharp instruments used in the MTF. Because as little as 0.0001 ml of blood can transmit the infection, even a scratch from an infected instrument can result in the disease. This is why it is imperative for MTF personnel to be immunized with the hepatitis B vaccine (the vaccine also immunizes you against type D). The vaccine is mandatory for all military healthcare workers. The risk of transmission is another reason that you must immediately report to your supervisor all needle sticks or wounds received on duty. You should be tested for hepatitis after any sharp instruments injury or other exposure to blood or body fluids.

Human immunodeficiency virus

One of the most widely publicized, life-threatening, and incurable disease-causing virus is HIV; it is the virus that causes AIDS. This virus poses a serious occupational health risk to medical personnel.

The human immune deficiency virus is transmitted by exposure to infected blood, blood components, or other body fluids—primarily those that contain white blood cells. The virus has been found in blood, semen, vaginal secretions, saliva, tears, breast milk, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, and urine. The virus may be spread by unprotected contact with any of these fluids, but is **NOT** spread by casual contact with an infected person.

The HIV virus may remain dormant for 10 years—maybe even longer—before any symptoms of infection develop. When the HIV virus develops into AIDS, it virtually destroys the body's immune system. This makes the body susceptible to nearly all diseases or pathogenic agents. Death is inevitable and results from complications associated with numerous diseases occurring simultaneously.

All healthcare workers who handle or are exposed to blood and body fluids run a significantly greater risk of being infected than the average person. As a result of this increased risk, the CDC recommends healthcare workers consider all patients as potentially infected with HIV; it also recommends healthcare workers take standard precautions with all patients. The Occupational Safety and Health Administration (OSHA) issued the standard, Occupational Exposure to Bloodborne Pathogens; Final Rule. This standard requires employers and employees at risk of exposure to follow certain rules and wear certain attire.

General rules and practices

The following rules are a guide for giving safe care to the patient requiring infection precautions:

- Floors are contaminated. Therefore any object that is on the floor or that falls to the floor is also contaminated.
- Floor dust is contaminated. Mops used for cleaning floors should be wetted with a disinfect solution. A wet mop keeps dust down.
- Drafts should be prevented. Pathogens are carried in the air by drafts.
- Paper towels are used to handle contaminated equipment and objects. This keeps the hands or gloves clean.
- Contaminated items are bagged before being removed from the room. (Plastic bags are used to bag contaminated items because they prevent leakage and microorganisms cannot penetrate them).
- Do not touch your hair, nose, mouth, eyes or other body parts when caring for a patient in isolation.
- If your hands become contaminated, they must not touch any clean area or object.
- Wash your hands if they become contaminated.
- Place clean items or objects on paper towels.
- Do not shake linen.
- Use paper towels to turn faucets on and off.
- Tell your supervisor if you have any cuts, open skin areas, a sore throat, vomiting, or diarrhea.

If you follow the universal and general precautions presented here you will greatly reduce the chance of getting or spreading an infection. Remember to consider ALL patients as if they were infected.

009. Medical asepsis techniques

Medical asepsis refers to practices used to reduce the number of microorganisms and prevent their spread. Some of these techniques you are familiar with include hand-washing, handling of food and linen, and contaminated items. Many of the infectious illnesses discussed in the previous lesson can be controlled by being aware of your own behaviors and how you may contribute to the spread of an illness. The medical asepsis techniques we discuss here include hand-washing and disinfection procedures.

Hand-washing

It may sound simplistic, but proper hand-washing has historically proven it can and will save lives. Hand-washing is the single, most important means of preventing infections.

Hand Washing	
Type	Description
Hand-washing principles	<p>The following hand-washing principles are the best way to prevent infections. You should wash your hands:</p> <ul style="list-style-type: none"> • When coming on duty. • Before and after any patient contact. • Before and after eating, smoking, or drinking. • After blowing or wiping the nose or coughing into the hands. • After using the toilet. • After any contact with patients body fluids. • When putting on and taking off gloves. • Upon completion of duty.
Steps to hand-washing with liquid or foam soap	<p>Wet hands first with water.</p> <p>Apply an amount sufficient for lather to cover all surfaces of hands and wrists.</p> <p>Rub hands together covering all surfaces of the hands and fingers with special attention to areas around nails and between fingers for a minimum of 15 seconds.</p> <p>Rinse well with running water.</p> <p>Dry thoroughly with paper towel.</p> <p>Use paper towel to turn off faucet.</p> <p>Avoid using hot water; as repeated exposure to hot water may increase risk of dermatitis.</p>
Steps to hand-washing with alcohol gel	<p>Apply to hands that are not visibly soiled.</p> <p>Rub hands vigorously to apply gel to all surfaces of hands, fingers and fingernails, until hands are dry. If hands feel dry after rubbing hands together for 10 to 15 seconds, insufficient volume of gel was applied.</p>

Contaminated hands are a prime cause of cross-infection. That's why it's so important you follow the steps provided to prevent and control further transmission of microorganisms.

Disinfection

When you are working with clients in the mental health clinic or on a mental health unit, items you or the client uses may require cleansing, disinfecting, or re-sterilization. Cleanliness inhibits the growth of most infections; however, disinfection actions destroy the cell proteins disrupting the internal functions of the microorganisms that cause infections. The Air Force has very specific steps that must be followed to accomplish these tasks.

Chemical disinfection

All disinfectants used must have prior approval by the Environmental Protection Agency (EPA) and the local MTF's ICC. You cannot use just any disinfectant sold by your local grocery or hardware store. These are disinfectants used for cleaning floors, walls, and other environmental surfaces. Disinfectant agents fall into two categories: Housekeeping/environmental agents and Immersion agents. Use disinfectant agents for high-level disinfection of instruments that cannot tolerate heat sterilization.

Disinfection steps

1. Prior to any disinfection or sterilization of instruments or equipment, items should be thoroughly cleaned to remove any blood or organic matter.
2. Inanimate objects coming in contact with body fluids receive disinfection and/or sterilization.

3. When cleaning with disinfectants, you must wear the appropriate gloves.
4. Sterility is critical for items that will normally touch sterile tissue (e.g., surgical instruments, or instruments used for a sterile dressing change). Sterilization can be achieved by steam, gas, dry heat, and chemical vapor methods.
5. Sterile items have shelf-life sterility that is event-related (sterility lasts only as long as the package is not torn, dropped, or made wet) and time-related (based on the type of packaging and regulations regarding how long the item may sit on a shelf).
6. Sterile items are to be checked for event-related and time-related factors before use.
7. Disposable items are not reused or reprocessed.
8. Sterile items are **NEVER** mixed with clean items or dirty items.
9. Clean items are **NEVER** mixed with sterile items or dirty items.
10. Dirty items are **NEVER** mixed with clean items or sterile items.

You now have a basic knowledge of several infection control procedures and know the importance of following the infection control principles and practices. In the next lesson we will discuss special procedures a mental health care provider may order you to do. There are specific instructions for performing these procedures that you will need to know and follow to minimize and prevent the spread of infections. So, pay close attention to the information discussed in this next lesson and to any locally developed infection control policies used by your facility.

010. Identify structure and function of the neurological body system

This lesson will identify the major functions of the neurological system. Special significance is placed on the neurological system due to role this system has in relation to all others.

Neurological system

Human anatomy features many major body systems that work in conjunction with each other. No body system is capable of working in isolation. The nervous system controls and coordinates the functioning of all other systems in response to your surroundings. Each stimulus or change in your environment is detected by your senses and messages are interpreted by the brain, which, in turn, sends directions to the various organs to respond and adapt according to the external conditions that affect your body.

Neurological system function

The function of the neurological system is to transmit and receive a constant series of messages carried by electrical impulses to and from the control center located in the brain. These messages are either receiving “information” from various body tissue sensory nerves, or initiating the function of other tissues such as organs, muscles, etc.

The nervous system is divided into two parts: the central nervous system (CNS) and the peripheral nervous system (PNS). The CNS includes the brain and spinal cord; the PNS includes nerves emerging from the brain (cranial nerves) and nerves emerging from the spinal cord (spinal nerves). These nerves are further divided into sensory nerves that conduct messages from various parts of the body to the CNS, while motor nerves conduct impulses from the CNS to muscles and glands. The PNS is further divided into the somatic nervous system (SNS) and autonomic nervous system (ANS), depending on the area of the body these messages are transmitted to and from.

The SNS consists of sensory neurons from the head, body wall, and extremities; and motor neurons to skeletal muscle. The motor responses are under conscious control and, therefore, the SNS is considered voluntary. Certain peripheral nerves perform specialized functions and form the autonomic nervous system. They control various activities that occur automatically or involuntarily such as the contraction of smooth muscle in the walls of the digestive system. The autonomic system

is further divided into the sympathetic and parasympathetic systems. These two systems provide nerve stimuli to the same organs throughout the body, but bring about different effects.

The sympathetic nervous system helps prepare the body for “fight or flight” and creates conditions in the tissues for physical activity. It is stimulated by strong emotions such as anger and excitement and will, therefore, speed up heart rate, increase the activity of sweat glands, adrenal glands, and decrease those of the digestive system. It also produces rapid redistribution of blood between the skin and skeletal muscles.

Conversely, the parasympathetic nervous system slows down the body and helps prepare for more relaxed state, ready for digestion and sleep. It will, therefore, increase peristalsis in the alimentary canal, slow down the heart rate, and constrict the bronchioles in the lungs. The balance between these two systems is controlled to create a state of homeostasis—that is where the internal stability of the bodily systems is maintained in response to the external environment.

The neurological system can be affected adversely by smoking, lack of sleep, poor diet and stress. Also, the nervous system is naturally adversely affected by age. As we grow older, neurons are lost and not replaced. There is a decreased capacity for transmitting impulses to and from the brain. In addition, both voluntary and reflex actions become slower.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

008. Infection control precautions and procedures

1. What led to the CDC issuing universal precautions in 1985?
2. What is the primary focus of standard precautions?
3. What are the responsibilities of the ICC?
4. Where has HIV been found and how is it spread?

009. Medical asepsis techniques

1. What is the minimum amount of time you should wash your hands when using liquid or foam soap?
2. How will you know if you haven't applied enough alcohol gel to clean your hands?

010. Identify structure and function of the neurological body system

1. Describe the function of the neurological system.

2. The nervous system is divided into what two systems?
3. What can affect the nervous system adversely?

2-2. Making the Mental Health Environment Safe

Safety is a basic need. People need to be safe from accidents, danger, and infection. While consideration of patient safety is a primary concern, so is the safety of you and your co-workers. After all, without you, who would treat the patients? Your safety and health is vitally important to the Air Force. Injuries, illness, and work-related deaths caused by accidents cost the Air Force millions of dollars each year in lost time and medical expenses. When people are injured, the Air Force loses one of its most valuable resources—its people.

The latest research indicates MTFs have a higher injury rate than many industries. The report states that most of the accidents and injuries could have been avoided if the medical personnel involved used a little common sense, had an awareness of their surroundings, and were more familiar with the equipment and procedures they used to treat patients. This lesson will provide information you can use to help reduce or eliminate accidents and injuries to your patient and others. We'll begin with a discussion of some of the Air Force Occupational and Environmental Safety, Fire Protection, and Health (AFOSH) program standards that you will practice to help maintain a safe patient and working environment.

011. Risks and Safety Procedures

The Occupational Safety and Health Act (OSHA) of 1970 directed all federal agencies to establish programs to protect personnel from work-related deaths, injuries, and illnesses. The AFOSH program was established to comply with this directive. You can find an outline of the Air Force instructions and guidance in AFI91-301, *Air Force Occupational and Environmental Safety, Fire Protection, and Health (AFOSH) Program*. The program applies to all Air Force military and civilian personnel worldwide, including members of the Air National Guard and the Air Force Reserve.

AFOSH program

The Air Force complied with OSHA directives by establishing methods of providing a comprehensive and aggressive program to protect all Air Force personnel from work-related deaths, injuries, and occupational illnesses. It includes standards for all safety, fire prevention, and health activities that affect your safety and health at your workplace. Basically, it states:

1. Commanders must provide all personnel with a safe place to work.
2. Air Force facilities must comply with all safety, fire prevention, and health guidance. Your facility has several programs, such as the infection control program, that relate to the health guidance area.
3. You must eliminate or control unsafe or unhealthy working situations. An example of a “controlled” situation might be a hole being dug to repair water pipes. This creates an unsafe condition. In the health care arena, using rubber gloves when doing an examination is a good example of a controlled situation. The gloves help to control the spread of infection. All *controlled situations must be eliminated* at the nearest opportunity. This, of course, is impossible with a patient who requires care. Therefore, you must try to maintain control as much as possible in unsafe situations that involve communicable diseases.
4. Your unit must be inspected and validated compliance with appropriate regulations.

5. You must be provided the opportunity to take part in the AFOSH program.
6. Commanders must establish procedures to ensure that personnel are not subject to restraints, interference, coercion, discrimination, or reprisal for exercising their rights under AFOSH.

This last AFOSH program standard statement is very important. It guarantees every Air Force member and employee the opportunity to file grievances regarding unsafe working conditions. This especially applies to civilian personnel. Most active duty personnel bring unsafe conditions to their supervisor's attention with little fear of reprisal. However, many civilian personnel are afraid that, if they mention these items, they may be viewed as "complainers". AFI 91-301 guarantees them the right to request assistance without fear of coercion, discrimination, or reprisal. Your rights under the AFOSH program also include:

- The right to request an inspection of any area you feel is unsafe for you or the patients you care for.
- The right of access to the health and fire prevention regulations.
- The right to decline to do a task because of a reasonable belief that, under the circumstances, the task poses an imminent risk of death or serious bodily harm, coupled with the belief that there is not enough time to seek effective redress (make the condition right or safe) through normal hazard reporting procedures.
- The right to use official time to participate in AFOSH programs.

As you can see, this is a very focused and regulated safety program. This should tell you that the Air Force is concerned about job safety, that you should take time to recognize potential hazards, and that you should take the time to correct them. The AFI also spells out the responsibility of every echelon, and this includes you. If you fail to comply with stated guidelines regarding safety, fire prevention, and health hazards, the Air Force could very well exercise its right—the right to hold YOU responsible. Remember, with rights come responsibility. AFI91-301 spells out your responsibilities, how to recognize hazards, how to rate them according to probability of risk and danger, and how to report them.

Now that you know about the standards, let's turn our attention to your specific responsibilities and how to recognize hazards. The main focus of our discussion is you and the mental health environment. Take the time to study these instructions.

Common risk factors and general safety procedure

In the mental health care environment the safety risks and hazards that may threaten a patient's safety and result in physical or psychological injuries usually fall into four categories:

1. Falls.
2. Patient-inherent accidents.
3. Procedure-related accidents.
4. Equipment-related accidents.

As a mental health journeyman you must recognize the risk factors associated with these four potential problem areas and the steps to take for preventing or minimizing accident occurrences. Every procedure you do has specific safety precautions to follow. Note that the general safety procedures we discuss below are not all inclusive. Additional safety precautions not specifically covered by AFOSH standards and this section are addressed in conjunction with procedure and treatment modality application covered in subsequent volumes of this CDC.

Falls

Falls are a source of injury to hospitalized patients. Of all patients seen in a hospital, 2% experience a fall, and 2% of those who fall suffer some type of a fracture. The occurrence of falls increase during the evening and after midnight. Falls generally result from slipping or sliding, fainting, or tripping

over equipment or furniture. Some of the other risk factors and safety precautions that you need to be aware of in order to minimize fall injuries to your patients are discussed below.

Spills

Your work involves many liquid items, ranging from bath water to intravenous fluids. Occasionally these liquids get spilled. Always wipe up spills immediately. Oil or alcohol on a tile floor is very hazardous (to say nothing of the infection potential). Remember, your patients are probably not as steady on their feet as you are. Combine that with poor eyesight and you have increased risk of a fall.

Walking areas

Congested hallways present a challenge for normal ambulation and present a hazard for the patient using assistive ambulation devices. For safety's sake, always make sure that the patient has a safe area in which to ambulate. To provide a safe area for ambulating, remove linen carts, gurneys, weight carts, trash cans or any other obstacles from traffic areas. These should be stored in an area where they do not pose a risk for the patients. Do not leave beds or other similar items in the hallways. If it is necessary to move beds from one room to another, move one at a time in order to avoid hallway clutter.

Side rails

One of the most common sources of accidents in the hospital is the forgotten side rail! Not using the side rails may result in an incapacitated patient falling out of bed. Always be aware of your patient's physical and mental state and, if necessary, put the side rail up.

Equipment-related accidents

Equipment used in and around a patient's area can pose a safety problem. The following are some general safety practices that cover the use of all equipment:

1. Give time and thought to the use of any piece of equipment—haste can be hazardous.
2. Keep equipment in good repair. Know the maintenance schedules for each piece of equipment.
3. Secure and fasten equipment when required.
4. Check the manufacturer's recommendations.
5. Avoid using makeshift or improvised equipment.
6. Maintain a surveillance program that requires a daily inspection of equipment items.

Most importantly, to avoid injury to yourself and others *do not* operate any monitoring or therapy equipment that you have not been trained to use.

Electrical supply

Electrical equipment is a major concern. Electrical equipment should be plugged directly into the wall receptacle. Avoid using an extension cord whenever possible. If an extension cord is necessary, it must be an approved (hospital grade) cord with a three-prong, grounded plug.

Glass and plastic

Do not give used or damaged equipment to a patient. Always inspect glass and plastic equipment before use. Check equipment for cracks, chips, and sharp or rough edges, which can easily cut, stab, or scratch patients.

Procedure-related accidents

These are accidents that occur during patient treatment or therapy. They include accidents related to improper performance of procedures, medication and fluid errors, and improper application of external devices such as restraints. You can prevent many procedure-related accidents by observing the following general safety practices.

Drug safety

Most medication errors occur when someone fails to follow routine procedures. Preparing and administering medications requires accuracy. You must pay full attention to preparing medications and must not attempt to do other tasks simultaneously. To ensure safe drug administration, you should follow the “***Five Rights***” of drug medication:

1. The ***right*** drug.
2. The ***right*** dose.
3. The ***right*** patient.
4. The ***right*** route.
5. The ***right*** time.

Water temperature

Always check the temperature of hot water bottles, heating pads, hot soaks, and bathing water before allowing the water or equipment to come in contact with the patient. Use a thermometer to check water temperatures.

Moving and lifting patients

Moving and lifting patients are major causes of injuries to medical personnel and patients. Moving patients by wheelchair or litter can be hazardous if accident prevention methods are not followed. When moving a patient by litter, always use litter straps. Normally they are not needed for wheelchair patients unless the situation demands. Moving and lifting helpless patients is most difficult and provide an opportunity for injury. When moving and lifting a patient it is essential that you use proper body mechanics. As a general rule, lifting a patient requires more than one person. The following are some important techniques for moving bedridden and helpless patients.

1. Arrange the bed clothing so that the patient will not be hampered.
2. Get close to the patient being lifted. Avoid reaching in. Move in and hold the patient in a close position.
3. Stand with your feet apart, keep your back straight, and take as much of the strain as possible with your leg muscles.
4. Never twist your body, but shift your feet when you are ready to turn.
5. Coordinate your efforts with the patient’s contributing effort.
6. Avoid sudden jerks and pulls.

Syringes and needles

Never leave a syringe and needle lying around where a patient can get to them. Always follow local policy for proper disposal of syringes and needles. Basically this means adhering to the universal method—placing the syringe and needle in a “sharps” container. Syringes and needles in a full sharps container are usually incinerated.

Patient-inherent accidents

There are many reasons why some patients cannot protect themselves. Age, poor vision, loss of hearing, impaired motor-skills, and reduced awareness are just some of the factors that put patients at a risk for an accident. You need to be aware of any factor that may cause injury so that you can ensure the safety of your patient. Examples of patient-inherent accidents include self-inflicted cuts, injuries and burns, ingestion or injection of foreign substances, and pinching fingers in drawers or doors.

High risk patients

Mental health patients may pose significant safety hazards to themselves or others. In addition, patients experiencing a great deal of stress or anxiety are more accident prone because they are often

too preoccupied with their stressors to notice potential danger sources. You must remain constantly alert to common hazards that may cause injury. You are also responsible for preventing opportunities for suicide, and for protecting others from patients who may be suicidal, assaultative, destructive, or confused. A major responsibility when caring for mental health patients is practicing general safety precautions and the safety measures identified in this unit.

Other hazards and precautions

Anything in the MTF that can cause injury or death to a patient or others is called a hazard. Many otherwise avoidable accidents are caused by newly waxed floors, cleaning materials, and insecticides left carelessly around. Contraband articles, such as sharp instruments, should be put away in locked cabinets. You must constantly assess your duty area for threats to your patient's safety. Here are a few more potential hazards and precautions you should consider.

Other Potential Hazards	
Hazard	Precautions
Toxic agents	Always store poisons away from patient access areas. Most units have special cabinets where cleaning agents and poisonous substances are stored. Ensure that disinfectants and drugs for external use are stored separately from internal and injectable medications. Also, poisons must be separated from therapeutic agents.
Flammable liquids	Keep supplies of flammable liquids as small as possible. If more than 10 gallons (aggregate total) must be maintained, an approved flammable storage cabinet is required.
Heavy and/or bulky items	Store heavy and/or bulky items on lower shelves. If storage space is above 6 feet, use suitable stepladders to retrieve the items. Do not use chairs, boxes, etc., as substitutes for ladders. (Remember, right tool for right job?)
Fire hazards	You can eliminate the potential for fire by keeping the three elements of combustion— fuel , oxygen , and heat —separated. A fire cannot exist without these three elements. Know exactly what to do if a fire does start. Be conscientious in the fire drills established in your treatment facility; if you practice wrong you'll perform wrong. Remember, practice doesn't make perfect, perfect practice makes perfect.

Smoking hazards

Cigarette smoking in medical facilities is prohibited. Because of the increasing amount of data about smoking and its effects on health, the Surgeon General eliminated smoking in all military facilities. This has not, however, stopped people from smoking. To be fair to those who choose to smoke, some facilities have designated outdoor smoking areas. Most of these areas are well-marked. Some facilities do not have designated outdoor smoking areas but suggest that smoking should not occur within 15 feet of a building's entrance or exit. Each unit should have posted guidelines about smoking, and they should be made known to all patients, all hospital personnel, and the public. For safety's sake, if you must smoke be sure that these guidelines are followed:

- Smoke only where authorized!
- Do not use a trash receptacle as an ashtray!

Unsafe work practices

A crash cart knocked over, slick floors from "water fights", or running into someone ambulating with crutches are just a few examples that result from horseplay. It is not only unprofessional, but can also lead to serious injury or damaged equipment. Think about where you are and what you're doing at all times; professional standards of conduct work in the clinic, too.

Working too fast is unsafe. The patients are stacked up in the waiting room, SrA Moton is on leave, you have a headache and the faster you go, the “behinder” you get. Pace yourself. Work at a safe, consistent speed. You’ll be able to work longer and more safely.

Always use the right tool for the job. Use a screwdriver to loosen the hardware on the ultra lamp stand, not the letter opener or the blade side of a ruler. Use bandage scissors to cut dressings, not a scalpel.

As you gain experience, many techniques become almost second-nature for you. You’ll get into a routine. Your work becomes automatic. Accidents happen! Safety is never automatic; it must be a conscious, disciplined effort on your part. You must take the initiative and incorporate safety as part of the total treatment. Safety is not just a good idea, it is a must!

012. Reporting accidents, incidents, and hazards

Accidents, incidents, and hazards must be reported. Accurate, detailed information is extremely important when reporting accidents, incidents, or hazards involving patients, visitors, and staff. The information is required by the facility risk manager and is helpful for future situations with the same or similar characteristics. The information also is used to formulate accident prevention measures. Most MTFs require that these reports be made in writing. In this lesson we discuss general reporting procedures. You should follow the standard procedure for reporting accidents and incidents found in your unit’s OIs or SOPs.

4C0X1 incident reporting procedures

All incidents, regardless of severity, should be reported to your supervisor or charge nurse. All fatalities, injuries requiring hospitalization, injuries involving three or more people, property damage, injuries resulting in lost time, or injuries to patients should be reported on AF Form 765, Medical Treatment Facility Incident Statement. This form is used to report any incident, accident, or unusual occurrence that happens in the medical facility. You may obtain assistance from your unit safety representative in completing this form. The information is required by the hospital risk manager and becomes a vital record that will be used in investigations of the same or future situations of similar characteristics. The information is also used in accident-prevention measures.

Hazard reporting

Detecting unsafe or unhealthful working conditions at the earliest possible time and abating hazards promptly at the lowest possible working level are essential elements of the AFOSH program. The hazard reporting program provides a system of reporting hazardous conditions and for investigating and correcting those hazards. You should report all situations or conditions that could have a potential for personal injury, hazard to health, or damage to equipment or a building. AF Form 457, USAF Hazard Report, is used to report unsafe conditions and practices which may cause mishaps. AFI 91-202, *The US Air Force Mishap Prevention Program*, explains the hazard reporting program in detail.

Reporting accidents

All accidents should be investigated and appropriate action taken to prevent recurrence. Each unit should have an established policy for reporting accidents. Supervisors have the primary responsibility for accident notifications. AF Form 765 may also be used to report situations that could result in an accident.

Reportable accidents and incidents

Report all fatalities, injuries requiring hospitalization, injuries involving three or more people, property damage, or injuries resulting in lost time on incidents, accidents, or unusual occurrences which may include, but are not limited to, falls, burns, or theft of a patient’s valuables. For example, a specialist injured while attempting to place a combative patient in restraints should complete an AF Form 765.

The staff member who discovers or is involved in an incident must initiate this form. The completed form is routed to the MTF commander according to local policy. Usually, this involves going through the NCOIC, OIC of the section, chief nurse, chief of hospital services, and hospital administrator. These individuals review the report and determine ways and means to prevent recurrences; then the report and their recommendations are forwarded to the MTF commander.

Accurate reports can protect your unit from false claims made by patients, visitors, or even staff members. More importantly, the report helps to determine whether an accident trend is developing with respect to treatments or procedures, equipment, or personnel. In addition, the reports can indicate the need to develop a safety training program for the equipment or procedures identified in these reports.

Remember, all accidents should be investigated and appropriate action taken to prevent recurrence.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

011. Air Force Occupational and Environmental Safety, Fire Protection, and Health program

1. What are your rights under the AFOSH program?
2. What Air Force instruction spells out your responsibilities under AFOSH?
3. What are the “five rights” as it relates to drug administration?
4. What three elements should be kept separated to prevent a fire?

012. Reporting accidents, incidents, and hazards

1. What kinds of things should be reported on AF Form 765?
2. Who receives the recommendations and AF Forms 765 once they are completed for corrective action?

2-3. Crisis Management, Restrictive and Protective Measures

In this section we discuss crisis management and nonviolent crisis management. Crisis intervention is an increasingly effective treatment modality. Studies have found that by the time their appointment date was reached when individuals came to mental health professionals for help, their crisis was either maladaptively resolved or the coping mechanisms were so severe that hospitalization and long-term treatment were required. Mental health professionals have found that by seeing individuals immediately in a crisis intervention mode, they often are able to resolve the immediate crisis. As a

result the individuals often had higher levels of functioning after the intervention. However, patients do sometime lose control and try to hurt another patient or a staff member, usually physically. In addition to crisis management, we also discuss nonviolent crisis management for those situations in which restrictive measures to control the patient may be warranted

013. Crisis management

A crisis can be defined as a state of disequilibrium resulting from the interaction of an event with an individual's or family's coping mechanisms, which are inadequate to meet the demands of the situation, combined with an individual's or family's perception of the event. Individuals who are in crisis are *not* always mentally ill, and an event that causes a crisis in one individual may not cause crisis in another. There must be three factors to produce a crisis:

1. An event.
2. The meaning of the event to the individual and/or family.
3. The nature and extent of the individual's or family's coping mechanisms.

As you can see by these factors, the individual's family is an important consideration in determining if there is a crisis. While an event may not affect an individual very much, it may cause disequilibrium within the family; thereby creating what is considered a crisis.

Types of crises

There are two types of events that may cause a crisis—developmental and situational.

Crisis Types	
Type	Description
Developmental crisis	Usually, this crisis occurs during the transition from one stage of personality development to another. An example is the midlife crisis: when people begin to see signs of their own aging and recognize their mortality. They wonder if they are going to meet their career goals and if they have met other goals in life. A developmental crisis often can be predicted and subsequently prevented through education.
Situational crisis	An unexpected loss of a loved one, loss of job, or natural disaster, such as floods or tornadoes, often can precipitate a situational crisis. There are events that the individual or family may deem to be hazardous to the equilibrium. Situational events <i>do not necessarily</i> have to be bad to cause a crisis. A promotion that causes increased responsibility and additional working hours may cause a crisis in an individual whose coping mechanisms are inadequate to meet these increased demands. While the promotion, with its increased status and pay, may appear to be good, the individual's inability to cope with the increased responsibility, or the family's inability to cope with the thought of increased absences by the individual, may cause a situational crisis.

Characteristics of crises

Individuals in a state of crisis usually demonstrate certain characteristics. They usually have feelings of being overwhelmed and unable to cope. This often causes much free-floating anxiety which can be seen as anxiety, depression, or anger, depending on which stage of the crisis the individuals are in. Because individuals cannot tolerate tremendous amounts of anxiety for long periods of time without gross personality disorganization, a state of crisis is usually self-limiting, lasting only 4 to 6 weeks. Usually the crisis is resolved—either in a healthy or unhealthy manner—within this timeframe. Another characteristic is that the event is seen as a hazard—a threat to basic needs or the individual's integrity, a real or imagined loss, or a challenge. As stated earlier, crises usually involve an individual's family. However, this may be expanded to include those significant people who make up an individual's social support system. These people are almost always affected by an individual in a crisis state.

Stages of crises

The stages discussed in the following chart are usually seen whether or not an individual or family is in a state of crisis. They may overlap but usually are very definable. Let's review the stages shown in the following chart.

CRISIS STAGES	
Denial	This is the initial stage and usually lasts for only a couple of hours.
Increased tension	During this stage, individuals continue with their usual activities but have increasing amounts of anxiety. This anxiety does not limit their activities but often is seen by an outsider as hyperactivity or psychomotor retardation.
Disorganization	During this stage, individuals begin to feel as if they are "falling apart". They have a great deal of anxiety and are often unable to function. They may or may not realize that they are in a crisis state and become anxious about their anxiety, often compounding the problem. Individuals usually seek professional help during this stage.
Attempts to reorganize	Individuals try to use previously used coping mechanisms for their current crisis. The mechanisms are likely to be short range and usually aimed at the specific immediate problem. When these attempts are successful, they often lead to general reorganization. The individuals then continue with their lives, experiencing anxiety or depression only when specific stimuli are present to remind them of the event.
Attempts to escape	If attempts to reorganize are unsuccessful, individuals may try to escape their problem by projecting responsibility for its existence on to others. They may try to place the blame on other people, institutions, God, or fate. Blaming behaviors are rarely effective because they add tension to a system already loaded with tension.
Local reorganization	When attempts to escape the problem fail, individuals move into this stage. Its characteristics are the same as the attempts to reorganize stage.
General reorganization	This final stage of the crisis may last up to a year. While the immediate crisis lasts only from 4 to 6 weeks, it may take as long as a year for individuals to integrate their new patterns of behavior into their personality or families' interactional structure and communication system.

Crisis intervention techniques

Individuals or families fail to resolve the crisis state when they use pathological adaptations in any stage of the crisis. These pathological adaptations tend only to hide or make the crisis worse. The goal of crisis intervention is to help individuals seek new and useful adaptive mechanisms within the context of their social system; whether it is family, close friends, or neighbors.

Crisis Intervention Techniques	
Step	Description
1	The initial step in crisis intervention is to evaluate the situation completely. This may involve asking many questions because the individual more than likely is in the disorganization stage—hindering his or her ability to think clearly. In addition to the individual, it is also important to find out who else may be involved in the crisis. During this step, it is important that you offer the individual increased emotional support, and to instill confidence that someone is interested in helping.
2	The next step is to identify the event that is causing the crisis. Individuals often seek help when they are in a state of crisis and are focusing on their immediate anxiety without being able to identify the specific precipitating event. In these situations, it is often helpful to ask the individual to go back over what he or she has done over the past couple of weeks. Individuals will often recognize the event when they go through this process. If they don't, it may be helpful for you to point out events that you think might have caused the individual's problem.

Crisis Intervention Techniques	
Step	Description
3	<p>Once the precipitating event has been identified, it is time to develop a plan for coping with the crisis.</p> <p>Explore with the individual the resources that are available in addition to the resources you might suggest. If the individual is to benefit from this step, it is important that he or she make as many of the arrangements for help as possible. Keep in mind, however, that because the individual is probably in a disorganized stage, he or she may have difficulty thinking clearly. It might be helpful to write down the steps the individual is to take so that he or she retains the information after talking to you.</p>

These crisis intervention steps are designed to make an individual aware of the situation and to help keep the situation in his or her consciousness. Another important facet of crisis intervention is making the individual aware of his or her feelings regarding the event and how to manage those feelings. Verbalizing feelings allows for desensitization and mastery of those feelings. Follow-up appointments allow for continuous evaluation of the effectiveness of the coping plan. During these follow-up appointments, it is important that you reinforce successful handling of the situation and support the individual emotionally during unsuccessful attempts.

014. Restrictive measures

Restriction means many things to many people, depending on the sense and context when using the word. To restrict or seclude yourself for the purpose of obtaining some peace and quiet is a pleasant thought. However, to restrict or seclude someone else provokes anxiety in both the individual restricted and the person doing the restricting. Unfortunately or fortunately, depending on how you view the act and the results, you are usually the person doing the restricting. Why do you feel anxious about restricting or secluding someone? Is it because you sense taking away the individual's freedom? Or, are you afraid of the consequences? Or, are you just uncomfortable in the role of confining or limiting another human being even if it may prove beneficial to that individual? Regardless of your thoughts on the subject, restriction and seclusion remain important therapeutic tools that, when used appropriately, can prove to be extremely effective. Let's talk about these two areas as therapeutically beneficial and discuss the reasons why they are used.

Restriction

The dictionary defines the word restriction as "a limitation, to keep within limits, to confine, and in a literal sense, to restrain". Whenever a patient begins to lose control, becomes agitated, and displays preaggressive behavior, you need to consider placing restrictions on that patient. Note that we said "consider". Not every patient requires restrictive measures. Circumstances surrounding the individual situation dictate your action. A patient acting out or becoming agitated may be responding appropriately to a situation. We want to encourage appropriate response by all patients. Our main concern is not allowing preaggressive behavior to advance to the point at which the patient, other patients, or staff members may be physically hurt.

Preaggressive behavior

As you read the following, recall what you learned about preaggressive behavior in technical school. To begin, let's quickly review some preaggressive behavior examples that you should be aware of when working with patients:

- Pacing or walking in the halls, looking out windows and doors, staying near the exit doors.
- Interest in weapon-type items, picking up pool cues or balls, grasping coffee cups or other glassware, and repeatedly handling other objects that could conceivably be used as a weapon.
- Sleep disturbance—up at odd times during the night, can't go to sleep, and awakens early.

- Withdrawal—a patient who is normally very active on the unit becomes quiet, stays to him- or herself, or seems preoccupied or troubled.
- Hyperactivity—unable to sit still, short attention span, easily distracted.
- Changes in voice level—a normally soft-spoken individual or a normally loud-spoken individual using an opposite voice pattern.

These are just some of the more common signs of preaggressive behavior that you may see. Keep in mind that any of these symptoms alone may simply indicate minor disturbances in the normal flow of daily living for the patient. Usually, you see a combination of these signs in a patient destined to become aggressive.

Causes of preaggressive behavior

Preaggressive behavior can be caused by many factors. Some are medication changes, major weather changes, staff turnovers, shift changes, menses, loud voices or high volume on radios and televisions, and construction sounds. Other precipitating factors may include fears, frustration, feelings of rejection, and psychotic thinking. Although we are not positive that these things “cause” aggression, they often seem to precede it. When aggressive behavior becomes apparent, it must be controlled. Hopefully, your awareness will lead to successful intervening at the preaggressive level.

Time to respond

When do you intervene? When do you restrict? What restriction is appropriate? These are all questions that you and other members of the nursing staff must answer. Hopefully, common sense will prevail and the response will be limited to the least restrictive measures available. Quick, decisive intervention is the key to successful resolution of most preaggressive behavior problems.

Talking with patients

Talking to a patient normally is your first approach in reacting to preaggressive behavior. This is the least restrictive attempt at control. Sometimes, it is all that is necessary. The patient often ventilates to such an extent that talking helps him or her feel better about the situation. There are times however, that talking about the problems just increases the patient’s stress. This could result in increased anxiety and eventual aggressive behavior.

Area restriction

This restriction limits a patient to a quiet area on the unit. It not only reduces possible stimuli but also allows the patient time to think through the problem or situation that is creating the current stress or anxiety. When behavior appears to improve, it offers the staff an opportunity to constantly observe the patient without total limitation of movement. Always explain to the patient why you are initiating the restriction, its purpose, and the length of time you expect the area restriction to last. Once the patient has been informed of the restriction plan, he or she may actually help you to attain the planned goals, mainly due to the sense of security the restriction action provides. It is also helpful to tell the patient what you have observed regarding behavioral changes. This is best done during your explanation of why you are initiating the restriction. Remember, sharing the treatment approach and goals with the patient can be helpful and effective. Area restriction is one of the easiest methods to use to calm a patient in a preaggressive mood. Most patients will want the controls placed on them even though they may not always admit it.

Room restriction

This form of restriction is often used when area restriction fails. It allows the patient to relax in an environment free of almost all stressful stimuli. The patient’s sleeping area is used most often because of the sense of rest and relaxation it conveys. A certain sense of security is also present within one’s own room. In addition to limiting those factors that may cause preaggressive behavior, room restriction allows the staff an extremely close observation opportunity. Again, this restrictive technique may not be appropriate for every patient at any time. A highly anxious patient is probably

more willing to retreat to the quiet of his or her bedroom or other area that allows for relaxation and provides quiet, uninterrupted solitude. While room restriction serves a valuable and useful purpose, be careful not to allow the patient to become dependent on its use. If room restriction is used too frequently, the patient may tend to hide feelings and problems rather than deal with them.

Other helpful methods

In addition to the preceding, the following methods of calming patients in the preaggressive stage may also be helpful:

- Redirecting patients' attention from whatever is upsetting them can be an effective calming technique. Getting patients involved in unit activities is an example of redirecting.
- Ask patients directly in a firm, confident and reassuring voice about the problems they are experiencing. Statements like, "Are you upset?", "Can I help you?" or "Are you angry?" help in eliminating the patients' specific problems.
- Reflect or tell the patient what you are observing. We mentioned this technique earlier when we talked about initiating restrictions. Use statements like, "I noticed you pacing" or "I saw you hitting the wall." Many times, just pointing out the behavior is enough to help the patient discontinue it.

Affirming to patients that you understand how they feel is very helpful. Patients will know that you are concerned and that they have someone they can come to, knowing they will be understood. It is important that you "really do understand." Otherwise, patients will quickly sense any insincerity you display. You can affirm your understanding simply by saying, "I sense you are angry and I understand why."

015. Seclusion measures

Seclusion is confining a patient in a single room. It has many variations—restraining a patient to a bed in a locked room, locking a patient in a room with only a mattress on the floor, or allowing the patient the privacy of his or her room without locking the door. How seclusion is used should be determined by the patient's specific condition or needs. Seclusion may be used to control behavior, to provide a quiet environment for hyperactive patients, provide security, or, in behavior modification, to act as a negative reinforcer. A physician's order must be obtained before you place a patient in seclusion and this must be accomplished within a specified time period. Review your clinic/unit OIs to ascertain the time period at your base.

Whenever possible the whole treatment team should decide on using seclusion. Careful examination of the reasons is necessary because seclusion may appear to be a form of punishment. Ask questions such as, "Will the patient be better as a result of the seclusion?" or "Is this for the nursing staff's benefit?"

Technique

When a patient is placed in seclusion, consider the number of personnel involved and patient safety. Secure the patient's valuables. Take lighters, matches, and dangerous objects from the patient. Offer food, fluids, and bathroom privileges often. This contact gives you an excellent opportunity to observe and communicate with the patient. The staff should continually evaluate the patient's need for seclusion. The nursing care the patient receives while in seclusion must be recorded carefully.

Alternatives

Whenever seclusion is necessary, the staff should review the events leading up to that action. It may be possible to determine where intervention may have prevented using these measures. Perhaps giving the patient the opportunity to discuss what was bothering him or her or offering an ordered (as needed (PRN)) medication might have prevented the patient from demonstrating the behavior that necessitated seclusion.

Suppose, for example, that you arrive for duty one afternoon and notice that a male patient, Mark Miller, is pacing the floor in the dayroom. There is no mention in the change of shift report of any unusual behavior on his part. Afterwards, you notice that Mark is pacing much faster, and clenching and unclenching his fists. But since you are assigned other responsibilities, you complete those assignments. A little later, Mark throws a table through the dayroom window and has to be restrained and secluded. It is very possible that had you approached the patient when you first came on the unit and noticed his behavior, this explosive behavior may not have occurred. In this example, good communication between the staff could have led to early intervention, which may have prevented the incident from occurring.

Seclusion should only be used when other therapeutic measures fail. Some authorities believe the use of seclusion is antitherapeutic, and, when its use becomes necessary, it is because the staff *has not been effective in its use of other therapeutic modalities*. Because of this belief, some personnel may not use seclusion, even when it may be of therapeutic value to the patient such as a hyperactive patient who needs relief from external stimuli, or the patient who feels as if he or she is losing control and asks for controls.

Whatever philosophy your unit adheres to, remember that seclusion or restraining should be used only as a last resort. The patient should be restrained or secluded only as long as necessary; and stringent guidelines dictate the direct observation of the patient. Always try area or room restriction before using seclusion measures. You should remove patients from seclusion as soon as their behavior improves.

016. Physical response techniques for protection

In the event you are assaulted by a patient you should know the best methods for protecting yourself. Being assaulted is a very disturbing thought, but the reality is, it happens! Patients who lose control often try to hurt—usually physically—other patients or a staff member. As a mental health professional, your response should always be: how you can safely intervene without getting yourself or anyone else hurt while assisting the patient to gain control of inappropriate behavior.

We discussed the use of area or room restriction and seclusion for controlling some patient behavior and symptoms of anxiety. Physical intervention, in the interest of protecting yourself or others, is the final stage of intervention. In the following paragraphs we discuss the graded intervention scale, recognition of the assaultive cycle, and various measures you can use to protect yourself and the patient. We will also discuss methods of assuming physical control of patients who are out of control in preparation for escorting them to other parts of the unit.

Graded intervention

No one wants to be hurt, including you! Normally, you find yourself in a situation requiring you to protect yourself or others because less restrictive intervention techniques were not successful. When approaching a patient who is out of control, there are four steps of graded intervention you should follow. The sequence of steps begins with the least restrictive and continues to the most restrictive:

1. Step I: Verbal intervention.
2. Step II: Body positioning.
3. Step III: Less restrictive physical intervention (includes touching and holding).
4. Step IV: More restrictive physical intervention (includes forcible movements and takedown procedures).

When you have progressed to the point with an assaultive patient that physical intervention is probable or required, your highest priority should be protecting yourself, the patient, and others. Of course, your ultimate goal is to control the patient's behavior with the least restrictive intervention possible.

Assaultive cycle

Earlier in this section we discussed preaggressive behavior and how to control it through least restrictive intervention. When a patient progresses beyond preaggressive behavior and is looking to strike out at something or someone, that person has reached the *assaultive* cycle. There are *four active phases* to the assaultive cycle. You should attempt to prevent the patient reaching the crisis phase of this cycle. Let's look briefly at the phases of the assaultive cycle.

Trigger phase

This phase can be caused by many different factors: anger, frustration, fears (real or imagined), even weather changes. Whatever the cause, there may be pacing, voice level changes, some mild verbal outbursts, and other indicators of anger or frustration displayed by the patient.

Escalation phase

When the patient reaches this phase, you will note some trigger phase behavior mentioned but to a greater extent. There will be a loss of control over anxieties by the patient. He or she begins to challenge authority, namely you and those who work with you. The patient begins to raise questions about the need for hospitalization. There may be physical aggressiveness indicators such as slapping fists into an open palm or against the walls. The patient may refuse to comply when asked to control his or her behavior and may even attempt to verbally or physically intimidate you or others. At this point, controlling your own emotions becomes very important.

You may be called names you have never heard before; one of your first thoughts may be to lash out physically or verbally against the patient. At this point in the assaultive cycle, you must remain confident of your abilities. Personal experience is a great teacher, and I can tell you that remaining confident and responding realistically is the best strategy. If you are called a no good son-of-a -----, you might respond by saying to the patient, "That language isn't necessary. I know you're angry right now, and I'll be happy to talk with you about whatever is going on. But you don't have to swear to get my attention." This may or may not help in letting the patient know you understand at least part of the frustration. However, it does define some limits the patient needs to respect if he or she wants to discuss the problem. Even if the patient swears at you again, remain confident that your verbal intervention will help, and again offer to discuss the situation.

Crisis phase

In this phase, the patient has lost all, or most all, control, and is aware of this fact. This can be particularly frightening to an individual. Threats are easily perceived and the patient feels as if no one is willing to help. The patient feels as if the entire health care team is not responding in a time of crisis. This is when the patient is most likely to assault someone. This is also the time when physical restriction must be applied; if not, someone will get hurt. Your goal, remember, is to use the least amount of force necessary in helping the patient resume control over his or her feelings and behavior. As we progress through this lesson, we will concentrate on this phase.

Recovery phase

Following the use of restrictive measures—such as takedown, seclusion, or restraint—you must pay close attention to the patient and try to reestablish rapport as soon as possible. If the patient is in restraints or seclusion, vital signs must be taken and properly recorded every 15 minutes. At this time documentation of the entire episode leading to the restriction process applied is extremely important. This is especially important regarding methods of intervention attempted prior to physical intervention. This phase offers the opportunity for therapeutic growth for both the patient and staff. Talking to the patients, telling them you understand their frustrations and reasons for their behavior, is very important. Reviewing what occurred and the reasons for actions taken can help the staff determine how to respond in future situations requiring physical intervention.

Self-protection

As we mentioned earlier, this is a key area of concern. There are techniques you can practice and use to help maintain a safe posture when a patient is out of control. Let's review some of these techniques.

Body positioning

When dealing with an assaultive patient this is the next step following verbal intervention. The most important part of positioning is maintaining a safe distance from the patient. A general rule to remember is to remain an arm's length plus 1 foot away from the patient. This is considered a safe verbal intervention range and also allows the patient his or her personal space without feeling cornered or threatened. I realize we have already discussed verbal intervention; however, this least restrictive method of intervention has a role throughout the process of intervention, even when placing a patient in restraints.

PERSONAL SAFETY PRECAUTIONS

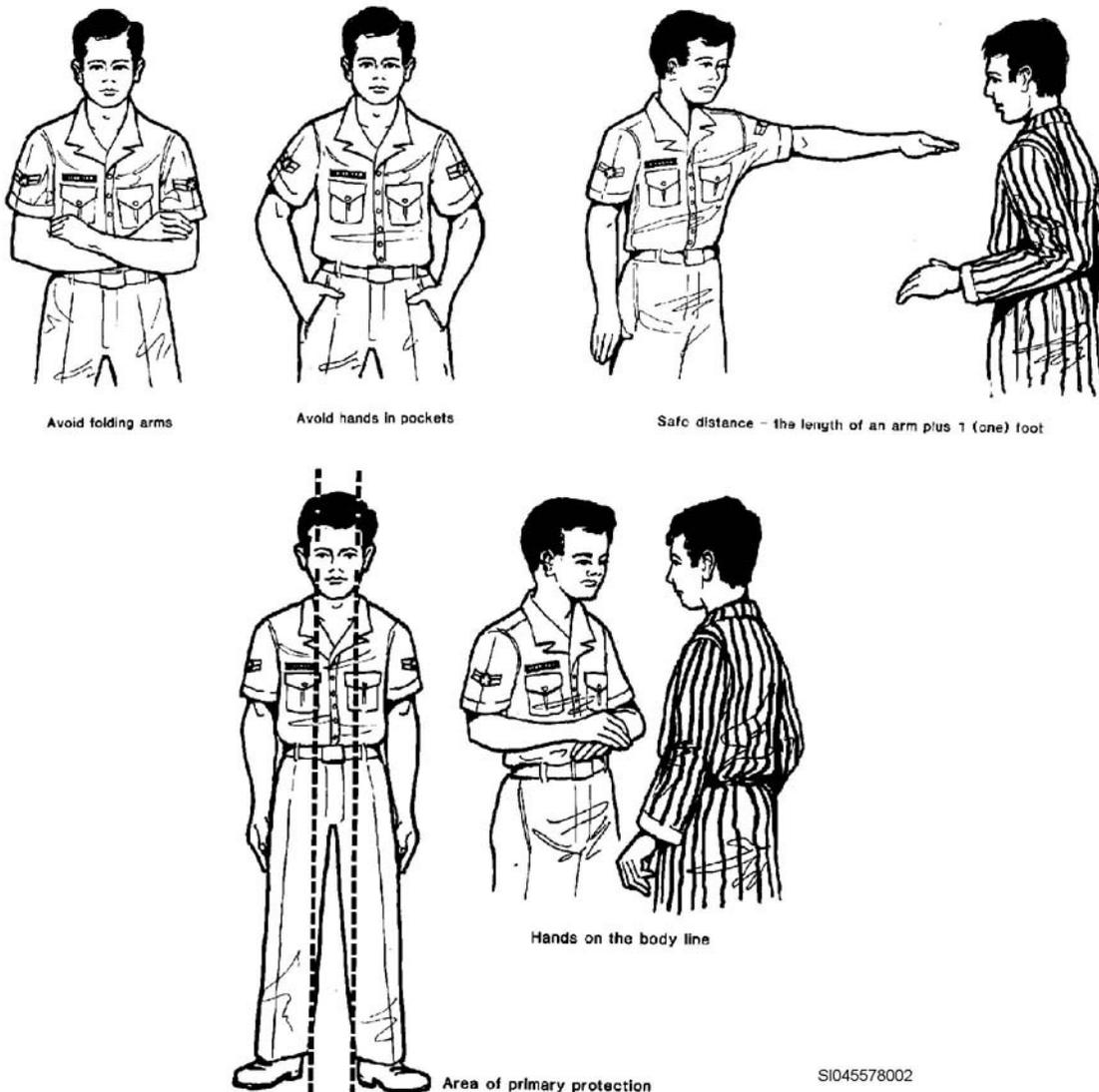


Figure 2-2. Body posturing.

Areas of primary protection

The figure on the left in figure 2-2 shows the areas that need to be protected should a patient attempt to strike you. Note that they are all on the body midline. These areas, if struck, will normally cause you the most pain and, quite possibly, render you defenseless. Standing at an angle (about 45°) to the patient not only makes your presence less threatening but also offers less of a target. Note that the individual on the right in figure 2-2 has his hands placed at waist level or, as you were taught in technical school, at the “body line”. This position allows you to move quickly to a defensive posture and still maintain a less threatening posture from the patient’s point of view. ***Never***, never approach a potentially assaultive patient with your hands in your pockets or with arms folded in front of you (fig. 2-2). While this may make you feel more “secure” because of your own anxieties, you may spend the evening picking up your teeth! Not only do these positions of approach put you at a significant disadvantage for defensive maneuvers, they also reflect an attitude of indifference. In addition, folding your arms presents a defensive posture to the patient, suggesting possible reasons for an altercation.

Defending against attack

There are many ways patients may choose to initiate an attack. They may bite, scratch, kick, punch, pull hair, choke, or combine any of these methods. Sounds pretty bad, doesn’t it? Well, it can be unless you’re prepared to defend yourself. Let’s review some of the defensive maneuvers you can use in protecting yourself and these patients from harm. Rather than simply list the maneuvers, we begin by discussing the attack method and then cover the protective measures.

Kicking

This is one of the favorite attack modes of frightened patients. They don’t want to get any closer to you than they have to because of their own fear of harm. The leg, being one of the longest extensions of the body, serves to maintain this safe distance for them. Refer to figure 2-3 as we discuss defense methods.

If you are fortunate enough to see the kick coming, one of the best methods to avoid it is to simply step back. Remember, you should already be at a 45° angle from the patient. Turn your thigh forward toward the patient for further protection. Place one palm on top of your other hand and prepare to absorb the force of any ensuing kicks if you are unable to retreat out of range. Avoid leaning backwards. This may cause you to lose your balance. If you can’t “scoot out” of range, “run” out of range. Don’t be embarrassed to run! Remember, your goal is protecting yourself and others, not to prove your courageousness. This doesn’t mean run off the unit; just get out of range. Also, remember to verbally caution the patient during the entire episode. You never know when you might say something that will work and stop the attack. Never lean forward anticipating a kick (fig. 2-3). This could lead to very serious injury to your head, face, neck, or chest. The key thing to remember is to *avoid contact with the foot at all times*.

Biting

A naïve student in technical training once asked, “Do you have to worry more about female patients biting more than males”? In my experiences working on an inpatient unit, the answer is definitely NO. When a person, whether male or female, is being manually restrained and does not have free use of arms and legs, the instinct is to do anything to get away. If exhausted from struggling, biting a technician can help them get free. Normally, a bite is applied to an extremity, but it is possible for bites to occur on all parts of the body.

DEFENDING AGAINST KICKING ATTACKS

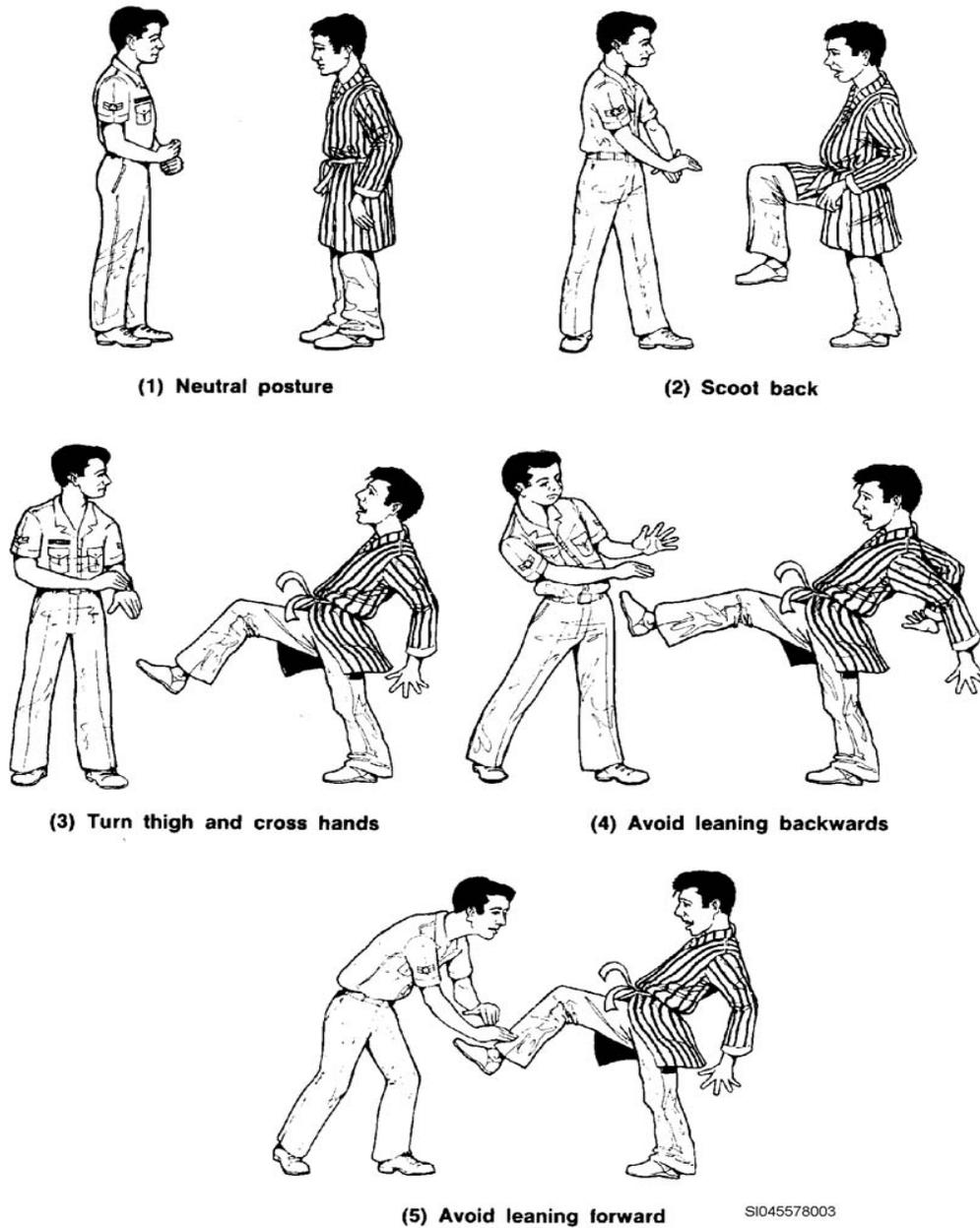


Figure 2-3. Defending against kicking attacks.

When this occurs, there are two suggested methods to release the bite pressure:

Methods to Release Bite Pressure	
Method	Description
Cheek pressure method	Place two fingers on the patient's cheek and apply pressure, pushing the skin between the patient's teeth. This gradually applies pressure between the upper and lower back teeth and causes pain within the lining of the cheek, which, in turn, causes the patient to slowly release the bite pressure.
Nose push method	Place two fingers under the patient's nose and push upward. This is an extremely sensitive area and the patient will quickly release the bite pressure to avoid pain.

Both of these methods need to be applied in combination with pushing forward the extremity being bitten. This helps avoid further damage to your extremity by making it more difficult for the patient to apply additional bite pressure. While this may sound too simplistic, these techniques are extremely effective when used. Try them with other technicians or staff members acting the role of patients.

HOLDING BEAR HUG



Figure 2-4. Securing patient with the holding bear hug.

Nail scratch

Another way a patient attempts to protect/defend is using the nails to scratch at the staff or other patients. Again, “scooting” backwards out of harm’s way may help. You may have to pin the patient’s arms to his or her body by using the holding bear hug (fig. 2-4). The figure depicts the ideal way of approaching the situation. However, you may not have the luxury of finding yourself behind the patient as depicted. In this case, you may have to forcibly spin the patient around or grab head-on and maneuver yourself around the patient until you are in position to apply the procedure. Figure 2-4 illustrates the method used to tire the patient and avoid any kicking that may take place. Many times, just securing the arms and using verbal intervention is enough to convince the patient to cease

struggling and attacking. This procedure is, at best, a temporary measure until additional help arrives. If you feel you cannot safely manage this intervention, do not attempt it.

Choke hold

The choke hold is often used by patients with real intent of doing physical harm to you or another patient. A patient that spits, kicks, hits, bites, or scratches at you may just want you to get away from them; the patient may see this as an act of self defense. A patient does not choke you to have you “get away from” them; they want you to stop talking or breathing, even if it is for a short period of time. Being choked is probably the most dangerous situation to be in with a patient.

If a patient is being attacked by another patient, you and at least one other staff member must respond and break the hold as best you can without injuring either patient. Be prepared for the attacked patient to respond angrily and to possibly lash out in retaliation toward the individual initiating the attack. Now you’ve got double trouble! Normally, you can “talk down” the initial victim. However, you may have to physically push him or her out of the general area in order to prevent further clash. The attacking patient may have to be physically restrained if you cannot verbally calm him or her.

If you are caught in a choke hold, the best response is the “spinning choke release and yell” (fig. 2-5). This not only surprises the patient, but also relieves pressure from your throat and allows you to break the hold.

PROTECTING - FRONT CHOKE



Figure 2-5. Spinning choke release.

Spinning choke release and yell

When grabbed, immediately raise your arms straight up into the air and give a loud yell, like a karate expert uses when breaking a board with the fist. A yell will sometimes frighten the patient or get his or her attention immediately. Most often, the patient will look upwards, expecting you to use your hands in attack. Instead, at the end of the yell, immediately spin away from the hold as shown (fig. 2-5), and position yourself to ward off any further attack. This procedure not only breaks the choke hold but, normally, results in little or no injury to the victim.

Obviously, you will not be able to use this measure if the patient has you trapped on the floor and is on top of you applying pressure to your throat with both hands. In this situation, two fingers of each hand, firmly driven into the upper sides of the patient's body, are normally enough of a surprise to cause a release, allowing you to use your arms and freed head to gain some leverage in casting the patient off to one side or the other. If the first poke doesn't work, quickly apply another and another about 2 inches below the patient's armpits. This is an extremely sensitive area and will elicit a response from the strongest patient if applied firmly enough.

The bottom line regarding a choke hold is this: you must do everything you can to get out of the situation as soon as physically possible. Your life may depend on it.

Other personal safety maneuvers

The patient who pulls hair or grabs for your hands or arms most often does not intend severe physical harm. Normally, these patients are trying to regain a sense of control or are responding to perceived threats. For example, grabbing someone or pulling hair usually is seen as far less harmful physically as taking a punch at someone. Constant verbal intervention is a definite asset that often keeps the formally described true incidents from occurring.

Arm or wrist grab release

Patients often use arm grabs to try and control or respond to a perceived threat. Often failing to maintain a safe distance and moving your arms is interpreted as an attack. The patient will instinctively grab for your arms in a protective response. Normally, your thought and response is that you are being attacked. Again, to clarify the situation, use verbal intervention and ask the patient why he or she has hold of your arms. Assure the patient that your movement was innocent and that you mean no harm. If the patient refuses to release you at this point, you must take action to free yourself.

The weakest point of the patient's grasp is the open area between the thumb and first finger as shown in the arm grab illustration (fig. 2-6). In this situation, while verbally intervening, you have time to assess that a pull upward by you will break the weak point. If the patient has large or strong hands, the best approach is to swing your arms downward and upward applying most of the effort in the direction of the weak point. Normally, this confuses the patient as well as makes it difficult to maintain control of the grasp. Although you may have to swing your arms several times before a break is made, this method has proven successful. Again, practicing these moves with fellow technicians is extremely beneficial in preparing you for their use.

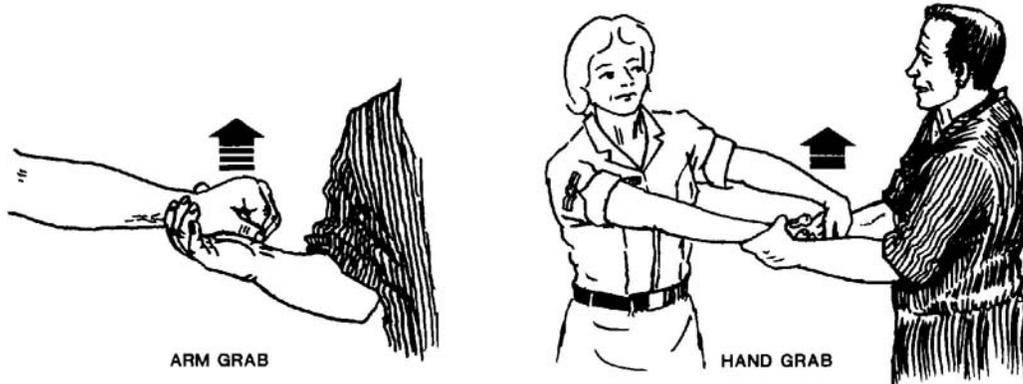
Hand grab release

If a patient grabs you by the hand instead of the wrist, normally, one of your hands remains free. I say this because it is much more difficult for the patient to maintain control if he or she grabs either of your hands with just one of his or hers. Normally, if the patient grabs both of your hands, the flexibility of the fingers allows you to free yourself with little pulling effort.

The most common experience is a patient grabbing your wrist with one or both of his or her hands (fig. 2-6), or grabbing your wrist with one hand and your fingers with another. In either case, your best response is to:

- Reach with your free hand, grab as much of your trapped hand as possible.
- Quickly thrust upward as shown in figure 2-6.

HAND GRAB RELEASES



HAIR PULLING RELEASE



- PUSH HEAD IN DIRECTION OF HAIR PULL
- APPLY PRESSURE ON PATIENTS KNUCKLES WITH HANDS

Figure 2-6. Personal safety precaution.

Again, try verbal intervention first; if results are negative, respond as quickly as possible without hurting the patient or yourself.

The methods described for breaking holds have been tested and can be used successfully with little or no harm to either the patient or staff member. Of course, it is always best to have more than one staff member in the area when dealing with an assaultive patient. But, as this is not always possible, using these methods may give you enough time to act or take alternative actions. Remember, practice is a lot easier than personal experience when it comes to assuring your preparation for use of these procedures.

Hair pulling release

While this form of attack is not extremely harmful, it is painful and will give you a headache. Your most effective tools for breaking a hair hold are the palms of your hands. Whether you are dealing with a single hold or the classical two-fister, the method shown in figure 2-6 is very effective. In the event of the single-handed hair pull:

- Lock the fingers of both hands together.
- Place the palms of your hands on top of the highest knuckle of the patient's hand, and apply downward pressure.
- Move your head down and towards the patient.

The downward pressure of your hands causes the patient pain which, in turn, causing release of the grip. The motion of your head down and toward the patient bends the patient's wrist inward, causing additional discomfort and difficulty in maintaining a grip. The two-fisted hair pull is handled in the same way; however, because you will be using one palm for each of the patient's hands, you will have to put forth a little more effort when applying pressure to the patient's knuckles. The same motion of the head—down and towards the patient—is applied to break the patient's wrist lock.

017. Control and transport holds

Physical restraint probably is one of the oldest methods used to control combative or out of control patients. In its earliest forms, patients were restrained by shackles and chains. As more humane treatment of the mentally ill developed, ankle and wrist cuffs, and seclusion rooms came into use. Now, due to pharmacology and new treatment modalities, there is less need for physical restraint. However, there are times when physical and mechanical restraints are required. Some patients simply cannot maintain control at all times. While there is an increased awareness of the patient's legal rights, you still have an obligation to protect both combative patients and other patients on the unit. Physical and mechanical restraints should be used **only as a last resort**. Keep in mind that good nursing care and verbal assuredness are still absolutely essential.

Use of control holds

There are times when you have to use force to control a combative or assaultive patient. Most patients want the staff to exercise control; if the staff cannot or will not do this, it heightens anxiety levels. Proper nursing intervention prior to the patient getting to this point may negate the need for physical or mechanical restraint. However, we are not concerned with the patient who is out of control. Many times, all that is needed to control a situation that would normally require intervention is a show of force by the staff. Staff members working together as a team, showing determination and willingness to control the situation, is often enough to reduce a patient's aggressive tendencies. If you are alone, however, and it becomes necessary to control a patient physically, many factors must be considered. Let's review three of the key factors.

1. Is there a clear and present danger of physical injury to warrant physical intervention?
2. Can you physically control the patient by yourself?
3. Is there a good chance that you or the patient may get hurt?

If you do not feel physically strong enough to handle the patient by yourself, then do not attempt to do so! Physical restraint of an extremely angry patient usually requires at least four staff members. Let's begin with physical control and transport of the reluctant or confused patient.

Single-technician control

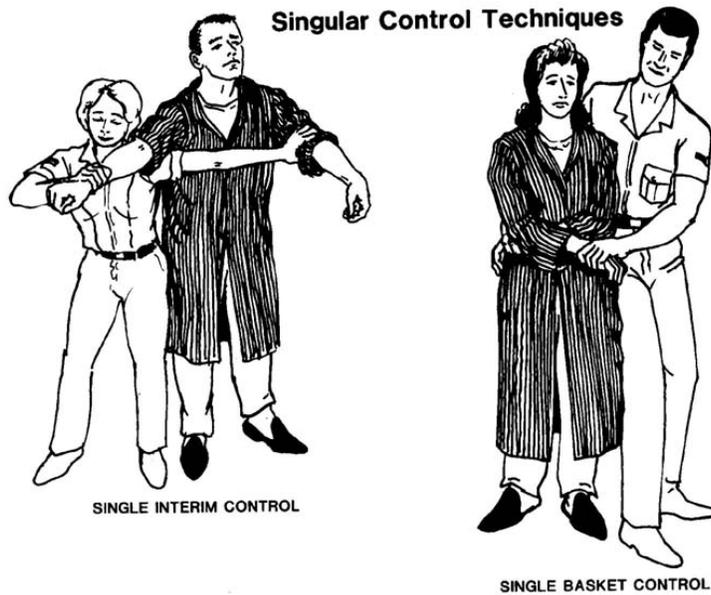
If you are alone and must establish control of a reluctant or confused patient, start by approaching the patient from the side while using verbal intervention.

- Explaining to the patient the reasons he or she must return to the unit or other area helps provide direction for the patient.
- Firmly place your hand closest to the patient's body on the patient's nearest shoulder, again remembering verbal messages of assurance.
- Place your other hand around the patient's nearest wrist. Usually this position is enough to move the confused patient in the direction you want him or her to go.

If you sense that the patient is somewhat reluctant or may attempt to repel your control, we recommend that you use the single interim control (fig. 2-7) to assist in transporting the patient.

- While holding on to the patient's wrist, slide your other hand off the patient's shoulder and under the arm you are holding by the wrist.
- Grasp the other arm at or below the elbow. At this point, your nearest arm should be under the patient's far arm.
- If the patient attempts to swing his or her far arm toward you, simply lift the arm you are holding by the wrist to block the swing. You are not likely to have much of a problem with this because you maintain control over both arms.

SINGLE TECHNICIAN CONTROL TECHNIQUES



DUAL TECHNICIAN CONTROL



Figure 2-7. Single and dual technician control.

Remember, the single interim control hold is suggested for transporting a confused, mildly reluctant patient only. If the patient becomes somewhat more reluctant to move, the single basket control (fig. 2-7) may be helpful in starting the patient underway.

- You grab opposite wrists.
- Cross the patient's arms in front of his or her body.

This position allows you to use your weight and hip to gently push the patient along. It also maintains control over the patient's hands. Practice both of these maneuvers to become proficient at them.

Two-technician control

When it is necessary to control a patient who is likely to become assaultive or physically reluctant, a minimum of two technicians should be available before any attempt at contact is made. Once again, this method should *not* be used on an extremely combative patient. Your judgment is crucial in determining the risk involved. Once you have made a decision to control and transport a patient, one staff member should be in place on each side of the patient. This should be a planned action that takes place quickly, allowing the patient as little time as possible to react. Once again, explain why returning to the unit is necessary and ask the patient to do so. If the patient is still reluctant, place your plan in motion. On cue, which you decide ahead of time:

1. Grab the patient's arms as shown in the transport position in figure 2-7. If the patient senses you are in control, more often than not, this is all that is necessary.
2. If the patient begins to struggle, you may need to assume the team control position (fig. 2-7.) To gain this position of advantage, each technician should place a leg in front of the patient while placing a hand on the patient's shoulder at the same time.
3. Quickly, without hesitation, push the patient forward and push the head down while maintaining balance, and grasp the patient by the outstretched arms (fig. 2-7). This places the patient in a helpless position, feeling as if any struggle would cause him or her to hit the floor face down. Placing the patient in a defenseless position is the purpose of the control position.
4. If the patient agrees to cooperate, return him or her to an upright position. If not, call for assistance to apply additional physical or mechanical restraint as needed.

Often, this show of controlled transport is enough to gain the patient's cooperation. It is advisable that you practice this maneuver to gain a sense of how helpless the patient will feel when placed in this position. When using this control procedure, your main concern is maintaining a secure grasp of the patient's shoulders and not twisting his or her arms.

Remember, protect the patient from harm. Do not initiate any physical restraint with thoughts of hurting a patient. If you are angry at the patient or feeling like you want revenge for a painful blow you have received, step away from the situation. You will not be of any positive use during the procedure. Do not feel ashamed of your thoughts. It is a natural response to get angry when someone intentionally hurts you. Relax, cool down, and attempt to reestablish rapport with the patient as soon as possible.

Mechanical restraints

Quite possibly, the most anxiety provoking situation you will encounter during your tenure as a mental health technician is the takedown of a patient for the purpose of applying restraints. Afterwards, you will feel as if you earned a month's pay, and you probably have. This is not only anxiety provoking for you but is also frightening for the patient.

Place yourself in the following situation: Verbal intervention has been attempted several times, and a patient remains uncooperative and out of control. It is obvious that the patient will hurt someone if you and the staff do not gain control soon. The patient has already attempted to hit a staff member who approached him earlier. This patient is too confused to listen to reason and verbally abusive

towards other patients. He or she is becoming more of a threat with each passing minute, and is working towards the dayroom pool table. What do you do? Where do you start?

Plan of action

This is the type patient everyone working on a mental health unit fears. Not only is the patient unconcerned about his or her own welfare, he or she normally is willing to fight for false beliefs, perceived threats, or to maintain control. The first step is to plan, as a team, your approach to the patient. Though verbal intervention did not work so far, it still remains a valuable commodity.

Select a team leader. Once that person is chosen, others should support him or her from that point on, regardless of personal feelings about how the situation is handled. Normally, the team is in agreement on the decision to employ takedown procedures. However, many technicians have been hurt in such procedures because they were not in agreement on tasks involved such as who handles which extremity, who applies the restraint set, and other tasks. The team leader sets the rules for the takedown! For safety, you should have a minimum of four technicians. Ideally, five personnel should be available: four to handle the patient and one to handle all other aspects such as getting restraints ready, clearing the way through the unit if other patients have gathered on the scene, and assuring that the seclusion room or appropriate area is ready to house the patient.

Once a time has been decided, all personnel should remove watches, pens, name tags, combs, and belts from their uniforms. This reduces the patient's opportunity to grab for potential weapons during the struggle. Normally, removing belts is not necessary; this should be determined by the individual situation and the patient's history of response to these situations. Determine whether the patient is right- or left-handed. This is important for defensive movements and in determining the direction a potentially harmful blow may originate from. The key action word or body movement should also be decided on. The word or movement is the team's cue to begin the procedure. Some technicians may get so focused on the key action word they don't jump in when a staff member is being attacked. Make sure this does not happen to you! Confusion at this critical point in the maneuver is not what you want. Good planning is essential for a successful takedown with little or no injury to anyone.

Takedown

If possible, the takedown should be done in an area free of dangerous objects and at a time determined by the staff to allow for preparation of the unit and movement of other patients. This is not the case in most takedown situations; therefore, caution must be taken not to injure the patient. Approach the patient as a determined group, showing confidence in your abilities. The team leader should use verbal intervention once again to gain the patient's attention and attempt to explain the need for maintaining control. The patient should be assured that he or she is not going to be hurt. On approach, the team members should position themselves toward the side of the patient to which they have been assigned. On cue, each team member acts in unison with the others to secure the assigned limb. Your goal is to get the patient in a face-down position as quickly as possible. This position reduces the patient's ability to move or strike out.

1. Grasp the limbs of the patient just above the joints. This provides better leverage and minimizes the risk of injury.
2. Technicians assigned to the arms can employ a move similar to that of the team control position we talked about earlier, pushing the patient forward and down at the shoulders.
3. At the same time, the technicians assigned to the legs should attempt to get the patient's feet approximately 2 inches off the floor and, while maintaining control, pull the legs back behind the patient to help with the face-down movement and to avoid kicks.
4. Once you have the patient in the face-down position, allow the patient some movement so that he or she can regain some sense of self-control.

The important thing to remember when the patient is face down is *do not let go* until the patient is controlled with restraints or can be trusted enough to agree to a verbal contract regarding getting to his or her feet and cooperating with limitations. Here are some important general rules to remember:

1. Physical intervention can be dangerous for both patient and staff and should be used only as a last resort.
2. Use your weight and leverage against the patient's strength. Avoid trying to overpower the patient.
3. Containing the patient face down (prone position) restricts his or her movement. However, there are risks in doing so.
 - Excessive weight on the back of a patient while in the prone position can cause the patient to asphyxiate by restricting the expansion of the patient's lungs.
 - Do not cover or bury the patient's face in an effort to prevent him or her from biting or spitting. Ensure his or her airway is unobstructed at all times.
4. Minimize space available to the patient and maximize the space available to the staff.
5. Use teamwork to your advantage.
6. Have enough personnel to do the job.
7. Don't attempt control without enough trained personnel. If necessary, clear the area of other patients and, if need be, allow the acting up patient to leave the area until enough personnel are available.

Application of restraints

For purposes of clarity and understanding, we limit our discussion about the application of ankle and wrist restraints to current Air Force mental health unit practices. Once the patient has been secured on the floor, the restraints may be applied. The fifth person on the team should do this one limb at a time. The team member in charge of the limb being restrained should maintain control while allowing enough movement to apply the restraint cuff. Before moving the patient, you need to determine if only the ankle restraints are necessary or if four-point (extremities) restraints are required.

Many times, patients and staff have been injured trying to get the patient from the point of takedown to a bedroom or seclusion room. Restraints should be applied at the point of takedown unless the patient can be trusted to walk to an alternate area. Once in the area of confinement, the decision of how to restrain the patient to the bed must be made.

- If *two-point* restraints are indicated, secure one arm and the opposite leg to the bed frame.
- If *four points* are required, you have an option when securing the arms: Either secure each arm to the bed frame or secure them to a restraint strap that has been placed around the patient's waist.

The latter method is quickly gaining popularity because it allows the patient a more comfortable lying position and permits some limited hand movement, but not enough to hurt anyone nearby.

Only padded restraints are applied in order to prevent injuring the patient's wrists and ankles. You may also need to add additional padding to the restraints in order to keep patients of smaller stature from slipping out of them. Normally, all restraint sets are padded by the staff as soon as they are received on the unit. This eliminates using crucial time to accomplish this task during or after a takedown. Adjustments to the initial padding can usually be made quickly and easily.

The key item to remember during restraint application is the restraint key. Restraint keys **disappear!** No one ever seems to know where or how; they just do, especially when you need them the most. If you don't have your own restraint key now, get one. Carry it in your wallet, on your key ring, in your

shoe, or any place you choose, but get one. Restraint application needs to be done quickly. There will be no time to look for a key.

In most instances, a doctor's order should be obtained before a patient is placed in restraints. The only exception should be if time does not permit obtaining the order. In this situation, obtain the order as soon as possible after the restraints are applied.

Aftercare

Your work is not complete when the patient is restrained. You need to offer the patient nourishment and bathroom privileges often. Circulation around the restrained extremities must be checked. Vital signs must be checked at intervals *not to exceed* 15 minutes, especially if the patient was administered medication as a result of his or her behavior. Your verbal support and reassurance should continue. Using restraints requires constant nursing care. Your goal is to get the patient out of restraints as soon as possible. Failure to act appropriately to protect the patient's rights and health could be, and has been, viewed as abuse. Provide the best care possible!

018. Identify chemical/psychopharmacological restraints

This lesson is intended to orient you to the different types of psychopharmacological restraints that may be available to a physician and help you become familiar with their intended purpose. You may be asking why you must learn about something that you will not be able to administer or direct? It is important for you to familiarize yourself with all aspects of treatment.

In addition to the various types of intervention, including mechanical restraint discussed in the previous lesson, there is an option for chemical restraint. Officially referred to as psychopharmacological restraint, this is often used to complement another form of restraint that has already taken place. It is *never* used as a first line restraint method for an aggressive/assaultive patient.

Unlike popular Hollywood portrayals of psychopharmacological restraint, the medication is not the panacea for acute aggressive behaviors. The notion that the patient will immediately fall into a drug induced stupor on administering the medication is a fallacy. An elderly patient may be asking in the sweetest voice "please, let me go" one minute, and violently shaking his arms and legs screaming "you want a piece of ME!?" while trying to break free the next.

There are limits and reasons for using a pharmacological intervention and the physician must weigh each carefully.

Physiological etiology

At times a patient's physical condition may be masked by aggressive or bizarre behavior. Any physiological etiology should be ruled out before medication is administered. If the staff knows the patient, this is easily ascertained. You will readily have access to the patient medical history. However, if the patient is unknown to the treatment facility, several initial questions should be asked before proceeding with chemical restraint.

1. Is the patient currently intoxicated or under the influence of an illicit or prescribed medication?
2. Has the patient undergone recent medical treatment?
3. Has the patient recently suffered a head injury?
4. Is the patient diabetic?
5. Is the patient suffering from delirium?

If the patient is unknown to the staff, at the very least vital signs should be taken. This may mean the patient needs to be placed in mechanical restraints before obtaining the vital signs. Family members

accompanying the patient are often excellent sources of information on the patient's medical past. If this is not possible, the physician may order a blood glucose and toxicology screen as a means to ferret out any physiological condition that may be masked by the patient's aggressive or bizarre behavior.

If physiological causation can be ruled out, the physician may entertain using a chemical restraint. The concept of chemical restraint hinges on whether an agent is given as a part of the treatment of the patient's condition or simply to control the patient's behavior.

Common psychopharmacological interventions

The objective of a pharmacological intervention is typically to decrease agitation by inducing a level of sedation. There are many medications that can be used and some are preferred by physicians over others. Our discussion focuses on four types of medications commonly used in psychiatric emergencies: droperidol, lorazepam, haloperidol, and atypical antipsychotics.

Experts consider droperidol, lorazepam, and haloperidol the most effective medications for reducing agitation. The most sedating of the four agents includes droperidol and lorazepam.

Onset

Again, as was addressed earlier in the "make believe" world of Hollywood, sedation is not immediate. Intravenous (IV) medication of any class is considered to have the quickest onset. Intramuscular (IM) medications are the next quickest venue for onset followed by concentrate or orally dissolving formulas.

Now that you know the routes of administration, you may be asking about the feasibility of administering each if the patient is uncooperative. IV administration of medication to an agitated psychiatric patient is *not* recommended and may not even be possible. More often than not you will witness an IM administration of medication which, in some cases, can have as quick an onset as an IV as in the case of droperidol.

Note that the onset of IV administration is relatively quick, occurring normally within 5 minutes. Again, the practicality of such rapid onset makes it virtually impossible to utilize. Haloperidol's effects generally occur within 30-60 minutes post IM injection.

The effects and onset will vary from patient to patient based upon the amount of medication used and the venue it is administered. Sometimes medications are mixed with each other in a synergistic effect commonly referred to in slang terms as a "cocktail." One such example is referred to by the slang "B52," this "cocktail" mixes 5 mg. of haloperidol and 2 mg. of lorazepam. It is easily administered via IV, IM, and PO. Each provider may have a favored medication and this is simply an example of one physician's preferred method.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

013. Crisis management

1. What three factors are usually present to produce a crisis?
2. What type of crisis is often predicted?
3. What kind of events normally results in a situational crisis?

014. Restrictive measures

1. Define restriction.
2. Identify six examples of pre-aggressive behavior.

015. Seclusion measures

1. How do you determine if seclusion is necessary?
2. When should seclusion be used?

016. Physical response techniques for protection

1. What are the active phases of the assaultive cycle?
2. What is the most important part of body positioning for self-protection?
3. What is the best method of response if the choke hold is applied to you and why?

017. Control and transport holds

1. What are the three key factors to remember when you are alone and trying to control a patient physically?
2. In what situation is the single interim control hold suggested?
3. When restraining a patient, what purpose does the key action word serve?
4. If two-point restraints are used, where should the client's body be positioned?

018. Identify chemical/psychopharmacological restraints

1. What should be determined prior to the introduction of any medication?

2. What is the objective in administering any psychopharmacological restraint?
3. Of all the venues for administering administration, which method is considered the quickest?
4. Why are some medications mixed at the time of administration to the patient?

Answers to Self-Test Questions

008

1. Motivated by the spread of HIV which eventually leads to AIDS, the CDC issued universal precautions.
2. Reducing the risk of transmission of microorganisms.
3. Collecting data on all infections acquired within the facility, investigating the causes of any breakout of infections in the facility and most important of all educating all personnel of current concepts in prevention and control of infections.
4. The virus has been found in blood semen, vaginal secretions, saliva, tears, breast milk, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, and urine. It is spread by unprotected contact with any of these fluids, NOT by casual contact with an infected person.

009

1. 15 seconds.
2. If hands feel dry after rubbing hands together for 10 to 15 seconds, insufficient volume of gel was applied.

010

1. To transmit and receive a constant series of messages by electrical impulses to and from the control center located in the brain.
2. The central nervous system (CNS) which includes the brain and spinal cord, and the peripheral nervous system (PNS) comprising of cranial nerves and spinal nerves.
3. Smoking, lack of sleep, poor diet and stress.

011

1. The right to request assistance without fear of coercion, discrimination, or reprisal. Your rights under the AFOSH program also include: (1) The right to request an inspection of any area you feel is unsafe for you or the patients you care for; (2) The right of access to the health and fire prevention regulations; (3) The right to decline to do a task because of a reasonable belief that, under the circumstances, the task poses an imminent risk of death or serious bodily harm, coupled with the belief that there is not enough time to seek effective redress (make the condition right or safe) through normal hazard reporting procedures; (4) The right to use official time to participate in AFOSH programs.
2. AFI 91-301, *Air Force Occupational and Environmental Safety, Fire Protection, and Health (AFOSH) Program*.
3. The right drug, right dose, right patient, right route, right time.
4. Fuel, oxygen, and heat.

012

1. Report all fatalities, injuries requiring hospitalization, injuries involving three or more people, property damage, or injuries resulting in lost time on incidents, accidents, or unusual occurrences may include, but are not limited to, falls, burns, or theft of a patient's valuables. For example, a specialist who is injured while attempting to place a combative patient in restraints should complete an AF Form 765.

2. The MTF commander.

013

1. (1) An event.
(2) The meaning of the event to the individual and/or family.
(3) The nature and extent of the individual's or family's coping mechanisms.
2. Developmental crisis.
3. An unexpected loss of a loved one, loss of job, or natural disaster, such as floods or tornadoes.

014

1. A limitation, to keep within limits, to confine, and in a literal sense, to restrain.
2. Pacing or walking the floors. Interest in weapon type items. Sleep disturbance. Withdrawal. Hyperactivity. Changes in voice level.

015

1. If and how seclusion is used should be determined by the patient's specific condition or needs.
2. Seclusion should only be used when other therapeutic measures fail.

016

1. Trigger phase, escalation phase, crisis phase, recovery phase.
2. The most important part of positioning is maintaining a safe distance from the patient.
3. The best method of response is the "spinning choke release and yell".

017

1. (1) Is there a clear and present danger of physical injury to warrant physical intervention?
(2) Can you physically control the patient by yourself?
(3) Is there a good chance that you or the patient may get hurt?
2. Transporting a confused, mildly reluctant patient only.
3. The word or movement is the team cue to begin the procedure.
4. One arm and the opposite leg should be secured to the bed frame.

018

1. Any physiological etiology should be ruled out.
2. To decrease agitation typically by inducing a level of sedation.
3. Intravenous (IV) medication of any class is considered to have the quickest onset.
4. Sometimes medications will be mixed with each other in a synergistic effect commonly referred to in slang terms as a "cocktail."

Do the unit review exercises before going to the next unit.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter.

19. (008) Which Centers for Disease Control (CDC) germ-spreading preventative measure is *used universally throughout the Air Force*?
 - a. Universal precautions.
 - b. Standard precautions.
 - c. Body substance isolation.
 - d. General substance isolation.
20. (008) How many years can the human immunodeficiency virus (HIV) remain dormant before symptoms develop?
 - a. 5.
 - b. 8.
 - c. 10.
 - d. 15.
21. (009) Which organization *must* approve all disinfectants used in the medical treatment facility (MTF)?
 - a. Occupational, Safety and Health Administration (OSHA).
 - b. American Psychological Association (APA).
 - c. Environmental Protection Agency (EPA).
 - d. Joint Commission.
22. (010) The somatic nervous system's *motor responses* are
 - a. automatic.
 - b. voluntary.
 - c. involuntary.
 - d. delayed.
23. (010) What slows down the body and helps prepare for more relaxed state, ready for digestion and sleep?
 - a. Fight or flight response.
 - b. Peripheral nervous system.
 - c. Sympathetic nervous system.
 - d. Parasympathetic nervous system.
24. (011) In order to ensure that personnel are safe from work-related deaths, injuries, and illnesses, the Air Force complies with what organization's guidelines?
 - a. Joint Commission.
 - b. Environmental Protection Agency (EPA).
 - c. American Psychological Association (APA).
 - d. Occupational, Safety and Health Administration (OSHA).
25. (011) According to the Air Force Occupational Safety, Fire Prevention and Health (AFOSH) Program, civilian employees have the right to request assistance *without fear of all of the following except*
 - a. redress.
 - b. reprisal.
 - c. coercion.
 - d. discrimination.

26. (011) When lifting or moving a bedridden patient, what part of your body should endure most of the strain?
- Arms.
 - Legs.
 - Back.
 - Feet.
27. (011) Which of the following is *not an element of combustion*?
- Fuel.
 - Heat.
 - Oxygen.
 - Ignition.
28. (012) When a staff member is involved in or discovers an accident, who initiates the AF Form 765, Medical Treatment Facility Incident Statement?
- Only the safety officer.
 - Only the supervisor.
 - The staff member.
 - Any nurse.
29. (013) Which type of crisis is often predicted?
- Situational.
 - Transitional.
 - Disorganized.
 - Developmental.
30. (013) During which crisis stage does the individual try to use previously used coping mechanisms on his or her current crisis?
- Disorganization.
 - Local reorganization.
 - General reorganization.
 - Attempts to reorganize.
31. (013) During which crisis stage does the individual realize that attempts to escape the problem fail and move into this stage?
- Disorganization.
 - Local reorganization.
 - General reorganization.
 - Attempts to reorganize.
32. (014) Which is *not* considered a pre-aggressive behavior?
- Withdrawal.
 - Hypoactivity.
 - Sleep disturbance.
 - Changes in voice level.
33. (014) What approach should you use when *area restriction fails*?
- Talk to patient.
 - Room restriction.
 - Manual restraints.
 - Mechanical restraints.

-
-
34. (015) Which is *not* considered a *seclusion measure*?
- Restraining a patient in a bed in a locked room.
 - Limiting interactions between the patient and peers.
 - Locking a patient in a room with only a mattress on the floor.
 - Allowing the patient privacy in his or her room without locking the door.
35. (016) What is the *first phase* of the active phases in the *assaultive cycle*?
- Crisis.
 - Trigger.
 - Escalation.
 - Recovery.
36. (016) The patient is *most likely to assault* someone during which phase of the *active phases*?
- Crisis.
 - Trigger.
 - Escalation.
 - Recovery.
37. (016) Which phase of the *active phases* offers the *opportunity for therapeutic growth* for the patient and staff?
- Crisis.
 - Trigger.
 - Escalation.
 - Recovery.
38. (017) The *minimum number* of staff required to *physically restrain a patient* is
- 2.
 - 4.
 - 5.
 - 6.
39. (017) When physically restraining a patient, who sets the rules for the takedown?
- Highest ranking.
 - Team leader.
 - Provider.
 - Nurse.
40. (018) Before proceeding with chemical restraints, all of the following questions should be asked *except*
- is the patient diabetic?
 - is the patient currently intoxicated?
 - how much has the patient eaten today?
 - has the patient recently undergone medical treatment?

Please read the unit menu for Unit 3 and continue →

Student Notes

Unit 3. Cultural Diversity and the Counselor

3–1. Understanding Ethnic and Racial Issues..... 3–1
 019. Identify the influence of ethnicity on the counseling relationship 3–1
 020. Identify barriers in the counseling relationship 3–3

3–2. Understanding Age and Gender Issues 3–10
 021. Identify specific age-related issues 3–10
 022. Identify gender-related issues that may influence the counseling relationship..... 3–14

WE LIVE in a world that is increasingly diverse. It is diverse in terms of multi-ethnic identities, socioeconomic background, lifestyle choices, religious thoughts, political stances, and manners of self-expression. The list could be virtually endless. Evidence of this abounds in our Air Force culture. Fearing that which is different is human nature. However, taking the time to understand and appreciate differences will reduce that fear and enhance the counseling relationship.

3–1. Understanding Ethnic and Racial Issues

Each person possesses unique qualities that require not only the recognition of differences and how it may affect your interaction but also to gain a broader understanding of the counselee/counselor relationship. Education and exposure to other cultures foster a greater understanding of how these differences influence the counseling relationship.

019. Identify the influence of ethnicity on the counseling relationship

Your social and personal interactions with people are usually based upon a commonality you share with that group. Understanding your feelings toward specific groups of people and, likewise, understanding their feelings towards you will help you build a more productive counseling relationship.

Key terms

To understand the key terms used throughout this lesson, we will define the terminology. According to *Webster’s II New College Dictionary*, ethnicity, race, and culture are defined in the following way:

Key Terms	
Term	Definition
Ethnicity	Of or relating to a religious, racial, national, or cultural group.
Race	A local geographic or global human population distinguished as a more or less distinct group by genetically transmitted physical characteristics.
Culture	The totality of socially transmitted behavior patterns, arts, beliefs, institutions, and all other products of human work and thought typical of a population or community at a given time.

It’s important to clarify exactly what you mean when using the terms ethnicity, race, and culture. As you can see, although related, these terms are very distinct. Ethnicity may include a race and is primarily concerned with the commonality of groups of people. On the other hand, culture refers to the behavioral manifestation of ethnicity. Take our Air Force family for example. In the Air Force, collectively, everyone subscribes to the same traditions and core values. We participate in promotion ceremonies, award ceremonies, commander’s calls, retirement ceremonies; behaviors that reflect our commonness in thoughts and values. These are the elements that make the Air Force a culture.

Social influences

From the time you were born, you were influenced by your surroundings. You made decisions based upon acceptable norms in your family or community. Social influences change as you get older and tend to focus more on peers, social activities involving school, and your neighborhood. Many facets are included in people's social influences; for example, race, geography, language, finances, religion, politics, and class to name a few. You brought a part of your community and family influences with you when you joined the Air Force. Recognizing these influences within yourself and those perceptions others may have about you are necessary as a mental health journeyman. Cultural diversity training has progressed far beyond race, ethnicity, and culture. Cultural diversity really encompasses all things different from your individual experiences. It includes gender, class, geographical origin, socioeconomic status, lifestyle choices, and every other combination of factors you could possibly think of.

Racism

The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) defines racism as follows:

"Any distinction, exclusion, restriction, or preference based on race, color, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment, or exercise, on equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural, or any other field of public life."

No doubt, each of us has experienced the opportunity to participate in discussions regarding racism. We may have discussed slavery, the Japanese internment camps, or the Native American conditions. All of these dynamics have influenced race relations. Such conversations typically digress to exercises in finger-pointing. We become mired in historical rhetoric that prevents us from moving forward and improving race relations. That is not to minimize the significant impact of these events. Simply not talking about racism or oppression does not mean it does not exist. Yes, racism is alive and well in our society, including our military culture. However, some may rarely concern themselves with it until it touches them in a very personal way. The reality is that these obstacles will not change until people start to change their attitudes toward differences. The way to change attitudes and open up to differences is through exposure to new cultures, experiences, and traditions. Indeed, it is essential to develop and cultivate a genuine interest in understanding diverse people.

Prejudice

The *American Heritage Dictionary* defines prejudice as "An adverse judgment or opinion formed beforehand or without knowledge or examination of the facts or a preconceived preference or idea." Taken literally, prejudice essentially means to pre-judge something. We tend to make assessments about a situation or people based on past experience, a learned stereotype, or what we've seen in the media. It is a perception that may or may not be accurate. We all have prejudices, although we don't often like to admit it. Prejudices serve a useful purpose in that they help us determine our likes and dislikes. Our prejudices then facilitate the development of preferences.

Can you think of a time in your clinic when a new referral came in? A typical referral might be the young, male airman who was in a fight in the dorms while underage drinking. Well, we all know how the "new breed" of airman is; right? No respect for anyone else and does what he pleases when he pleases with little regard for the consequences. Have you prejudged the individual? Absolutely, you have! Does this attitude have the potential to affect the quality of care you provide? The answer is certainly yes.

Discrimination

The *American Heritage Dictionary* defines discrimination as "to make clear distinction; distinguish; differentiate or to act on the basis of prejudice." You discriminate when you act upon your prejudices. Just as prejudices are not inherently good or bad, the same is true for discrimination. If your behavior

places someone else at a disadvantage, then you need to find some way to make changes. Discrimination deprives someone of something. It may deprive someone of an opportunity, equal access to services, or certain rights. For instance, the counselor's preconceived notion that the young airman has little regard for consequences could potentially deprive that airman of communicating key feelings about the incident—for instance, his shame in disappointing his commander, fear over the pending disciplinary action, and remorse for fighting with a fellow airman. Eventually, the attitude and bias such a counselor displays will squash the airman's potential to gain insight from his experience that might compel him to change his behavior.

020. Identify barriers in the counseling relationship

Perhaps you have had an experience that caused you to be weary, suspicious, or distrustful towards an individual. Did your encounter cause you to label every member of that community in a bad light based upon your sole experience? Patients will sometimes hold perceptions based not only upon the racial, cultural, or gender differences which may exist, but also their perception of you as a member of the healthcare community.

Stereotypes

Again we turn to the *American Heritage Dictionary* to define stereotype:

“A conventional, formulaic, and usually oversimplified conception, opinion, or belief or a person, group, event, or issue considered typifying or conforming to an unvarying pattern or manner, lacking any individuality.”

A stereotype is a relatively simple and inflexible set of traits consistently applied to some category of people. Most of us have heard these examples at one time or another:

- Men are aggressive and oversexed.
- Women are weak and talkative.
- Fat people are jolly and lazy.
- Master Sergeants never do any work.

Stereotyping is a normal part of our day-to-day functioning and has been used to simplify things. Stereotyping gets “credibility” from your belief that it helps you to keep track of all life's complexities. It's okay as long as reality remains the ultimate arbiter of truth, but that is often not the case. Here are a few examples of the potential pitfalls that derive from stereotyping:

Sweeping generalization

When you generalize, you tend to take the traits associated with a group and force them upon an individual belonging to that group. However, an individual group member may not reflect the traits associated with the group, even if those traits are accurate. Norms need not be adhered to; averages are fictions. How would you like to be denied a job because your appearance suggests to the employer that you won't work efficiently?

Hasty generalization

Hasty generalization is taking an individual's traits and assuming that they apply to all members of that individual's group. People often build stereotypes on the flimsiest of foundations, such as the following:

Hasty Generalization Sources	
Type	Description
Second-hand information	Many, if not most, stereotypes are based on what others tell us; those social influences such as our families, teachers, friends, media, etc. who may, in fact, have heard it from someone else. Where did you get that stereotype about Muslims, for example? Have you actually met a Muslim? How well did you get to know them, if you did?
Out-dated information	Even if the second-hand information contains some truth, it may well be based on experiences of long ago. Many stereotypes are rooted in the hatreds towards immigrant groups developed 100 or more years ago.
Limited samples	Whether the stereotype is second-hand or is based on personal experience, it may well be based on limited experience with the group in question. If you have indeed met some folks who were Muslim, how many have you met, and are they a representative population? Take Italian food for example. Most Americans think of Italian food as involving pasta, olive oil, and tomato sauce; in fact, much Italian food is a matter of bread, fish, butter, and white sauce. Most immigrants to the United States were from the southern regions of Italy, and that is the "sample" of cooking which we are familiar!
Vividness	What is most noticeable about a group, what makes them more different from others or us is often falsely considered to be the norm. Arabs are oil-rich, the Dutch wear wooden shoes, American Indians wear feathers...all three of these are exceptional, yet, because they are distinctive, they stick in our minds. Yet, these images are often prominent in our thoughts. Polynesians are sensual, Japanese are extremely polite; even when the characteristics contain a certain amount of truth, they often hide other, equally true, characteristics. The Polynesians, for example, have some pretty strict rules about modesty, and the Japanese can be very direct, even cruel, when dealing with outsiders.

Unjustified inferences

We add information that is or isn't there. Inferences made from observations in your own society may be entirely irrelevant when applied to another. For example a society may consider bathing only once a week as being dirty, and being dirty is considered anti-social, and being anti-social is considered very, very bad. Do you have a right to make such inferences? Does dirty mean bad? Some cultures consider us rather dirty: The Japanese, for example, wash themselves completely before getting into a bath. Or, to take another example, ragged clothes may mean mental illness in the suburbs, but it just means poverty elsewhere.

This is often the result of lack of information or misunderstanding. We seldom have all the information we need to understand another group of people. Behaviors considered bizarre by your standard or other's expectations often have logical basis. In some countries, for example, water is less plentiful and the dryness evaporates most perspiration. In poor countries, plumbing and clean water may be hard to find. In cold countries, bathing may be downright dangerous. We forget that not so long ago our own grandparents rarely bathed more than once a week. In many places, people do not have the rather intense sensitivity that we have about body odors; you don't have to be antiseptic to be clean.

Sometimes there's the influence of self-fulfilling prophecies. People often "live up" to other's expectations. For a fat person, being jolly might mean acceptance. For some ethnic groups, pride is

shown by exaggerating ethnicity. For example, in some instances Native Americans, have adopted the dress, rituals, and art of other tribes and vice versa.

Stereotypes evolve out of the need to provide an explanation for behavior different from your own. Misperceptions, distortions, or isolated experiences often form the basis of a stereotype. Stereotypes are dangerous for a number of reasons. First, stereotypical thinking prevents you from considering new ideas. Second, these thoughts are usually the basis for and precede discriminatory behavior. Finally, stereotypes prevent you from regarding the person as an individual.

Language as a barrier

What you say, how you say it, your body posture, eye contact—all have an impact on communication. There is an almost endless list of prescriptions that impact the way you communicate. These are often misunderstood, causing the meaning to get lost in personal interpretation. We've all heard or made comments like: "He never makes eye contact when he speaks, so he can't be trusted or he's lying." "She talks with such a southern accent," (assumption—she's uneducated). "He's got a northern accent and talks so fast," (assumption—he's rude). You've heard these generalizations and perhaps you have assigned your own interpretations of how people speak. Being aware of your own thoughts and prejudices about the manner in which a person communicates is not only beneficial for the patient but for you as well. With this in mind, let's look at two of the more common barriers to language.

Verbal language

For our purpose, verbal language refers to both the written and spoken word. Certain characteristics of verbal language may create communication barriers. Obviously, if the people communicating do not speak the same language, it is difficult for them to understand one another. Translating from one language to another can be challenging. Translation sometimes alters the meaning of a word or phrase. Additionally, many people whose primary language is not English report that, although they have a good command of English, they process their thoughts in their native language. This internal translation can create longer pauses than we are normally accustomed to and can lead us to erroneously conclude that the person is mentally slow.

The words people choose may also affect understanding. For instance, some people may have difficulty understanding slang terms. The volume of spoken words varies from culture to culture as well. Persons from cultures that value conversations that quickly get to the point may become annoyed when the conversation seems to be prolonged with unnecessary chitchat. Conversely, other cultures consider it rude if pleasantries are not exchanged before getting to the point of the conversation.

Rate of speech is another consideration. In some cultures, speech is fast and loud, and the speakers use many gestures. This is sometimes seen by different cultures as aggressive, confrontational, bossy, intimidating, and arrogant communication.

Nonverbal language

Two important considerations of nonverbal language are eye contact and use of personal and interpersonal space. The meaning of eye contact varies from culture to culture. Some cultures consider direct eye contact confrontational, hostile, or aggressive. On the other hand, other cultures avert the eyes to show respect for the person's position, authority, or age. Westerners place a high premium on direct eye contact. Mental health workers may consider lack of eye contact as indicative of depression or low self-esteem. It is important to clarify the meaning behind the individual's behavior. Arbitrarily assigning meaning based on our understanding of the behavior can lead to misperceptions.

The comfort of personal space versus interpersonal space varies among individuals and from culture to culture. In the Western culture, four zones are associated with the amount of space relative to comfort:

Comfort Space	
Zone	Description
Intimate space (Contact to 18 inches)	This area is very sensitive for most people—only those with whom they are intimate are allowed in this area. However, the nature of healthcare often dictates contact in intimate space. For instance, taking a patient's vital signs necessitates working within the intimate space.
Personal space (18 inches to 4 feet)	This space is where most friendships and therapeutic relationships occur.
Social space (4 to 12 feet)	This space is where the business of day-to-day interaction takes place.
Public space (Greater than 12 feet)	This space is where formal interactions (i.e., commander's calls, formations, attending classes) take place.

Culture-specific considerations

Each of us comes from a unique culture. Your family might be considered a sub-culture within your community. You fit into your community, but within your family are unique qualities that mold your thoughts, prejudices, and reactions to others or those considered outsiders. There is no possible way to define every unique quality of each culture. However, in this discussion we discuss generally recognized qualities that are unique to specific cultures. Be aware that generalizations may not provide an accurate depiction of your patient. Always take the opportunity to educate yourself and ask questions that will increase your awareness of your patients and the unique cultural attributes they bring to treatment.

Healthcare providers share a common culture, just as an ethnic group does. Four general observations of the healthcare provider's culture are:

1. The education and training of healthcare providers often changes their perception of healthcare. Providers abandon past beliefs and values regarding medicine and adopt those of their new medical community.
2. Westernized healthcare providers typically value empirically supported diagnostic tools and treatment approaches.
3. Healthcare providers are accustomed to the power position. Based on their education and training, there is an expectation for the patient to place blind faith in the provider. They may feel offended when their decisions and recommendations are questioned.
4. Providers may unwittingly become ethnocentric, unable to consider alternatives to scientifically based healthcare approach.

These beliefs potentially lead to the clashing of values between provider and patient. The provider's faith in the scientifically based healthcare system may make it difficult to consider the importance of the patient's belief system. Some cultures emphasize the power of prayer, the influence of a spirit world, New Age medicine, witchcraft, or even magic spells. Depending on how firmly patients hold onto these beliefs, scientific evidence may not be very assuring in validating effectiveness. The challenge is for the provider to become well-enough acquainted with the patient to identify conflicting values and beliefs and then figure out a way to construct a treatment approach that aligns treatment goals with patient expectations. Failure to do so risks creating frustration between patient and provider. This may impair treatment unnecessarily and risk mislabeling the patient as non-compliant, resistant, or a treatment failure. Let's look at the following chart that provides an overview for a variety of ethnic groups and key historical influences, core cultural values, on the influences on accessing health care.

	Key Historical Influences	Core Cultural Values	Influences on Health Care Use
Mexican American	Mexicans were early migrants to the Americas; over thousands of years and several civilizations they have adapted and acculturated. Eventually settled in Mexico and border areas then annexed to the US, which created adverse social conditions.	Women were held in high regard in Aztec culture but later excluded during the colonial period. Traditional family values survive; loyalty, solidarity, community, and extended family are important, as are cooperation, respect, and the Catholic religion.	Use of herbal treatments and prayer provides healing on emotional, spiritual, and physical levels. Traditional healing complements modern medicine. Revival of positive cultural attributes holds hope for disease-preventing lifestyles.
Puerto Rican	There are two distinct groups; in Puerto Rico and in the US mainland. Island economy has transformed from rural to urban, service-based economy.	Strong family ties, female-headed and single-parent households are common. Lifestyles differ between US mainland and Puerto Rico groups, but core values and religion cut across the regions.	Cost, language, and discrimination are often barriers to care in the US mainland. The view that physicians are insensitive is often a barrier.
Cuban American	There have been several waves of immigration to the US, in the 1950s and 1960s and again in the 1980s. Most immigrants have been political exiles fleeing an oppressive government regime.	Cuban society is highly patriarchal, with men expected to provide for their families; this seems to have led to greater strain on males. Loyalty to family is an important value.	A sense of “specialness” and take-charge attitude may promote self-care. Early surveys found high fear and fatalism about cancer. Culturally and linguistically targeted preventative health programs seem to have been effective.
African American	First brought to the US as slaves, African Americans have historically been in a disadvantaged position. Racial integration and equal legal rights remain a challenge for this community.	African American women are traditionally in a subordinate position. Family and kinship networks are strong, with churches often central to a sense of belonging. Women have a key role in stability and caring for the family.	African Americans are more likely to use preventive care if it uses culturally appropriate methods, such as lay peer educators, family and community networks, and community outreach.
Asian American	Wide variations in history exist; more than 25 ethnic groups ranging from 5 th generation to recent immigrants and refugees. Experiences in immigration and acculturation in the US are also widely divergent.	An internal balance or equilibrium is believed to support health; keeping balance between “cold” (yin) and “hot” (yang) elements leads to good health; “chi” is energy circulating through the body.	Access to and use of health care is related to cultural, linguistic, and other social barriers. Traditional healers and herbal medicines are common; Asian Americans may feel no need for Westernized preventive care.

	Key Historical Influences	Core Cultural Values	Influences on Health Care Use
Native Hawaiian	Europeans introduced disease and brought cultural and social disruption to the indigenous Polynesian population. Hawaii's monarchy was overthrown by the Americans and it was annexed to the US in 1898. Intermarriage has reduced the number of ethnic Hawaiians.	Efforts to preserve and enhance cultural heritage and overcome historical displacement have recently intensified. Emphasis is on social harmony, family, interdependence/oneness , and ties to the land. Women are seen as powerful actors in society.	Provision of culturally acceptable services is a continuing problem. Women respond to personal interaction communication, problem solving. Traditional healers and remedies are often used. Limited number of Native Hawaiian health professionals is a further barrier.
American Samoan	Residing in Samoan archipelago or US mainland, American Samoans have a Polynesian heritage and village leadership systems. The US has influence, and migration patterns are usually family related.	Communities are tightly knit, with close ties to churches and families. Some adjustment difficulty occurs among migrants, more in Hawaii than anywhere else.	Culturally based beliefs about diseases are common and many prefer traditional healers and herbalists. Belief in supernatural causes of disease may lead to a delay in seeking westernized health care.
American Indian	Land base and resources were lost with European migration; displacement, relocation to reservations, epidemics, and poverty ensued.	Male-oriented traditions dominated for many years. View of health is holistic, emphasizing harmony/balance in body, mind, spirit, and emotions.	Illness can have natural/supernatural causes; it is taboo to talk about cancer owing to "power of language". Many are reluctant to "look for illness" (preventive medicine).
Alaska Native	Indigenous people were disrupted by European/Western culture and commerce.	Alaska Natives have strong family/communal ties, spirituality, and a traditional subsistence lifestyle.	Women may neglect their health in favor of their families; traditional healing practices are common, although communication styles may differ.

Strategies for becoming culturally competent

It is unreasonable to insist that a counselor be knowledgeable about every culture, ethnic group, race, minority, and subculture. However, counselors have a responsibility to make the most of every opportunity to learn about the various groups in the area where they are assigned. Patients will appreciate a genuine attempt to understand and learn about their particular ethnic group or culture.

Characteristics of culturally skilled counselors

Culturally skilled counselors demonstrate nine common characteristics:

Culturally Skilled Counselor Characteristics	
<i>Characteristic</i>	<i>Description</i>
Awareness	This is the first, and also the most important, characteristic for a culturally skilled counselor to have. They understand their cultural background and are aware of the dynamic interplay in the counseling relationship with patients from other cultures.
Aware of their biases and prejudices	They understand the potential for these to adversely affect the counseling relationship and move to resolve these before they create conflict.
Knowledgeable about racism, discrimination, oppression, and stereotypes	They seek to understand how these dynamics have influenced their relationship with the patient.
Recognize the limits of their cultural experience	They are skilled at building rapport with their patients in a way that fosters direct and open dialogue regarding cultural issues.
Appreciate and respect differences	They are comfortable consulting and making referrals when it becomes necessary.
Take steps to overcome language barriers	They are aware of resources in their community that can help both the patient and the provider overcome this obstacle. This may take the form of using an interpreter or referring the patient to community-based programs designed to improve his or her use of English.
Take time to be active in their communities	Self-explanatory.
Participate in specialized training to assist them in developing their skills and understanding in working with diverse groups	They keep abreast of research projects and findings that influence healthcare models.
Incorporate key information into their initial evaluation process	This information concerning the patient might include the number of years in the country, the number of generations in the country, the patient's fluency in English, the extent of family support, the patient's level of education, the change in the patient's social status as a result of coming to the country, and obstacles associated with acculturation.

Achieving cultural competency

Many strategies can be used to improve cultural competence. Read books, attend cultural events, talk to your peers and supervisors, and, most importantly, talk to your patient. Strive to improve your cultural competence and awareness, and keep in mind your ethical responsibilities in working with differing populations.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

019. Identify the influence of ethnicity on the counseling relationship

1. Define racism.
2. Define prejudice.
3. Define discrimination.

020. Identify barriers in the counseling relationship

1. What is a stereotype?
2. What two nonverbal language cues are considered important?
3. What are the four comfort zones in the western culture?
4. What kind of key cultural skill might a counselor incorporate into his or her evaluation process?
5. What are some suggested strategies to improve cultural competence?

3-2. Understanding Age and Gender Issues

Advances in science and technology have provided the human race with unprecedented longevity. This increased longevity is reflected in our military retiree population which continues to grow. Additionally, the changing roles of men and woman also require us to be well-versed in gender issues. Understanding the unique issues associated with both age and gender will help you to be aware of how these affect the counseling relationship.

021. Identify specific age-related issues

Aging is a fact of life; however, decisions about healthcare may vary greatly between cultures. Too often, younger generations view the aged as weak or lacking the mental faculties to contribute to society or to make healthcare decisions. In western societies specifically, seniors are often seen as liabilities rather than as contributing assets. The elderly may experience diseases that impair their ability to move about freely or to articulate their treatment goals. As a result they often distrust healthcare providers and feel like objects rather than patients.

Defining age

How do we define “old age”? Sociological research has resulted in groupings that are used to define age. Presently, age is grouped into four categories:

Age Groupings	
Category	Age Range
Young old	65 to 75 years-of-age
Old	75 to 85 years-of-age
Old-old	85 to 100 years-of-age
Elite old	100+ years-of-age

The number of people in each age group continues to grow. With this growth comes an entirely new set of medical and psychosocial concerns. For instance, older people suffer fewer acute illnesses but experience more chronic illnesses. You might also be surprised to learn that less than 5 percent of the elderly are institutionalized.

Gender and culture also play a role in how we view the elderly. Older females, for example, are more likely to be widowed and live alone than male counterparts. If an older male is widowed, he is more likely to remarry than a female counterpart. Finally, different cultures view the elderly with varying levels of respect and esteem. It is important to understand the cultural dynamics in working with the elderly patient and to be aware that these factors may impact and influence the counseling relationship.

Age and healthcare

Not only does aging bring specific physical and mental challenges, it also affects the patient-provider relationship in many ways. Consider these:

- Mental health providers frequently under diagnose the elderly. The elderly are perceived as too old to be capable of change.
- Being old implies an inherently lower quality of life. Medical care may be doled out in quantities of “just enough to get by.” Healthcare typically overlooks prevention efforts among the elderly; focusing instead on managing symptoms rather than finding a solution.
- Older patients are less likely to demand their provider’s attention or to question treatment protocols.
- Access to quality treatment is dramatically reduced as the number of minority factors increases (i.e., elderly, black, and female).
- Because most are on a fixed income, the elderly have decreased access to quality healthcare.
- Age is often viewed as a disability irregardless of the individual’s actual capabilities.

Mental health and aging

There are several myths about the aging population’s mental health. For instance, many people believe that senility, mental incompetence, and decreased mental functioning are inherent with old age. In addition, some people believe personality changes as a person ages; often older persons are perceived as becoming more childlike, rigid, and irritable as they age. Unfortunately, these erroneous ideas and beliefs result in a high rate of undiagnosed and untreated mental illness among the elderly. Because these factors are regarded as a natural part of aging, they often go unrecognized as symptoms of mental illness.

The fact is that a quarter of the elderly community and half of those in nursing homes have symptoms of mental illness. People who are 65-years-old or older account for nearly 20 percent of all suicides.

Ten percent of the elderly population suffers from alcoholism. Finally, the prevalence and intensity of depression increases with age.

Problems with common diagnoses

Without a conscious effort it is very easy for the healthcare provider to attribute ailments and actions to aging. Let's look at some areas where healthcare providers should take particular care to treat the patient as an individual, not simply as an older person.

Depression

Unfortunately among older people, dementia symptoms look very much like symptoms of depression. This may lead to misdiagnosis or difficulty in making the correct diagnosis. Depression may also occur due to medication or a combination of medications. In addition, depressive symptoms may be dismissed as being the natural consequence of a lower quality of life that we expect for the elderly.

Anxiety

Aging persons may become increasingly anxious as they struggle with changing capabilities and needs. Although the symptoms remain essentially the same, they are explored less frequently with the elderly than with the general population. Again, the tendency to overlook quality of life issues may account for the lack of exploration.

Alcoholism

As people approach important milestones—such as retirement, loss of loved ones, and physical disability—they may begin using alcohol to manage the accompanying depression or anxiety. When alcoholism is addressed among the aged, it is secondary to the physical consequences of alcohol use. Generally the elderly are not routinely screened for substance abuse and it is not usually identified until the abuse has affected their health. In addition, few if any prevention efforts are aimed at the elderly and there are even fewer treatment centers that address the specific needs of the addicted elderly patient. Detoxification of the elderly presents unique challenges. Dosages of common medications used to ease detoxification may need to be adjusted to accommodate changes in metabolism. The prevalence of multiple, chronic medical complaints and multiple medications further complicate treatment.

Suicide

Suicide poses a serious threat to the elderly. However, society believes older persons are enjoying the “golden years” and couldn't possibly have a reason for committing suicide. Society expects certain conditions inherent with old age to be accepted with grace. For example, outliving friends and family, medical concerns, and living on a fixed income are what we expect to face as we grow older. This completely ignores the fact that, expected or not, they are unpleasant conditions to face. In much of the elderly population, suicide attempts or gestures are not apparent. The elderly may use self-starvation as a slow means of death. In addition, they may fail to take medications, take medications inconsistent with prescribed instructions, or participate in high-risk behaviors. Again, we do not consider the elderly to be a population at risk for suicide and so we often fail to screen them sufficiently for signs and symptoms of suicide. Undetected, untreated depression can account for a number of suicides.

Generational considerations

You may have heard our newest airmen referred to as the “new breed of airmen”, or maybe have known a senior NCO that is the typical “crusty, old, brown shoe”, but what is meant when these terms are used and what are the implications? In essence, these terms are used in recognition of the differences that exist between generations. In addition, it also assumes there are similar behaviors associated with each. However, working with patients and working with each other harmoniously calls for some degree of understanding of the differences between generations and an awareness of how a difference in generation may influence the counseling relationship.

Defining generations

Researchers have divided generations into four different groups using birth year as a defining factor. Although the titles used for each generation may vary, the birth years are fairly standard and consistent. Here is one example of how generations may be defined:

The Generations	
<i>Identified As</i>	<i>Born</i>
Veterans	Between 1922 and 1943
Baby Boomers	Between 1943 and 1960
Generation Xers	Between 1960 and 1980
Generation Nexters	After 1980

Let's take a look at some of the characteristics of each of these.

Veterans

Each generation is shaped by the events and circumstances of their times. The Veterans, for example, lived through the Great Depression, the bombing of Pearl Harbor, and the first and only detonations of the atomic bomb in Hiroshima and Nagasaki, Japan. These times called for a different work ethic, a different mindset, and an ability to be creatively resourceful. People of this generation are survivors. They work very hard for very little, tend to be satisfied with being comfortable without luxury, have little patience for extravagance, and learned early on that complaining doesn't change things.

Baby Boomers

Individuals in this generation were raised in post-war prosperity. Boomers have a huge capacity to take control, define themselves, redefine themselves, and live in the moment. These were the free loving, "us against the system", "don't trust anyone over 30" turned college-graduate, career professionals, and soccer moms and dads! They have a combined attitude of "what's in it for me" that, coupled with their high regard for duty to community service, make them a very hard-working class of people.

Baby Boomers, in contrast to their Veteran parents, demand more from their healthcare providers. They expect to be listened to by their providers, may question prescribed treatments, and are less likely to blindly follow the provider's advice. Boomers may seek a second opinion with greater frequency and have ushered in the use of alternative or holistic medicines.

Generation Xers

Deemed Generation X, people from this era have not had the same ease in defining themselves as their Baby Boomer parents. These are the latch-key kids of the dual-career families and single-parent homes. They were raised by television, video games, and computers. Parents overcompensated for their lack of presence by excessively providing in material gifts. This situation bred a generation that:

- Has difficulty managing delayed gratification.
- Is resourceful in getting what they want.
- Remains dependent on their parents longer.
- Is generally less goal-directed.

Generation Xers primarily turn to the Internet and other technology to inform themselves about healthcare issues. Due to their access to information, Generation Xers are more likely to approach their provider requesting specific procedures or medicines. In comparison to other age groups, this generation participates in preventive health practices with greater frequency.

Generation Nexters

Also referred to as the Millennium Generation, this generation includes the young people of our Air Force. This generation, like the Generation Xers, is computer savvy, intelligent, and eager to make a place for themselves in society. Because they are young, they don't access the healthcare system with much frequency and are generally very healthy. This makes it difficult to understand what their emerging attitudes toward healthcare are or will be in the future.

022. Identify gender-related issues that may influence the counseling relationship

Men and women are different in so many ways—some obvious and some subtle. As the roles of men and women continue to be shaped by our ever-changing society, we are forced to examine how the changes and the effects of the changes influence the relationship between men and women. Let's begin by examining some of the important issues of each gender.

Gender socialization

Men and women are socialized to understand what it means to be male or female. This begins at a very early age. Think about the big event of bringing a newborn home. How is the infant dressed? Typically, if it's a boy, we dress him in blue and, if it's a girl, we dress her in pink. As the infant grows, little girls are taught to "act like a lady", and little boys are expected to be "rough and tumble". Little girls play with dolls, and little boys play with racecars. Little girls help mommy in the kitchen, while little boys head to the workshop with their dads. Even in play, little girls and boys seem to know their expected station in life. Take a familiar game like house, for instance. Little boys model the stereotype "daddy brings home the bacon", while little girls play the wife and mommy who "fries it up in the pan". Even at a young age, they seem to be keenly aware that men should have careers and women should take care of the family.

Nevertheless, times are changing! In recent times, parents have adopted a parenting style that emphasizes the ability to achieve regardless of gender. The result has been more and more women:

- Entering the workforce.
- Having careers.
- Putting off marriage to establish their independence with regard to both their careers and financial status.
- Delaying starting a family until a later age.

We have also witnessed a shift in societal expectations in terms of gender equality—unisex clothing and unisex fragrances, commercials depicting empowered women, and earrings for boys. All of these point to changes in traditional roles and stereotypes. More young men are entering into healthcare fields, such as nursing or physical therapy, that were traditionally filled by young women. In contrast, more young women are entering fields, such as engineering and business, which were traditionally held by men. Today more couples share an equal burden of parenting and household chores than ever before. In some respects, these changes have been very beneficial to both men and women; however, there have been some negative consequences as well.

Benefits and negative consequences for women

There has been much debate about the positive and negative benefits of women's changing role in society as a whole. How you view the issue is affected by your experience whether positive or negative. Any debate on the outcome should provide both sides of the issue for those still undecided. The following paragraphs provide information on both positive and negative aspects of the debate without favoring either side.

Benefits

The roles of women have changed dramatically over the years. The women's movement began in the 1920s with the campaign for equal rights to vote. Since that time, the issues and advances have ranged from pursuing careers traditionally held by men, moving into management positions, earning equal pay and benefits, and working in an environment free of harassment and glass ceilings. For the most part, the outcomes have been very productive for women. In the last 10 years in the Air Force alone, females have assumed command positions at every level and women are flying in combat aircraft. These are incredible accomplishments not just for individuals, but also for all those women who follow. Indeed, the result of these efforts is that women have a wider range of personal and professional choices than ever before.

Negative consequences

Not all women's progress has been seen as positive. For instance, some of today's youth problems have been attributed to the perceived absenteeism of mothers. While women are free to enjoy more professional choices and men are invited to take a more active role in parenting and family matters, society still seems to hold women primarily responsible for the condition of the family. When kids get into trouble, the most common question society still asks is, "Where was the mother?" Therefore, while society has allowed women to move out of the home and into the workplace, the stress and pressure to perform has somewhat doubled in terms of what society still expects. Often, women are expected to fill the quintessential role model characterized by TV moms of the 1950s and 1960s, while juggling many other expectations. In comparison to their male counterparts, women are also penalized in choosing to have children. Having a child often results in women taking a leave of absence from their jobs. Sometimes this results in women falling behind in terms of promotion, advancement, or recognition in their professional careers.

Benefits and negative consequences for men

Like changes impacting women, there has been much debate on the positive and negative consequences men's changing role in society as well. To reiterate: How you view the issue is affected by your experience whether positive or negative. Any debate on the outcome should provide both sides of the issue for those still undecided. The following paragraphs provide information on both positive and negative aspects of the debate without favoring either side.

Benefits

Men have benefited from shifting roles in that they have been relieved of some of the pressure to be the sole provider for the family. With women entering the workforce and pursuing careers, families have been able to raise their standard of living and provide their children with more opportunities because of an improved financial base. In addition, where it was once thought that men were not capable of nurturing their children, men are breaking down those old stereotypes and becoming much more involved in rearing their children and participating in their growth beyond the role of disciplinarian.

Negative consequences

In some instances in the progress towards equal rights for women, men have been either overlooked or completely disregarded. For example, in many states, women are awarded custody of children after a divorce simply because society still holds the view that children belong with their mother. In the matter of reproductive rights, women exclusively hold the right to terminate a pregnancy without regard to the father's rights.

Men remain at a disadvantage in domestic violence issues. Traditional domestic violence models still presume the male as the perpetrator and the female as the victim. In most cases, these models of abuse place disproportionate emphasis on blaming and labeling men as violent, antisocial personalities with little hope for change, and offer very little comprehensive services for males. On the other hand, while women and children's shelters are common throughout the country, few of these

facilities provide any assistance for the male involved in domestic violence. This occurs even though many states— misleadingly—appear open to offering services for men.

Finally, as women have been successful in their quest to take on new roles in our society, men have face challenges in redefining their changing roles in society. Where the historic male role was clear—men took care of their families, were the heads of households, and ultimate decision-makers—men are struggling to find their way within the changing roles of men and women in modern society.

Gender issues in healthcare

So, what is gender's impact on healthcare? The answer is a great deal. In healthcare in general, most of what we know comes from research conducted on adult white males. To bring it a little closer to home, many of the psychological theories we work with in mental health are also based on the adult white male. Only recently has the healthcare community recognized the need to conduct meaningful research into not only women's particular needs, but also into the needs of other ethnic groups.

Traditional stereotypes of women as being weak and dependent on men, and men as being strong and able to care for themselves have had two devastating effects on the mental health care received by men and women. Studies have shown that women are typically over diagnosed with depression, anxiety disorders, Dependent Personality Disorder and Borderline Personality Disorder. On the other hand, if women are over diagnosed, then men are certainly under diagnosed. Society expects men to keep a stiff upper lip and handle things in general without showing emotion and without difficulty. Perhaps this societal expectation contributes to the disproportionate suicide rates for men and women. In recent years, as women have improved their academic performance, it would appear that men are being punished as a result. Young boys are twice as likely to be diagnosed with learning disorders as young girls, and boys are more likely to be taking medication for Attention Deficit Hyperactivity Disorder than girls.

This does not make it easy for mental health professionals to care for their patients. We need to be aware of how stereotypes and societal expectations can impact our patients—and ourselves—so that they are provided with the best possible care within the resources available to us.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

021. Identify specific age-related issues

1. What four categories do sociologists use to identify old age?
2. When is alcoholism addressed among the aged?
3. During what period of time were baby boomers raised?

022. Identify gender-related issues that may influence the counseling relationship

1. What advances have women continued to pursue since the 1920s?
2. Studies have shown that women are typically over diagnosed with what conditions?

Answers to Self-Test Questions

019

1. Any distinction, exclusion, restriction, or preference based on race, color, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment, or exercise, on equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural, or any other field of public life.
2. An adverse judgment or opinion formed beforehand or without knowledge or examination of the facts or a preconceived preference or idea. Taken literally, prejudice essentially means to pre-judge something.
3. To make clear distinction; distinguish; differentiate or to act on the basis of prejudice.

020

1. A conventional, formulaic, and usually oversimplified conception, opinion, or belief of a person, group, event, or issue considered typifying or conforming to an unvarying pattern or manner, lacking any individuality.
2. Eye contact and use of personal/interpersonal space.
3. (1) Intimate space (Contact to 18 inches)—This area is very sensitive for most people, who only allow those with whom they are intimate in this area. However, the nature of healthcare often dictates contact in intimate space. For instance, when taking a patient's vital signs, it is necessary for us to work within the intimate space.
(2) Personal space (18 inches to 4 feet)—This space is where most friendships and therapeutic relationships occur.
(3) Social space (4 to 12 feet)—This space is where the business of day-to-day interaction takes place.
(4) Public space (Greater than 12 feet)—This space is where formal interactions (i.e., commander's calls, formations, attending classes) take place.
4. Might include the number of years in the country, the number of generations in the country, the patient's fluency in English, the extent of family support, the patient's level of education, the change in the patient's social status as a result of coming to the country, and obstacles associated with acculturation.
5. Read books, attend cultural events, talk to your peers and supervisors, and, most importantly, talk to your patient.

021

1. Young old = 65 to 75 years-of-age; Old = 75 to 85 years-of-age; Old-old = 85 to 100 years-of-age; Elite old = 100+ years-of-age.
2. When it is secondary to the physical consequences of alcohol use.
3. Baby boomers were raised in post-war prosperity.

022

1. Establish an equal right to pursue careers traditionally held by men, to move into management positions, to earn equal pay and benefits, and to work in an environment free of harassment and glass ceilings.
2. Depression, anxiety disorders, Dependent Personality Disorder, and Borderline Personality Disorder.

Do the unit review exercises before going to the next unit.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter.

41. (019) What is defined as “to make clear distinction; distinguish; differentiate or to act on the basis of prejudice?”
 - a. Racism.
 - b. Culture.
 - c. Ethnicity.
 - d. Discrimination.
42. (020) Which is *not* considered a hasty generalization?
 - a. Second-hand information.
 - b. Out-dated information.
 - c. Unjustified inferences.
 - d. Vividness.
43. (020) What distance is considered the *personal space* in a comfort zone?
 - a. Contact to 18 inches.
 - b. 18 inches to 4 feet.
 - c. 4 feet to 12 feet.
 - d. More than 12 feet.
44. (020) Which ethnic group is more likely to use preventive care if it uses culturally appropriate methods, such as lay peer educators, family and community networks, and community outreach?
 - a. Puerto Rican
 - b. Cuban American.
 - c. African American.
 - d. Mexican American.
45. (020) In what ethnic group is it likely women may neglect their health in favor of their families and traditional healing practices are common?
 - a. American Samoan.
 - b. Cuban American.
 - c. American Indian.
 - d. Alaska Native.
46. (020) Culturally skilled counselors employ strategies and knowledge for all of the following *except*
 - a. discrimination.
 - b. oppression.
 - c. stereotypes.
 - d. radicalism.
47. (021) A patient born in 1962 is considered a part of which generational group?
 - a. Veterans.
 - b. Baby boomers.
 - c. Generation Xers.
 - d. Generation Nexters.

48. (021) Which generational group is considered computer savvy, intelligent, and eager to make a place for themselves in society?
- a. Veterans.
 - b. Baby boomers.
 - c. Generation Xers.
 - d. Generation Nexters.
49. (022) Studies have shown that *women are typically over diagnosed* with all of the following disorders *except*
- a. anxiety.
 - b. bipolar.
 - c. dependent personality.
 - d. borderline personality.

Student Notes

Unit 4. Client Education and Key Briefings

023. Identify primary types of briefings	4-1
024. Identify key aspects of a guided discussion.....	4-2
025. Conducting client education briefings	4-4
026. Develop lesson plan.....	4-7

IN ADDITION to speaking with patients/clients one-on-one, you will also have the opportunity to brief personnel in a variety of settings. For some of you the thought of public speaking is terrifying. Practice and preparation will alleviate many of your anxieties. Nearly every base or community also offers opportunities to practice public speaking. Organizations such as the National Speakers Association or Toastmasters are excellent beginnings.

The purpose of a briefing is to be *brief* in presenting information to one or more persons. Most of the briefings you will provide are in a set format or organization following a predetermined outline. This doesn't mean you merely study your presentation and regurgitate its content. If this were the case, the audience could easily read the presentation on their own. You will need to familiarize yourself and provide supplementary material to your audience when asked.

023. Identify primary types of briefings

A briefing is an oral presentation that can be used to fill a variety of needs. Briefings are most effective when they are *precise* and *compact*. Someone once said “brevity is the essence of clarity”; never is this more evident than in the briefing. Your task is to present current information in a specific amount of time. This means your briefing must be organized and skillfully presented. The briefing often forms the basis for decision-making or operations.

There are many types of briefings; we will look at two, formal briefings and informal briefings.

Formal briefings

Formal briefings are one-sided with limited, if any, verbal participation by the audience. Formal briefings are usually given to large audiences such as a commander's call. Though structurally organized, the formal briefing should use a natural and conversational delivery style without overusing notes.

Informal briefings

Usually the informal briefing audience is smaller than that for a formal one. Another difference is that there is often considerable verbal interaction between the briefer (you) and the audience. This often results in both questions and discussion. The delivery style is conversational, often addressing audience members directly by name. Squadrons with small flights typically use informal briefings extensively.

Briefing tips

Successfully conducting a briefing requires you to be prepared and organized. AFH 33-337, *The Tongue and Quill*, provides an excellent guide for developing your briefings. As a mental health journeyman you will be called upon to brief flights, squadrons, groups, senior leadership, and do other organizationally requested briefings. As mentioned earlier, time spent preparing for a briefing will go a long way in successfully articulating your message. Preparation ensures your information is accurate and that you are prepared to answer likely questions. Here are a few tips to remember when preparing and presenting a briefing:

- The audience came together to hear something new about a topic. What they take from your briefing depends on your skill in delivering the message as well as their efforts to understand and retain what is said.

- Carefully and logically organize your ideas and facts so they can be presented in a short period of time.
- Ensure all visual aids are correct and large enough for all attendees to read them.
- Arrive 15 minutes prior to your briefing to prepare and organize.
- If at all possible, when scheduling a briefing first thing in the morning, have a person ready to back you up if you can't make the briefing due to car trouble, last minute emergencies, or faulty alarm clocks.

Have your introduction and conclusion memorized. Even if your introduction is as simple as, “Good morning, ladies and gentlemen, I am Airman Magwood from the Mental Health Clinic and I’m here to brief you today on stress management.” This gives you something to say before you step up in front of the crowd. There is nothing more awkward than watching the briefer stumble through the first few words. They may get the false impression that they can tune you out. We’ll have more to say about the introduction and conclusion later.

Also, within reason, use a style that fits your personality. If you are a funny person, tell jokes; if you are not a funny person, do NOT tell jokes. While humor can loosen up both you and the audience, it should fit the briefer and the situation. There are many other “ice breakers” you can use to open a briefing. You can ask how many people have experience with the topic or tell a story related to the topic to get their immediate attention.

Get the crowd involved early. If it is a small crowd, you may start with a question. “How many of you have experienced stress? You sir, you raised your hand... what is your biggest stressor?” (Be ready to hear this response: “Being voluntold to come to a mental health briefing!”) With larger crowds, you may not want to give them the chance to start “talking” amongst themselves by singling out a person or two. Instead you should ask the same question about stress management and ask for a “show of hands” only; then press on into your briefing.

Try not to give handouts at the beginning of the briefing. You’ll find that the audience will be too busy reading the information and won’t hear everything you have to offer them. Instead, wait until just before you end the briefing or after your conclusion to mention handouts: “there are handouts on the table as you leave.” This is an easy and effective way to prevent the audience from being distracted by the handouts during your briefing.

Remember, your image has a significant impact on how people view the entire mental health service. You represent all 4COs as you stand before your audience. Remember the odd things some of your peers said during their practice briefings in technical training school? Keep those examples in your head of how NOT to do a briefing. Be a professional!

024. Identify key aspects of a guided discussion

Another method of presenting information is the guided discussion. As you are well aware, people gather in groups to talk over their common interests, problems, worries, and joys. Discussion is common and adaptable—make the most of it in your small groups. In this lesson, we look at some of the uses, limitations, and techniques, and what makes an effective discussion. Let’s begin by defining discussion and then focus on its objective, advantages, limitations, and effectiveness.

Discussion is a method of teaching in which you use questions to elicit student participation in a learning situation. The learning is enhanced by exchanging ideas, opinions, and experiences to reach conclusions that support the learning objectives. In a classroom situation, your task is to ask questions, pose problems, and direct student participation. Your students will answer questions and solve problems by coordinating their thinking. You guide them toward an understanding of the learning goals.

Objective

The objective of a guided discussion is for trainees to achieve specific learning results through thinking and discussion, pooling their knowledge of it, and applying constructive imagination to a subject. It is *not* merely talking about a subject.

Advantages

Discussion presents a very natural learning situation for a group of students. Since this will be your primary method for conducting your mental health and substance abuse educational classes, knowing its advantages will be helpful.

Guided Discussion Advantages	
<i>Advantage</i>	<i>Description</i>
Promote student participation	A well-planned and directed discussion provides for active student participation. The more ways students actively participate in a lesson, the better their chances of learning. Discussion provides students with an opportunity to respond actively—either physically or mentally—to a lesson objective. As each student contributes personal ideas, the others participate mentally by judging the validity of what is said.
Stimulates reflective thinking	As a facilitator one of your primary responsibilities is to cause students to think reflectively. Why? Because deeper learning takes place through reflective thinking. Discussion provides a stimulus to reflective thinking. (This is the kind of thinking that consists of turning a subject matter over in the mind and giving it serious consideration.)
Promotes class spirit	Discussion is another way to promote class spirit. By allowing all students to participate, each one becomes part of a team effort, pursuing a logical conclusion of the lesson objectives. Under your direction, each student learns to get along and cooperate with others.
Corrects misconceptions	Discussion allows for correction of misconceptions students may have gained. As students express their ideas, you may discover that their thinking is not sound. In a tactful manner, you can correct misconceptions before they become firmly implanted in students' minds—or students can correct themselves.
Allows student expression	Discussion allows for the expression of student knowledge, experience, ideas, and opinions. The saying, "Two heads are better than one" is frequently true. Groups can arrive at more solutions to problems than individuals. The learning situation is not limited to examples common to any one person's background. Discussion promotes learning from the collective experiences of the class.

Disadvantages

As with any "good thing", there are certain limitations—and guided discussion is no different. The following limitations, while small in nature, deserve your attention to prevent them from stifling your class.

Disadvantages of Guided Discussion	
<i>Disadvantage</i>	<i>Description</i>
Time-consuming	Even with the best planning and guidance, discussions take more time than lectures. For this reason, plan discussions carefully; making an effort to take advantage of the allotted time.

Disadvantages of Guided Discussion	
<i>Disadvantage</i>	<i>Description</i>
Limited by class size	For a good, informal exchange of ideas, a discussion class should not exceed 15 to 20 students. One advantage to using discussion is that it stimulates active student participation. There is no advantage if your class is so large that some students do not take part. It is very difficult to maintain the spirit of informality and include everyone in the conversation if more than 20 people are in a group.
Limited to class knowledge and experience	If an exchange of ideas is to be successful, the participants need to have enough background to talk about the subject. Use discussions to develop abstract concepts with which most people are familiar, such as freedom, equality, liberty, and rights. You can use discussions effectively for technical material; however, you must first determine whether your students have enough knowledge to make the discussion worthwhile. If all members of your class do not understand the basics of the subject, the discussion can be dominated by a few students. You must make sure the students have the proper background knowledge, either through reading assignments or lectures, before the discussion starts.

Measuring effective discussion

You can conduct briefings until you are blue in the face, but if your message is ineffective or without purpose, you are wasting time. What are your anticipated exit outcomes from the briefings? How do you measure your effectiveness? We focus on those topics next.

Organizational skills of facilitator

The best of intentions can go terribly awry if the facilitator is unorganized. Thorough preparation and a clear understanding of milestones you intend to reach in your discussion are essential for success. There must be a beginning, middle, and end. You should be prepared to ask carefully crafted questions with the intent of moving the discussion forward and keeping focus on the main points.

Non-threatening environment

You need to create an environment where students are comfortable presenting their ideas, thoughts, and opinions. Your challenge is to show respect for all questions and comments. This can be particularly difficult when discussing an emotionally charged topic. This doesn't mean you have to agree with the student. Remember, blatantly erroneous assertions must be challenged and corrected.

Strategic facilitator participation

While your role is guiding the discussion, you should limit your involvement in the discussion itself. Solicit input from all students so that the discussion doesn't turn into a conversation between you and a participant—a student-facilitator interaction. Encourage participation and ideas from all students. You should not answer your own questions. The students must be given time to think and formulate a response. At times this is difficult for you because silence can feel very uncomfortable. Patience is the key.

025. Conducting client education briefings

You will have many opportunities to educate clients in both individual as well as group or audience settings. Perhaps the most disarming aspect for many of you is the opportunity to speak in public. The various types of briefings are outlined below.

First Term Airman Center (FTAC)

If you are doing these CDCs for the first time, you probably remember your FTAC experience pretty vividly. It may have seemed inconvenient at the time, but most Airmen believe it is far superior to previous programs.

In the "old days" reporting to your first Air Force duty station following technical school could be confusing for the first-term airman, and frustrating to supervisors. Airman Gasper, a newly arrived troop, reports to her duty section, but then has to leave for various inprocessing appointments, such as finance (to complete her travel vouchers), the military personnel flight, the base medical clinic, legal office, etc. Since Amn Gasper also didn't have a vehicle upon arrival, she had to rely on the base shuttle bus or ask co-workers to take time from their responsibilities to get her to her appointments.

First-term airmen reporting to a first duty assignment are required to attend many briefings mandated by federal law or military regulations. Previously, these briefings and appointments were scheduled separately which meant the new airman was in and out of the duty section for the first 4 to 6 months after arrival. It's hard for a supervisor to set up an "on the job training program," just to have their new troops continually yanked out of the section for a mandatory briefing/appointment at a critical time in their training

As MHTs, we usually brief newly arrived Airmen on such topics as:

- Drugs.
- Alcohol.
- Local substance abuse threat.
- Personal responsibility.
- Responsible uses of alcohol.
- Medical recommendations related to substance use.

Newcomers Orientation

The Newcomers Orientation is for personnel on a second or subsequent permanent change of station (PCS). This orientation is for two targeted audiences with separate messages for each. These are outlined below.

E-1 through E-4

This Newcomers Orientation is for junior enlisted troops in the grade of E-1 through E-4 on their second or subsequent permanent change of station. The orientation must occur within 60 days after the member's PCS. The focus of this orientation is similar to that of the First Duty Station training emphasizing standards, healthy lifestyles, responsible behavior and consequences to self and career of substance abuse. At a minimum the orientation is 30 minutes in length.

NCOs and officers

The Newcomers Orientation is for NCOs and officers on a second or subsequent PCS. The orientation must occur within 60 days after the member's PCS. This orientation is for personnel who are or could be placed in a supervisory position based upon their rank. This orientation emphasizes unique elements of the command's substance abuse prevention and treatment program, local substance abuse threat, military and civilian resources, identifying substance abusers, the referral process, and supervisors' responsibility in the treatment/process.

Overseas Orientation

The Overseas Orientation is provided to military and DOD civilian employees at an overseas duty assignment. This orientation mirrors the Newcomers Orientation and adds specific guidance relating to the country of assignment, individual responsibilities, and military discipline. This orientation varies in length based upon local requirements.

Substance Abuse Awareness Seminar

At the time of this writing, the substance awareness seminar is slowly being phased out across the Air Force. The Substance Abuse Awareness Seminar is an educational program for all patients referred for a substance abuse assessment who do not meet diagnostic criteria for alcohol abuse or alcohol

dependence. An exception is an erroneous referral where alcohol was clearly not involved or when the provider determines awareness education is not warranted. The seminar focuses on individual responsibility, standards, legal and administrative consequences of abuse, decision making, dynamics of substance abuse, biopsychosocial model of addictions, values clarification, impact of substance abuse on self and others, family dynamic, and goal setting. The minimum seminar length is 6 hours.

Community Suicide and Violence Prevention Awareness

The Community Suicide and Violence Prevention Awareness programs are conducted IAW AFI 44-154, *Suicide and Violence Prevention Education and Training*. The briefings can be conducted together, but we'll look at each program separately.

Suicide Awareness

The Suicide Awareness program is provided to all Air Force personnel—active duty, guard and reserve, as well as civilians. This briefing focuses on creating an organizational sense of team and promoting help-seeking behavior. Specifically, the program provides attendees with general knowledge about suicide prevention, but more importantly how and why to seek help, and how to identify others at risk for suicide and the appropriate response. Risk factors are discussed and resources are identified. The program emphasizes the benefits of seeking help early before a problem becomes unmanageable. AFI 44-154 provides a suicide awareness curriculum guide along with recommendations for content, duration, and delivery method. Unit commanders ensure that all personnel complete the training during the 20-month Air Expeditionary Force (AEF) training cycle.

Violence Awareness

The Violence Awareness program is provided to all Air Force personnel including active duty, guard and reserve, as well as civilians. The focus is bringing attention to violence associated with the workplace and improving identification of those at risk for workplace violence. The program should also include who the common targets of violence are, the potential perpetrators' motivation, and referral and response procedures. AFI 44-154 provides a violence awareness curriculum guide with recommendations for content, duration, and delivery method. The training is mandatory and on the same timeline as Suicide Awareness.

Key Personnel Briefing

The Key Personnel Briefing is provided to all newly assigned commanders, command chiefs, first sergeants, and other designated key personnel. This briefing emphasizes the importance of active support from leadership for substance abuse prevention programs. Furthermore, the briefing encourages leadership to seek early intervention for suspected substance abusers and explains the referral and treatment process. Finally, the briefing seeks leadership support in reducing the stigma often associated with substance abuse treatment.

Stress and anger management

Managing stress and anger for some is a full-time task. Stress and anger have proven negative physiological consequences if not identified and managed. Anger management generally focuses on self-evaluation of problems in anger control, and recognizing and developing skills for managing anger. Stress management generally focuses on the causes of stress, stress management techniques, communication skills, and the impact of alcohol use.

Stress and Anger Management is provided in a variety of venues. Stress Management may be provided in various levels of Professional Military Education (PME), at the Health and Wellness Center (HAWC), Mental Health Clinic, or at commander's call upon request. The Family Advocacy Program provides both stress and anger management as part of prevention and treatment.

026. Develop lesson plan

Developing a lesson plan can seem like a daunting task. This is especially true if you are not familiar with the content. This lesson focuses on the basic concepts of creating a lesson plan for conducting briefings specific to the 4C0X1 AFSC. Many of the briefings you will be asked to conduct already have lesson plans in place and are considered standard briefings. However, you may be asked to speak on a topic that requires you to prepare a lesson before speaking.

Have you ever walked into an exam feeling completely unprepared? Ever taken your fitness test when you were out of shape? What about briefings or speaking—ever felt like you were “tap dancing” through a subject because you were unprepared or unfamiliar with the subject? Hopefully, these scenarios are not a regular occurrence or part of your everyday lifestyle. Occasionally we are able to “pull something off” but more often than not, such unpreparedness ends in disaster.

When conducting a briefing you are an ambassador for those (clinic staff, 4C0’s) you represent. Individuals who “shoot from the hip” are likely to appear less competent than those that are prepared and organized. Furthermore, when you are prepared you feel more confident in the material and this is reflected in your presentation or briefing.

Methods of preparation

There are about as many approaches to briefings as there are briefings given in the Air Force. In the following paragraphs we provide a brief summary of a suggested approach. We begin by looking at an eight-step lesson planning process:

1. Determine the objective.
2. Research the topic.
3. Select the appropriate instructional method.
4. Identify the lesson planning format.
5. Decide how to organize the lesson.
6. Choose support material.
7. Prepare the beginning and ending of the lesson.
8. Prepare a final outline.

Determine the objective

Determining the objective is the initial step in creating a lesson plan. Knowing the objective or the desired outcome is the starting point for creating your lesson plan. The objectives must be centered on your target audience/participant. For instance, the phrase “the audience/participant will...” is used in writing the objectives. The objectives must be audience centered in order to show what the student is required to learn, not what you want to teach.

Researching the topic

After the instructional objective has been identified, it is time to outline the main points of the lesson and gather materials needed in order to develop the lesson plan. During this step you may find that you need to modify an objective or rearrange points. This often occurs as you select supporting material.

When selecting material keep in mind that your selection needs to be both useful and appropriate. In order the material to be useful it should aid in the teaching-learning process. If you choose support material simply because you find it interesting but it yields very little to the learning process, you are likely to lose credibility or a sense of direction with the audience. In order for the material to be considered appropriate it should relate to the lesson objective and have a high possibility for audience retention.

This is not to say your lesson should be boring. A dry, uninteresting briefing filled with facts often makes the audience feel like sleeping is better than enduring your briefing. Strive to find interesting materials to support your lesson and arrange them to enhance learning. Research material comes from three sources: yourself (personal experiences), experiences of others (from conversations or interviews), and written or observed material. Let's look at these more closely.

Sources of Research Material	
Source	Description
Self	When researching a topic always start with what you know about the subject. Your knowledge helps to organize the lesson or point out gaps where you have no experience and require more extensive research.
Others	Discussing the subject with someone experienced in the topic could provide ideas, facts, and suggested sources of information for the research.
Written or observed material	Depending on the topic, written material can provide an enormous amount of support for most any topic you are researching. Knowing how and where to obtain this information can help you prepare.

Select an instructional method

When your research is complete, the next step is to select your instructional method. This is the “how” of presenting your lesson or briefing. The instructional method is determined by two factors: your audience and the topic. When selecting a teaching method, consider the ways in which people learn: by doing, by discussing, by listening, by observing, by participating. No single method is suitable for all teaching/briefing situations. The method selected should be the one that best supports your learning objectives/outcome.

Identify a lesson plan format

Many formal lesson plan formats are available. Rather than tie yourself to a specific layout, our recommendation is to make it as user friendly as possible. The intent is to make the briefing a “turn-key” operation that others can use in your absence.

Decide how to organize the lesson/briefing

At this point, the objectives are in place, research is complete, you've selected the presentation method, and identified a lesson plan format. The natural question is what next? Simple—its time to organize your lesson.

Every lesson/briefing consists of three areas: an introduction, body, and a conclusion. Most of the time, it is advisable to construct the body of the lesson as the first step. Completing the main part of the lesson makes it easier develop the introduction and conclusion. The body should consist of two to five points main points. Sub-points that support your main points should be arranged in one of the following patterns: time, space, cause-effect, problem-solution, pro-con, or topical.

Choosing support material

The background of your intended audience often dictates what support material is required. More support is needed for an audience with little background in the subject you are discussing. The more familiar your audience is with your topic, the less support material is needed.

Select support material that meets your purpose and is meaningful to your audience. Simply stating statistics or defining words that have no significance is time consuming, irrelevant, and will likely lose audience attention. The method of instruction, student ability, and audience size help determine what support and how much is needed.

Support can take many forms: definitions, examples, comparisons, testimony, and statistics. Be aware that statistics are the most misused and misunderstood type of support. They can certainly be beneficial and clarify ideas when used and presented properly. Too many statistics or those that are ambiguous or slanted to support only one point of view without solid documentation often confuse or aggravate your audience. Statistics should show a relationship or summarize facts and data. Some figures, however, are just numbers, not statistics. Always state the exact source of your information when citing statistics.

I once worked with an NCO who was a wonderful speaker. During one of his briefings I noticed that he used the statistic of 41% three separate times for three separate things. When I voiced my doubts, he said “it’s close to that, I just kind of made the numbers up.” Remember, if your audience gets a sense that you are not being truthful with them, they may tune out your message.

Introduction and conclusion of the lesson/briefing

Before you start the final outline, you must consider the introduction and conclusion. Both of these areas should compliment each other and summarize what has been discussed.

The introduction serves the following purposes:

- Establishes a common ground between instructor and students
- Holds the student’s attention
- Outlines the lesson and show how it relates to the entire course
- Shows students how the instruction will benefit them
- Leads into the instruction
- The introduction contains three elements: attention, motivation, and an overview.

Attention

There are several approaches to gain the audience/students attention. You may use a joke, startling statement, talk about an incident related to the lesson, thereby leading into the lesson, or ask a rhetorical question that relates to the material. These are some suggestions for focusing your audience’s attention on the lesson.

Motivation

The purpose of motivation is to show the audience/students how the lesson relates to them and why they need to know the material. Before students will learn, they need to understand how that learning will benefit them.

Overview

The purpose of the overview is to tell the audience what you will be teaching—show them the “big picture” so to speak. The overview should serve as a roadmap, showing the students what they will be learning, and the route to be taken to achieve success. Visual aids can be used to support this area, but you must ensure that they are purposeful and meaningful to your audience. Visual aids just for the sake of having them are useless and not beneficial to the learning process.

The conclusion will usually remain with the audience longer than any other part of the lesson. The conclusion should accomplish three things: summarize, remotivate, and provide closure.

Final summary

A final summary is always made at the end of the lesson and should retrace the critical elements of the lesson. Reviewing the main points aids the audience in retaining the information and allows them to jot down any missed information.

Remotivation

This is your last opportunity to tell the students why the information is important to them. To be effective, you should use remotivation throughout.

Closure

For some, this can be a difficult portion of the lesson. Use inflection in your voice to show the lesson is ending. An appropriate story or thought-provoking question related to the topic can signal the closing comments for the briefing/lesson. If you are giving a briefing, it is always wise to finish with a request for attendees to ask questions. When all questions are answered, finish by giving your name, your clinic, operating hours, and contact phone numbers.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

023. Identify primary types of briefings

1. What aspect makes briefings most effective?

2. What reference is an excellent guide in helping you prepare for a briefing?

024. Identify key aspects of a guided discussion

1. How does the guided discussion method of teaching enhance learning?

2. What are some of the disadvantages of the guided discussion?

025. Conducting client education briefings

1. Which briefing is tailored for personnel on a second or subsequent permanent change of station?

2. During what time do Unit commanders ensure all personnel complete Suicide Awareness training?

026. Develop lesson plan

1. During what step of the lesson planning process would you modify an objective or rearrange points?

2. Support for your topic can be presented to an audience in what forms?

3. What is the purpose of the motivation portion of the lesson?

Answers to Self-Test Questions

023

1. Precise and compact.
2. AFH 33-337, *The Tongue and Quill*.

024

1. By exchanging ideas, opinions, and experiences to reach conclusions that support the learning objectives.
2. Time-consuming, limited by class size, and limited to class knowledge and experience.

025

1. Newcomers orientation.
2. During the 20-month Air Expeditionary Force training cycle.

026

1. Researching the topic.
2. To show the audience/students how the lesson relates to them and why they need to know the material.
3. Definitions, examples, comparisons, testimony, and statistics.

Do the unit review exercises before going to the next unit.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter.

50. (023) Which briefing is considered one-sided with no verbal participation by the audience?
- Formal.
 - Informal.
 - General.
 - Key.
51. (024) Which is *not* considered an *advantage* of a guided discussion?
- Promote student participation.
 - Stimulates reflective thinking.
 - Nonthreatening environment.
 - Corrects misconceptions.
52. (024) Which is *not* considered a *disadvantage* of a guided discussion?
- It is time-consuming.
 - It is limited by class size.
 - It allows for student participation.
 - It is limited to class knowledge and experience.
53. (025) What is the *maximum period after a permanent change of station (PCS)* that an E-3 has to participate in the required Newcomers Orientation?
- 15 days.
 - 30 days.
 - 45 days.
 - 60 days.
54. (025) Which briefing encourages leadership to seek early intervention of suspected substance abusers and explains the referral and treatment process?
- Stress management.
 - Key personnel briefing.
 - Newcomers orientation.
 - Substance abuse awareness seminar.
55. (026) Using a joke or talking about an incident related to the topic *before a briefing* is called
- attention.
 - motivation.
 - introduction.
 - inappropriate.

Please read the unit menu for Unit 5 and continue →

Unit 5. Administrative Tasks

5–1. Records Maintenance	5–1
027. Outpatient medical records	5–1
028. Mental health service records	5–4
029. Family advocacy program records	5–6
030. Mental health inpatient records	5–9
5–2. Clinical Administrative Management	5–12
031. Identify principles of budgeting	5–12
032. Ethical/legal issues related to managed care	5–13

BUILDING a reputation as a dependable, reliable, and knowledgeable mental health journeyman begins by mastering the many administrative tasks you will be asked to manage. The operational aspects of conducting daily business in the clinic or unit you are assigned to are paramount in accomplishing the mission and instilling a sense of confidence with peers and patients alike. This unit introduces you to your responsibilities in record management as well as a variety of clinical programs in which you will be a key team member.

5–1. Records Maintenance

Mental health records maintenance is unique because you are responsible for a variety of records. Before looking at specific records, we'll begin with a discussion of the move towards a paperless record system. Then we'll look at outpatient medical records (OPR) and continue on to examine mental health and family advocacy records. We reserve discussion of ADAPT records for another volume in the course.

027. Outpatient medical records

Health records are a system for maintaining the documents used in providing health care for our patients. You should approach the records with the same level of care and professionalism you show towards you patients. Doctors use the information in the record to determine treatment plans, technicians use the information to ensure the doctors' requests are followed, insurance companies use the information to provide financial reimbursement to the clinic, and resource management (RM) personnel use the information to bill insurance companies and validate your clinic's work. Take pride in maintaining the patient's medical records. Treat them as if they were yours. You would not be happy if your medical treatment information were lost. Who could blame the patient for becoming upset if his or her information is lost?

Medical records contain an abundance of information on your patients' health history. They're also used during auditing to determine appropriateness and timeliness of care. Records maintenance needs to be taken seriously.

Armed Forces Health Longitudinal Technology Application (AHLTA)

AHLTA (formerly CHCS II ; US DOD military health system) is the military's electronic health record (EHR) and marks a significant new era for the military health system. AHLTA has its origins in the goal set by the president in the January 2004 State of the Union address: ensuring most Americans have an EHR by 2014. The Department of Defense is leading this effort with its plan to fully implement AHLTA—the interoperable, globally-accessible, protected, and always available EHR for Uniformed Services members, retirees, and their families—by 2011.

AHLTA gives healthcare providers access to data about beneficiaries' conditions, prescriptions, diagnostic tests, and additional information essential to providing quality care. At the time of this

writing, AHLTA impacts 9,100,000 beneficiaries, 132,700 MHS staff, 412 medical clinics, 414 dental clinics, and 65 military hospitals.

Benefits of AHLTA

AHLTA leverages advanced technology to its fullest potential, ensuring that healthcare providers have instant access to invaluable medical information about their patients. AHLTA is as capable in field mobile units as it is in peace-time medical centers. According to the Health Affairs website, the AHLTA system is consistently:

- Powerful – Valuable, life-saving beneficiary information is available 24/7.
- Legible – Beneficiary records are complete, accurate, and clear.
- Secure – Only authorized users can access records and they are protected from natural or man-made disasters.
- Longitudinal – 25 months of laboratory, anatomic pathology, pharmacy and radiology data is pre-entered from MHS legacy systems.
- Knowledgeable – Offers healthcare providers wellness reminders for their patients.
- Efficient – Interoperability ensures that costly tests, labs, and scans are not needlessly duplicated.
- Proactive - AHLTA provides critical information that lets healthcare providers know about disease outbreaks, allowing early intervention in targeted populations. This medical surveillance facilitates military force health protection.

The benefits of an automated system in military health care are practically immeasurable. In the “old days” of hard copy outpatient records there was no backup for critical information in the event a fire or natural disaster (like Hurricane Katrina) destroyed the outpatient records section. A cancer patient probably couldn’t reliably remember every treatment received and you couldn’t expect a psychiatric patient to remember all of the medications that had ever been prescribed. Combat situations are even more threatening and it is not unusual to see medical records destroyed or lost. Medical records have literally been sucked up into a helicopter’s rotors and shredded. And, as we are all well aware, doctors penmanship isn’t always the best or most legible, whether in a combat zone or in the clinic. AHLTA provides clear, readable entries that are easily read and help prevent medication and treatment errors.

Future of AHLTA

While the current policy is to use AHLTA, you may also encounter the Veterans Administration’s automated records system called VistA—the Veterans Health Information System and Technology Architecture. Some say that if you can point and click a mouse, you can use AHLTA, while others think AHLTA is difficult to learn, cumbersome to navigate, and has a long wait time. VistA has many fans, but does not have an outpatient system at this time. In the next few years, AHLTA may evolve or it may be replaced by another automated records system. Any switch from AHLTA has to be calculated in terms of human and financial costs—not to mention totally redoing a system while continuing to support one of the largest health care operations in the world

AF Form 2100A

At present, most clinics receive a “hard copy” of the outpatient medical record, but your clinic may not. The AF Form 2100A, Health Record—Outpatient, Series, isn’t a single form but 10 different forms. This is why the word series is used. You’ve probably noticed that health records come in different colors. The color is keyed to the second to last digit of the patient (or sponsor’s) Social Security account number (SSAN). For example, if the second to the last number of the SSAN is 1 the record is green. If the second to last number is 4 the color is yellow, and if 5 is the lucky number, the record is blue. These are just a few examples. Now you know why there are so many different colored records.

The health record has four sections, or parts. This is to provide a logical organization for the documents that are placed in the record. As a mental health journeyman, it's important for you to know where the various documents are located. The following table provides an overview of this organization and their associated forms or documents.

Heath Record Parts	
Section (Part) I	DD Form 2766, Adult Preventive and Chronic Care Flowsheet, on top.
	A variety of inpatient forms and summary's of care underneath the DD Form 2766.
Section (Part) II	AF Form 745, Sensitive Duties Program Record Identifier, on top (if the patient is on the Personnel Reliability Program (PRP)/Presidential Support Program).
	SF 600, Health Record—Chronological Record of Medical Care, on top (unless an AF Form 745 is needed).
	SF 513, Medical Record—Consultation Sheet. Most consultations are now handled through the CHCS so you may not see the SF 513 as much.
Section (Part) III	AF Form 422, Physical Profile Serial Report.
	DD Form 2005, Privacy Act Statement—Health Care Records (filed at very bottom of this section).
	SF 88, Medical Record—Report of Medical Examination.
	Miscellaneous forms.
Section (Part) IV	Laboratory reports
	SF 519B, Radiologic Consultation Request/Report (filed under lab reports).

Uses of the health record

The health record isn't just a place to store documents. It's used for a variety of purposes that are described in the following table.

Uses of the Health Record	
Planning	The health record forms a basis for planning patient care. By knowing of any previous treatment or consultation with all aspects of mental health services as well as the outcome, the provider can better plan a course of care that will avoid redundancy. This should help in providing the best treatment.
Documentation	Records hold the documentation of exams, test results, issue of medical devices (glasses; contacts), and successes/failures of treatment. Good documentation is important for medical and legal reasons.
Communication	Health records are a form of communication from one caregiver to the next. When there's confusion about what was said or done, it's amazing how a quick look in a well-documented health record clears up most questions.
Data	A well-organized and documented health record will provide an invaluable source of information for continuing education and research concerns.
Protection	The health record serves to protect the medical and legal interests of the patient, health care staff, and Air Force. It's important those using the record write clearly, put the date on exam forms, follow the proper Subjective Objective Assessment Plan (SOAP) format, and document thoroughly. All actions and treatment are critical.

As you can see, the health record serves many purposes. Because records are important and used for many purposes, it is helpful to take a look at various individual's responsibilities for them.

Commander responsibilities

The medical treatment facility (MTF) commander must be knowledgeable about the control of health records, release of information from them, and requirements for documentation at the provider level. The MTF commander is also the custodian for outpatient and inpatient health records. However; you won't see him or her pulling and handing out records at the records window very often.

Director of Patient Administration responsibilities

The Director of Patient Administration acts for the commander on matters relating to health records management. This individual ensures that all caregivers are informed and comply with documentation, maintenance, and release of information procedures outlined in Air Force directives.

Health records committee responsibilities

Each hospital and clinic establishes a health records committee to appraise the quality of care rendered as documented in the MTF's health records. The committee also checks to make sure that health records are prepared and kept in accordance with AF directives.

Provider responsibilities

Doctors must document in the health records an accurate, legible, and complete description of all services rendered to patients.

Technician responsibilities

One of the most important aspects of your job is annotating health records. It's a vital part of overall patient treatment and administration of care. Protecting the patients' privacy is always a concern. Generally, notes made in the outpatient medical records (OPR) originating from mental health, Family Advocacy Program (FAP), or Alcohol and Drug Abuse Prevention and Treatment (ADAPT) are brief. A detailed note is maintained in the individual's treatment record in mental health services (MHS). Whenever a patient is treated in your clinic, make sure an entry has been made in the medical record before it leaves your clinic. If not, return it to the treatment team member to annotate the care provided. If a patient's medical records aren't available, annotate any exam on an SF 600 (or whatever form your clinic uses) so there's a record of the visit. Take care to ensure your entries are made correctly.

028. Mental health service records

One of your most important responsibilities as a mental health service technician is ensuring the clinic's administrative duties are carried out. Because of the sensitive nature of mental health care, a separate set of records is maintained for each client seen. This lesson discusses the preparation, maintenance, and disposition of outpatient mental health records. We also cover some general guidelines and formats for recording information in the patient's record.

One of your responsibilities is documenting patient treatment in both the patient's medical treatment record and either the inpatient/day treatment, outpatient mental health, or FAP records. Again, these records are maintained by clinic or unit personnel depending on where the care originated. The primary reason for the separate records maintenance is the sensitive and personal nature of the therapies conducted in the clinic.

It may be possible that mental health records become automated in the future, but for now we still maintain a separate physical record. Be aware that the setup at your base may vary from our discussion due to provider preferences. Let's begin by discussing the most commonly accepted version of the outpatient record.

Mental health service outpatient record

Whenever care or administrative tasks are accomplished, you must document it in both the OPR and the MHS record. To state it plainly: if you annotate something in one you must also document it in the other. These are considered synonymous and each should be a reflection of the other. The following discussion looks at the MHS outpatient records in three stages: *Development*, *Maintenance* and *Disposition*.

Record development/preparation

The MHS outpatient record is a file folder. It must be clearly marked on the front with the clinic's name—**Mental Health Clinic Record, Behavior Health Clinic**, or whatever name your clinic uses. This marking indicates that it is a separate record. There is usually a stamp with the clinic name that is used to mark one or both sides of the folder. The lettering on the stamp should be large enough to be easily and readily identifiable.

Outside cover

In the upper left corner of the inside back cover is a label with the client's name. The label may also include rank, SSAN, unit, and duty phone number. For non-military status patients, continue to use the sponsor's SSAN and the family member prefix (FMP) code: 30 for spouse and 01 through 19 to indicate the sponsor's children. While there are many other prefixes to indicate patient status, these are the most common. Some records may use other abbreviations for a patient's status: D/W for dependent wife; D/H for dependent husband, D/S or D/SS for dependent son/stepson, D/D or D/SD for dependent daughter/stepdaughter. However, their use is less frequent and may entirely disappear.

On the upper right corner on the inside back corner is a label used for the clinic's coding system. The coding system is used to indicate reviews, annual summaries, terminations etc. This system may use colors, numbers, or letters. Local policy or operating instructions (OI) will dictate the system and codes used.

Inside record

The paperwork on the inside is held in place by paper fasteners at the top of the right side and on the bottom of the left side. The left side of the record is used primarily for administrative paperwork, while the right side contains treatment documentation. The left side also includes:

- DD Form 2005.
- Clinic Information Sheet (describes services).
- SF 513.

The left side of the folder contains psychological testing materials and narrative summaries for those clients that have been admitted to the hospital for treatment. The right side contains SF 600s. The SF 600s are often overprinted so that providers/technicians can easily document important aspects of the patient's situation. If applicable, include the AF 745, which are maintained on the top of all other documentation on the right-hand side of the record.

Some duty assignments will afford you the opportunity to become extensively involved in patient care while others will not. No matter which situation best describes your working environment administrative management of records is a priority for you. Ensuring completeness of requirements for documentation or the "mechanics" of a patient's record is expected. Among the things that you must ensure are:

- Patient Identification block is complete.
- Each entry has the appropriate stamp (MHS, FAP, ADAPT, PRP), if applicable.
- Date is recorded on each entry.
- Signatures are within existing guidelines.
- Forms are in proper place.

NOTE: All mental health apprentices/journeymen/craftsmen signatures documenting treatment or care must be co-signed by a credential provider.

Record maintenance

Now that you have an assembled MHS outpatient record, what is the next step? How are the records managed? Who has primary responsibility for maintenance of the records? Well, the answer is you! You are responsible for the preparation, security, and disposition of mental health clinic records.

Quality control (QC)

In the area of records management, quality means a degree of excellence. Quality recordkeeping is the goal you should strive for. It allows you to accomplish your duties to the best of your abilities. Quality documentation and accurate descriptions of services provided enhances patient care and ensures continuity of care. All active records are usually reviewed semiannually to ensure that all administrative tasks have been accomplished appropriately. Peer reviews also provide a venue for reviewing documentation among other things. Due to the sensitive nature of our information, these reviews are done internally by exchanging client records among providers. Each case must be reviewed at least annually and a statement indicating this review is documented in the records.

Security

Few things will damage the credibility of your clinic or its staff more than a security violation. Security of the mental health records is a top priority and of the utmost concern. Privacy laws and patients rights demand that we protect this information. Due to the sensitive nature of discussions between patient and provider and the therapies involved, mental health records must be maintained under a double lock system. This means that the files are not only kept locked in a filing cabinet, but the filing cabinets are also kept in a locked room. An individual's files should be out only when someone is working on them. Record security is a serious matter. Nothing can ruin the reputation of a clinic faster than when patients feel that what they say in confidence will be accessible to everyone. Therefore, access to mental health records should be limited to mental health personnel only—specifically those involved in the case. Do not peruse records unnecessarily or simply out of curiosity. This is illegal—you have no right to access the client's information. We discuss this area in more detail later in this CDC. Unauthorized access to records could cause legal problems, embarrass the patient, ruin the patient-to-provider relationship, and ruin the reputation of the mental health clinic.

Record disposition

An annual rite in mental health services is the retirement of records. Mental health/substance abuse records are retired 2 calendar years after the patient's last date of treatment. They are maintained at the MTF during the two-year period. AFI 33-364, *Records Disposition-Procedures and Responsibilities*, provides specific guidance and variances in the record retirement process. Record disposition is now an internet web-based system. The Air Force-Record Information Management System (AFRIMS) provides the Records Disposition Schedule (RDS) for Mental Health Service records.

Records are filed into boxes specifically designated for records retirement. All active duty and retiree treatment records eligible for retirement are filed in the box alphabetically.

029. Family advocacy program records

The Family Advocacy Program (FAP) deals with extremely sensitive matters. Allegations and substantiated cases of physical, sexual, and emotional abuse are exhaustively documented and maintained in the FAP records. Counseling, prevention, and attempts at intervention are maintained as well. Like MHS records, all FAP maintained records must be secured under double locks and must be secured at all times unless authorized personnel are accessing the file cabinet to retrieve records.

A separate case record is established for each family referred for Special Needs Identification or suspected maltreatment. FAP records, unlike mental health records which maintains a treatment

record for each individual patient, are filed under the sponsor's name and includes the entire family's notes in a single record.

Because family advocacy prevention programs manage their own records, we will not discuss them at length. The FAP office maintains the New Parent Support Program (NPSP), Family Advocacy Strength-Based Therapy (FAST) Services (referred to as an FSR record) records for 2 years after closure. At the end of the retention period these records are destroyed by FAP office maintaining them.

FAP may be located away from the mental health clinic in a different area of the MTF or it may be separated from the MTF entirely and located elsewhere on base. You will encounter different configurations as you move from base to base during your career, Now that we've covered some basic information, let's turn our attention to the contents and preparation guidelines for the family advocacy record.

Preparing a family advocacy program record

The FAP maltreatment record is maintained in a six-part folder. As we said earlier, the records are organized by family, meaning that all family members' documentation is kept in one file that is identified by the sponsor's name. The front and back covers of the record are stamped with "FAMILY ADVOCACY RECORD". The sponsor's name is placed on a label on the left front corner of the record. Social Security numbers are *not* placed on the outside of the FAP record. Additionally, a label on the top left- or right-hand corner identifies the assigned incident number and the victim name(s). A label that clearly indicates the content is placed on the divider for each section of the record.

Record maintenance

Each functional section activated in the record is clearly marked. You should be familiar with the FAP record contents and organization because part of your responsibility is to retrieve and file important data in the FAP record. Therefore, it's important that you understand each area of the record and the forms used for documentation. As stated earlier, the FAP record is divided into the six sections listed below:

- A. Administrative.
- B. Data Collection Instruments.
- C. Record/File Cross-Reference.
- D. Supportive Documentation.
- E. Intervention Management Tools.
- F. Chronological Documentation.

Let's take a closer look at each section and the forms used.

FAP Record Sections and Contents	
Section	Contents
A. Administration	<p>This section contains administrative documentation that initiates the record and contains the following forms and documents:</p> <ul style="list-style-type: none"> • AF Form 2522, Family Advocacy Program Intake. • DD Form 2005, Privacy Act Statement(s)–Health Care Record, signed by each adult family member interviewed. • AF Form 2524, Family Advocacy Information Maltreatment Intervention Services, signed by each adult family member interviewed. • Request for Release of Information documentation (when applicable). • Permanent change of station (PCS)/temporary duty (TDY) orders of the client are maintained in this area as well.

FAP Record Sections and Contents	
Section	Contents
B. Data Collection Instruments	<p>This section contains data collection that may be deemed appropriate for each case.</p> <ul style="list-style-type: none"> • FASOR 2486, Child/Spouse Incident Report. • Any completed standardized assessment inventories required by Air Force Medical Operations Agency (AFMOA). • Any other completed inventories selected by FAP staff.
C. Record/File Cross-Reference	<p>This section is to provide continuity between different aspects of care. Common items cross-referenced in this section include</p> <ul style="list-style-type: none"> • NPSP. • FAST Services. • Mental Health Clinic Records. • ADAPT records.
D. Supportive Documentation	<p>This section contains supporting documentation including investigative reports, relevant medical information, photographs and correspondence, etc. Law enforcement, Child Protective Service (CPS), and criminal investigative reports are included in this section as well.</p> <p>All documentation is filed in chronological order.</p>
E. Intervention Management Tools	<p>This section includes all intervention-related documentation:</p> <ul style="list-style-type: none"> • Intervention plans. • Contracts. • Related information. • Referral Form. • Clinical tools including a genogram, cycle of violence, power and control wheel, and questionnaires/inventories. <p>This is filed chronologically.</p>
F. Chronological Documentation	<p>A chronological record of events documented on the SF 600, DD Form 2161, Medical Care for Civilians, or equivalent forms, including automated versions, are maintained in this section. Unlike any other record containing a SF 600, the FAP record containing a SF 600 will <i>not</i> have the sponsor's Social Security number on the patient information block.</p> <p>Section F will include the following information:</p> <ul style="list-style-type: none"> • If the military member is assigned duties under the PRP, then the first document in the record is AF Form 745, Sensitive Duties Program Record Identifier. DODR5210.42_AFMAN1, Nuclear Weapon Personnel Reliability Program, provides guidance regarding PRP. This form remains the first item in the record in this section as long as the sponsor is assigned Personnel Reliability. • FASOR-generated Adult Intake Form for each adult family member interviewed. • FASOR-generated Child Intake Form for each child interviewed by a FAP provider. • FASOR-generated SF 600 for all client visits, phone contacts, and collateral contacts. • Assessments/diagnoses results. • Documentation of all risk assessments and safety plans. <p>This section will not include any identifying information on an informant who requests anonymity.</p>

Record disposition

Like mental health records, the FAP records are maintained at the MTF for 2 years after the last date of treatment. FAP charts are filed alphabetically in the boxes for shipment. Prior to placing the records in the boxes they must be removed from the six-part folders, as they will not fit into the boxes otherwise. Reconstruct the file into a two-part folder and label each with the client's name for identification purposes.

Complete the SF 135, Records Transmittal and Receipt (refer back to the discussion on mental health records) and forward it to the National Personnel Records Center (NPRC) Military Personnel Records (MPR) for acceptance. NPRC maintains the FAPs for 25 years before final disposition/destruction.

030. Mental health inpatient records

Inpatient records provide a comprehensive record of the patient's condition and care throughout hospitalization and the time following discharge. The records provide a clear picture of the care that a patient should receive, is receiving, and has received. The inpatient records also serve as a source of peer review (checking each other's work for accuracy as a way of guaranteeing consistency) as well as a part of the accreditation process. We discuss various aspects of records maintenance in the remainder of this lesson.

Inpatient (clinical) record preparation

Most mental health units have sets of forms prepackaged and ready for each individual admission. The normal arrangement is chronological order; however, some units arrange them in order of use. When a patient is admitted to your unit, you stamp the patient's identification data in the designated area on each form. The commonly used admission forms for most mental health inpatient units are listed below.

Common Forms Used by Mental Health Inpatient Units	
SF 504, Clinical Record—History Part 1	AF Form 3066, Doctor's Orders
SF 505, Clinical Record—History Parts 2 and 3	AF Form 3068, PRN Medication Administration Record
SF 506, Clinical Record—Physical Examination	AF Form 3069, Medication Administration Record
SF 509, Medical Record—Progress Notes	AF Form 3241, Adult Admission Assessment
SF 510, Clinical Record—Nursing Notes	AF Form 3255, Nursing Progress Note
SF 511, Medical Record—Vital Signs Record	AF Form 3256, Patient/Family Teaching Flow Sheet
SF 513, Medical Record—Consultation Sheet	AF Form 3257, ADL/Treatment Flow Sheet
SF 519B, Radiology Consultation Request/Report	AF Form 3259, Work Activity

Most of the forms mentioned above are maintained in a patient's inpatient chart. The exceptions are AF Form 3069 and AF Form 3259 which are usually maintained in a separate area. Some units use a book called the Kardex and others may use the Medication history and Reconciliation System (MARS). Local policy determines which of these forms is used and in what order they are maintained in the patient chart.

Forms and their uses

Let's take a brief look at a few key forms mentioned above and their uses.

SF 506, Clinical Record—Physical Examination

This form must be filled out by the physician within 24 hours following a patient's admission. All physical examination findings must be indicated on this form. If the patient is readmitted for the same condition to the same hospital within a month's time, the physician may enter a note referring to the previous examination. You complete the vital signs area of the form during the patient admission

process. This saves the physician a step in the process and, if the physician desires, the information serves as a basis for comparison of vital signs data within a 24-hour period.

SF 510, Clinical Record—Nursing Notes

This is one of the most useful forms available on nursing units. Not only does it serve to house the nursing notes, as we will see later; but after being stamped with overprinted information it is also used to note patient historical data. Sometimes there are as many as five overprinted pages to be completed. You or the unit nurse normally collects this data. Once you have collected and noted the requested information, the unit nurse normally cosigns the forms to indicate review. This peer review, designed to assure accurate data, is a requirement in most major facilities.

SF 513, Medical Record—Consultation Sheet

The physician uses this form to request patient services located outside the unit's normal activities. The SF 513 is routinely completed if any ancillary services are required. In addition, this form is used to request psychological testing, physical therapy, and appointments with various medical and surgical clinics. The health care provider decides which services the patient needs, writes an order on the AF 3066, and completes the SF 513. The SF 513 is then forwarded to the office providing the service being requested. The service office normally calls the unit with an appointment time and date. After the patient is seen, the service office writes its report of findings on the SF 513 and returns it to the unit. Any care provider's orders on the SF 513 are then transferred to the AF Form 3066. After the provider sees the report and initials it, the report is filed in the patient's chart.

AF Form 3066, Doctor's Orders

Physicians use this form to transmit written orders for patient care and treatment to the nursing staff. The original of this form remains in the patient's record. The pharmacy staff uses the perforated copy to maintain drug profiles on each patient. When an individual unit dose of medication is requested, a portion of the perforated copy is used to order the medication. The nurse normally completes this form. A physician's verbal orders are usually reserved for emergencies only. These orders can *only* be accepted by a nurse and must be countersigned within a 24-hour period. What if you are on a unit and a physician telephones orders? You must advise the physician that you cannot legally take responsibility for the order.

AF Form 3068, PRN Medication Administration Record, and AF Form 3069, Medication Administration Record

These forms are used to record a complete, concise profile of a patient's in-hospital, past, and present prescribed medications. As stated earlier, these forms are maintained in a unit's specific system like a Kardex or MARS. They are only placed in the patient's chart after completely filling them out, all medications are discontinued, the patient is discharged or transferred, or the patient goes to surgery.

Record maintenance

It is very difficult to separate the mechanical process of record keeping from the applications required to complete the records. In this section, we look at both where and how the forms are maintained while the patient is hospitalized.

After the physician and nurse have completed and verified a patient's record, you are responsible for combining all parts of the record and assembling them in the proper order. Follow the steps listed below:

1. File the AF Form 565, Record of Inpatient Treatment, if it is used.
2. The AF Form 560 is followed by the standard forms in numerical sequence. (There may be local exceptions to the filing of standard forms.)
3. If SF 539, Medical Record—Abbreviated Medical Record, is used, it may be required to be filed in place of SF 504, Clinical Record—History Part 1, SF 505, Clinical Record - History

Parts 2 and 3, and SF 506, Clinical Record—Physical Examination. The standard forms are followed by the Department of Defense (DD) forms in numerical sequence. One exception is that DD Form 792, Twenty-four Hour Intake and Output Worksheet, is filed after SF 512A, Medical Record—Plotting Chart—Blood Pressures (if used). The DD forms are followed by AF forms in numerical sequence (with exceptions already noted).

All local and command forms should be filed beneath those already mentioned in sequence according to local policy. Remember, this is a general guideline. Your local operating instructions will provide more complete information.

Records disposition

Before the patient can leave the hospital several administrative procedures are required. First, the physician must complete the patient's record and check it for accuracy. The physician must write the final progress note on SF 509, Medical Record—Progress Notes, fill out the disposition information on AF Form 560, Authorization and Treatment Statement, and sign the form. The diagnostic nomenclature (identifying terms) that the physician places on AF Form 560 is based on, and should be consistent with, the Diagnostic and Statistical Manual of Mental Disorders (DSM), current edition, American Psychiatric Association. Secondly, a physician must accomplish a narrative summary, SF 502, Medical Record—Narrative Summary, before the record is considered closed.

After the record is fully assembled, it should be placed in an envelope and sent to the Admission and Disposition (A&D) clerk.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

027. Outpatient medical records

1. What is AHLTA?
2. Besides being used as a place to store documents, what other purpose does the outpatient medical records serve?
3. Who is responsible for keeping all caregivers informed of documentation, maintenance, and release of information procedures?
4. How should you document a patient's visit if the outpatient medical record is not available?

028. Mental health service records

1. What forms are located on the left side of the MHS record?
2. What does it mean to have MHS records under double lock?

3. How long are MHS records maintained in the clinic after the patient's last visit?

029. Family advocacy program records

1. How are FAP patient records maintained and located in family advocacy?
2. What are the sections of the FAP record?
3. What should you do with the FAP record to prepare it for retirement?

030. Mental health inpatient records

1. Where are medication administration records normally maintained?
2. What form does the physician use to transmit written orders for patient care and treatment to the nursing staff?
3. What form is used by the physician to write the final progress note before closure of the record?

5-2. Clinical Administrative Management

As a mental health journeyman it is very likely you will be responsible for maintaining a budget for your duty section. Have you ever visited or been to a clinic that seemed to have all the latest/greatest materials, computers, furniture, or audiovisual support? You can thank an NCO. Someone educated himself or herself on the budgeting and acquisition process and the clinic staff and patients/clients alike are the benefactors.

031. Identify principles of budgeting

Anticipating, projecting, and managing expenditures for the entire calendar year (CY) can be challenging. Knowing how to plan ahead and be prepared when its time to submit an annual budget will pay dividends.

Understanding the budget process

The entire budget process begins with a budget call, a formal set of instructions that explains how and when to submit the base budget. A few months before the beginning of the new fiscal year (FY), the resource management office (RMO) gathers all the MTF cost center managers (CCM) together and distributes the "call" instructions. As the CCM, you return to your duty section and begin to develop budgets. Once completed, your budget is returned to RMO who compiles the information with all the other proposed budgets for the MTF. This combined MTF budget is submitted to the base level RMO who consolidates the base budget and a similar process continues up the chain and is input into the

Air Force budget. This continues until the Air Force chief of staff is sitting in front of a group of congressmen defending the requested eight new ping pong paddles and a video game system for your inpatient unit. Just kidding! But the process does eventually reach Congress for approval.

Every year you hear about the Pentagon budget process in the news. Well, it starts with you. Your input may seem minor at times, but it is a vital piece of the overall fiscal package that the Air Force uses to conduct business. It is critical that you do your best in this area, not only for your immediate needs but the future needs of the Air Force. Request and use funds wisely.

Identify types of budgets

Another important aspect of understanding the budget process is knowing the different types of budgets that the military uses. The two that we will discuss are capital and operating budgets.

Capital budgets

Capital budgets cover acquisition of land, buildings, and other large value items. Acquisition of these types of items may be projected many years into the future. You may not work with this budget level in your capacity as a mental health journeyman, but you need to be aware of and its purpose. The Air Force uses a capital budget for the acquisition of new weapons systems like the F-22 aircraft. Air Force capital budgets are generally used at the DOD and Headquarters level. These do not normally impact your clinic's budget planning.

Operating budgets

On the other hand, the operating budget is used at the MTF level. You may be managing your clinic's annual operating budget which forms a small portion of your MTF's annual operating budget. This is an awesome responsibility and one you should take very seriously. These are the funds that are available for your clinic's operations. Your operating budget funds must cover all of your clinic/unit's operating supplies, fund your TDYs, and purchase needed equipment. Your operating needs are covered by the approved version of your operating budget.

Draft budget

You may be asked to provide input for a draft budget. If you request that a specific item be included in the budget, be prepared to provide the supporting information that covers the initial costs, maintenance, and life expectancy of the item. If the item is to be added to an inventory for continued usage, you should be prepared and ready to present anticipated monetary expenses for the item's life cycle.

Review information/complete final draft

Once you've completed your final draft, review it for errors and omissions. Take this opportunity to let someone else look at the budget. Find an NCO whose input you value and ask for assistance. Use this time to add any items not previously identified or remove items that can't be justified or are the responsibility of a different office.

Now, you have a budget! This should provide an accurate view of the financial resources needed to operate your clinic through the next year. Remember to keep your own personal copy readily available. A budget is absolutely worthless if it's not used properly. If you just leave it on the shelf and conduct business as usual, you will have wasted all the time and effort that went into creating your budget. Additionally, you will be doing yourself, your clinic/unit, and MTF a huge disservice.

032. Ethical/legal issues related to managed care

Ethical principles permeate every aspect of the services 4C0s provide. This includes administrative, clinical, and referral services. Certified Alcohol and Drug Abuse Counselors (CADAC) have a code of ethics and some bases have a code of ethics for 4C0s. We began this volume with a discussion of personal ethics. Recall that discussion as we conclude this unit by taking a brief look at areas where ethical verses legal considerations often meet.

Differentiating between what is ethical versus legal can sometimes lead to unexpected decisions. Simply because an act is legal doesn't guarantee it is ethical. Ethics and legal matters related to managed care can be masked in acts of genuine kindness or appreciation.

Critics of the managed care system argue that managed care reduces the introduction of new technology, interferes with the physician-patient relationship, worsens outcomes, restricts clinical research, reduces funding for physician training and adversely affects community based hospitals. Others raise concern about monopolistic trade practices, ruthless business techniques and the subversion of medical ethics. As managed care continues to grow, the relationships among providers, hospitals, physicians and other healthcare professionals are undergoing change and, in many cases, strain.

In any balanced discussion of this topic, you should keep in mind that if appropriate ethical standards are employed, managed care programs can work with reasonable success. They can provide systems that encourage effective and long-standing relationships between patients and their primary care providers; they can commit to provide quality medical care to their patients; and they can ethically assume a population-based approach that incorporates public health concerns as well as individual medical strategies. They can encourage-outcome management studies and apply the most current standards to both diagnosis and treatment while rejecting unproven and inefficient treatment methods.

The Hippocratic Oath emphasizes the primacy of trust in the physician-patient relationship. It obligates the physician to keep patient information confidential, to avoid mischief and sexual misconduct, and to give no harmful or lethal agents. In short, the physician becomes the advocate for the patient, combining knowledge and the patient's trust for the good of the patient. Managed care forces physicians to balance the interests of their individual patients with the interests of other patients in the system (rationing of care and constraining cost) and may place the physician in a position where his patient's needs are in conflict with his own financial interests.

Can a TRICARE provider in your community invite all the CADACs out for a steak lunch once a month? Can a local treatment facility provide an in-service and luncheon to the entire MHS staff? Is there an expectation by the hosting facility that you will now use them solely for your inpatient clients? These are just a few questions that occur daily throughout the mental health system.

The core of behavioral health care is ethical behavior by technicians and providers. Some of the ethical and legal issues you may encounter or be privy to are discussed below. Spend some time reviewing how each of these areas may blend both ethical and legal issues. Some areas will have examples.

Ethical and Legal Issue Areas	
Teaching	Dangerousness (e.g. suicidal/homicidal, duty to warn, child/spouse abuse)
Counselor/technician competence	Children and vulnerable adults
Testing/assessment	Individual differences (e.g. gender, race, cultural/ethnicity, religion)
Risk management	Documentation and record keeping
Psychotherapy (Especially "fringe" approaches)	Financial issues (e.g. this is not only related to clinical aspects but also to your role as a financial/resource manager for your area)
Confidentiality/privileged communication	Telecommunications (e.g. unauthorized sharing of patient information on the Internet)
Conflict of interests (e.g. flight commander/NCOIC and counselor to member, or consistently referring clients to a setting, facility, or provider which you are a financial stakeholder, or the relationship between you and the accepting provider is nepotistic which could create an impression of impropriety)	

This by no means is meant to be an all-inclusive list, but merely a sampling of areas you may encounter as a craftsman.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

031. Identify principles of budgeting

1. How does the budget process begin?
2. Who gathers all of the budgets for the MTF?
3. What items are normally procured through capital budgets?
4. What items are normally procured through operating budgets?

032. Ethical/legal issues related to managed care

1. How are ethical and legal matters related to managed care often masked?
2. What are some examples of conflicts of interest?

Answers to Self-Test Questions

027

1. AHLTA (formerly CHCS II ; US DOD military health system) is the military's electronic health record (EHR) and marks a significant new era in healthcare for the military health system and the nation.
2. Planning, documentation, communication, data, and protection.
3. Director of Patient Administration.
4. Annotate his or her exam on an SF 600 (or the automated version).

028

1. (1) DD Form 2005.
(2) Clinic Information Sheet.
(3) SF 513.
2. This means that the files are not just locked in a filing cabinet, but also kept in a locked room.
3. Two years.

029

1. FAP records are filed under the name of the sponsor with the entire family's notes maintained in one record.
2. (1) Administrative; (2) Data Collection Instruments; (3) Record/File Cross-Reference; (4) Supportive Documentation; (5) Intervention Management Tools; (6) Chronological Documentation.
3. The records must be removed from the six-part folders as they will not fit into the boxes otherwise.

030

1. In the Kardex or MARS.
2. AF Form 3066, Doctor's Orders.
3. SF 509, Medical Record—Progress Notes.

031

1. The entire budget process begins with a budget call, a formal set of instructions that explains how and when to submit the budget.
2. Resource management office.
3. Land, buildings, and other large value items.
4. Fund your clinic's operating supplies, fund TDYs, and purchase equipment.

032

1. Acts of genuine kindness or appreciation.
2. Flight commander/NCOIC and counselor to member, or consistently referring clients to a setting, facility, or provider which you are a financial stakeholder, or the relationship between you and the accepting provider is nepotistic which could create an impression of impropriety.

Do the unit review exercises before going to the next unit.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter.

56. (027) The Armed Forces Health Longitudinal Technology Application has been touted as consistently encompassing all of the following elements *except*
- secure.
 - powerful.
 - latitudinal.
 - knowledgeable.
57. (027) Who is responsible for the appraisal of the quality of care rendered based upon documentation in the health record?
- Provider.
 - Health Records Committee.
 - Director of Patient Administration.
 - Medical treatment facility (MTF) commander.
58. (028) What system is used to ensure mental health records are protected from security violations?
- Double lock.
 - Quality control.
 - Record disposition.
 - Information protection.
59. (028) How long are mental health records maintained *after the last date of treatment*?
- 1 year.
 - 2 years.
 - 3 years.
 - 4 years.
60. (028) Mental health records are prepared for retirement shipment in what order?
- Date of birth.
 - Date of rank.
 - Alphabetically.
 - Chronologically.
61. (029) The FASOR 2486, Child/Spouse Incident Report, is maintained in what section of the Family Advocacy Program (FAP) record?
- Section A.
 - Section B.
 - Section D.
 - Section F.
62. (029) What section of the Family Advocacy Program (FAP) record is used for Supportive Documentation?
- A.
 - C.
 - D.
 - F.

63. (030) Which form must be filled out by the physician within 24 hours of a patient's admission?
- a. SF 506, Clinical Record—Physical Examination.
 - b. SF 510, Clinical Record—Nursing Notes.
 - c. AF Form 3255, Nursing Progress Note.
 - d. AF Form 3066, Doctors Orders.
64. (030) Which form is used when a physician wants to request services located outside the unit's normal activities for a patient?
- a. SF 506, Clinical Record—Physical Examination.
 - b. SF 510, Clinical Record—Nursing Notes.
 - c. SF 513, Medical Record—Consultation Sheet.
 - d. AF Form 3066, Doctors Orders.
65. (031) The entire budget process for the medical treatment facility (MTF) is compiled by the
- a. Resource management office (RMO).
 - b. Cost center managers (CCM).
 - c. MTF administrator.
 - d. MTF commander.
66. (031) Which budget covers acquisition of land and buildings?
- a. Operating.
 - b. Personal.
 - c. Capital.
 - d. Draft.
67. (032) What emphasizes the primacy of trust in the relationship between a patient and physician?
- a. Hippocratic oath.
 - b. Legal behaviors.
 - c. Ethical behaviors.
 - d. Common courtesy.

Unit 6. Mental Health Readiness

6–1. Combat/Disaster Casualty Management.....	6–1
033. Identify mental health assets.....	6–2
034. General stress management	6–4
035. Reactions to combat.....	6–8
036. Mental Health Implications for Traumatic Injuries	6–15
037. Key points of a field assessment.....	6–18
038. Performing Psychological Triage	6–20
039. Understanding BICEPS	6–21
6–2. Air Evacuation Classification Codes, Movement Precedence, and Responsibilities	6–26
040. Air evacuation terminology	6–26
041. Patient classification categories and precedences.....	6–27

OUR GENERATION’S innocence and naivety was shattered one beautiful Tuesday morning in September, not so long ago. Most of you probably didn’t know a single person who died that tragic day, but each of you carries a psychological reminder of the attack. Asking where you were, what you were doing, and what your thoughts were on that day immediately conjures up vivid recollections. From that day forward many of you may have changed the way you conduct your lives. The mere mention of 9–11 causes a variety of thoughts and emotions.

The level of anxiety, worry, and fear has increased for all Americans; and for good reason. How do you deal with patients who are experiencing very real psychological and physiological reactions to events that are beyond their control? How do you identify peers and troops who are slowly succumbing to combat stress?

In this unit you will familiarize yourself with likely tasks you may encounter as a team member of mental health readiness.

6–1. Combat/Disaster Casualty Management

The 11 September 2001, terrorist attacks caused the incomprehensible collapse of the twin towers of the World Trade Center in New York City. Approximately 40 minutes after the World Trade Center was attacked, a similar terrorist attack was perpetrated against the Pentagon in Washington, DC. The resulting physical devastation was beyond anything this nation has ever experienced. The psychological devastation may not be fully understood for years.

Everything came to a screeching halt that day. Schools and stores closed, events were cancelled, and every single aircraft—with the exception of military combat aircraft—were grounded for the first time in aviation history. The terrorists succeeded in creating a lasting psychological scar with their unconventional warfare.

The role of the armed forces of the United States is to defend our country and our way of life from those forces that threaten our government and its people. This defense has been carried out in many different wars since the founding of this country. Every war, including those that occurred before the conception of the USA, has had victims of combat stress. This stress has had devastating results for the fighting force and the ultimate outcome of the war itself. One result is casualties rendered immobile by the overpowering control of one’s own mind.

A similar reaction can occur when people are victims of peacetime disasters. In addition to the events of 9–11 mentioned earlier, disasters occur without warning and can include tornadoes, hurricanes, earthquakes, fires, and airplane crashes—to name a few. Peacetime disasters can be just as devastating as wartime disasters. They differ, however, in terms of the duration of the precipitating

stimulus. A battle may continue for days, months, and even years, creating seemingly endless destruction, while a peacetime disaster usually ends quickly. The victims can begin assessing damages without fear of reprisal. Nonetheless, patient care techniques for both wartime and peacetime situations are similar. The difference is that war casualties come to the treatment facilities in one seemingly endless wave after another.

033. Identify mental health assets

Mental health personnel have specific duties and responsibilities during both war and military operations other than war (MOOTW). Previously, mental health assets were divided into two deployable packages: the Mental Health Rapid Response Team (MHRRT) and the Mental Health Augmentation Team (MHAT). Their mission was to provide rapidly deployable mental health manpower and equipment to wartime and MOOTW.

The MHRRT and MHAT concepts were designed for short term MH contingencies, not the full scale contingencies we face today. Providers and/or MHTs are now attached to actual Army units and included in convoys to provide MH services “in the field” rather than waiting for patients to come to an OPMHC. Medical behavioral health rapid response teams have replaced the MHRRT and MHAT. To understand why the change was needed it’s important to know their previous role.

Mental Health Rapid Response Team

The mobility unit tasking code (UTC) assigned to the MHRRT was FFGKV. The team was responsible for mental health triage, short-term management of combat/traumatic stress patients, critical incident stress debriefings (CISD), and command consultation including outreach services. The FFGKV code identified the MHRRT as the primary deployable team. Team members included one psychologist, one medical social worker, and one mental health technician.

Mental Health Augmentation Team

The MHAT was assigned mobility UTC FFGKU. This team deployed to locations where the MHRRT (FFGKV) was already deployed and augmented and assisted the MHRRT. It was never deployed alone. The MHAT supplemented the MHRRT by assisting with psychiatric triage and stabilization, managing combat stress patients, conducting critical stress debriefings, and providing command consultation including outreach services. The MHAT included one psychiatrist, three mental health nurses, and two mental health technicians.

Medical Behavioral Health (BH) team

The original concept of operations (CONOPS) for the MHRRT and MHAT received USAF Surgeon General approval in 1998. The second version was approved in 1999. The third, and most recent version of the CONOPS, is called Air Force Tactics, Techniques, and Procedures 3-42.78. The Tactics, Techniques, and Procedures (TTP) title has replaced the term CONOPS.

BH UTCs are designed to provide a wide spectrum of care in multiple locations. The BH UTCs provide rapidly deployable BH personnel and equipment to:

- Perform prevention/outreach services;
- Provide outpatient behavioral health services, either in a typical Outpatient Behavioral Health Clinic (OPBHC) or in other medical settings as dictated by the deployment; and
- Provide combat stress support services while operating a Combat Stress Facility (CSF) and engaging in prevention activities as described above.

BH Rapid Response Team Members

The BH UTCs can be flexibly deployed on an individual basis or in combination to provide the right mix of behavioral health capabilities and manpower required to support the mission. The following table provides more information about the BH UTCs and the team composition.

BH Unit Tasking Code	Nomenclature	Composition
FFBH1	Medical Behavioral Health Rapid Response Team-Psychologist	One Psychologist One 7-level MHT
FFBH2	Medical Behavioral Health Rapid Response Team-Social Worker	One Social Worker One 7-level MHT
FFBH3	Medical Behavioral Health Rapid Response Team-Psychiatrist	One Psychiatrist One 5-level MHT
FFBH4	Medical Behavioral Health Rapid Response Team-Nurse	Two MH nurses
FFBH5	Medical Behavioral Health Rapid Response Team-Enlisted	Two 5-level MHTs

Team Capabilities

BH teams provide an initial and cost-effective response to SSCOs and wartime contingencies. They are also capable of providing psychological first aid/traumatic event management for such events as shootings, aircraft accidents, suicides, homicides, work place deaths, terrorist bombings, combat deaths, etc. In general, a BH team (typically FFBH1, FFBH2, or FFBH3) supports each bed-down at risk population of 2,000 or greater. A BH team may be deployed to bed-downs with populations under 2,000 as necessary in response to a traumatic stress event described above. Capabilities include operating a OPBHC, inpatient BH services, prevention/outreach services, individual and group therapy and counseling, operating a CSF, supporting Contingency Aeromedical Staging Facilities (CASFs), psychiatry support to U.S. Army missions (FFBH3 only), inpatient psychiatric care services within military detention centers, and consultation in support of detention and intelligence operations.

Team Differences

The five BH teams share the same core capabilities—providing prevention/outreach services, outpatient behavioral health services, and combat stress support services within their scope of practice. In addition, these teams have unique capabilities. When psychological testing and/or formal commander-directed evaluation is required, FFBH1 should be selected as the deployment team. Otherwise FFBH1 and FFBH2 have the same capabilities. FFBH3 should be selected when the capability of prescribing psychotropic medications is required (in the future, FFBH4 may also provide capability for prescribing medications as additional nurses acquire psychiatric nurse practitioner status). FFBH3 can also provide formal command-directed evaluations. When increased capability for assessment and management of patient physical health needs are required, FFBH4 should be selected. FFBH5 should be selected when augmenting a deployed BH team is needed or supporting a larger in-place mission requires technician oversight from a provider or nurse.

An individual BH team with only two staff members does not have the personnel required to operate 24 hours per day. When the workload demands exceed BH team resources, augmentation by another team, as appropriate, must be considered.

Military Operations Other Than War

MOOTW can range in size from involving only individuals or small teams, to single units, flights, squadron, groups, wings or air expeditionary forces (AEF) sized operations. Some examples of the range of MOOTW are:

- Peacekeeping.
- Nation assistance (helps to build infrastructure).
- Humanitarian and civic assistance (assist with fixing endemic problems).
- Disaster relief operations (post natural or man-made disasters).

- Demonstration and show of force (deployment of sufficient forces to deter aggression or other offensive action by an aggressive or hostile force).
- Strikes or raids (i.e., to disable illegal nuclear, biological or chemical (NBC) or weapons of mass destruction (WMD) facilities).
- Operations to restore order.

Contingency Aeromedical Staging Facilities

The contingency aeromedical staging facility (CASF) provides personnel and equipment necessary for 24-hour staging operations for patients transiting the worldwide Aeromedical Evacuation (AE) system. The CASF coordinates and communicates with medical and AE elements to accomplish patient care and patient movement, including ground transportation. It provides patient reception, complex medical/surgical nursing, limited emergent intervention, and ensures patients are medically and administratively prepared for flights.

The CASF is a medical staging facility designed to provide patient holding capabilities for casualties entering or in-transit for patient movement. It is designated to support light, lean, modular, scalable and easily deployable medical assets. The CASF is utilized at airlift hubs where casualty flow is expected to be heavy. It also functions as an extension of a Medical Treatment Facility (MTF), Expeditionary Medical Support (EMEDS) and/or a joint theater hospital platform complementing patient care with the addition of specific personnel UTCs. It can be used for the full spectrum of contingency operations, from AEF operations, to humanitarian relief operations (HUMRO) and Homeland Defense missions, including Integrated CONUS Medical Operations Plan (ICMOP).

CASFs can be scaled in size and level of care to supply combatant commanders a flexible expeditionary platform that can be right-sized to meet changing theater requirements. The CASF is composed of three personnel UTCs. In addition, the building block approach to scaling CASF to medical needs allows incremental adaptation in size as requirements change and airlift availability allows.

Patient stay in a CASF should be limited to 72 hours or theater A/E operations policy limits. When supporting a facility such as an EMEDS (or other service theater hospitals), or CONUS MTF, patients can remain in the facility as space and staging requirements allow. This depends on the casualty flow, nature of the injuries, availability of AE resources, and mission requirements. For robust AE and staging missions, however, patient stay has been reduced to 12 hours. This increases throughput capability due to projected use of retrograde airlift, civilian hospitals, air ambulances, and other-than-AE lift options. However, this level of patient movement is dependent on available airlift.

Mental health and the CASF

CASF manning includes psychiatric nurses and mental health technicians who provide medical surgical and psychiatric nursing care to patients that are in transition from in-theater medical treatment facilities to out-of-theater care at facilities in USAFE or CONUS. The average length of stay for the patients in the CASF is 3 days. The nurses and technicians work with inbound and outbound missions, manage patient's pain, and escort the more critical patients to medical and psychiatric inpatient units. CASF nurses conduct daily mental health and risk assessments on all CASF psychiatric patients and manage these patients' medication.

034. General stress management

Before we get into the *treatment* of stress brought on by combat or a natural disaster, we need to take a closer look at the stress reactions. Then we'll discuss how you can help people manage it.

Stress is a part of life. We can't get away from it. *Taber's Medical Dictionary* defines stress as "the result produced when a structure, system or organism is acted upon by forces that disrupt equilibrium or produce strain". In simpler terms, stress is the result of any emotional, physical, social, economic, or other factors that require a response or change. Stress is the body's response to a threat (real or

imagined). It is accepted that some stress is okay, sometimes referred to as “challenge” or “positive stress”, but when stress occurs in amounts that the patient cannot handle, both mental and physical changes may occur. We can, however, manage it.

Stressors are things (people, events, places) that an individual perceives as a threat. Stressors differ from person to person. The same event can happen for two people and the event will “stress” those people in different ways. The difference is in how the individual perceives the event. For example, the workload in your duty section may be very fast paced. You might feel challenged, rise to the occasion, and be very productive. On the other hand, your peer may feel overwhelmed and consider dealing with the constant flow of work stressful.

A patient may come in with a story similar to this: “My wife left me, my dog died, my car exploded and my trailer burnt down.” That sounds like someone who needs a suicide contract, doesn’t it? Well, you need to ask the next question, “How are you handling these events?” If the patient responds with despair and tears, you may assume he is feeling stress. However, if the patient responds with, “Well, I couldn’t stand that woman, I have a new girlfriend. I couldn’t stand that dog, he never shut up. That car was a piece of junk and I had great insurance on both it and my trailer. Now I drive a new truck and have a brand new double wide trailer with a hot tub!,” then you know your patient is probably handling the situation relatively well.

There are as many different ideas about stress as there are people who experience a change in their lives. Stress, quiet simply, is the way you react emotionally and physically to change. Stress can be positive or negative. Positive stress is called *eustress* and negative stress is usually referred to as *distress*. An example of eustress might be winning the lottery, getting a promotion, getting married, or completing a challenging task. Distress might be the sense of concentration you feel when faced with a new and challenging situation or being overloaded at work. So, as you can see, any situation—positive or negative—that requires adjustment is stressful.

Categories of stress

As a military member you face stressful situations daily. Your challenge is often greater than that of your peers: you must not only learn to deal with stressors, but you must also be knowledgeable enough to teach your patients coping skills so that they, too, can learn to deal with stress. It’s a fact of life that many people seen in mental health clinics or admitted to inpatient mental health units are simply there because they do not know how to deal effectively with stress. This lesson will provide you with the basics about the three basic stressor categories: frustrations, conflicts, and pressures.

Frustrations

Frustration occurs when an individual is blocked from obtaining a goal. Frustration is particularly difficult for most people to cope with because it can lead to self-devaluation. It can make individuals feel that they have failed in some way or are lacking in some area. Frustrations can be caused by both external and internal obstacles. Prejudice and discrimination, unfulfillment in a marriage, and the death of a loved one are frustrations from the environment; physical handicaps, loneliness, guilt, and poor impulse control are sources of frustration that can result from personal limitations.

Conflicts

Many times stress results from the simultaneous occurrence of at least two or more incompatible needs or motives. In other words, the requirement of one eliminates the satisfaction of the other. In essence, an individual has a choice to make and experiences conflict trying to choose. A simple example is a child in a candy store. He or she only has one dollar but there are so many different types of candies he or she wants to taste. To buy one excludes the others.

The necessity of making a choice usually involves both cognitive and emotional strain. It is difficult to make up your mind, especially when each possible alternative offers something that the other does not, and the choice is an important one. A major factor in determining the one choice seems to be an attempt to reduce the amount of stress being experienced in making a selection. Conflicts that

everyone has to cope with can be conveniently classified as *approach-avoidance*, *double-approach*, and *double-avoidance*.

Classification of Conflicts	
Approach-avoidance	These conflicts involve strong tendencies both to approach and to avoid the same goal. They are sometimes referred to as mixed-blessing dilemmas because negative and some positive features or outcomes must be accepted regardless of which course of action is chosen. An example of this is a patient who wants to join a right-to-life group and who also has strong feelings about children not being adopted and left homeless.
Double-approach	These conflicts require choosing two or more desirable goals. Simple positive-positive conflicts result from limitations in one's time, space, energy, and personal and financial resources. The cost of one opportunity is the loss of another. Most double-approach conflicts are handled with relative ease. However, when an individual is torn between two good career opportunities—or between present satisfactions and future ones—decision-making can be very difficult and stressful.
Double-avoidance	In these conflicts the choice is between more or less equally undesirable options. Neither option is desirable, so the task is to choose the least disagreeable, or least stressful. For example, you're given the option of participating in the following fitness routine; you can either run a mile and a half or walk three miles.

Pressures

Stress can also come from pressure to achieve specific goals or to behave in particular ways. Pressures can force a person to speed up, intensify effort, or change the direction of goal-oriented behavior. We all encounter stress in our daily life and, to some extent, it's beneficial. However, pressures can seriously diminish out coping resources. If the stress is chronic, it may lead to maladaptive behavior.

Pressures can be either external or internal. An airman may feel under intense pressure by parents to make it through technical training. Another student may feel pressured to make good grades and win the distinguished graduate award. For some people, the most demanding pressures are those self-imposed, due to inner motivations. Still, it is apparent that a given situation may involve elements of all three categories of stressors: frustrations, conflict, and pressure.

Factors influencing the severity of stress

The severity of stress is measured by the degree of disruption that it causes. The actual degree of disruption is the result of two variables. The first is the stressor's characteristics. Stressors that are chronic, multiple in nature, and life-threatening cause more damage than those that are not. The second variable depends on the individual's resources, both personal and situational.

Nature of the stressor

The severity of a stressor depends mostly on its importance, duration, accumulative effect, and imminence. While stressors affect people differently, some events tend to be universally accepted as being stressful—death of a loved one, divorce, loss of a job, or diagnosis of a serious illness, all tend to be exceptionally distressing. Also, having multiple stressors at the same time tends to compound the individual's stress and feelings of being overwhelmed. An example may be the loss of a job, legal problems, and contracting a sexually transmitted disease—all at the same time. The resulting stress is far more severe than if the events occurred separately. Sometimes seemingly positive events can create negative stress; for example a new job, new home, pregnancy, and the upcoming visit of relatives all simultaneously can become overwhelming as well.

Stress tolerance and resources

We all know that one person's stress is another person's euphoria. This difference is due to three factors:

Stress Factors	
Factor	Description
Perception of threat	<p>If a person sees a situation as threatening, then it will be stressful, regardless of the actual threat. This is especially true if resources for dealing with the stress are felt to be inadequate. Often, new situations that have not been anticipated, and for which no ready-made coping behavior is available, place an individual under severe stress. This is why people such as pilots, infantry soldiers, and firefighters are placed into stressful situations over and over again until new coping patterns are developed.</p> <p>If a person is PCSing to Alaska, there are three things they need to know: It is going to be cold; it is going to be dark; and it is going to snow in the winter. If a person wakes up in December in Alaska and says "if it is cold outside today, I'm going to be stressed"... then, guess what? They are going to have a bad day. As a matter of fact, they are going to be stressed until about April!</p>
Stress tolerance	The term <i>stress tolerance</i> refers to a person's ability to deal with stress without having functioning impaired. People vary greatly in overall vulnerability to stressors, as well as in the type of stressors to which they are most vulnerable. Also, an early traumatic experience can leave an individual especially vulnerable to certain kinds of stressors.
External resources and social supports	There is much evidence to support the theory that positive social and family relationships can moderate and even lessen the effects of stress and reduce illness and death. This is one of the reasons that married people, on the average, tend to live longer and have healthier lives than single people. This also supports the belief that a lack of external support can make a stressor more powerful and weaken an individual's ability to cope with stress.

General Adaptation Syndrome

The General Adaptation Syndrome (GAS), formulated by Hans Selye, describes the psychological and physiological changes people experience when confronted with a stressful event. When there is sustained and excessive stress, the body goes through three distinct stages described below.

GAS Stages	
Stage 1: Alarm Reaction	This is the immediate reaction to a stressor. The body releases adrenaline and a variety of other psychological defense mechanisms to stay in control. This is referred to as the fight or flight response. The individual may experience an increased heart rate and breathing, tensed muscles, and perspiration. This initial response can also decrease the effectiveness of the immune system, making persons more susceptible to illness during this phase.
Stage 2: Stage of Resistance	This is sometimes referred to as the stage of adaptation as the body attempts to adapt to the stressors. The individual's body begins to secrete additional hormones that increase blood sugar levels to sustain energy. Sustained overuse of the body's defense mechanisms can lead to disease. Long periods of stress during the resistance stage can cause individuals to become prone to fatigue, concentration lapses, irritability, and lethargy.
Stage 3: Stage of Exhaustion	At this stage the body has depleted itself of body energy and immunity. Psychological, physiological, and mental resources suffer heavily. The body is completely exhausted leading to decreased stress tolerance, progressive mental and physical exhaustion, and illness, disease or collapse.

035. Reactions to combat

The specific psychological and physical symptoms seen in combat vary considerably depending upon the severity, the nature of the exposure to a traumatic experience, and the individual's personality characteristics. Among combat personnel common symptoms include dejection, apprehension and vague fears, hypersensitivity, sleep disturbances, and tremors.

In World War II (WWII), an estimated 23 percent of evacuations were "battle fatigue" cases compared to only 6 percent in the Korean War. Even so, combat stress caused the greatest loss of military personnel in WWII. In Vietnam, there were fewer combat stress reaction cases. Researchers attribute the decrease to a number of factors, including:

- Better medical care near the front lines.
- The sporadic nature of the fighting in which brief intensive encounters were followed by periods of relative calm and safety.
- A policy of rotation after 12 months of service unlike World War II when some members were in place for 4 years.

PTSD versus combat stress

The role of the US armed forces is to defend our country from those forces that threaten our way of life. Our military has exercised its might on several occasions since the founding of this country.

Every war or major conflict has produced victims of what is now called Combat Stress Reaction (CSR) or Combat and Operational Stress Reaction (COSR). What is CSR? Some describe it as the result of repeated exposure to the HELL LIKE conditions of war. Opposing forces attempt to inflict hell like conditions until the opponent can no longer endure the stress of combat. Army Field Manual (4-02.51) *Combat Operational and Stress Control*, defines it as:

"The expected, predictable, emotional, intellectual, physical, and/or behavioral reactions of Service members who have been exposed to stressful events in combat or military operation other than war."

It is easy when a troop says "I have a broken limb; I can't go back out there just yet." It's not so easy when someone is trying to describe symptoms of combat stress and expect his/her comrades to accept it. Others may see a person with CSR as weak, inferior, or unstable. Defining the condition is important because by naming the syndrome, it becomes an acceptable perception of real symptoms stemming from the battlefield.

One might assume CSR is the same as Post-Traumatic Stress Disorder. PTSD, by DSM-IV's own criteria, cannot be diagnosed until 1 month after the traumatic event is in the past. In general, combat stress corresponds more closely to DSM classification of "acute stress disorder," which is used in the interval from 3 days to 1 month after the traumatic event (when PTSD becomes appropriate). This temporary disturbance can be described as the normal human response to very abnormal, threatening conditions. Using a "normalizing" label such as CSR is an important therapeutic maneuver intended to impress upon the person the idea that he/she is not mentally ill but is just tired and can expect to recover easily.

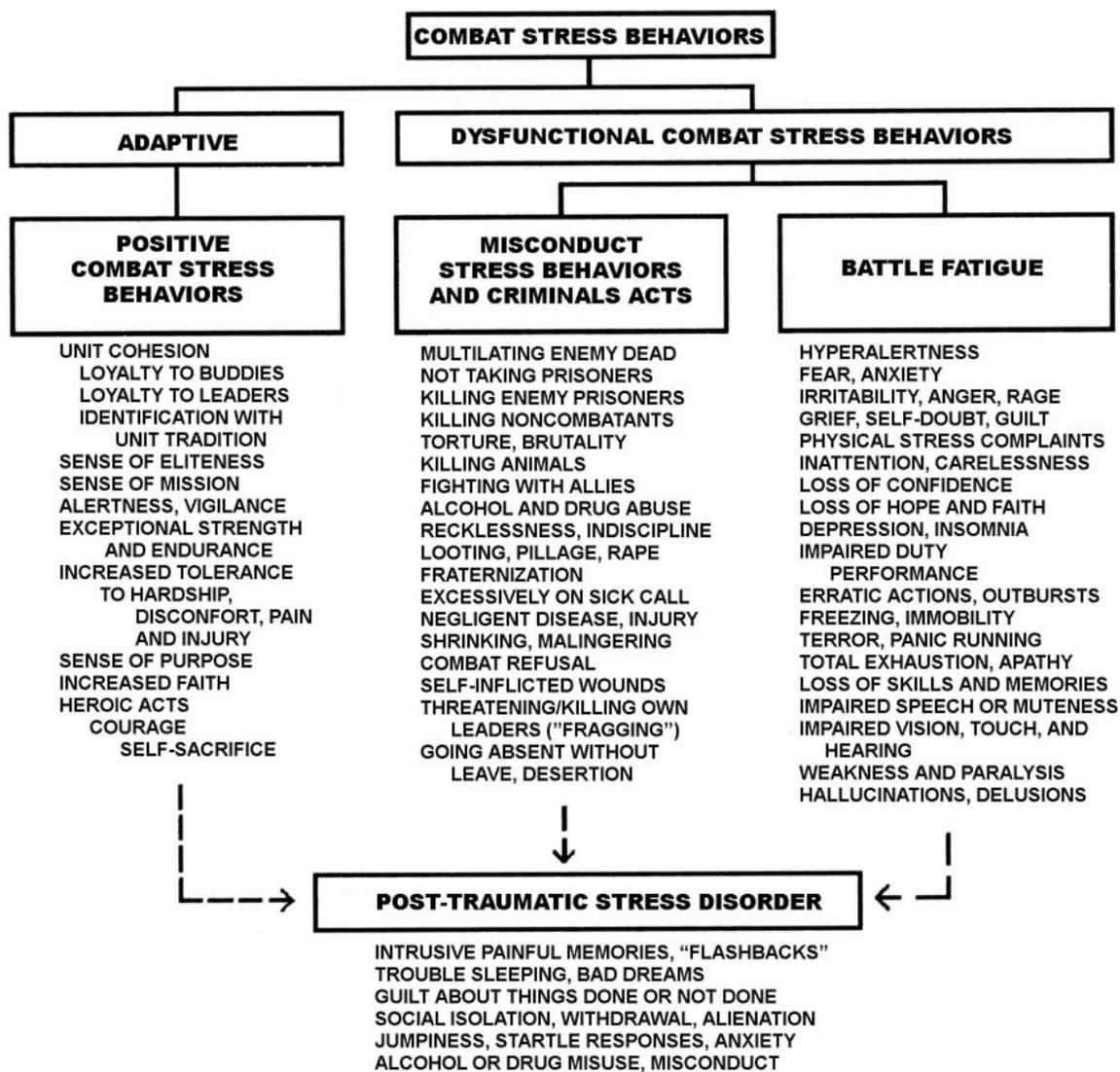
Subtypes of PTSD

The following table describes the three subtypes of PTSD.

PTSD	
Subtype	Description
Acute	Symptoms persist for more than 1 month, but less than 3 months.
Chronic	Symptoms persist beyond 3 months.
With delayed onset	At least 6 months have passed between traumatic event and onset of symptoms.

Combat stress

Combat stress is defined as a psychological reaction manifested by a variety of symptoms during, or immediately after, combat (fig. 6-1). It is the sum of all internal stress reactions to conditions on the air-land-sea battlefield, and all stressors that result from soldier performance. As we learned earlier, stress can be positive or negative. Figure 6-1 provides a diagram of potential combat stress behaviors.



SI045578008

Figure 6-1. Combat stress behaviors.

Risk factors related to combat stress

US Army Field Manual (FM) 22-51, *Leaders' Manual for Combat Stress Control*, details the top 12 factors that were found to contribute to combat stress. In the following paragraphs, the top five areas are detailed with explanations for each, and the last seven are briefly outlined.

Home front risk factor

Problems and uncertainties on the home front:

- Worrying about what is happening back home distracts military members from focusing their psychological defenses on the combat stressors. It creates internal conflict over performing their combat duty and perhaps not surviving to resolve the uncertainties at home. An Israeli Defense Force study conducted after the 1973 Yom Kippur War found concerns about the home front to be the strongest predictive factor that distinguished between soldiers who became “battle shock” casualties and those who were decorated for heroic acts.
- The home front problem may be a negative one—marital or financial problems, illness, uncertain job security (if a reservist)—or it may be something positive—newly married, new baby. All military members face greater potential problems and uncertainties with personal matters if the military conflict is not popular at home.

New soldier risk factor

Soldier is new in the unit:

- The new military member has not yet established trust and cohesion with buddies and leaders. The Israeli study, discussed above, found this to be the second strongest predictor distinguishing battle shock casualties from decorated heroes.
- New replacements who have no prior combat experience are at special risk because not only are they facing extreme stress for the first time, but veteran military members also have little basis on which to trust them. Veteran military members coming to a new unit after recovering from a wound or as survivors from other units are also at risk. These veterans may adapt quicker than the new replacements, provided they do not have internal conflicts and too much unresolved battle fatigue.
- Military members who have been given increased/new job responsibilities, such as just being promoted to NCO/PO, are at risk. These military members may also be under special stress for a while as they adjust to no longer being “one of the old gang” and develop new horizontal bonding with other NCOs/POs.
- Building unit cohesion is extremely important. The most important motive that keeps military members doing their duty in combat is personal bonding. Personal bonding is the personal trust and loyalty among members of a small unit. This bonding makes them prefer to stick together in exceedingly stressful situations, even when great hardship and danger are present.

First exposure risk factor

First exposure to a major stressor:

- The first exposure to a significant stressor is usually a time of high stress and risk of battle fatigue. Likewise, it is inevitable when a unit or individual first encounters true combat with its extreme noise, confusion, wounding of military members, and violent death. Tough, realistic training helps, but no training can fully equal the real consequences of kill-or-be-killed. The shock is also intense for medical personnel, even in rear area hospitals, unless they have had extensive emergency room experience.
- Even experienced troops may suffer increased battle fatigue when confronted with a surprise enemy weapon, tactic, or attack. Examples include the following:

- The first exposure to tanks and gas in World War I (WWI).
- German blitzkrieg tactics with Stuka aircraft, the “88” antitank gun, and later the “Screaming Meemie” mortar.
- Improved conventional munitions and napalm bombs (Israel against Egypt, US against North Vietnam) and wire-guided antitank missiles (Egypt and Syria against Israel).
- Strange, hostile terrain and climate. This type stressor can demoralize even experienced units. (At first, a crack Australian division suffered severe stress casualties when suddenly transferred from the desert of North Africa to the jungle of New Guinea.)

Unit casualties risk factor

Casualties in the unit:

- Military members in the unit being killed and wounded are the strongest indicator of “combat intensity” and usually are accompanied by increased battle fatigue casualties. This is especially true if many casualties occur in a short time.
- Heavy casualties naturally shake military members’ confidence in their own chance of survival. The impact is strongest if losses are in the members’ own small unit. Loss of a trusted leader or close buddy is both an emotional shock and a threat to unit integrity and survival. New replacements are an unknown quantity that may not know the standard operating procedures and cannot yet be fully relied upon. Losses naturally arouse the battle fatigue symptoms of reduced confidence, feeling exposed and abandoned, and perhaps guilt, anger, and mistrust.
- These feelings are magnified if the military member does not feel that everything feasible was done to care for and evacuate the wounded and that respect for the dead was not shown. Confidence in the health service support system can help compensate for the fear of being wounded.

Passive posture, defenseless to attack, or hit by friendly fire risk factor

Under attack and unable to strike back:

- Indirect (artillery) fire usually causes more battle fatigue casualties in relation to killed and wounded than does direct fire. This is partly because of the massed, impersonal destruction that a barrage can cause.
- Even more, it is because the troops feel themselves helpless victims of pure chance. Armor and air attacks also tend to produce disproportionate battle fatigue casualties in troops who are not trained to shoot back, such as rear area support units.
- In WWII, many battle fatigue casualties were attributed to the troops’ perception that German tanks, “88” artillery, and other weapons were far better than our own, so that we did not have a fair chance to strike back.
- In MOOTW (conflicts), similar frustration is produced by hidden snipers who fire from areas where return fire is limited by the rules of engagement. It may be caused by mines and booby traps and by combatants who cannot be distinguished from the civilians one is supposed to protect. However, this is more likely to trigger misconduct stress behaviors than battle fatigue.

Immobility risk factor

Immobility during static, heavy fighting is a risk factor.

Lack of information/support risk factor

Lack of information and failure of expected support occurs when troops do not know what is planned; they feel isolated, unappreciated, and forgotten. Whenever support or relief does not show up, they

may feel deserted. This is especially true if the failure is unexplained. They lose the perspective of the greater mission and are less able to maintain a positive perspective on the combat stressors. They tend to fear the worst, and rumors take hold and lead to battle fatigue and even panic.

NBC weapons risk factor

High threat of NBC weapons use and actual use. The invisible, pervasive nature of many of these weapons creates a high degree of uncertainty and ambiguity with fertile opportunity for false alarms, rumors, and maladaptive stress reactions. The terrible nature of some of these weapons will create fear for the future, the homeland, and perhaps even for the survival of civilization.

Deprived of sleep risk factor

Battle fatigue can occur without sleep loss, but insufficient sleep can be a major contributing factor. The sleep-deprived soldier or leader has difficulty thinking and reasoning and becomes easily confused and overly suggestible with poor judgment. Pessimistic thinking takes hold and everything seems too difficult. Sleep loss alone can cause the tired brain to see things which are not there (visual hallucinations) or to perceive things which are there as something totally different. When anxiety and vigilance (staying awake on watch) are added, the soldier may be temporarily unable to distinguish between reality and what he fears. Normal physical symptoms of stress can become magnified into disabling illnesses.

Physically run-down risk factor

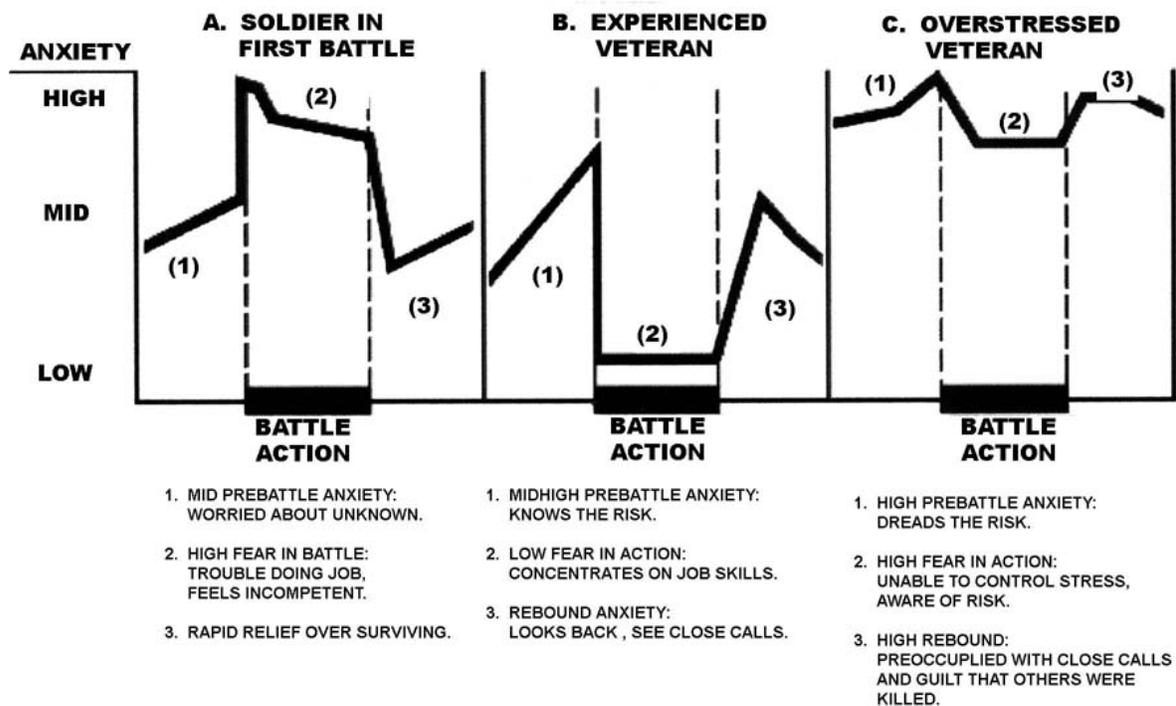
A run-down physical condition contributes to battle fatigue by sapping the military members' ability to function and, therefore, their confidence in accomplishing the mission and surviving. Neither physical fatigue nor sleep loss necessarily causes battle fatigue, but they can be strong contributing factors. To the extent that these factors are involved, they are easier to prevent or correct than are most of the factors listed earlier. The more physical exhaustion is present in battle fatigue casualties, the more confident you can be that soldiers will recover completely. These soldiers return to duty once you have replenished the physical resources. However, your treatment must also restore their confidence.

Inadequate fitness risk factor

Lack of physical fitness or being physically fit is not a guarantee against becoming a battle fatigue casualty, but not being physically fit is an invitation for it. Sudden overuse of the cardiovascular system, muscles, joints, and bones that have not been prepared for the strain can lead to immediate failure and serious injury. Even if these are avoided, the unfit soldiers will be subject to days of stiffness, aching, and weakness. During this time, they are at extremely high risk for battle fatigue, especially if further demands are made on them.

Older veteran or short-timer risk factor

Cumulative combat exposure compounds the physically run-down member and often makes him or her consciously careless, which tends to increase the member's stress. Fear tends to be debilitating, "I've made it this long; I don't want to take any risks!" Figure 6-2 clearly illustrates the digression some battle-worn members can experience.



SI045578009

Figure 6-2. Combat exposure.

Signs of combat stress

Battle fatigue is a negative combat stress reaction. It is used to describe a broad group of physical, mental, and emotional signs that result from the heavy mental and emotional strain of facing danger under difficult conditions. The term “battle fatigue” applies whether its signs occur in a new soldier, sailor, airman, marine, or veteran.

The difficult combat conditions that cause battle fatigue include sleep loss, physical fatigue, and such physical stresses as heat, cold, and noise. Like physical fatigue, battle fatigue can develop either slowly or quickly. Its speed of onset depends on the intensity and duration of the stress and on the military member’s prior training experience and fitness. Signs of battle fatigue can start before the actual fighting, during the action, or in the period after the fighting. It can even affect those stationed away from the actual fighting. Battle fatigue impairs performance but usually gets better when soldiers can rest and replenish their supply of food, water, and sleep. In the following chart is a list of symptoms which the cumulative effect can result in a military member experiencing signs of combat stress.

General Signs of Combat Stress		
Physical	Behavioral	Emotional
Fatigue	Decreased performance	Depression/anxiety
Sleep problems	Decreased memory	Emotional outbursts such as crying
Headaches	Decreased concentration	Dreams/memories
Gastrointestinal problems	Irritability	Guilt
Decreased appetite	Aggressiveness	Anger
Poor motor responses	Substance abuse	Intense irrational fear and frustration

General Signs of Combat Stress		
Physical	Behavioral	Emotional
Bowel/urinary incontinence	Poor communication	Dissociative states
Cold sweats	Altered alertness	Constricted emotions
Sweaty hands	Decreased attention	Moodiness
Hyperventilation	Decreased perception	Pessimism
Palpitations	Decreased reasoning	Tension
Nausea	Decreased judgment	
Vomiting	Decreased comprehension	
Cramps	Decreased self-control	

Classifications of battle fatigue

Battle fatigue is only a label, not a medical or psychiatric diagnosis. Its three classifications are mild, moderate, and severe. They are based solely on whether the military member can be managed on an acute basis or will require more extensive intervention. Whether a case of battle fatigue is called mild or moderate depends more on the tactical situation, mission, and resources of the unit than it does on the signs the soldier displays.

Mild reactions

Military members with mild battle fatigue can stay in the unit to rest and then be restored to full duty. The range of symptoms may vary from showing little outward appearances to serious signs of battle fatigue, and effectiveness to ineffectiveness to perform their duties. However, these are considered mild cases because the individuals pose no risk or burden to the unit.

A mild combat stress reaction may require little more than sleep, food, a shower, and clean dry clothing. A military member at this level may need time to ventilate. Usually, discussing his or her problems with others who are experiencing similar reactions will help. This discussion is efficiently carried out in a structured group environment. Physical activity and exercise also may facilitate recovery.

Moderate reactions

Military members with moderate battle fatigue cannot stay in the small unit; they must be removed from the immediate area for temporary rest and replenishment. These military members usually present too great a risk or burden to stay with their own unit, especially for a tactical unit.

A moderate combat stress reaction requires more intervention from the mental health services staff than the mild reaction. Of all combat reactions, it is estimated that 15 percent will be moderate. Depending on the severity of the reaction and the ability of the staff to provide the care needed, processing to the next echelon of treatment may be indicated (we will discuss the purpose and capabilities of each echelon later in this unit). A military member at this level certainly needs more of the same treatment provided to the mildly affected individuals. In addition, the military member may require medication. Medication should be limited to that minimally required to restrain the patient or to induce sleep. Individual counseling will also be needed. Military members need to be assured that what is being experienced is a normal reaction to a highly stressful situation.

Severe reactions

Military members with severe battle fatigue must be sent to a health care provider for evaluation and treatment. Severe applies to soldiers with more serious signs of battle fatigue. These signs include serious memory loss, hallucinations and delusions not caused by sleep deprivation, extreme physical pain, and dangerous threatening behavior which is not simply a disciplinary problem.

036. Mental Health Implications for Traumatic Injuries

There are neurological and physiological disturbances and behavioral changes that follow major amputations, spinal cord injury with paralysis, facial disfigurement from missile wounds and burns, and blindness. An increase in Traumatic Brain Injury (TBI) from Improvised Explosive Devices (IEDs) is also being seen. Changing conditions of warfare (urban combat) and the greater explosive power of weapons have raised the proportion of some types of wounds, and increased the incidence of multiple injuries. Improved methods of evacuation, body armor improvements, and the development of new surgical techniques have resulted in the survival of many troops who previously would have died.

Survivors of disabling and disfiguring injuries share a number of problems. Along with their physical limitations, they experience an altered body image, lowered self-esteem, and changes in their personal relationships. Some bear the social stigma associated with crippling and deformity. It is only since WWII that these features have been recognized and specialized programs set up for amputees, paraplegics, and the burned and the blind. Sustaining a combat wound does not preclude the development of PTSD, and depression, denial, and drug abuse pose major problems in therapy.

Amputation

Amputation of a limb as a result of an injury in combat has profound and special behavioral consequences. These are the emotional reactions to the initial trauma, the problems of coping with the motor disability, and the alterations of body image caused by the loss of a previously healthy arm or leg. There are also many incidences of individuals feeling actual pain in the stump that is left or phantom pain in the lost limbs.

Behavioral disturbances are not usually a problem in the early postoperative period over which the combating of infection, the maintenance of metabolic balance, and the management of other injuries are the paramount considerations. Also, newly wounded troops are apt to be euphoric, glad to be alive, and thankful that their injuries were not more severe. Even at this early stage, however, what the emergency room, surgical, and ward staff say to the patient (or to each other within hearing distance) is important even if they think the patient is unconscious. Depression may follow elation, but it is mainly when the patient encounters the stresses of further treatment and recovery, and begins to realize the extent of his physical and social limitations, that emotional problems arise. The physical stresses include surgical revisions of an infected, often painful, stump, learning to use a temporary prosthesis, and experiencing the fatigue caused by alterations in posture, balance, and locomotion. Patients worry how they will be accepted by their family and community, and whether they will be able to make a living and lead a normal life.

Anxiety and depression are the most common forms of emotional distress. These states are experienced as feelings of tension, sleep disturbances, somatic complaints, phobias such as fears of falling or otherwise injuring the amputation stump, irritability, outbursts of anger, and feelings of worthlessness and social withdrawal. The circumstances of the initial injury are a factor in that soldiers who have undergone a particularly traumatic experience involving the death or mutilation of others are more severely stressed.

Spinal cord injuries (SCI)

The systematic study of the behavioral aspects of spinal cord injuries (SCI) did not begin until World War II, as 80% of men with SCI in World War I died within a few weeks of injury. Even with the advances in surgery, antibiotics, and methods of evacuation in World War II, the majority of patients arrived at hospitals in the United States suffering from ulcers, urinary tract infections, and malnutrition.

SCIs vary in completeness and are often caused by shell fragments or bullets with the foreign bodies piercing the cord directly, or driving bone into the spinal canal. Blast injuries may produce intramedullary hemorrhages. Falls and vehicle accidents are other sources of injury. Alcohol

exacerbates the neurochemical and behavioral effects of spinal cord trauma. SCIs are commonly associated with abdominal and chest injuries, and with brain damage, especially with high cervical cord lesions.

Patients respond to the loss of control over their bodies and the overwhelming sense of helplessness and dependence in a number of ways. Some become childish and demanding while others withdraw and show little emotion. Some are hostile, others are anxious or depressed. Many express denial.

Disfigurement

Major disfigurement, involving the face and hands, occurs mainly as the result of burns, and of blast and missile wounds. Thermal injuries include exposure to flames, flash burns from gas explosions, the effects of chemical and high-voltage electrical agents, and smoke and carbon monoxide inhalation. Burns occur principally in tank warfare, and after vehicle explosions including airplane crashes and ship sinkings. Facial injuries are produced by bullet wounds, and by blast from mortars, mines, and other explosive devices, which commonly cause other disabilities such as blindness. Survivors of high-velocity missile wounds are more apt to have had facial and jaw fractures than penetrating orbital injuries, which are often fatal.

Burns are more likely to involve other organs including the brain, pose the most difficult problems in cosmetic surgery, and have the most severe and lasting behavioral consequences. The survival rate following even severe burns is high: more than 50% of patients 15- to 40-years-old with burns covering 75% of total body surface (TBS) live. Life-threatening complications, however, are frequent with burns involving more than 30% of TBS. These involve the hormonal and cell immune systems, heart, lungs, liver, adrenals, kidneys, gastrointestinal tract, hematopoietic and blood clotting systems, and central nervous system and peripheral nerves.

The surviving patient is subject to a broad range of stresses throughout the process of recovery. Pain is exacerbated by debridement, dressing changes, skin grafts and other plastic surgery, and the need to exercise burned limbs to avoid contractures. Gastric stress ulcers are another source of pain. The patient may have to be isolated until the danger of infection has passed, and extensive bandaging further reduces environmental contact. A tracheotomy may interfere with communication. In the patient's state of relative sensory isolation all fears are magnified. If they have facial burns and edema of the eyelids they worry that they will be blind, and burns in the genital area cause concern about sexual function. Insomnia can be a problem. When they are with other patients, the sight of charred bodies and the odor of wounds and dressings are distressing. The patient's first look at themselves in the mirror can be a shocking experience and should be managed sensitively.

After survival is assured and the patient is no longer preoccupied with the issue of life and death, new problems arise. Since they are now able to participate in their own care, they need less attention from nurses and other staff members to whom they may have become attached, and therefore may feel betrayed and abandoned. Although their wounds have healed or been covered by grafts, they must face the fact of disfigurement and wonder if they will be socially rejected or unable to work. Burns of the exposed parts of the body, the face, and the hands, have the most serious social consequences. The burned troop must anticipate the reactions that may range from horrified, curious, hostile, or pitying. Eventually they must come to recognize that burned faces may all look much the same, without individuality, and that their capacity to smile or use other muscles of expression to convey emotion may be reduced. If their hands have been severely burned, they are handicapped in using them in gesture. Moreover, posture, which reflects so much of personality and attitudes, may become rigid and distorted due to limited mobility.

Blindness

Loss of vision is a catastrophic event that thrusts a person into an unfamiliar world, profoundly alters their perception of reality, robs them of mobility, and ends a way of life. Changing conditions of warfare have markedly increased the incidence of eye injuries. In the Civil War, ocular wounds made up 0.5% of surviving casualties. The figure rose to 2.14 % in World War I. In Korea the rate was

8.1%, and in Vietnam 9% of surviving combat casualties had ocular injuries. In Vietnam the great majority of wounds were generated by fragments from explosive projectile shells, rockets and bombs, grenades, booby traps, and land mines. Most casualties sustain other wounds as well. In Vietnam, it was not uncommon for a man to be blinded by the same explosion that caused multiple facial fractures, and blew off a leg. Chemical agents may result in blindness as occurred with mustard gas in World War I. Eye trauma from high velocity fragments is frequently accompanied by brain injury and blindness of central origin results from intracranial wounds involving the visual pathways.

The following do's and don'ts in dealing with a blind patient have been suggested:

- Address them directly rather than their escort.
- Do not shout unless the patient has a hearing loss.
- Do not avoid the words “look” and “see” for fear of embarrassing the blind person.
- Do not hesitate to ask the person how much sight they have.
- Announce when you are entering or leaving his room.
- Give specific directions on location of objects rather than using vague term, “over there.”
- Ask the patient to take your arm rather than taking theirs and propelling them.
- Tell a patient you have not guided before when coming to steps.
- Walk in line with the patient but in going up and down stairs keep one step in front.
- Do not feel offended if the blind person refuses help.

Traumatic Brain Injury (TBI)

America's armed forces are sustaining attacks by rocket-propelled grenades, improvised explosive devices, and land mines almost daily in Iraq and Afghanistan. These injured soldiers require specialized care from providers experienced in treating traumatic brain injury.

Mild traumatic brain injury and concussion are currently the most common combat-related injury. Traumatic brain injuries and spinal cord injuries account for nearly 25 percent of combat casualties. Better body armor and the use of Kevlar helmets do protect troops and they have saved the lives of many men and women in areas of conflict like Afghanistan and Iraq, as has improved medical care. But helmets and body armor cannot protect the frontal area of the head, the face, and the exposed area of the spinal cord. The result is that more and more soldiers are surviving, but some are left suffering the long-term effects of severe brain damage.

Traumatic brain injuries that occur in combat are often complex. Sudden air pressure changes following a blast cause internal and external injury; the explosion can injure the brain, producing concussions (traumatic injury to tissues) or contusions (bruising). Injuries may then be worsened by flying fragments; then more damage can occur when a soldier's body is physically propelled, possibly hitting the head against another hard surface—something unlikely to happen outside of war zones. It's a type of injury some military doctors say has become the signature wound of the Iraq war. It has also sometimes been called the “silent handicap” because if you meet someone on the street you would not know they were affected by it.

Signs and Symptoms of Traumatic Brain Injury

A traumatic brain injury is defined as an insult to the brain caused by an external force. This force may produce a diminished or altered state of consciousness, resulting in impaired cognitive abilities and/or physical functioning. These changes can include problems with thinking, sensation, movement, language, and concentration. Brain injury can result in personality and emotional changes, irritability, tiredness, depression, violence, disinhibited behavior, and the inability to carry out basic, everyday tasks.

The brain is a complex organ and the damage caused by TBI can sometimes seem really bizarre. Areas of previous functioning may be intact, like driving a car, but someone may not be able dress properly or carry out the job they used to do before. Another person may be able to do their job with no problem but their personal relationships are changed profoundly. (A patient suffering from traumatic brain injury may have what is called 'blind sight'. This is where a person believes they are blind, yet they can 'see' to follow an object around a room, walk down the street, and never bump into any object. The brain is receiving information from the eye yet the connections from the part of the brain that 'sees' is severed or so severely damaged that the person does not perceive the sensation of sight.)

Signs and symptoms of TBI depend on the extent of the damage to the brain. In war, blast injuries can result in multiple traumas, a.k.a. polytrauma. There are injuries to internal organs, limb loss, sensory loss, and psychological disorders. Blasts produce huge external and internal forces that can cause great damage and penetrating injuries to the brain, not only producing focal damage but also infection.

Most symptoms are obvious immediately after an injury, but sometimes symptoms may appear only days or weeks following the injury. People may not admit or recognize difficulties following a brain trauma and the brain can also play tricks. Sometimes when people have deficits in memory, they 'fill in' the gaps, a process known as confabulation. They do not realize they are doing it, and unless you know someone well and know what they have been doing, their accounts of their lives can appear completely normal.

Recovery Prognosis Following Traumatic Brain Injury

For most troops with post-concussion or mild TBI, recovery time is within a few weeks or months, although a small percentage will have persistent symptoms. Patients with moderate to severe TBI may never fully recover their pre-injury function. Their lives and the lives of their loved ones will have been permanently changed. Many troops who go to war and have severe TBI will require a life time of health support services and treatment.

The Defense and Veterans Brain Injury Center (DVBIC) works to identify all soldiers who have sustained a closed head injury during combat operations and to ensure that they receive the best care available. For example, at Walter Reed Army Medical Center, DVBIC reviews all incoming casualty reports and screens all patients who may have sustained a brain injury including those injured in blasts, motor vehicle crashes, falls, and gunshot wounds to the head. Brain injury specialists evaluate patients who are identified with a brain injury. Recommendations are made for treatment and duty status.

037. Key points of a field assessment

During intakes we gather information from our clients and build rapport on the way to finding out the best way to provide treatment. We do the same in a deployed environment but, due to reduced resources (manning and referral services) and higher operations tempo, our assessments and interventions need to be faster.

Conducting a brief field assessment

While a CONUS clinic intake may take 45-60 minutes to accomplish, we probably have, at best, 30 to 45 minutes to interview and assess a troop in our deployed clinic. In a deployed environment, it may not be necessary to ask about jobs held before the military, high school activities, or the age of their first sexual experience. We need to get to the heart of the matter and find out why they are seeing us today.

Many of our patients may have seen action and some are victims of the action. One of the issues we may deal with is that soldiers returning from a Forward Operating Base (FOB) often do not want to

go back. We need to identify those with real mental illness as opposed to those who are just scared or worn out from being at the front. Who can blame them! But our job is to get them back to the fight.

Deployed environment intake evaluation

When conducting a field assessment in a deployed setting you may want to assess the areas discussed below.

Presenting complaint

What brings the client into the clinic today? Were they involved in any incident recently? As you know, the reason someone finally comes into the clinic is not always the specific issue they need to discuss while they are in the office with us.

Current stressors

Is the client experiencing marital stressors such as a recent divorce, separation, or infidelity? We have heard of countless stories of a deployed member getting a “Dear John/Dear Jane” letter. While the deployed member is going through significant stressors, the family members back home are going through their own stressors as well. Some may choose inappropriate ways to deal with those stressors.

Other stressors include:

- Social—Loss of friend, broken romance, loneliness.
- Occupational—Discrimination, supervisor conflict, excessive hours, bored, harassment.
- Military- —Deployment, pending retirement, administrative separation, failure to make rank.
- Family—Illness, death, separation, fight child rearing, custody concerns.
- Financial—Debt, bankruptcy, bad checks, pay problems, child support.
- Legal—Article 15, court martial, divorce/custody.

Psychiatric history

Has the member ever been seen by a mental health provider recently or in the past? Has the member ever taken psychiatric medications before or ever been admitted to a psychiatric facility? Has a family member ever been treated for a mental health condition? Has the client ever felt suicidal or homicidal, now or ever in the past?

Substance use history

Does the member smoke or chew tobacco? Does the member use caffeinated beverages (coffee/soda/tea) or energy drinks? If so to any of the previous, how much and how often? If alcohol is available, how often and how much do they use? Any abuse of over the counter or prescription medication? Has the client ever felt a need to stop using any substances? Have they ever participated in a substance use treatment program?

Family history

Is the client married, and if so, how long? Are they divorced or separated? How many previous marriages has the client been in? Any significant engagements? How would they describe their current marriage or intimate relationship? How many children do they have?

Educational history

What is the highest level of education the member has obtained? What was their degree in and what types of grades did they receive? Did they have any disciplinary issues in school? Did they participate in any special education classes?

Military history

What is the person's job title? What career field are they in and in what capacity are they serving in the deployed location? What are their current duties and responsibilities? Have they ever had any Uniform Code of Military Justice actions or Article 15s?

Intakes in a deployed setting are going to be much shorter than the ones we may do back at our home bases. During a deployment the MHTs role is going to be more significant during intake and treatment.

038. Performing Psychological Triage

Modern combat casualty evacuation has become so immediate and efficient that it can result in a mass casualty situation at MTFs within the military medical care system. Consequently, a method of dealing with the conflicting factors of severity of injury, the tactical situation, the mission, and the resources available for treatment and evacuation is essential. Triage is an attempt to impose order during chaos and make an initially overwhelming situation manageable.

Triage can be defined as the dynamic process of sorting casualties to identify the priority of treatment and evacuation of the wounded, given the limitations of the current situation, the mission, and available resources (time, equipment, supplies, personnel, and evacuation capabilities). Triage occurs at every level of care, starting with buddy and medic care, extending through the OR, the ICU, and the air evacuation system.

The ultimate goals of combat medicine are the return of the greatest possible number of soldiers to combat and the preservation of life, limb, and eyesight in those who must be evacuated. The decision to withhold care from a wounded troop who in another less overwhelming situation might be salvaged, is difficult for any surgeon or medic. Decisions of this nature are infrequent, even in mass casualty situations. Nonetheless, this is the essence of military triage.

Triage categories for combat and operational stress reaction (COSR) cases

The following are triage categories that may be used for COSR cases. Help-in-place (HIP), Rest, Hold, and Refer cases are discussed below.

Help-in-place cases

Help-in-place is used to identify cases that do not have severe COSR or BH disorders. They are provided CSF consultation and education, as appropriate, and remain on duty. These interactions may occur in any setting (for example, dining facility, workplace, or the base/post exchange). Individual identifying information is not retained or documented. There is no implicit or explicit therapist-patient or therapist-client relationship in HIP interactions.

The unit identifies those cases that remain with or return to their original unit, either for full duty with their section/platoon/squadron or for light duty with extra rest and replenishment within a headquarters element. This option depends on the unit's mission, resources, and the individual's symptoms. Personnel performing triage must, therefore, be familiar with the unit's situation and take that into account. When the troop's condition improves, the troop and/or unit may not feel that additional triage is necessary.

Rest cases

Rest identifies cases that are provided rest and replenishment in a non-medical support unit, usually one that supports their unit. These troops do not require close medical or MH observation or treatment. They are unable to return immediately to their own unit because:

- Their unit cannot provide an adequate environment for the 5 R's.
- Transportation is not available for at least a day.
- The 5 R's can best be coordinated from the non-medical support unit.

This option depends on the resources and mission of the available combat stress units, as well as on the troop's symptoms. Someone must be designated to be in charge of the sailor/soldier/airman and ensure the 5 R's are provided. There must be a reliable transportation link to return the member to his original unit after a day or two. When their condition improves sufficiently for them to return to their unit, the troop and/or the supporting unit may feel that additional triage is unnecessary.

Hold cases

Hold refers to those cases that require close medical/MH observation and evaluation at a Level III or combat stress facility (CSF) because the troop's symptoms are potentially too disruptive or burdensome for any available support unit or element. Symptoms may be caused by a BH disorder that could suddenly turn worse and require emergency treatment. The Level III facility or CSF must have the capability to provide the necessary medical observation, diagnostic tools, and adequate stabilization for emergency treatment. When deciding among capable MTFs or CSFs, refer the troop to the one closest to their unit that meets their CSF needs. Assessment of closeness considers speed and reliability of transportation and return. Consider transferring to another Level III facility or CSF with increased capabilities before changing a troop's triage category to Refer. All Hold cases are triaged again by CSF personnel or other trained medical personnel after they have been placed in this category.

Refer cases

Refer cases are similar to the Hold cases, except Refer cases are too disruptive and burdensome for the Level III or CSF that is not resourced to care for this particular case. The Level III or CSF cannot provide the necessary level of diagnostic and treatment capabilities. Refer cases requiring more care at a Level IV facility or a higher level of care are triaged by the provider or other trained medical personnel prior to being transferred to these facilities.

Certain diagnoses will almost guarantee a troop will need to be Air Evac'd out of the theater of operations. These diagnoses are:

- Major Depressive Disorder
- Bipolar Disorder
- Psychotic Disorders
- Anxiety Disorders (PTSD, Panic Disorder)
- Patients with persistent suicidal ideations
- Unresolved/recurrent Conversion Disorder
- Dissociative Disorders
- Commanders with Combat Stress Reaction

039. Understanding BICEPS

The term "three hots and a cot" is often used to describe this short term treatment. Get them healthy and then get them back out to the fight. A couple of ways of stating this short term treatment is referring to it as BICEPS or PIE. By simply removing the military member from combat, allowing them regular hot meals, rest, a shower, and relaxation, most symptoms of combat stress will resolve.

BICEPS

The acronym BICEPS is used as a memory aid for the principles of brevity, immediacy, centrality, expectancy, proximity, and simplicity. Let's take a look at what each letter of this acronym means and how it can assist you in treating combat casualties.

BICEPS Principles Explained	
Principle	Description
Brevity	This means treatment should be as brief as possible. The faster individuals are back to duty, the less likely they will take on the "sick" role. Treatment generally will not exceed 24-72 hours. Those requiring further treatment are moved to the next level of care. Since many require no further treatment, military commanders expect their troops to return to duty (RTD) rapidly.
Immediacy	This simply means identifying the need for care as soon as possible. As with any treatment principle, the sooner the problem is identified, the more likely the treatment will be successful. Secondly, the sooner treatment has been initiated, the greater the chance of return to duty without significant chronic impairment.
Centrality	<p>Battle fatigue casualties should be treated in one location; however, they should be separated from the physically sick and injured patients. The purpose of separate treatment areas is to avoid having the combat stress casualties take on the "sick" role. This treatment is normally conducted in a special location (most often a tent) called the CSF.</p> <p>As of July 2006, the Army uses Contact to cover this area and states the Soldier must be encouraged to continue to think of himself as a war-fighter, rather than a patient or a sick person. The chain of command remains directly involved in the Soldier's recovery and return to duty. Whenever possible, representatives of the unit or messages from the unit tell the troop that they are needed and wanted back. MH coordinates with unit leaders, through unit medical personnel or chaplains, any special advice on how to assure quick reintegration when the troop returns to their unit.</p>
Expectancy	In every way possible, the MHSA impresses upon the individual that he/she will return to their unit in a short time. The MHSA should convey to the individual that the experiences, circumstances, and stressors that they reacted to would affect anyone, and that their reactions are quite normal. Do not allow member to take on the patient role and address them by rank and last name. Wear of the uniform is mandatory in a mental health care facility. Throughout treatment at the CSF, the MHSA will emphasize to members that they are expected to return to their unit. The individual is explicitly told that he is reacting normally to extreme stress and is expected to recover and return to full duty in a few hours or days. A military leader is extremely effective in this area of treatment. Of all the things said to a troop suffering from COSR the words of his immediate leadership have the greatest impact due to the positive bonding process that occurs. A simple statement from the leader to the troop that they are reacting normally to COSR and are expected back soon will have a positive impact. Leaders should tell the member that their comrades need and expect them to return. When they do return, the unit treats them as every other troop and expects them to perform well.
Proximity	Care is provided in an area as close as possible to the individual's unit of assignment. Not only does this facilitate the member being sent in and out of care rapidly and efficiently, proximity allows unit members, supervisors, commanders, and first sergeants to visit the individual, if possible. Encouraging visits from unit members, as you can imagine, enhances morale and encourages recovery from combat stress symptoms. Proximity to the member's unit also re-enforces the expectation that the individual will be returning to that unit and enhances unit camaraderie. COSRs are often more effectively managed in areas close to the troop's parent unit. On the noncontiguous battlefield characterized by rapid, frequent maneuver and continuous operations, MH personnel must be innovative and flexible in designing interventions which maximize and maintain the troop's connection to their unit.
Simplicity	<p>The goal of treatment is to restore the individual to combat readiness, not to do deep psychodynamic interventions. Keep treatment simple: rest, replenishment, recreation and reassurance with eventual return to duty. Your goal is to get the person back to the mission; not to solve years of psychiatric angst. We can utilize physical exercise and allow recreational time when available. The five 'R's are used to describe how simplicity is supposed to take place:</p> <ul style="list-style-type: none"> • Reassure of normality. • Rest (respite from combat or break from the work). • Replenish bodily needs (such as thermal comfort, water, food, hygiene, and sleep). • Restore confidence with purposeful activities and contact with unit. • Return to duty and reunite troop with their unit.

General guidelines for using BICEPS

The best treatment for combat stress casualties is quick and simple treatment. Let the individual rest; at minimum 4 hours, 6-8 hours is even better. Afford them a chance to bathe and obtain fresh clothing. Food should be hot if at all possible. Allow the individual adequate time to eat without distractions. Reassure the individual that what he is going through is temporary, that it's not a personal weakness but exhaustion, and that many others have felt the same way. For example, your patient may say he feels he has a major medical problem because he lost his bowels when he witnessed his buddy's head blown off during an attack. You should reassure him that this is a normal response to seeing his friend killed in action and not a medical problem. Provide education and support, not by doing guidance or support counseling, but by helping the individual gain an understanding of the symptoms he is experiencing. Help the individual to express his/her feelings and respond with acceptance, not criticism. Help the member enhance coping mechanisms and emphasize unit integrity, appeal to pride, and sense of duty. Provide group support by keeping individuals from the same unit together for discussion, eating, and sleeping.

The use of medications is limited to those absolutely necessary as directed by medical authorities. Restraints should never be used unless there is an obvious and imminent physical danger (to self or others). Maintain military discipline, customs, courtesies, duties, and proper wear of the uniform. As the individual starts to recover, use them for additional manpower as needed. As stated previously, don't let them become "patients." 80% to 90% should be able to return to duty within 24-48 hours. If the individual doesn't show improvement within 72 hours, the member will be evacuated to the next level of care.

PIE

Historically the Army had used the terms proximity, immediacy, expectancy and simplicity (PIES) but began using BICEPS when it became the approved joint service terminology.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

033. Identify mental health assets

1. What teams took the place of the MHRRT and the MHAT?
2. What team members are included on the FFBH5 team?
3. What is a medical staging facility designed to provide patient holding capabilities for casualties in-transit for patient movement?

034. General stress management

1. What are the three basic categories of stress?

2. Match each of the classification of conflict in column B with its definition in column A. Items in column B may be used more than once or not at all.

Column A

Column B

- | | |
|--|------------------------|
| ___ (1) These conflicts are sometimes referred to as mixed-blessing dilemmas because negative and some positive features or outcomes must be accepted. | a. Double-approach. |
| ___ (2) These conflicts require the choosing of two or more desirable goals. | b. Double-avoidance. |
| ___ (3) These conflicts are those in which the choice is between more less equally undesirable options. | c. Approach-avoidance. |

3. What do the GAS stages describe?

035. Reactions to combat

1. What did researchers attribute to the lower number of combat stress cases in Vietnam?
2. What is the description of acute PTSD?
3. Which combat stress risk factor occurs when troops do not know what is planned and feel forgotten?
4. What combat conditions can cause battle fatigue?
5. Military members with which classification of battle fatigue can stay in their unit and rest?

036. Mental Health Implications for Traumatic Injuries

1. What factors have resulted in the survival of many troops who previously would have died?
2. What usually accompanies eye trauma from high velocity fragments?
3. Define traumatic brain injury.

037. Key points of a field assessment

1. How long might we take to accomplish an intake in a deployed clinic?
2. What questions might we ask when gathering a psychiatric history?
3. What history are we assessing if we ask whether or not our client had disciplinary issues in school?

038. Performing psychological triage

1. What is the ultimate goal of combat medicine?
2. What are the four triage categories for combat and operational stress reaction cases?
3. What cases are similar to Hold cases, except they are too disruptive and burdensome for the Level III or CSF that is not resourced to care for this particular case?

039. Understanding BICEPS

1. What does the pneumatic BICEPS represent?
2. Match the principle of combat treatment in column B with its definition in column A. Items in column B may be used once, more than once, or not at all.

Column A

- ____ (1) Treatment should be as brief as possible, not to exceed 24 to 72 hours.
- ____ (2) Identifies the need for care as soon as possible.
- ____ (3) Treatment should occur in one location, and mental health patients should be kept separate from sick or physically injured patients.
- ____ (4) Impressing upon the individual that he or she will be returning to his or her unit in a short time.
- ____ (5) Care is provided as close as possible to the individual's unit of assignment.
- ____ (6) Treatment is to restore the individual to combat, not to do deep psychodynamic intervention.

Column B

- a. Centrality.
- b. Proximity.
- c. Simplicity.
- d. Brevity.
- e. Immediacy.
- f. Expectancy.

6-2. Air Evacuation Classification Codes, Movement Precedence, and Responsibilities

In this section we discuss categorizing patients so that air evacuation personnel can easily identify the types of patients they are receiving aboard their aircraft. Patient classification enables air evacuation personnel to determine the priority for loading and unloading patients, as well as the approximate amount of room the patient will need while aboard the aircraft. For example, a patient that sits in a seat takes up little room compared to the patient traveling on a litter who requires special equipment. Also, air evacuation personnel must be aware of the patient's behavior and what type of actions they can expect from the patient. For example, the flight nurse may need to pay closer attention to a psychiatrically disturbed patient or one who recently experienced suicidal ideations as compared to an outpatient going for follow-up care.

040. Air evacuation terminology

The following terms associated with air evacuation will help you understand more clearly the air evacuation process.

Aeromedical evacuation

Aeromedical evacuation (AE) is the movement of patients under medical supervision to and between MTFs by air transportation. There are four types of AE:

Aeromedical Evaluation Types	
Type	Description
Forward	The phase of AE which provides airlift for patients between points within the battlefield, from the battlefield to the initial point of treatment, and to subsequent points of treatment within the combat zone.
Theater (Inratheater)	The phase of AE which provides airlift for patients between points of treatment outside the combat zone, within a theater of operations.
Strategic (Intertheater)	The phase of AE which provides airlift for patients from overseas areas or from theaters of active operations to the CONUS or patient movements between theaters i.e., a patient movement from Central Command (CENTCOM) to the European Command (EUCOM).
Domestic	The phase of AE which provides airlift for patients between points within the CONUS, and from near offshore installations.

Aeromedical evacuation system

The AE system provides control of patient movement by air transport, and specialized medical attendants and equipment for in-flight medical care. It also encompasses facilities on or in the vicinity of flightlines and air bases for the limited medical care of in-transit patients entering, en route, or leaving the system. The system includes communication with originating, en route, and destination MTFs concerning patient requirements.

Aeromedical staging facility

The aeromedical staging facility (ASF) is vital in the successful flow of patients and attendants in the AE system. It provides significant support and suitable accommodations for patients required to remain at installations while awaiting aeromedical transportation. The ASF mission is to receive, shelter, process, and provide medical and nursing care to patients who enter, travel in, or leave the AE system. ASFs are established at points where aeromedical routes originate, terminate or interface, or where other suitable accommodations are provided.

ASFs are either a series of large tents or fixed facilities, usually collocated with an MTF. They function as holding units in both peacetime and wartime for patients awaiting further transportation

while en route in the AE system. The patient capacity ranges from 25 to 250 beds, and turnover is rapid. The Chief of Staff, HQ USAF, must approve the activation or inactivation of a designated ASF or the partial curtailment of the mission assigned to an ASF. The mobile ASF or (MASF) is a 10 to 25 bed tent-type facility used as a collecting point or holding ward during wartime or contingencies. MASFs are usually strategically positioned near active flightlines to provide quick access to onplaning/deplaning patients involved with AE.

CONUS patient

A CONUS patient is a member of a uniformed service or other eligible beneficiary hospitalized in a Continental United States (CONUS) MTF.

Global Patient Movement Requirements Center

The Global Patient Movement Requirements Center (GPMRC) is responsible for coordinating all patient movement once the mission arrives at the CONUS reception aerial port, ensuring the patients are continued to final destinations as appropriate. The lessons learned from combat airlift of war casualties also apply in civilian disaster situations. Our system of air transportation of sick or injured from all parts of the world to MTFs offers the finest diagnostic and definitive care, and has improved health care delivery in the United States.

Destination medical facility

The destination medical facility is the MTF the patient is en route to for specific medical care.

Originating MTF

The originating MTF is the MTF that initiates the transfer of a patient to another MTF. Your MTF becomes the originating MTF when you, as the mental health journeyman, initiate the action to transfer a patient from your MTF to another MTF using the AE system.

TRANSCOM Regulating and Command & Control Evacuation System

The TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES) is the automated information system responsible for combining transportation, logistics, and clinical decision support elements into a seamless patient movement information management system which is capable of visualizing, assessing, and prioritizing patient movement requirements, assigning proper resources and distributing relevant data to efficiently deliver patients. TRAC2ES replaced the antiquated Defense Medical Regulating Information System (DMRIS).

Theater Patient Movement Requirements Centers

Theater Patient Movement Requirements Centers (TPMRC) are directly responsible for managing patient movement within their respective theater or area of responsibility (AOR) or intratheater AE. The primary role of the TPMRC is to coordinate and communicate patient movement requirements and proposed lift-bed plans to the service transportation components which execute the patient movement decisions, and then monitor their execution in concert with the GPMRC.

041. Patient classification categories and precedences

The classification a patient is given is determined by his or her physician. The classification is critical for identifying to the medical aircrew those patients who must travel on a litter or in an ambulatory status, and whether or not the patient will need assistance in an aircraft emergency. It is your responsibility, if you are placed in the role of patient movement technician, to manifest the patients by using DD Form 601, Patient Evacuation Manifest. The following patient and attendant classification codes will be used during normal peacetime operations:

Class 1: Psychiatric patients

Close attention should be rendered to patients with a psychiatric classification. They are not allowed items that present a danger to themselves or others (e.g., sharp objects, matches, cigarette lighters).

However, common sense should be the guiding factor in determining what is or is not dangerous. This class is divided into three categories.

Class 1: Psychiatric Patients	
Category	Description
Class 1A	Severe Psychiatric Litter Patients. Psychiatric patients requiring the use of restraining apparatus, sedation, and close supervision at all times.
Class 1B	Psychiatric Litter Patients of Intermediate Severity. Patients requiring tranquilizing medication or sedation, not normally requiring the use of restraining apparatus. Restraining apparatus must be sent with the patient for potential use.
Class 1C	Psychiatric Walking Patients of Moderate Severity. They are cooperative and reliable under observation.

One way to memorize these categories is this. Class 1A patients are Agitated, class 1B patients may Become agitated, and class 1C patients are usually Chilled out.

Class 2: Litter inpatients

If patients require rest during a long flight because of recent surgery or have difficulty safely ambulating, they should be classified as litter patients. This class has two categories:

Class 2: Litter Inpatients	
Category	Description
Class 2A	Immobile litter patients (nonpsychiatric) who are not able to move about on their own volition under any circumstance.
Class 2B	Mobile litter patients (nonpsychiatric) who are able to move about on their own volition under certain circumstances.

Class 3: Ambulatory inpatients

This class consists of patients who require minor attention en route. There are three categories in this class:

Class 3: Ambulatory Inpatients	
Category	Description
Class 3A	Ambulatory patients, nonpsychiatric and nonsubstance abuse, going for treatment or evaluation.
Class 3B	Recovered patients, returning to home station.
Class 3C	Ambulatory, drug or alcohol (substance) abuse patients going for treatment.

Class 4: Infant patients

Children under the age of three are transferred under one of these five categories:

Class 4: Infant Patients	
Category	Description
Class 4A	Infant, under 3 years of age, occupying an aircraft seat, going for treatment.

<i>Class 4B</i>	Recovered infant, less than 3 years of age, occupying an aircraft seat.
<i>Class 4C</i>	Infant requiring an Ohio incubator.
<i>Class 4D</i>	Infant less than 3 years of age occupying a litter.
<i>Class 4E</i>	Outpatient less than 3 years of age.

Class 5: Outpatients

There are six categories in the outpatient class:

Class 5: Outpatients	
Category	Description
<i>Class 5A</i>	Ambulatory outpatient, nonpsychiatric and nonsubstance abuse, going for treatment.
<i>Class 5B</i>	Ambulatory outpatient, drug or alcohol (substance) abuse, going for treatment.
<i>Class 5C</i>	Psychiatric outpatient, going for treatment or evaluation.
<i>Class 5D</i>	Outpatient on litter for comfort, going for treatment.
<i>Class 5E</i>	Outpatient returning from treatment, on a litter for comfort.
<i>Class 5F</i>	Returning outpatient.

Class 6: Attendants

Individuals, other than the patient, traveling in the AE system are classified as attendants in one of the two categories:

Class 6: Attendants	
Category	Description
<i>Class 6A: Medical attendant (MA)</i>	Medical attendants must be familiar with the patient and possess the level of skills appropriate to the patient's needs. They are the clinical authority for their patient's care. They may be called on to assist in care of or consult on other patients on the aircraft as needed. They are required to document all patient care given. At en route RON stops, they must brief the personnel who will be caring for their patient and remain available for consultations. They remain with the patient until acceptance by a physician on arrival at the patient's destination medical facility.
<i>Class 6B: Nonmedical attendant (NMA)</i>	One person, normally a family member, may accompany a patient as an NMA if deemed necessary by the attending physician. Guards that accompany patients are listed as NMAs. Attendants should be advised to have sufficient money to pay for food and accommodations. All attendants <i>must</i> accompany the patient to the final destination. Attendants must be self-care and ambulatory. Physician recommendation for an NMA should be included on patient's medical record and DD Form 602, Patient Evacuation Tag.

Let's look at a quick recap to become familiar with the six different classifications:

Class	Category
1	Psychiatric
2	Litter Inpatients
3	Ambulatory Inpatients
4	Infants
5	Outpatients
6	Attendants

AE movement precedences

The movement precedence is determined by the attending physician. In some cases, the attending physician will consult with the flight surgeon or patient movement clinical coordinator (a nurse with “special” training and experience in operational and medical aspects of AE) to help determine the appropriate movement precedence. The Air Force (fixed wing) and Army (rotary wing) both use the same AE precedence categories; however, the timelines for transport are different. The AE precedence categories are:

- Urgent (U).
- Priority (P).
- Routine (R).

Let’s take a closer look at each of these categories.

AE Movement Precedences	
Precedence	Description
Urgent	Urgent applies only to the need for immediate life, limb, or eyesight-saving procedures not locally available. Report these patients directly to theater TPMRC or GPMRC. They should be picked up and delivered to the destination facility as soon as possible (ASAP).
Priority	Priority applies to the need for prompt medical care not locally available. Report directly to theater TPMRC or GPMRC. These patients will be picked up within 24-hours and delivered with the least possible delay.
Routine	Routine applies to all other patients. Report through TPMRC or GPMRC. Routine patients will be picked up and delivered on regularly scheduled flights normally within 72 hours.

US Army precedence

It is important to understand the Army’s AE precedence as their timeline differs from the Air Force. This is significant because you will need to prepare your patient for transport on a different timeline if evacuation is via Army rotary winged aircraft. The Army AE precedence timeline is listed below:

Army AE Precedence	
Precedence	Description
Urgent	This precedent is the same as the Air Force and the patient will be evacuated ASAP.
Priority	These patients will be picked up within 4 hours and delivered with the least possible delay.
Routine	Routine patients will be picked up within 24 hours if the Army is transporting the patient.

Always be clear when coordinating who will be picking the patient up initially as this will dramatically affect the timeline you are working to meet.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

040. Air evacuation terminology

1. What are the four types of AE?

2. What is the purpose of the ASF?

041. Patient classification categories and precedences

1. What classification is assigned to psychiatric patients?
2. Define the individual categories of the classification assigned to psychiatric patients.
3. What are the requirements for an MA when traveling in the AE system?
4. What are the AE precedence categories?

Answers to Self-Test Questions**033**

1. Behavioral Health Rapid Response Teams.
2. Two 5-level MHTs.
3. CASF.

034

1. Frustrations, conflicts, and pressures.
2. (1) c.
(2) a.
(3) b.
3. Describes the psychological and physiological changes people experience when confronted with a stressful event.

035

1. (1) Better medical care near the front lines.
(2) The sporadic nature of the fighting in which brief intensive encounters were followed by periods of relative calm and safety.
(3) A policy of rotation after 12 months of service which was unlike World War II when some members were in place for four years.
2. Symptoms persist for more than one month, but less than three months.
3. Lack of information/support risk factor.
4. Sleep loss, physical fatigue, and such physical stresses as heat, cold, and noise.
5. Mild reactions.

036

1. Improved methods of evacuation, body armor improvements, and the development of new surgical techniques.
2. Brain injury and blindness of central origin results from intracranial wounds involving the visual pathways.
3. An insult to the brain caused by an external force.

037

1. 30-45 minutes.
2. Has the member ever been seen by a mental health provider recently or in their past? Has the member ever taken psychiatric medications before or have they ever been admitted to a psychiatric facility? Has a family member ever been treated for a mental health condition? Has the client ever felt suicidal or homicidal, now or ever in the past?
3. Educational history.

038

1. Return of the greatest possible number of soldiers to combat and the preservation of life, limb, and eyesight in those who must be evacuated.
2. Help-in-place (HIP), Rest, Hold, and Refer.
3. Refer cases.

039

1. Brevity, Immediacy, Centrality, Expectancy, Proximity, and Simplicity.
2. (1) d.
(2) e.
(3) a.
(4) f.
(5) b.
(6) c.

040

1. Forward, Theater, Strategic, Domestic.
2. It provides significant support and suitable accommodations for patients required to remain at installations while awaiting aeromedical transportation.

041

1. Class 1.
2. *Class 1A*: Severe Psychiatric Litter Patients. Psychiatric patients requiring the use of restraining apparatus, sedation, and close supervision at all times. *Class 1B*: Psychiatric Litter Patients of Intermediate Severity. Patients requiring tranquilizing medication or sedation, not normally requiring the use of restraining apparatus. Restraining apparatus must be sent with the patient for potential use. *Class 1C*: Psychiatric Walking Patients of Moderate Severity. They are cooperative and reliable under observation.
3. Medical attendants must be familiar with the patient and possess the level of skills appropriate to the patient's needs. They are the clinical authority for their patient's care.
4. (1) Urgent (U).
(2) Priority (P).
(3) Routine (R).

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter. When you have completed all unit review exercises, transfer your answers to ECI (AFIADL) Form 34, Field Scoring Answer Sheet.

Do not return your answer sheet to the Extension Course Program.

68. (033) Which mental health readiness team *used to be* considered the primary deployable team?
- Mental Health Response.
 - Mental Health Augmentation.
 - Mental Health Rapid Response.
 - Mental Health Rapid Augmentation.
69. (033) The correct number of personnel for a Medical Behavioral Health Rapid Response Team-*Psychologist* is
- one psychologist and one 7-level MHT.
 - one psychologist and two 7-level MHTs.
 - two psychologists and one 7-level MHT.
 - one psychologist, one 7-level MHT, and one 5-level MHT.
70. (033) The correct number of personnel for a Medical Behavioral Health Rapid Response Team-*Nurse* is
- one MH nurse.
 - two MH nurses.
 - one MH nurse and one 7-level MHT.
 - two MH nurses, one 7 level MHT, and one 5-level MHT.
71. (033) In general, a *behavioral health team* supports a bed-down population of
- 500.
 - 1,000.
 - 1,500.
 - 2,000.
72. (033) What provides personnel and equipment necessary for 24-hour staging operations for patients transiting the worldwide Aeromedical Evacuation (AE) system?
- Combat care clinic.
 - Joint theater hospital.
 - Expeditionary medical support.
 - Contingency aeromedical staging facilities.
73. (034) Which category of stress is difficult for people to cope with and leads to self-devaluation?
- Frustrations.
 - Conflicts.
 - Pressures.
 - Stressors.
74. (034) The body has depleted itself of body energy and immunity during which General Adaptation Syndrome (GAS) stage?
- Alarm reaction.
 - Fright reaction.
 - Stage of resistance.
 - Stage of exhaustion.

75. (035) What Post Traumatic Stress Disorder subtype is defined as symptoms persisting for *more than 1 month, but less than 3 months*?
- Acute.
 - Initial.
 - Chronic.
 - With delayed onset.
76. (035) Which subtype of Post-Traumatic Stress Disorder (PTSD) persists *beyond 3 months*?
- Acute.
 - Initial.
 - Chronic.
 - With delayed onset.
77. (035) In which battle fatigue classification does the member stay in the unit to rest and then be restored to full duty?
- Moderate reactions.
 - Chronic reactions.
 - Severe reactions.
 - Mild reaction.
78. (036) In the discussion on mental health implications for traumatic injuries, the survival of many troops who previously would have died is attributed to
- body armor improvements.
 - increased intelligence reports.
 - less frequent aeromedical evacuations.
 - presence of mental health technicians on the battlefield.
79. (036) Which of the following statements regarding amputation from a battlefield injury is *true*?
- Anxiety and depression are the rarest forms of emotional distress.
 - Behavioral disturbances are frequently a problem in the early postoperative period.
 - Newly wounded troops are apt to be euphoric and thankful that their injuries were not more severe.
 - What the surgical staff says to each other within hearing distance of the patient is not important if the patient is unconscious.
80. (037) During which history might we ask whether or not a person has had an Article 15?
- Legal.
 - Family.
 - Military.
 - Administrative.
81. (038) Cases that *do not* have severe combat operational stress reaction (COSR) or behavioral health (BH) disorders are placed in what *triage category*?
- Help in place.
 - Rest.
 - Hold.
 - Refer.
82. (038) Cases that need *replenishment in a nonmedical support unit* are placed in what triage category?
- Help in place.
 - Rest.
 - Hold.
 - Refer.

-
-
83. (039) Which combat treatment principle concept states that battle fatigue casualties should be treated in one location?
- Immediacy.
 - Centrality.
 - Proximity.
 - Simplicity.
84. (039) Which combat treatment principles concept impress upon the individual that he or she will return to the unit in a short time?
- Immediacy.
 - Centrality.
 - Proximity.
 - Expectancy.
85. (039) Which of the following is *not* a general guideline for using BICEPS?
- Wear of the uniform.
 - Maintain military discipline.
 - Maintain customs and courtesies.
 - Allow injured member to be a “patient” for a few days.
86. (040) Which aeromedical evacuation movement phase provides airlift for patients between points within the battlefield, from the battlefield to the initial point of treatment, and to subsequent points of treatment within the combat zone?
- Theater.
 - Forward.
 - Strategic.
 - Domestic.
87. (040) What organization’s mission is to receive, shelter, process, and provide medical and nursing care to patients who enter, travel in, or leave the aeromedical evacuation (AE) system?
- Aeromedical Staging Facility (ASF).
 - Global Patient Movement Requirements Center (GPMRC).
 - Theater Patient Movement Requirements Center (TPMRC).
 - TRANSCOM Regulating and Command and Control Evacuations System (TRAC2ES).
88. (040) Which organization is responsible for coordinating all patient transfers once the mission arrives at the Continental United States (CONUS) reception aerial port?
- Aeromedical Staging Facility (ASF).
 - Global Patient Movement Requirements Center (GPMRC).
 - Theater Patient Movement Requirements Center (TPMRC).
 - TRANSCOM Regulating and Command and Control Evacuations System (TRAC2ES).
89. (041) What ambulatory inpatient aeromedical evacuation class is used for *drug or alcohol abuse patients going for treatment*?
- 3A.
 - 3B.
 - 3C.
 - 3D.
90. (041) How many major classifications are there in the aeromedical evacuation (AE) system?
- Three.
 - Four.
 - Five.
 - Six.

Student Notes

Glossary of Abbreviations and Acronyms

A&D	admissions and dispositions
ADAPT	Alcohol and Drug Abuse Prevention and Treatment
AE	aeromedical evacuation
AEF	air expeditionary force
AFMOA	Air Force Medical Operations Agency
AFOSH	Air Force Occupational and Environmental Safety, Fire Prevention, and Health
AFRIMS	Air Force Record Information Management System
AHLTA	Armed Forces Health Longitudinal Technology Application
AIDS	Acquired Immunodeficiency Syndrome
AMA	American Medical Association
ANS	Autonomic Nervous System
AOR	area of responsibility
APA	American Psychiatric Association
ASAP	as soon as possible
ASF	aeromedical staging facility
BDI	Beck Depression Inventory
BH	Behavioral health
BSI	body substance isolation
BX	Base Exchange
CADAC	Certified Alcohol and Drug Abuse Counselor
CASF	Contingency Aeromedical Staging Facility
CCM	cost center manager
CDC	Centers for Disease Control
CDC	career development course
CENTCOM	United States Central Command
CHCS	Composite Health Care System
CISD	Critical Incident Stress Debriefing
CNS	Central Nervous System
CONOPS	Concept of Operations
CONUS	Continental United States
COSR	Combat and Operational Stress Reaction
CPS	child protection services
CSF	Combat stress facility
CSR	Combat stress reaction
CY	calendar year
DD	Department of Defense
D/D	dependent daughter

D/H	dependent husband
D/S	dependent son
D/SD	dependent step-daughter
D/SS	dependent step-son
D/W	dependent wife
DMRIS	Defense Medical Regulation Information System
DOD	Department of Defense
DSM	Diagnostic and Statistical Manual of Mental Disorders
DVBIC	Defense and Veterans Brain Injury Center
EHR	electronic health record
EMEDS	Expeditionary Medical Support
EPA	Environmental Protection Agency
EUCOM	European Command
FAP	Family Advocacy Program
FAST	Family Advocacy Strength-Based Therapy
FMP	Family member prefix
FOB	forward operating base
FTAC	First Term Airman Center
FTCA	Federal Tort Claims Act
FY	fiscal year
GAS	General Adaptation Syndrome
GPMRC	Global Patient Movement Requirements Center
HAWC	Health and Wellness Center
HSI	Health Services Inspection
HIP	help-in-place
HIV	Human Immunodeficiency Virus
HUMRO	Humanitarian relief operations
ICC	Infection Control Committee
ICERD	International Convention on the Elimination of all Forms of Racial Discrimination
ICMOP	Integrated CONUS Medical Operations Plan
IEDs	Improvised Explosive Devices
IM	intramuscular
IV	intravenous
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
MA	medical attendant
MARS	Medication history and Reconciliation System
MASF	Mobile aeromedical staging facility
MCFI	Million Clinical Multi-axial Inventory
MHAT	Mental Health Augmentation Team

MHRRT	Mental Health Rapid Response Team
MHS	mental health services
MMPI	Minnesota Multiphasic Personality Inventory
MOOTW	Military Operations Other Than War
MPR	military personnel records
MTF	medical treatment facility
NBC	nuclear, biological or chemical
NCO	noncommissioned officer
NCOIC	noncommissioned officer in charge
NMA	Non-medical attendant
NPRC	National Personnel Records Center
NPSP	New Parent Support Program
OI	operating instruction
OPBHC	Outpatient behavioral health clinic
OPR	outpatient medical records
OSHA	Occupational Safety and Health Administration
PCS	permanent change of station
PIES	Proximity, Immediacy, Expectancy, Simplicity
PME	Professional Military Education
PNS	Peripheral Nervous System
PO	petty officer
PRN	as needed
PRP	Personnel Reliability Program
PTSD	Post-Traumatic Stress Disorder
QC	quality control
RDS	Records disposition schedule
RM	resource management
RMO	resource management office
RTD	return to duty
SCI	Spinal cord injuries
SNS	Somatic Nervous System
SOAP	Subjective Objective Assessment Plan
SOP	Standard Operating Procedures
SSAN	social security account number
TB	Tuberculosis
TBS	total body surface
TBI	Traumatic brain injury
TDY	temporary duty
TPMRC	Theater Patient Movement Requirements Center
TPP	Tactics, Techniques, and Procedures

TRAC2ES	TRANSCOM Regulating and Command & Control Evacuation System
TRANSCOM	United States Transportation Command
UTC	unit type code
VistA	Veterans Health Information System and Technology Architecture
WMD	weapons of mass destruction
WW	World War

Student Notes

AFSC 4C051
4C051N 01 0903
Edit Code 03