Department of Veterans Affairs

Employee Education System

DISASTER MENTAL HEALTH SERVICES

A GUIDEBOOK FOR CLINICIANS AND ADMINISTRATORS

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660/2-98/750

Introduction

DEFINING DISASTER

Each day disasters occur, and each year millions of people are affected. Whether natural or human-made, the extreme and overwhelming forces of disaster can have far-reaching effects on individual, local community, and national stability. Though disasterous events may last from seconds to a few days, effects on communities and individuals can continue from months to years during the extended process of recovery, reconstruction and restoration. Long-term recovery varies significantly due to the complex interaction of psychological, social, cultural, political, and economic factors.

"A major disaster is defined as any natural catastrophe, or regardless of cause, any fire, flood, or explosion that causes damage of sufficient severity and magnitude to warrant assistance supplementing State, local, and disaster relief organization efforts to alleviate damage, loss, hardship, or suffering" *(FEMA, Pub 229 (4) November, 1995 p. 1).* Events associated with disaster are capable of causing traumatic stress when they cause or threaten death, serious injury, or the physical integrity of individuals.

In the event of massive destruction occuring in the United States, a Governor may request a Presidential declaration. This request must satisfy the provisions of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (PL93-288, as amended by PL-100-707). The Stafford Act provides the authority for the Federal Government to respond to disasters and emergencies in order to provide assistance to save lives and protect public health, safety, and property. High magnitude disasters can overwhelm state medical systems, posing public health threats related to food and

Photo by Donna Hastings

water supplies, housing and weather exposure, and injuries. Health care facilities may be severely structurally damaged or destroyed. Facilities with little or no structural damage may be rendered unusable or only partially usable because of a lack of utilities, losses of staff and equipment, limited resupply, and/or disruption of communication and transportation systems. Facilities remaining in operation face massive numbers of ill, injured, and/or stressed and disoriented victims.

Even in disasters with relatively few fatalities or injuries, disruptions of food supply, utilities, waste management, transportation, social, and educational services, together with property damage and survivor relocation often place intense demands on health services. Clearly, a timely and effective health care response is critical to the survivors' and the community's safety and recovery – and mental health care is an essential component in this response to disaster.

- In 1996-97, one hundred eighteen Presidential-declared disasters and eight national emergencies occurred in the United States, and the Federal Emergency Management Agency (FEMA) provided funding to 553,835 disaster victims.
  FEMA
- From 1984-1994, 285 Presidential-declared disasters occurred in the United States, one every two weeks on average.
  National Disaster Medical System Tenth Anniversary: A state by state guide (1994).
- Approximately 17 million people living in North America are exposed annually to trauma and disaster.
  Meichenbaum (1995).
- Approximately 25-30% of individuals exposed to unusually traumatic events such as disasters, combat, violence, and accidents develop chronic PTSD or other psychiatric disorders.
  Yehuda et al. (1994).

How This Guidebook Can Help

This guidebook is an introduction to the field of disaster mental health (DMH) for clinicians and administrators. Practical guidelines and background information are provided to assist you and/or your organization develop:

- ***Disaster Mental Health Response Strategies***

  Providing timely and phase-appropriate mental health services to disaster survivors, families, workers, and organizations.

We focus in detail on the pragmatics of delivering DMH services at disaster sites and over the long term in affected communities. Our goal is to help you provide a continuum of care for recovering survivors and their communities over the course of the days, months, and years following disaster.

- ***Disaster Mental Health Team Formation and Maintenance***

  Establishing a disaster mental health policy and team with operational protocols for timely and effective disaster mental health response and for team training and preparation.

Providing disaster mental health services is complex. We strongly advise developing a policy and a team *before* disaster strikes your community. Organizational policy must necessarily address the team's role during local or national emergencies/disasters, and outline how the team can become an integral element in the local and national response system.

We describe a series of practical steps necessary for creating, training, and sustaining a disaster mental health team. The roles of team leaders, mental health professional members, and non-professional ("peer") members are described.

- ***Strategies for Interfacing with the Federal Disaster Response System***

  Developing the capacity to interface with the federal disaster response system when mobilized for major disasters.

To respond to a high magnitude disaster, your team must be able to quickly integrate with the network of disaster response agencies and organizations. An overview of the federal disaster response system, its key agencies, and suggestions for how to join with this system is presented.

DISASTER MENTAL HEALTH SERVICES

In a major disaster, effective mental health response requires the delivery of both clinical and administrative services in ways that differ from services typically provided by mental health professionals. The primary objective of disaster relief efforts is to restore community equilibrium. Disaster mental health services, in particular, work toward restoring psychological and social functioning of individuals and the community, and limiting *the occurrence and severity of adverse impacts* of disaster-related mental health problems (e.g., post-traumatic stress reactions, depression, substance abuse).

Clinical Roles

The regular mission of mental health programs is significantly different from that of disaster mental health. Disaster mental health services are primarily directed toward "normal" people responding normally to an abnormal situation, and to identifying persons who are at risk for severe psychological or social impairment due to the shock of the disaster. Aspects of disaster intervention services are similar to the crisis work of mental health agencies and practitioners, and include the evaluation and treatment of persons whose pre-existing psychiatric disorders are exacerbated by the stress or trauma of disaster. However, most of the work of disaster mental health professionals occurs in "non-clinical settings" (e.g., shelters, disaster application centers, schools, community centers) and is delivered in the form of stress management education, problem solving, advocacy, and referral of at-risk or severely impaired individuals for more intensive clinical evaluation and care. In addition, defusing and debriefing, two commonly used disaster mental health interventions, may be unfamiliar to mental health clinicians.

Mental health providers thus face a unique challenge in the wake of disaster. In conventional clinical practice, patients generally arrive at a scheduled time having made an agreement (at least implicitly) to accept the clinician as a mental health expert. Clinics typically have private offices where clinicians and patients meet for a set time period. Following case management or therapeutic intervention, clinicians make progress notes, clients may do homework and return for follow-up work. After a few sessions, clinicians generally have an understanding of the client's presenting problem, coping style, and interpersonal dynamics. By contrast, disaster mental health involves services to people who often are not seeking mental health assistance, who may be ambivalent about receiving such help, or who may be outright resistant to any form of mental health service. Service settings may be chaotic, and lack privacy, quiet, or comfort – for example, a service center waiting line, a street curb, or a cot in a shelter. Moreover, administrative decisions about health services often change several times each day, requiring clinicians to frequently change their routines, locales, and the type of survivors

they serve. At most, 10-30 minutes can be spent with any individual, who is generally not seen more than once by the same clinician. "Instant" rapport and rapid assessment are necessary with many people who are experiencing extreme, but normal, stress reactions (e.g., exhaustion, irritability, grief). Although therapeutic skills and acumen provide a basis for disaster mental health assessment and intervention, mental health workers will not be doing "therapy" in the immediate wake of disaster. Rather, they address pragmatic concerns while using psychoeducational techniques to teach survivors about stress reactions and stress management methods.

Clinical roles change from setting to setting and they change over the course or "phases" of disaster. The primary clinical roles are discussed in detail in the sections "helping survivors," "helping the helpers," and "helping organizations." An outline of the primary clinical roles required during each phase is presented below.

Emergency Phase: Clinical Roles

	SURVIVORS	HELPERS	COMMUNITY	ORGANIZATIONS
Types of Disasters Mental Health Services	Protect Direct Connect Triage Acute Care	Triage / Assess Consult Defusing Debriefing Crisis intervention Referral when appropriate	Information dissemination	Consultation Needs Assessment Service development Support Employee Assistance Programs

Early Post-Impact Phase: Clinical Roles

	SURVIVORS	HELPERS	COMMUNITY	ORGANIZATIONS
Types of Disaster Mental Health Services	<u>Outreach Services</u> Assessment Referral Psychoeducational presentations Initial debriefings Follow-up debriefings Assistance with death notification Activities in large group settings & vigils	Assessment Consult Initial debriefings Referral when appropriate Follow-up debriefings Referral when appropriate	Psychoeducational articles, interviews, reports, brochures about stress reactions & stress management	Phone & on-site consultation to management Ad hoc counseling program design & implementation Support Employee Assistance Programs
SITES OF INTERVENTIONS	Shelters, meal sites, disaster application centers, Red Cross service centers, hospitals, schools, police stations, survivors' homes, morgues, (wherever survivors are)	Work sites Rest sites Home office	Newspapers, radio, TV, Internet, Community centers, shopping malls, schools, religious centers, business associations	Work sites Corporate offices

Restoration Phase: Clinical Roles

	SURVIVORS	HELPERS	COMMUNITY	ORGANIZATIONS
Types of Disaster Mental Health Services	Outreach Services PTSD Assessment Referral Psychoeducational presentations Debriefings Memorial & commemoration Clinical services Crisis intervention Consultation with schools; school programs PTSD and psychosocial assessment, Individual, couples, family & group counseling	Assessment & referral as appropriate Consultation Follow-up debriefings Referral when appropriate Commemoration planning	Psychoeducational articles, interviews, reports, brochures about stress reactions & stress management Needs Assessment survey Group education presentations Commemoration planning	Phone & on-site consultation Needs assessment surveys Educational presentations Consultations and trainings with Employee Assistance Programs

Administrative Roles

Following a disaster, administrators are faced with the challenge of having to quickly become familiar with disaster protocols (grant applications) and resources (mutual and other aid), while meeting rapidly emerging and changing disaster-precipitated needs. This work requires a good deal of "systems savvy" – ability to work within and effectively influence the institutional arrangements that define the overall disaster response and the community(ies) being served.

Disaster mental health response efforts are continuously subject to powerful real-world contingencies. All disasters become political events. Previously established networks and relationships, as well as political pressures, shape the disaster response. Consensus among agencies and organizations about matching resources with survivors is rare. The disaster setting is in constant flux as information and resources change rapidly. Hourly updates on community needs, political pressures, and the convergence of resources result in frequent reappraisal of how best to respond to the diverse groups of people affected.

Immediately following a disaster, administrators are beset by offers of mental health services from around the country (if not the world) inquiries from the media, and requests for needs assessments and logistical plans for how, where, and by whom mental health services will be delivered. Administrators also must begin preparation to shift services from crisis intervention to ongoing aid and assistance, because as early as one month after the disaster, the

major federal grants are reviewed, funded, and operationalized for ongoing disaster mental health services. All this begins within a period of 24-72 hours after the onset of disaster, leaving little time for information gathering and reflection.

Administrative crisis intervention in the wake of disaster involves several specific operations. An administrative team coordinating all on-site clinical provider teams will be convened quickly, and generally includes representation from key local and national mental health agencies and experts. Administrative representatives from various agencies (e.g., Emergency Medical Services, Office of Emergency Services, Critical Incident Stress Management, Department of Veterans Affairs, as well as representatives of professional mental health organizations) may be called upon to work within the rapidly forming mental health Incident Command established by county and state mental health organizations. Indigenous and non-indigenous mental health clinicians or administrators must have a portal of entry through at least one of these gatekeeper organizations in order to be legitimate "players" in the disaster response services. Administrators are best positioned if they have a prior working relationship with one or several of these teams, so as to have immediate access to experienced disaster mental health professionals .

Once "in the loop," administrative collaboration should occur with other mental health team leaders in order to sustain an effective overall intervention, including:

- communicating with other health and social services
- coordinating planning and decisions with the community's overall Incident Command System
- monitoring the delivery and effectiveness of mental health services in several sites
- converting ongoing assessments into timely reports, applications for funding, and guidelines for deployment of mental health programs and personnel

An outline of administrative roles and responsibilities in the immediate aftermath, early post-impact, and restoration phases of disaster follows:

EMERGENCY AND EARLY POST-IMPACT PHASE ADMINISTRATIVE TASKS

1. Coordinate response/liaison with other responding agencies	2. Coordinate immediate mental health response	3. Conduct needs assessment and/or gather information	4. Coordinate information to media for public dissemination	5. Coordinate services with other responding agencies to provide mental health services to emergency responders	6. Coordinate, allocate staff resources	7. Coordinate documentation of services
a. State Department b. American Red Cross c. Federal Emergency Management Agency d. County Office of Emergency Services e. School officials f. Community agencies	a. Mobilize team / staff to mass care sites b. If necessary, activate mutual aid system c. Establish disaster mental health crisis line (i.e., mechanism to respond to requests for services)	a. Impact on survivors: Number of fatalities, hospitalized, non-hospitalized, homes destroyed, homes with major damage, unemployed; schools destroyed; schools with major damage b. Impact on high-risk groups: Injured; high traumatic exposure; families and individuals relocated; frail elderly; economically disadvantaged; emergency responders / helpers		a. Defusing, debriefing, and crisis intervention services b. Education services c. Monitor DMH staff stress management	a. Existing local mental health staff b. Additional staff needed c. Specialized skills requirements (i.e., language, cultural, children, older adults, death notification, etc.)	

RESTORATION PHASE ADMINISTRATIVE TASKS

1. Coordinate response/liaison with other responding agencies	**2. Conduct needs assessment and/or gather information**	**3. Establish crisis counseling program**	**4. Coordinate outreach and clinical services**
a. State Department b. American Red Cross c. Federal Emergency Management Agency d. County Office of Emergency Services e. School officials f. Community agencies	a. Impact on survivors: Number of fatalities, hospitalized, non-hospitalized, homes destroyed, homes with major damage, unemployed; schools destroyed; schools with major damage b. Impact on high-risk groups: Injured; high traumatic exposure; families and individuals relocated; frail elderly; economically disadvantaged; emergency responders/helpers	a. Staffing b. Service contracts c. Program implementation d. Service facilities e. Equipment & supplies procurement f. Service announcements g.Obtaining specialized training for staff and inservices for staff h. Documentation of process and service provision i. Letters of acknowledgement j. Program evaluation k. After action reports l. Setting up archives	a. Staffing, scheduling, and assignments b. Monitoring staff stress c. Networking d. On-going assessment of special needs e. Develop library of psychoeducational materials for public dissemination f. Develop contacts with local media for information dissemination g. Commemorative event(s) planning

KEY CHARACTERISTICS & HELPING BEHAVIORS OF DISASTER MENTAL HEALTH WORKERS

Disaster mental health work requires a personal orientation toward adventuresomeness, sociability, and calmness. Equally important is having systems savvy, the ability to exhibit empathy, genuineness, positive regard for others, and the ability to provide therapeutic structure.

Generally speaking, adventuresomeness, sociability, calmness, systems savvy, and therapeutic acumen transcend theoretical orientation and are applicable across various disaster response settings. Moreover, they are essential to communicating with survivors and rescue workers whether informally or while providing practical help, defusing, debriefing, or information.

Adventuresomeness

Disaster work is a constant creative challenge with relatively few cardinal rules to provide *a priori* guidance. The inclination toward curiosity and learning from experience as well as the willingness to develop creative solutions to complex problems is necessary for disaster work. The person who relies upon routine with minimal uncertainty is likely to feel overwhelmed and adrift.

On the other hand, disasters require establishing regularity and certainty amidst intense turmoil, hence a major aspect of the adventure is creating structure in the face of chaos. The disaster worker who relies upon a series of "adrenaline rushes" by seeking out risky activities, extreme dangers, or opportunities to "push the envelope" is likely to be a charismatic success for a short time in disaster work ... but unable to facilitate, or accommodate, the gradual routinization necessary to provide stability for disaster survivors.

Sociability

Disaster mental health work demands long hours each day, as well as being on call throughout assignment. Survivors and workers alike are at their best and worst in a disaster – courageous, selfless, dedicated, resourceful, and compassionate ... yet also plagued by doubts, selfishness, resignation, confusion, and irritability. To work with people who may be experiencing extreme stress, and to maintain the stance of a sensitive and observant listener and helper, requires not just a professional commitment to others, but the capacity to enjoy and find the best in others.

However, sociability does not mean over-involvement or pseudo-friendliness. Disaster mental health professionals have the ethical and clinical responsibility to maintain clear and appropriate professional and personal boundaries with survivors and workers. Tact, discretion, and client-centeredness are an essential counter balance to being personable and friendly.

Calmness Disaster work is a form of non-stop crisis intervention challenging the equanimity of unexperienced and experienced clinicians alike. When nothing seems to be happening for hours at a time, powerful undercurrents of anxiety, despair, rage, and uncertainty threaten to break loose at any moment. Working and living conditions are often chaotic: noisy settings, long hours, substandard lodging, unstructured schedules, ambiguous roles and rules – these high-stress circumstances call for emotional poise.

Systems Savvy Disasters are political events. Turf and organizational politics are pervasive and volatile at disaster services sites, Incident Command center(s), and at national headquarters of response agencies. The disaster mental health professional represents a distinct interest – that of supporting and enhancing the psychosocial safety and functioning of helpers, survivors, and their community. By becoming familiar with the scope of disaster relief operations (i.e., community, state, and national political arenas), the mental health professional can better assume the role of an impartial mental health advocate.

Organizational and personal struggles may result in mental health professionals and programs becoming scapegoated as wasteful and an interference with the "real" work of restoring a community's physical and medical integrity after disaster. Alliances must be chosen carefully so that mental health is not marginalized.

Therapeutic Acumen To provide therapeutic assistance without "therapizing" disaster survivors or workers, the mental health professional's perspective must be grounded in empathy, genuineness, and respect. These "facilitative conditions" have been found to be essential across the spectrum of psychotherapy's theoretical models and help quickly promote a positive relationship between helper and survivor. These facilitative conditions are summarized on the following page.

Empathic behaviors:

- Express desire to comprehend survivor.
- Discuss what is important to survivor.
- Refer to survivor's feelings.
- Correctly interpret survivor's implicit feelings.

Genuine behaviors:

- Friendly and open.
- Spontaneous rather than rigid or overly formal.
- Actions congruent with intent.

Respectful behaviors:

- Be on time for appointments and meetings.
- Make statements that express respect for the survivor.
- Express non-verbal attentiveness and concern.
- Summarize survivor's messages accurately (e.g., appropriate eye contact, tone of voice).

Listening — Display a range of listening skills.

Listening behaviors

- Ask clarifying questions.
- Paraphrase survivors' statements accurately.
- Verbally reflect survivors' feelings accurately.
- Ask open-ended questions.
- Help clarify survivors' mixed (incongruent) messages.

Provide therapeutic structure — ability to conceptualize survivors' stress-related problems.

Behaviors providing therapeutic structure:

- Recognize overt and covert problems with stress.
- Recognize antecedent conditions that trigger stress responses.
- Understand how survivor's response to stress influences post-disaster behavior.
- Educate survivor about stress response syndromes & stress management strategies.
- Provide possible explanations for associated behaviors.
- Provide information that encourages alternative views and new behaviors.
- Assist, when appropriate, with pragmatic problems.
- Maintain the role of helper rather than friend or help-receiver.

Empathy:

Ability to help the survivor feel that he or she is understood.

Genuineness:

Ability to reduce the emotional distance or alienation between the survivor and oneself.

Positive regard for survivor:

Ability to convey respect for the survivor.

Listening

Ability to utilize array of listening skills

Section I - Stress Reactions of Survivors

OVERVIEW

Stress reactions can result from a variety of shocking events. Before, during, or in the aftermath of a disaster, survivors may have experienced additional traumas such as life-threatening accidents, sexual or physical abuse or assault, living or serving in the military in a war zone, kidnapping or torture, or the witnessing of terrible things happening to other people. It is important to avoid assuming that a disaster involves the same type and intensity of experience for all survivors, and that all survivors bring a similar personal history of trauma into the disaster.

Each Survivor's Disaster is Unique

In addition to involving terrifying close encounters with death and severe physical harm, disaster often causes significant losses that may vary greatly from survivor to survivor (e.g., loss of loved ones, friends, and/or property). Persons who were physically in the same place throughout much of a disaster may have been exposed to different specific traumatic events during and after the disaster. The "same" disaster may involve multiple elements ranging from accidental trauma (e.g., car, train, boat, or plane accidents, fires, explosions), to natural environmental cataclysm (e.g., floods, tornadoes, hurricanes, earthquakes), to deliberately caused devastation (e.g., lootings, riots, bombings, shootings, torture, rape, assault, and battery). Survivors may experience significant stress reactions, and among survivors, the type and intensity of these reactions vary greatly within the same disaster.

In the wake of disaster, survivors may experience financial difficulties related to vocational problems, unemployment, and/or problems associated with relocation, rebuilding, or repairing a home. Other long-term stressors may include resulting marital and family discord, medical illness, or chronic health problems. Seeking and receiving help for these various issues can, in and of themselves, result in additional stress for survivors.

Each Survivor is Unique

Each survivor's personal history and unique psychological and relational strengths and deficits influence his or her response to disaster. Individual, family, and community beliefs, values, and resources also shape the meaning of the experience and have a role in the process of recovery.

Implications for Understanding and Assessing Survivors' Reactions

Personal and cultural differences and pre,- intra-, and post-disaster experience are vital to understanding why survivors may show different patterns of stress reactions to what seems to be the "same" disaster. Even in the briefest and most informal contact with disaster survivors, it is important to make a rapid, sensitive, and nonintrusive assessment of the possible mediating factors that may be shaping each survivor's specific stress reaction.

Specifically, before judging or classifying a particular pattern of stress response, consider what is observable, what is disclosed, and what remains to be known about each survivor's unique background or experience in the following areas:

- Ethnocultural traditions, beliefs, and values
- Community practices, norms, and resources
- Family heritage and dynamics
- Individual sociovocational resources and limitations
- Individual biopsychosocial resources and vulnerabilities
- Prior exposure to traumatic experiences
- Specific stressful or potentially traumatic experiences during / since disaster

Factors Associated with Disaster Stress

People directly exposed to danger and life threat are at risk for the greatest impact. The literature examining the role of traumatic exposure is definitive. Regardless of the traumatic stressor, be it combat, physical abuse, sexual assault, or natural disaster, dose-response is a strong predictor of who will likely be most affected. The greater the perceived life threat, and the greater the sensory exposure, that is, the more one sees distressing sights, smells distressing odors, hears distressing sounds, or is physically injured, the more likely post-traumatic stress will manifest. Victims are not the only ones at risk. Helpers, including medical, morgue, and security personnel, rescue, fire and safety workers, may also experience either direct or indirect traumatization. Family members of victims, too, are at risk for what has been referred to as vicarious traumatization – relationships with traumatized individuals can create much distress for others.

Listed below are factors associated with disaster stress to take into consideration when having to make informal rapid assessments of survivors.

- Personal injury
- Injury or fatality of loved ones, friends, associates
- Property loss / relocation
- Pre-existing stress

- Level of personal and professional preparedness
- Stress reactions of significant others
- Previous traumatization
- Self-expectations
- Prior disaster experience
- Perception / interpretation of causal factors
- Level of social support

When considering the allocation and distribution of mental health resources, the role delineation model (Taylor and Frazier, 1989) may be useful to conceptualize different types of victims.

- **Primary victims:** people directly exposed to the elements of the disaster
- **Secondary victims:** people with close family and personal ties to primary victims
- **Tertiary victims:** people whose occupations require them to respond to the disaster
- **Quarternary victims:** concerned and caring members of communities beyond the impact area

Post-traumatic Stress Reactions: A Common Response to Disaster

Although individual reactions vary, clinical researchers have identified a common pattern of behavioral, biological, psychological, and social responses among individuals exposed directly or vicariously to life-threatening events. This response pattern is known as post-traumatic stress syndrome.

It is important to help survivors recognize the normalcy of most stress reactions to disaster. Mild to moderate stress reactions in the emergency and early post-impact phases of disaster are highly prevalent because survivors (and their families, community members, and rescue workers) accurately recognize the grave danger involved in disaster. Although stress reactions may seem "extreme," and cause distress, they generally do not become chronic problems. Most people recover fully from moderate stress reactions within 6 to 16 months (Baum & Fleming 1993; Bravo et al. 1990; Dohrenwend et al. 1981; Green et al. 1994; La Greca et al. 1996; Steinglass & Gerrity 1990; and Vernberg et al. 1996).

COMMON STRESS REACTIONS TO DISASTER

Emotional Effects
Shock
Anger
Despair
Emotional numbing
Terror
Guilt
Grief or sadness
Irritability
Helplessness
Loss of derived pleasure from regular activities
Dissociation (e.g., perceptual experience seems "dreamlike," "tunnel vision," "spacey," or on "automatic pilot")

Cognitive Effects
Impaired concentration
Impaired decision-making ability
Memory impairment
Disbelief
Confusion
Distortion
Decreased self-esteem
Decreased self-efficacy
Self-blame
Intrusive thoughts and memories
Worry

Physical Effects
Fatigue
Insomnia
Sleep disturbance
Hyperarousal
Somatic complaints
Impaired immune response
Headaches
Gastrointestinal problems
Decreased appetite
Decreased libido
Startle response

Interpersonal Effects
Alienation
Social withdrawal
Increased conflict within relationships
Vocational impairment
School impairment

Another perspective on stress reactions comes from anecdotal evidence gathered by experienced disaster mental health clinicians who have been involved in many disaster operations. It has been repeatedly observed that the normative post-disaster biopsychosocial reaction occurring in individuals and communities forms a relatively predictable pattern from the onset of the disaster through the following 18-36 months. This pattern is delineated by four relatively distinct phases. However these phases are variable with regard to their duration, and within each phase, there is significant individual variation in the reaction of survivors. Hence, this "aerial" view is presented as a heuristic so that clinicians who work for "only" a short period of time following a disaster can place their experience into a larger context. The phases have been referred to as the **heroic**, **honeymoon**, **disillusionment**, and **restabilization** phases.

Heroic This phase is characterized by individuals and the community directing inordinate levels of energy into the activities of rescuing, helping, sheltering, emergency repair, and cleaning up. This increased physiological arousal and behavioral activity lasts from a few hours to a few days.

Honeymoon Despite the recent losses incurred during the disaster, this phase is characterized generally by community and survivor optimism. Survivors witness the influx of resources, national or worldwide media attention, and visiting VIPs who reassure them their community will be restored, justice will be upheld, investigations will be conducted, etc. Survivors begin to believe that their home, community, and life as they knew it will be restored quickly and without complications. Less experienced disaster mental health clinicians working only within this phase are prone to leave with the same impression and fail to prepare survivors and/or administrators for what to expect in the following weeks and months. Generally, by the third week, resources begin to diminish, the media coverage lessens, VIPs are no longer visiting, and the complexity of rebuilding and restoration becomes increasingly apparent. At this same time, the increased energy that survivors and the community initially experienced begins to diminish and fatigue sets in, setting the stage for the next phase.

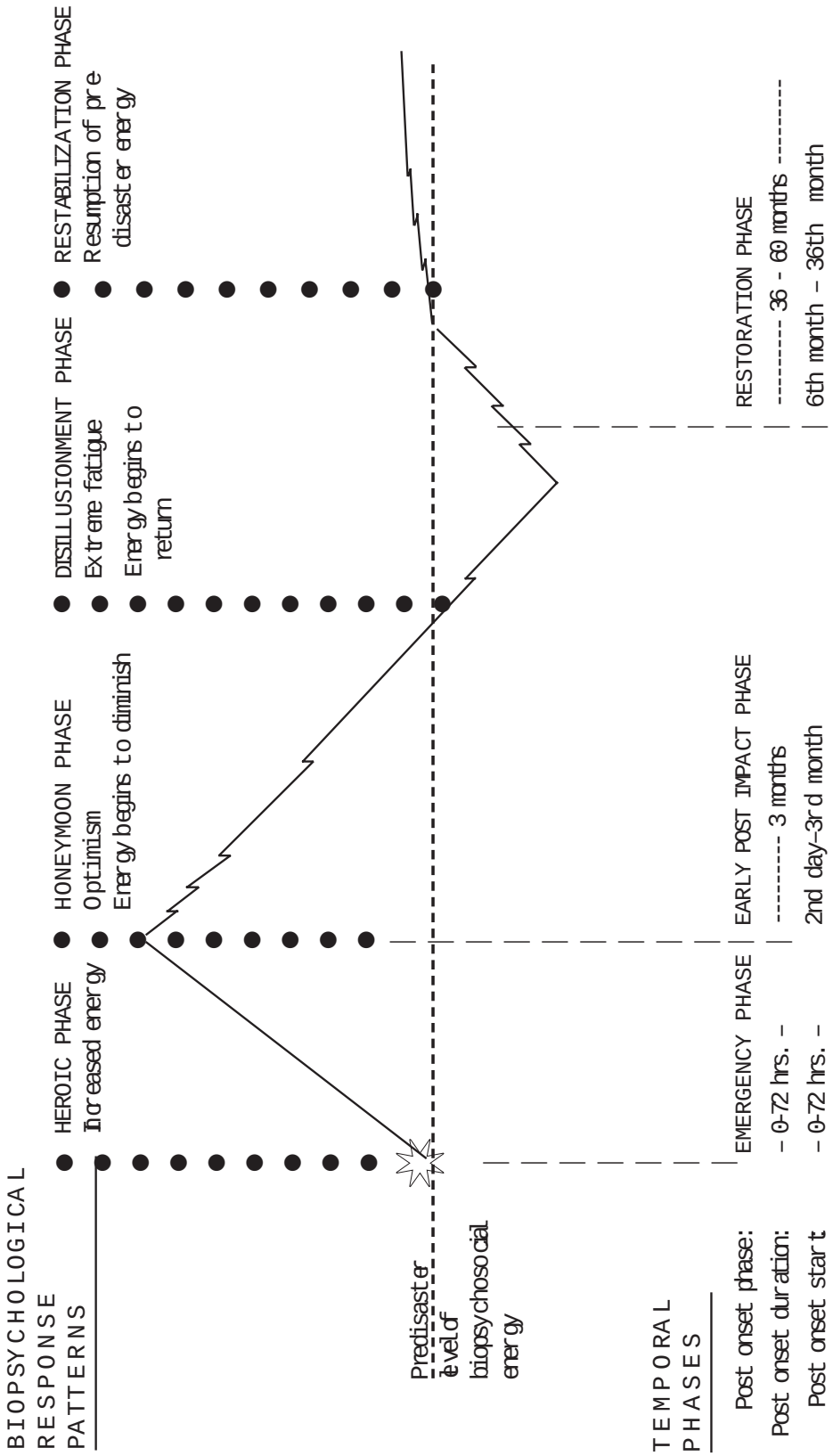
Disillusionment Fatigue, irritating experiences, and the knowledge of all that is required to restore their lives combine to produce disillusionment. Survivors discover that significant financial benefits are in the form of loans, not grants; that home insurance isn't what they understood it to be; that politics, rather than need, shape decisions; that a neighbor with a damaged chimney received greater benefits than a

neighbor whose roof collapsed. Complaints about betrayal, abandonment, lack of justice, bureaucratic red tape and incompetence are ubiquitous. Symptoms related to post-traumatic stress intensify and hope diminishes.

Restabilization The groundwork laid during the previous months begins to produce observable changes. Applications have been approved, loans worked out, and reconstruction begins to take place. "Long-term" disaster-related programs have been established (e.g., Federal Emergency Management Agency crisis-counseling programs for disaster survivors) and a majority of individuals regain their premorbid level of functioning. Again, significant individual variance occurs within this phase. Generally speaking, some individuals are able to regain equilibrium within 6 months. For others it may well take between 18 and 36 months. For some individuals, the first year anniversary of the disaster precipitates or exacerbates post-traumatic stress symptoms. A majority of survivors attribute their increased appreciation of relationships and life and their confidence to manage difficult circumstances to the lessons learned from the disaster.

Figure 1 illustrates the biopsychosocial response pattern and temporal phases of disaster is presented on the following page.

Figure 1. BIOPSYCHOSOCIAL RESPONSE PATTERN AND TEMPORAL PHASES OF DISASTER



EXTREME PERITRAUMATIC STRESS REACTIONS

Extreme "peritraumatic" stress symptoms (i.e., those symptoms which occur during or immediately after the traumatic disaster experience) include any of the following reactions **if** they are of sufficient intensity to cause significant impairment in reality orientation, communication, relationships, recreation and self-care, or work and education:

- **Dissociation** – depersonalization, derealization, fugue states, amnesia
- **Intrusive re-experiencing** – flashbacks, terrifying memories or nightmares, repetitive automatic re-enactment
- **Avoidance** – agoraphobic-like social withdrawal
- **Hyperarousal** – panic episodes, startle reactions, fighting or temper problems
- **Anxiety** – debilitating worry, nervousness, vulnerability or powerlessness
- **Depression** – anhedonia, worthlessness, loss of interest in most activities, awakening early, persistent fatigue, and lack of motivation
- **Problematic substance use** – abuse or dependency, self-medication
- **Psychotic symptoms** – delusions, hallucinations, bizarre thoughts or images, catatonia

People at highest risk for extreme peritraumatic stress include those who experience:

- **Life-threatening** danger, extreme violence, or sudden death of others
- **Extreme loss** or destruction of their homes, normal lives, and community
- **Intense emotional demands** from distraught survivors (e.g., rescue workers, counselors, caregivers)
- **Prior psychiatric or marital/family problems**
- **Prior significant loss** (e.g., death of a loved one in the past year)

Cardena & Spiegel (1993).
Joseph et al. (1994).
Koopman et al. (1994, 1995).
La Greca et al. (1996).
Lonigan et al. (1994).
Schwarz & Kowalski (1991).
Shalev et al. (1993).

People who experience extreme **peritraumatic stress reactions** are at greatest risk for delayed or chronic post-traumatic psychosocial impairments, for example, PTSD and other anxiety disorders, major depression, substance abuse (Cardena & Spiegel, 1993; Joseph et al. 1993; Koopman et al., 1994, 1995; La Greca et al.,1996; Lonigan et al., 1994; Marmar et al., 1996; Schwarz & Kowalski, 1991; Shalev et al., 1996).

Studies noting peritraumatic stress reactions following disaster:

Children: Green et al. (1994); Hardin et al. (1994); La Greca et al. (1996); Lonigan et al. (1994).; Pynoos et al. (1993); Rubonis & Bickman (1991); Vernberg et al. (1996).

Adults: Baum & Fleming (1993); Dohrenwend et al. (1981); Goenijian et al. (1994); Green et al (1990b); Hanson et al. (1995); Palinkas et al. (1992); Rubonis & Bickman (1991); Solomon et al. (1987); Turner et al. (1995); Webster et al. (1995).

Older adults: Goenijian et al. (1994).

ACUTE STRESS DISORDER

A minority of disaster survivors experience sufficiently persistent and debilitating stress and dissociative symptoms to warrant a diagnosis of acute stress disorder (Koopman, Classen, Cardena & Spiegel, 1995; Johnson et al., 1997).

The defining feature of Acute Stress Disorder is the development of anxiety, dissociation, and other symptoms that occur within one month of exposure to a traumatic stressor. Acute Stress Disorder is characterized by five major response patterns: dissociation or a subjective sense of emotional numbing, a re-experiencing of the event, behavioral avoidance, increased physiologic arousal and social-occupational impairment. To meet the DSM-IV diagnostic criteria, a person must exhibit three or more of the dissociative symptoms, and at least one form of re-experiencing, behavioral avoidance, physiologic arousal, and significant social and or occupational impairment. The disturbance must last for a minimum of two days and a maximum of four weeks and occurs within four weeks of the traumatic event.

DSM-IV Diagnostic criteria for Acute Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) the person's response involved intense fears, helplessness, or horror.

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

(1) a subjective sense of numbing, detachment, or absence of emotional responsiveness

(2) a reduction in awareness of his/her surrounding (e.g., "being in a daze")

(3) derealization

(4) depersonalization

(5) dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

C. The traumatic event is persistently re-experienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience, or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g.. thoughts, feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning, or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

H. The disturbance is not due to the direct physiological effects of a substance (e.g.. a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of preexisting Axis I or Axis II disorder.

POST-TRAUMATIC STRESS DISORDER

Post-traumatic stress disorder (PTSD) is a prolonged post-traumatic stress response. In addition, there may be much greater personality and social impairment than evidenced in the common stress reactions survivor's experience following a disaster. The DSM-IV criteria for PTSD require a minimum set of symptoms: one symtomatic form of re-experiencing the traumatic event, a minimum of three symptoms of persistent avoidance of stimuli associated with the trauma, and a minimum of two persistent symptoms of increased arousal. The duration of the disturbance (symptoms in B, C, and D criteria) must be at least one month (Criterion E). In addition, clinically significant distress or impairment in social, occupational, or other important areas of functioning are included (Criterion F). The diagnostic criteria for PTSD is listed below.

DSM-IV Diagnostic criteria for PTSD

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) the person's response involved intense fears, helplessness, or horror.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that

occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g.. unable to have loving feelings)

(7) sense of a foreshortened future (e.g.. does not expect to have a career, marriage, or children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C and D, is more than 1 month).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

DISASTER EXPERIENCES ASSOCIATED WITH CHRONIC PTSD

An important component of disaster mental health response during the early post-impact phase is identification of individuals at risk for long-term problems. Identifying and providing specialized preventive mental health services to high-risk survivors may improve prognosis and conserve scarce healthcare resources needed by the community in the months and years after disaster.

As noted earlier, severe stress reactions during or immediately following disaster occurrence are key warning signs. The research literature suggests that certain types of trauma exposure or post-disaster experiences also place survivors at high-risk for delayed or chronic trauma-related psychological problems.

- **Survivors/witnesses of mass destruction or death** (e.g., body handling; "ethnic cleansing;" torture) are at high risk for demoralization and post-traumatic psychosocial impairment.

  Goenjian et al. (1994); Ramsay et al. (1994); Ursano et al. (1995).

- **Unresolved bereavement** places survivors at high-risk for chronic post-traumatic psychosocial impairment.

  Livingston et al. (1994); Green et al. (1983); Joseph et al. (1994); Shore et al. (1986).

- **Loss of home or community** and associated emotional support places survivors at high risk for chronic bereavement and post-traumatic psychosocial impairment.

  Bland et al. (1996); Erikson (1976); Freedy et al. (1992); Keane et al. (1994); Lima et al. (1993); Lonigan et al. (1994); Palinkas et al. (1992); Phifer & Norris (1989); Quarantelli et al. (1986); Solomon et al. (1993); Shore et al. (1986); Vernberg et al. (1996).

- **Survivors with histories of prior exposure to trauma** are at high risk for post-traumatic psychosocial impairment.

  Bland et al. (1996); Goenjian et al. (1994); Hodgkinson & Shepherd, (1994).

- **Survivors who experience major life stressors** (e.g., divorce, job loss, financial losses) after experiencing a disaster are at high risk for post-traumatic psychosocial impairment.

  Bland et al. (1996; Garrison et al. (1995); Hardin et al. (1994); Joseph et al. (1994); Koopman et al. (1994); La Greca et al. (1996).

- **Survivors of toxic contamination** disasters are at risk for chronic strain due to a loss of fundamental sense of personal integrity and trust and a concomitant fear of uncontrollable and invisible physical deterioration.

  Baum & Fleming (1993); Dohrenwend et al. (1981); Hodgkinson (1989); Lopez-Ibor (1987).

OTHER FACTORS ASSOCIATED WITH CHRONIC PTSD

In addition, the literature suggests that risk for delayed or chronic problems following disaster is associated with survivor social support, coping style, and occupation.

- **Low levels of emotional/social support or high levels of social demand**

  [Children] La Greca et al. (1996); Vernberg et al. (1996).
  [Caregivers or Single Parents] Solomon et al. (1987), (1993).

- **Coping via avoidance, self-blame, or rumination**

  Hodgkinson & Shepherd (1994); Nolen-Hoeksema & Morrow (1991); La Greca et al. (1996); Norvell et al. (1993); Titchener et al. (1986); Vernberg et al. (1996); Webster et al. (1995).
  However: maladaptive patterns of coping may be the result rather than cause of post-traumatic stress impairment (Vernberg et al. 1996).

- **Coping via substance abuse**

  Joseph et al. (1993).

- **Serving as an emergency worker** (e.g., police, fire, EMT, healthcare professionals).

  Bartone et al. (1989); Hodgkinson & Shepherd (1994); Holen (1993); Lundin & Godegard (1993); Marmar et al. (1996); McFarlane (1988a).

In families, there appears to be a reciprocal relationship between the acute stress response of caregiver and child, that each individual's stress response amplifies the other's – placing both child and adult at risk for longer term problems.

- **Children whose parents are persistently psychologically impaired.**

  Green et al. (1991); McFarlane et al. (1987).

- **Children whose parents experience significant peritraumatic distress.**

  Earls et al. (1988); Handford et al. (1986); McFarlane et al. (1987); Milgram & Milgram (1976) .

PREVALENCE OF PTSD FOLLOWING DISASTER

Natural Disasters

Within United States

Buffalo Creek Disaster	Lifetime PTSD	59%
Green et al., 1992.	PTSD at 14 yr follow-up	25%
	PTSD in children	37%
Mt. St. Helens Volcanic Eruption	PTSD in exposed sample	3.6%
Shore et al., 1989.	PTSD among non-exposed	2.6%
Tornado	PTSD	2-21%
Smith et al., 1993 (2%); Steinglass & Gerrity, 1990 (21%).		
Madakasira & O'Brien, 1987 (59%).	Post-traumatic Stress Impairment	59%
Tornado and Flood	PTSD at 4 mos	15%
Steinglass & Gerrity, 1990.	PTSD at 16 mos	21%
Blizzard and Flood	Post-traumatic Stress Impairment in children at 10 mos	60%
Burke et al., 1986.		
Flood	PTSD	4%
Smith et al., 1993.		
Hurricane	PTSD in children at 2-12 months	5-56%
LaGreca et al., 1996 (18-54%); Shannon et al., 1994 (5%); Shaw et al., 1995 (39-56%).		

Outside United States

Bushfire	PTSD	16%
McFarlane, 1987, 1988.	PTSD in children	33%
Flood and Mudslides	PTSD in exposed sample	4%
Bravo et al., 1990; Canino et al., 1990.	PTSD among non-exposed	0.7%
Volcanic Eruption	Post-traumatic Stress Impairment	32-42%
Lima, Pai, Caris, et al., 1981; Lima, Pai, Santacruz, & Lozano, 1991.		
Earthquake	Post-traumatic Stress Impairment	32-60%
	PTSD in children	26-95%
Conyer et al., 1987 (32%); Goenjian et al., 1994 (10-68%), 1995 (26-95%); McFarlane & Hua, 1993 (46-60%).		
Cyclone	Post-traumatic Stress Impairment	23-100%
	PTSD	8%
Parker, 1977 (100%); Patrick & Patrick, 1981 (23%); Fairley, 1984 (8%).		

Human-Made Disasters

Technological Disaster	PTSD	7-50%
Palinkas et al., 1993 (9%); Realmuto et al., 1991 (13%); Silverman et al., 1985 (50%); Smith et al., 1993 (7%).		
	Post-traumatic Stress Impairment	22-43%
Haavenar et al., 1996 (36%); Weisaeth, 1989a (24%); Baum & Fleming, 1993 (22-43%).		
Major Fire	Post-traumatic Stress Impairment	54-66%
	PTSD in burned survivors	100%
Adler, 1943 (54%); Green et al., 1983 (58%); Turner et al., 1993 (66-100%).		
Transportation Disasters	PTSD	29-100%
Marks et al., 1995 (100); Newman & Foreman, 1987 (50-100); Smith et al., 1993 (29%).		
	PTSD in children	40-47%
Martini et al., 1990 (40%) Yule, 1992 (47%).		
Terrorist Kidnapping and Torture	PTSD	54%
Weisaeth, 1989b.		
Mass Shooting	PTSD	5%
Pynoos et al., 1987; Smith et al., 1993.	PTSD in children	5-47%
Rescue Workers (Industrial Accident)	Post-traumatic Stress Reactions	24%
Weisaeth, 1989c.		
Civil and Political Violence	Post-traumatic Stress Reactions	82-92%
Goenjian et al., 1994.		

Section III – Helping The Helpers

Rescuing and aiding survivors, and the tasks of body recovery, identification, and transport are but a few of the stressors that contribute to high levels of emotional distress among disaster workers (Uranso, R.J., McCaughey, B.G., & Fullerton, C.S. 1994). The task of mitigating disaster worker stress is a vital component of emergency service operations and may be organized as an ongoing process of prevention, early on-site intervention, and immediate follow-up. Interventions may be in the form of training, consultation, defusing, debriefing, or crisis counseling.

Disaster mental health work with helpers requires a broad clinical background and specific knowledge of stress reactions, post-traumatic stress disorder, crisis intervention, the nature of emergency work, stress management, and other intervention protocols appropriate to the disaster environment. Mitchell and Dyregrov (1993) suggest that the "wrong type of help provided by the wrong mental health professionals at the wrong time or under the wrong circumstances can be more damaging than no help at all."

STRESSORS ASSOCIATED WITH DISASTER WORK

Generally, disaster work is a combination of negative and positive experiences. Experiences may involve profound feelings of grief, despair, helplessness, horror and repulsion. On the other hand, the experience of sharing common goals and purpose, of social bonding, and other experiences that renew professional and renewed personal convictions or re-evaluation of life priorities also make disaster work very rewarding.

Occupational hazards of rescue work and workers' personal situation / stressors account for the majority of stress reactions.

Occupational Hazards

- Exposure to unpredictable physical danger
- Encounter with violent death and human remains
- Encounter with suffering of others
- Negative perception of cause of the disaster
- Negative perception of assistance offered victims
- Long hours, erratic work schedules, extreme fatigue
- Cross cultural differences between workers and community
- Inter-agency / intra-organizational struggles over authority
- Equipment failure and perception of low-control
- Lack of adequate housing
- Encounter with mass death
- Encounter with death of children
- Role ambiguity
- Difficult choices
- Communication breakdowns
- Low funding / allocation of resources
- Negative perception by community
- Weather conditions
- Over-identification with victims
- Human errors
- Time pressures
- Perceived mission failure

Personal Situation/Stressors

- Personal injury
- Injury or fatality of loved ones, friends, associates
- Property loss
- Pre-existing stress
- Low level of personal and professional preparedness
- Stress reactions of significant others
- Proximity to scene of impact
- Self-expectations
- Prior disaster experience
- Negative perception / interpretation of event
- Low level of social support
- Previous traumatization

STRESS REACTIONS OF DISASTER WORKERS

Stress reactions in disaster workers are normal and to be expected. Even experienced workers never fully become desensitized to exposure to mass violent death and they remain particularly vulnerable when victims include children. Stress reactions may result in psychic numbing, short-term impairment of memory, problem-solving abilities, and communication. Long-term stress reactions may include depression, chronic anxiety, or symptoms resulting from vicarious traumatization (re-experiencing, psychic numbing/behavioral avoidance, physiological arousal), and they may cause or exacerbate marital, vocational, or substance problems.

Common Stress Reactions of Disaster Workers

Emotional
- shock
- anger
- disbelief
- terror
- guilt
- grief
- irritability
- helplessness
- despair
- loss of pleasure from regular activities
- dissociation

Cognitive
- impaired concentration
- confusion
- distortion
- intrusive thoughts
- decreased self-esteem
- decreased self-efficacy
- self-blame

Biological
- fatigue
- insomnia
- sleep disturbance
- hyperarousal
- somatic complaints
- impaired immune response
- headaches
- gastrointestinal problems
- decreased appetite
- decreased libido
- startle response

Psychosocial
- alienation
- social withdrawal
- increased stress within relationships
- substance abuse
- vocational impairment

It is recommended that disaster mental health services for workers be pre-arranged with their purpose and protocols understood and accepted by command staff and team managers. Generally, on-scene mental health support is delivered through consultation, defusing, debriefing, or crisis intervention services. These services may be informal or systematic, and may be conducted individually or with a group in a quiet setting away from (but not too far) from the disaster scene. The goals of these interventions are to:

- Consult with team managers and line workers regarding information about stress reactions and stress management strategies
- Facilitate enhanced group cohesion and peer support
- Provide opportunities for emotional disclosure and cognitive reframing
- Identify and reinforce resiliency and positive coping styles
- Mitigate long-term stress reactions (PTSD)
- Improve readiness for future operations

TYPES OF EMERGENCY WORKERS

Emergency workers may be members of highly trained teams, victims trying to help those who have been more seriously affected, or bystanders. Many types of helpers respond to emergencies:

- Search and rescue workers
- Fire and safety workers
- Transport drivers
- Medical personnel and paramedics (EMTs)
- Medical examiner and staff
- Police, security, and investigators
- Clergy
- Mental health and social service personnel
- Elected officials
- Volunteers who staff shelters, provide mass care, assess and repair the infrastructure
- Media professionals

THE RESCUE WORK CULTURE

The culture among rescue workers combines shared values and individual differences. Myers (1987) noted that emergency service workers often seem to possess contrasting personality traits:

- Gentleness
- Trust
- High self-confidence
- Dependence
- Toughness
- Great strength
- Caution
- High self-criticism
- Independence
- Sensitivity

For example, whereas emergency workers often have a high capacity for trust among each other, they tend to be cautious about the competencies of individuals perceived as outsiders; rescue workers may demonstrate mental and emotional resilience during an operation, but have intense emotional reactions afterwards because of their sensitivity to the feelings of survivors and their families. If mental health workers tactfully acknowledge these polarities, it may serve to achieve the confidence of rescue workers while increasing their willingness to disclose feelings of vulnerability or self-criticism, and receive emotional support.

How rescue workers cope depends on several variables. The circumstances of the disaster, preparedness, pre-existing team / organizational stressors, and pre-existing personal stressors are all key factors. Generally speaking, many disaster workers appear to favor coping responses that take problem-solving action or use logical analysis to understand work-related stressors. Some workers value and benefit from solitude while others seek the company of others. Some are more comfortable talking with an unknown professional, others prefer to talk with a few trusted individuals. Given the short amount of time that mental health clinicians have contact with disaster workers, it is difficult to assess the effectiveness of these individual coping processes. However, the process of defusing can provide useful information to guide mental health workers in their efforts to help the helpers.

Guidelines to Consulting with Command Staff and Rescue Team Managers at the Scene of Operations

A cornerstone of the effectiveness of mental health support at the scene of operations is establishing rapport between the mental health team and the command staff, rescue team managers, and workers. Knowing intervention protocols is not enough to be effective. As Alexander (1993) points out, when offering help to members of well organized professional groups, the helpers themselves must be well organized and professional. The mental health team can expect to encounter ambivalent feelings about their role and view this as a natural reaction by people who are in the midst of an extraordinarily challenging situation. Understanding the stressors associated with rescue work and the rescue work culture can facilitate alliance building. An early presence can also foster becoming an integral member of the response operations team.

Consulting Phases

1. **Initial entry and contact:** Introductions, inquiries about the incident commander's or team manager's expectations of mental health services, and a description of mental health services.
2. **Information gathering:** Assessment of services needed. Speaking with "key informants," observing environment and worker behavior in break areas.
3. **Feedback and the decision to intervene:** In giving feedback to incident commanders or team managers, respond to resistance through collaborative planning of objectives.
4. **Implementation:** Administration of interventions.
5. **Termination:** Evaluation of interventions and recommendations, if any, for further services.

Pragmatic Suggestions for Managers

The following suggestions for team managers are adapted from the Community emergency response team: Participant handbook and prevention and control of stress among emergency workers: A pamphlet for team managers (FEMA, 1994).

- Rotate personnel to allow breaks away from the incident area
- Provide break area, back-up clothing, nutritious food and the time to eat properly
- Rotate teams and encourage teams to share with one another
- Phase out workers gradually from high-to medium-to-low stress areas
- Provide defusings for all workers as they go off duty or take breaks

Disaster mental health consultants can best assist emergency team managers in utilizing these stress management interventions in the context of an ongoing low-key observer and advisor role. Workers and team managers will be most likely to accept these suggestions if they come to perceive the consultant as an ex-officio helper for their team, not as a detached professional "outsider."

As an unobtrusive consultant, the disaster mental health provider is positioned to provide crisis intervention in rare cases of severe adverse reactions by workers. The decision whether a worker can return to the job, be transferred to less distressing tasks, or be released from work must be made judiciously, with sufficient information about the worker's capability to satisfactorily perform rescue duties, mental status (severity of stress reactions), and the availability of organizational and social support.

DEFUSING INTERVENTIONS

Defusing refers to a process intended to facilitate opportunities for rescue workers to express their thoughts and feelings about the rescue tasks at hand without feeling obligated to do so. It is vital that mental health workers distinguish the process of facilitating voluntary emotional ventilation from a process that may be misperceived (e.g., "voyeuristic" probing).

If rapport is established, other topics related to personal and occupational stressors may be interjected.

Helpful questions:

- "What are you from?"
- "What rescue tasks are you involved with?"
- "What is it about this situation that concerns you the most?"
- "How do you handle what's going on?"
- "How is this the same or different from other operations you've been involved with?"

Defusing gives rescue workers the opportunity to better understand their own reactions and allows mental health workers to look for indications of workers who may be at risk for long-term stress reactions. Unlike the time needed to conduct debriefings (2-4 hours), defusings can be brief (10-30 minutes) and offered continuously throughout the operation. "Aggressive hanging out," that is, finding ways to be in the vicinity of workers on breaks, is often a means to conduct informal defusings. (See page 40 for guide to defusing.)

Photo by Donna Hastings

Topics for Defusing with Disaster Workers

- Exposure to unpredictable physical danger
- Encounter with human remains
- Stress reactions of significant others
- Encounter with suffering of others
- Perception of cause of the disaster
- Perception of assistance offered victims
- Long hours, erratic work schedules, extreme fatigue
- Cross-cultural differences between workers & community
- Inter / intra agency struggles over authority
- Time pressures
- Lack of adequate housing
- Equipment failure and perception of control
- Personal injury
- Injury or fatality of loved ones, friends, associates
- Self-expectations
- Level of personal and professional preparedness
- Property loss
- Pre-existing stress
- Encounter with mass death
- Encounter with death of children
- Role ambiguity
- Difficult choices
- Communication breakdowns
- Low funding / allocation of resources
- Perception by community
- Weather conditions
- Over-identification with victims
- Human errors
- Perceived mission failure
- Proximity to scene of impact
- Prior disaster experience
- Level of social support
- Previous traumatization

TEACHING RELAXATION TECHNIQUES TO DISASTER WORKERS

Disasters workers have a deep commitment to working long hours without breaks and may quickly dismiss suggestions about using time to relax. The following guidelines are suggested to help mental health professionals establish rapport with disaster workers and to encourage them to consider stress-management strategies.

Guidelines:

1. Inquire about how long they have been on the job and about previous disaster experience.
2. Inquire about how coping styles (how he/she see their fellow workers coping, what he/she typically does to relax).
3. Inquire about unexpected stressors.
4. Inquire about sleeping patterns and level of fatigue.
5. Provide rationale for relaxation, first validating fatigue and its effects. Discuss disaster workers' general vulnerabilities (e.g., inability to stop working or thinking about the disaster).
6. Begin instruction and demonstration of techniques (e.g., muscle relaxation, conscious breathing, autogenics, visualization, etc.). Remember, the circumstances and settings that you will be teaching in are, more often than not, far from ideal. You may have from five to fifteen minutes to demonstrate the value of relaxation. The challenge is to efficiently facilitate the experience of relaxation in the midst of chaotic environments.
7. When possible, have handouts available that describe the techniques.

Sample script to use with a disaster worker

"You're working 15 hours a day, and its your second week here. I know you gotta be getting a bit tired. You're experienced and I know you know about burn-out and being here for the long haul. It sounds like the only break you get is when you hit the sack. I'd like to show you some simple, quick, and proven relaxation techniques that you can use on your own a few minutes each day to help you get some mini-breaks."

DEBRIEFING RESCUE WORKERS

Originally developed by Jeffrey Mitchell (1983) to mitigate the stress among emergency first responders, critical incident stress debriefing (CISD) is now a widely used protocol with victims and providers of all kinds (e.g., teachers, clergy, administrative personnel) in a wide range of settings (e.g., schools, churches, community centers).

Debriefing has become a generic term applied to a structured process that helps workers understand and manage intense emotions, further understand effective coping strategies, and receive the support of peers. Two types of protocols are commonly used: an initial debriefing protocol and a follow-up debriefing protocol. The rationale for this process is that providing early intervention, involving opportunities for catharsis and to verbalize trauma, structure, group support, and peer support are therapeutic factors leading to stress mitigation (Everly & Mitchell, 1992).

Case reports and anecdotal evidence about debriefing emergency workers suggest that the process may lead to symptom mitigation, however, there has not been rigorous controlled investigation to date. CISD may provide some immediate opportunities for rescue workers to talk with one another, but it is unlikely to be effective as the sole intervention for complex problems that are the result of stress reactions to the operation, pre-existing stress, or various organizational stressors. In such cases, additional individual assessment is recommended.

Initial Debriefing Protocol (IDP)[6]

The protocol for an initial debriefing (IDP) generally consists of eight steps:

1. Preparation
2. Introduction
3. Fact phase
4. Thought phase
5. Reaction phase
6. Symptom phase
7. Teaching phase
8. Re-entry phase

Depending on the emergency service roles of workers, time allotted for the debriefing, and the number of workers in attendance, debriefers will necessarily have to evaluate how much time to spend on each phase and whether or not each worker will have equal time to speak.

1. **Preparation:**

   - Make necessary arrangements with incident commander or rescue team managers and obtain information about the conditions of the rescue operation and if there are particular concerns about individual workers.

[6] IDP Model developed by Bruce H. Young

- Try to limit each debriefing group to 8-10 workers, but anticipate as many as 20-30 workers. The greater the number of workers attending, the less time each person has to actively participate. Advise that attendance be mandatory, but active participation during the debriefing be voluntary. The rationale given for mandatory attendance is that it reduces the stigma of attending and increases the potential for support among team members. Those who choose to solely listen can benefit from hearing peer experiences and receiving information about stress reactions and stress management strategies.
- The number of debriefings that workers should attend is best guided by the length and conditions of the rescue operations and the degree of worker exposure to traumatic stimuli. If conditions allow only one debriefing to take place, it may be preferable to schedule it as an "exit" debriefing; however, there is no empirical evidence to support this suggestion.
- Arrange to work with a co-debriefer and discuss respective roles.
- Arrange for a private quiet room for 2 to 4 hours.
- Those in attendance should not be on call. Have educational / referral handouts ready.
- Schedule time for post debriefing discussion with co-debriefer.

2. **Introduction:**

Debriefers begin with self-introductions, including brief description of disaster mental health experience, the purpose of debriefing (clarifying that debriefing is not a critique of how they have responded, nor a critique of agency operations and that it is not a "fitness for duty evaluation"). Explain that debriefing is an opportunity to talk about personal impressions of the recent experience, learn about stress reactions, and stress management strategies and that it is not psychotherapy. (See sample script, page 48.)

- **Review confidentiality:** Personal disclosures are to be held in strict confidence by the group. Educational information may be shared outside the group. Inform attendees about mental health professionals' limits to confidentiality and the duty to report .
- **Explain group rules:** Inform attendees that no one is required to talk, but participation is encouraged. Agree on length of time. Inform attendees that everyone must stay

until the end and that there will be no breaks. Advise that notes are not to be taken. Ask if anyone cannot meet these requirements and reconcile accordingly.

- **Facilitate participant introductions:** Depending upon the number of workers in attendance, worker introductions may include name, role, hometown or vicinity, and whether or not there has been previous experience with debriefing.

3. **Fact phase:**

Depending on the number of workers in attendance, the next phase of the debriefing is asking participant/volunteers to describe from their own perspective what happened, where they were, what they did, and what they experienced sensorily (perception of sights, smells, sounds). If there more than 12 workers in attendance, it may be necessary to limit 6-10 volunteers to share their descriptions.

Helpful questions:

"What role did you have in the rescue operation?"

"What happened from your point of view?"

"What do you remember seeing, smelling, hearing?"

"Was there anything anyone said to you that stands out in your memory?"

4. **Thought phase:**

In this phase, workers are asked to describe their cognitive reactions or thoughts about their experience. In many instances, there are several events within the entirety of the rescue experience that make a memorable impact. Target most prominent thoughts. If there are more than 12 workers in attendance the debriefer may ask each worker to recall their thoughts about the one event that "is the one thing you constantly think about."

Helpful questions:

"What were your first thoughts when you heard about the disaster?"

"What were your first thoughts when you learned you would be involved in the rescue operations?"

"What were your first thoughts when you first arrived at the scene?"

"What are your thoughts now that the operation is over?"

"What thoughts will you carry with you?"

During the course of descriptions, debriefers may interject to ask if other workers had similar thoughts. The intent, of course, is to universalize and normalize common cognitive reactions.

Helpful questions:

"What was the most difficult or hardest thing about this (event) for you?"

"How did you feel when that happened?"

"What other strong feelings did you experience?"

"How have you been feeling since your part of the operation finished?"

"How are you feeling now?"

5. **Reaction phase:**

In this phase, workers are encouraged to discuss the emotions they experienced during the course of the operations.

During the course of descriptions, debriefers may interject to ask if other workers had similar feelings. As in the thought phase, the intent is to universalize and normalize common reactions.

6. **Symptom (stress reaction) phase:**

In this phase, workers stress reactions are reviewed in the context of what they experienced at the scene, what stress reactions have lingered, and what they are experiencing in the present. Help participants recognize the various forms of stress reactions avoiding pathological terminology.

7. **Teaching phase:**

Teaching, in actuality, occurs throughout the process of debriefing. As debriefing becomes a more common intervention, workers are increasingly understanding the effects of stress. Debriefers must assess what workers know and don't know and ensure that they have accurate information about stress reactions and stress management strategies. Topics may include:

Common stress reactions in disaster workers:

- Emotional:
  Shock, anger, disbelief, terror, guilt, grief, irritability, helplessness, anhedonia, regression to earlier developmental phase.
- Cognitive:
  Impaired concentration, confusion, distortion, self-blame, intrusive thoughts, decreased self-esteem/efficacy.
- Biological:
  Fatigue, insomnia, nightmares, hyperarousal, somatic complaints, startle response.
- Psychosocial:
  Alienation, social withdrawal, increased stress within relationships, substance abuse, vocational impairment.

A. **Defining traumatic stress**

Quantitative and qualitative dimensions (DSM-IV criterion A; sensory exposure; phenomenology of loss – loved ones, property, perceived control, and meaning)

B. **Common stress reactions**

1. Emotional (shock, anger, disbelief, terror, guilt, grief, irritability, helplessness, regression to earlier developmental phase).
2. Cognitive (impaired concentration, confusion, distortion, self-blame, intrusive thoughts, decreased self-esteem / efficacy).
3. Biological (fatigue, insomnia, nightmares, hyperarousal, somatic complaints, startle response).
4. Psychosocial (alienation, social withdrawal, increased stress within relationships, substance abuse, vocational impairment).

C. **Factors associated with adaptation to trauma**

1. Degree of sensory exposure (severity, frequency, and duration).
2. Perceived and actual safety of family members / significant others.
3. Characteristics of recovery environment (existence, access, and utilization of social support).
4. Perceived level of preparedness.
5. Pre-disaster level of psychosocial functioning (coping efforts).
6. Pre-disaster level of psychosocial stress (vulnerability / resilience).
7. Interrelationship among factors of personal history, developmental history, belief system, and current and past stress reactions including previous exposure to trauma (war, assault, accidents).

D. **Self-care and stress management**

1. Relationship between behavior and stress (exercise, eating habits, exercise, receiving and giving social support, relaxation techniques – excessive and deficient behaviors).
2. Self-awareness of emotional experience and selected self-disclosure.
3. Stress-related disorders (PTSD; disorders which may be exacerbated by stress).
4. Parenting guidelines (how to enhance children's coping).
5. Disaster preparedness.
6. Characteristics of the disaster environment (phases of disaster).
7. When and where to seek professional help.

8. **Re-entry phase:**

The final phase of the debriefing is allotted to discussing unfinished issues, reactions to the debriefing, a summation of the debriefing, and the referral process. When possible, a follow-up debriefing should be schedule to take place within two weeks. The protocol for follow-up debriefings is described on the following page.

Debriefers should remain available after the debriefing to allow anyone in attendance to meet with the debriefers privately.

Large Groups Debriefing Protocol

Occasionally, circumstances require that you provide a "debriefing" to a large number of workers and adjustments to the formal debriefing protocol are necessary. The protocol for large group debriefing involves a modification of the process and content of the eight steps used in formal debriefings. The objective of these debriefings is to provide information about common reactions disaster work, useful stress management strategies, signs that suggest individual help may be beneficial, and where to get additional information or help. Even though not everyone will be able to participate, encourage participation and interaction and relate the material to their experiences.

Follow-up Debriefing Protocol

A follow-up debriefing should be held when circumstances allow, 10-14 days after the initial debriefing. A third debriefing is recommended 3 months later. Mitchell and Dyregrov (1993) recommend the following four questions for discussion:

- "How are things since the debriefing?"
- "Is anyone stuck on any particular part of the incident?"
- "How have things been on your own (or-off duty time)? "
- "What else do you feel you might need to get you past this particularly bad event?"

Additional questions for discussion:

- "What, if any, changes have you noticed in your work habits since the disaster?"
- "How has the disaster affected your personal relationships?"
- "What stress management strategies have you used?"
- "Which stress management techniques work for you?"
- "Which ones don't?"
- "Has this experience resulted in any positive changes in your professional or personal life?"

Section IV – Helping Organizations

When disasters occur, new economic, political, and personnel issues challenge organizations to make considerable adjustments. Routine procedures and resources are not enough to manage the situation. The post-disaster actions of management can contribute significantly to the mitigation of work performance problems and psychological distress.

Knowing disaster stress management protocols for individuals is insufficient to be an effective disaster mental health consultant to organizations. As with any form of organizational change, there is apt to be ambivalence, if not resistance, to changes recommended by outside consultants. Though crisis can result in the need for change, resistance is greater when individuals who have recently experienced a loss of control are being asked to consider or make changes, as is the case following a disaster.

Providing consultation to administrators of large organizations requires that consultants themselves be well organized and professional. Offering a clear strategy for intervention that is amenable to modification after organizational assessment and consultation with key decision-makers can facilitate alliance building and serve to limit resistance.

Photo courtesy of Chuck Revell

FIVE KEY STEPS TO ORGANIZATIONAL DISASTER MENTAL HEALTH CONSULTING

Initial entry and contact

Determine the most appropriate official to consult. Initial contact should include:

- introductions (description of consultant's background)
- consultant's inquiries about perceived organizational needs
- administrator's expectations of mental health services
- consultant's description of potential mental health services
- mutually agreed upon plan about how to get started

Information gathering

Conduct assessment of need for services. Interview and speak with various level department chiefs and other key informants. Consider the use of formal assessment instruments.

Feedback and the decision to intervene

Provide a well organized presentation of information gathered. Manage resistance to change by demonstrating appropriate empathy concerning the inordinate stress on the organization and its personnel and by focusing on maintaining a collaborative planning relationship. The organization bears the ultimate responsibility for disaster mental health interventions and has the ultimate authority for deciding what will be implemented; however, it is the responsibility of the disaster consultant to ensure that interventions do not compromise recognized standard professional practice.

Implementation

Interventions should have written procedures which include: clear job/role descriptions of disaster mental health staff, crisis management, liability, and a clear timeline. Keep accurate records of numbers of people seen, problems they were experiencing, and types of interventions delivered.

Termination

Evaluate interventions. Make recommendations, if any, for future services. Revise disaster plan, policies, procedures accordingly.

Organizational Stressors Associated with Disaster

1. Routine workload requires continued attention while role conflict and discomfort increase as a result of new and competing demands.
2. Routine management procedures are ruptured and tolerance among departments and personnel often decrease as stress, role conflict, and extreme fatigue set in.
3. Relationships with county, state, federal, and non-profit organizations are altered.
4. Limited credit may be given if emergencies are handled effectively; harsh judgments may increase if handled emergencies are poorly.
5. Increased media scrutiny of procedures.
6. Increased scapegoating as personnel seek to relieve anxiety.
7. Actual or perceived decreased safety, increased management demands for flexibility, and other disaster-precipitated stress result in staff having less tolerance for ambiguity and may result in their questioning their allegiance to the organization and the value of their job.
8. Disruption and increased stress results in a decrease in managers' ability to see the "big picture."

Organizational Response Plan

Though each organization may have its unique structure, cultural mores, and set of needs, disaster mental health consultants should consider each of the following elements in designing the organization's response plan:

Provide Outreach

Address Personnel Problems

Screen At-Risk Staff

Provide Managerial Support

Staff Recognition

Offer Services

1. Provide outreach to staff: Personnel who are disaster victims commonly do not seek mental health assistance. Create a marketing campaign to prevent the stigma of seeking assistance or participating in activities offered (e.g., "support services for normal reactions to abnormal situation").
2. Expect and prepare to address an increase in personnel problems related to substance abuse, marital and family dysfunction, and financial concerns.
3. Offer screening for staff who are primary, secondary, or tertiary victims if they meet at least one of the following criteria:
   - Their work area has been relocated because of property damage
   - They are new hires or are new in their positions
   - They have pre-existing health and / or psychological issues

4. Encourage managers to know the impact of the disaster on their staff in order to provide effective support:
   - Do employees have specific safety concerns?
   - Are there employees with injured relatives?
   - Are there employees who have had to relocate residence?
   - Is there in increase in on-the-job accidents?
   - Is there greater tension among employees or departments?
   - How significant is the change in work productivity?

5. Recommend formal recognition of staff for their contributions to the disaster effort, including those who stayed behind to "mind the store."

6. Offer a wide-range of services:
   - Assist in establishing sources of information for organization: newsletters, bulletin boards, briefings by administrators, brochures about resources, etc.
   - Large and small group educational presentations on mental health reactions of adults and children to disaster, self-help stress management suggestions, and where to call for additional help
   - Distribute brochures addressing mental health reactions of adults and children to disaster, self-help stress management suggestions, and where to call for additional help
   - Debriefings for small work units
   - Individual assessment and referral
   - Brief individual counseling (1-10 sessions) and referral
   - Stress management programs (e.g., child care, recreation, exercise, support groups, debriefing groups)

PRE-DISASTER ORGANIZATION PREPAREDNESS

All organizations can benefit from analyzing potential crisis situations. Preparedness can include strategies to manage worst case scenarios, including the potential effects of fatalities, employees unable to get to work, and damaged facilities. Though it isn't possible to fully prepare for the numerous types of disaster many aspects of managing a crisis can be anticipated (Kutner, 1996). Regardless of the type of the disaster, management will have to deal with the media, address productivity, work with insurance companies, handle security issues, and mitigate the psychological distress of employees.

Preparedness Plan

Kutner (1996) suggests that a preparedness plan include at least the following:

- Formal crisis communications procedures for addressing employees (including off-site workers), the media, community groups, and government agencies
- Security procedures to ensure safety of employees and property throughout the crisis and recovery stages
- Procedures to develop relationships with local law enforcement, fire fighting, emergency medical and related government agencies
- Procedures to address and monitor post-traumatic stress in the aftermath of the disaster
- Procedures to manage department or operations shutdowns, employee job reassignments, layoffs, or leaves of absence
- Legal counsel review of communications and employee relations policies

Establishing Disaster Mental Health Services

1. Establish a Disaster Mental Health Preparedness Committee.
2. Committee membership should represent administrative, environmental, allied mental health, and community relations interests.
3. Establish an emergency management organization chart.
4. Establish objectives of disaster mental health services.
5. Establish procedures for emergency response.
6. Incorporate procedures into organization's overall disaster plan.
7. Develop memorandum of understanding between the organization and other key agencies within the community (e.g., Red Cross, local mental health).
8. Hire outside disaster consultant for planning and support of administration during course of disaster.
9. Train mental health staff in disaster mental health plan, roles, responsibilities (see Team Formation and Development section).
10. Have education materials pre-assembled for distribution.
11. Schedule regular mock exercises with outside review.
12. Review and update Emergency Plan regularly (including evaluation of resources and what might hinder implementation).

Section V – Disaster Mental Health Services Team and Program Development

Disaster mental health teams take two basic forms.

Standing teams are formed before or shortly after disaster occurs (i.e., by agencies such as community mental health centers or the Department of Veterans Affairs; or by mental health and emergency service practitioners).

Ad hoc teams are formed at disaster sites, often joining together several standing teams to provide a coordinated response. In this section, we outline the basic considerations in forming and operating a standing disaster mental health team.

TEAM FORMATION AND SELECTION

Staffing Roles

1. Disaster Team Leader – responsible for administrative management of operating procedures including fiscal mechanisms, mobilization procedures, inter / intra agency relations, and staff development / training
2. Direct Service Providers – multidisciplinary team:
   a) Field Coordinator(s);
   b) First Responders;
   c) Back-up teams.
3. Ad hoc Secretarial Support.
4 Program Analyst / Researcher.

Direct Service Provider Selection Considerations

Candidates seeking to become a member of the disaster mental health team should have the following qualifications:

1. Possess a mental health clinical license.
2. Be available for service on "hours to days" notice for 10-14 day assignment.
3. Have letters of reference indicating that the candidate has:
   a) A high tolerance for difficult working conditions which may include:
      - long hours
      - substandard lodging, primitive facilities
      - unstructured or ambiguous situations
      - intense political competition
      - rapid change;
   b) Ability to establish rapport with people of various ages,

ethnicity, and social, economic, and educational backgrounds;

c) Training and experience in emergency mental health debriefing methods;

d) Organizational "savvy" and political sensitivity;

e) Ability to give educational group presentations to survivors, helpers, community groups;

f) Training as a disaster mental health volunteer with the American Red Cross.

STAFF TRAINING

All members of a disaster mental health team require specialized training because many of the intervention skills needed differ from those used in traditional outpatient or inpatient clinical work.

Although training cannot fully prepare disaster workers for the impact of disaster stressors (Hodgkinson & Shepherd, 1994; Paton, 1994), training and experience do predict optimal versus-maladaptive response in disaster emergencies (Weisaeth, 1989). Content of training should include the following:

- impact of disaster on individuals, disaster workers, organizations, and communities;
- factors associated with adaptation to disaster-related trauma;
- at-risk groups and individuals in the wake of disaster;
- specific interventions to match the needs of specific at-risk groups and individuals in each phase of disaster impact (i.e., on-scene, early post-impact, and restoration phase)
- operational guidelines for applying disaster mental health interventions, including defusing, debriefing, death notification, and ritual and psychoeducational interventions;
- operational guidelines for disaster mental health worker stress management;
- pertinent issues involved in forming and operating a disaster mental health team;
- an overview knowledge of the Federal Response Plan and the disaster mental health team's and practitioner's liaisons to other disaster response organizations

It is also important to develop a library of educational materials which can be made available to team members.

Development of Standard Operating Procedures

Each disaster mental health team will need to develop standard operating procedures to address fiscal, skills development and maintenance, mobilization, field services, return to home site, and evaluation practices. Each of these mechanisms is to a degree contingent upon the size and scope of the parent organization and whether the team is planning to respond to an in-house incident, a community-wide local disaster, or a disaster in another community. These considerations aside, standard operating procedures should address:

Fiscal

- Fiscal responsibility mechanisms
- Budget for equipment (cell phones, flashlights, identification badges, etc.)
- Budget for logistical support (transportation to and from site, on-site vehicles)
- Budget for lodging and per diem expenses
- Budget for miscellaneous expenses (postage, phone bills, laptops, miscellaneous stationary supplies, etc.)

Mobilization

- Equipment procurement procedures
- Staff notification procedures
- Staff check-in procedures
- Logistical support (providing staff transportation, lodging, and per diem expenses)

Field Procedures

- Conduct of needs assessment
- Coordination of staff assignments, frequency of status reports, scheduling
- Liaison with other agencies
- Mitigation and monitoring of stress levels of staff
- Intra-operation defusings
- Post-operation debriefing

Demobilization

- Demobilization procedures
- Reintegration back into regular assignment
- After action report formats
- Intra / inter-agency coordination

Education

- Development & distribution of educational materials for the public (e.g., common stress reactions in adults, elders, children; stress management techniques; other information)
- Continuing education of team
  - Trainings
  - Exercises

Program Policy and Evaluation

- Development of Disaster Mental Health Team policy including membership process, administrative structure, liability, referrals, clinical and statistical reporting forms, expense records, etc.
- Development of program evaluation mechanism

Stressors Associated with Disaster Mental Health Work

Disaster mental health work typically involves a combination of positive and negative experiences.

Stressors Affecting Disaster Mental Health Workers Assisting Survivors

- Exposure to survivor grief, terror, shame, guilt, confusion
- Vicariously experiencing death and injury to children and adults
- Pressure to provide answers / solutions to insoluble problems
- Prolonged physically and emotionally demanding activity with few if any breaks
- Separation from loved ones; inability to protect or communicate with loved ones
- Direct threats to one's own physical safety
- Witnessing or experiencing grotesque destruction and its aftermath
- Personal loss caused by the disaster (e.g., home, personal belongings)

Common Stress Responses of Disaster Mental Health Workers

- Compassion strain: Frustration, psychic numbing
- Vicarious traumatization: Shock, fearfulness, horror, helplessness
- Hyperarousal and hypervigilance
- Confusion and disorientation
- Urge to "anaesthetize" (e.g., substance abuse, excessive sleep)

Acute and Chronic Stress Disorder Indicators

- Compassion fatigue: Demoralization, alienation.
- Ruminative or compulsive re-experiencing
- Attempts to "overcontrol" relationships
- Withdrawal and isolation
- Addictive attempts to anaesthetize

DISASTER MENTAL HEALTH WORK STRATEGIES FOR SELF-CARE AND STRESS MANAGEMENT

Before an Assignment

Personal Preparation

- **Pre-existing stress:** Certain disasters may have personal significance to workers because of their own personal history of traumatization. If team members are requested to begin an assignment while experiencing an inordinate amount of stress, they are apt to become quickly fatigued, irritable, and ineffective and should probably forego the assignment.
- **Level of preparedness:** Personal preparedness can serve to mitigate worker stress before an assignment and help to create reasonable assignment outcome expectations.
- **Managing personal resources:** Pre-assignment planning to meet responsibilities while on assignment (e.g., financial, childcare arrangements, etc.).

Team and Organizational Preparation:

- Defining roles and rehearsing team intervention can reduce anticipatory anxiety and serve to establish reasonable self and team outcome expectations.
- Ensuring a coordinated organization plan for disaster response.

Safety of Family Members:

- Arrangements should be made to allow workers to secure the safety of family and to be given the time to contact family members.

Social & Organizational Support:

- It is critical that disaster workers have the support of their agency during an assignment. This requires that disaster workers' regular job duties be reassigned to others to minimize disruption in service and to prevent workers from being distracted by what and who has been left behind. In addition, the sponsoring organization must recognize and give credit to those who "cover" the responsibilities of the disaster workers who are in the field. Too often, disaster workers receive credit while the individuals who have contributed behind the scenes go unacknowledged, resulting in feelings of resentment and tension among staff after disaster workers return.

During an Assignment

Working with a partner:

- When at all possible team members should be partnered up.

Having someone to share the workload, to problem solve with, and to talk about the ups and downs of the day is extremely valuable and helps workers manage stress. Talking about particularly touching moments is often helpful.

Limit length of shifts:

- Limit length of shifts (e.g. a maximum of 12 hrs). and incorporate regular breaks and exercise. Often, arrangements can be made with a local gym to enable disaster mental health workers and other relief workers to have access to the facility. During an assignment, it is particularly important that workers eat and rest regularly and avoid excessive intake of sweets, caffeine, and alcohol.

Use stress management techniques:

- Disaster mental health workers are advised to use stress management techniques. It is beneficial to workers, and serves to create interest and credibility if witnessed by survivors or other relief workers.

Keep a notebook:

- It is recommended to keep a notebook. Keep your notebook with you to jot down key information. Divide the notebook into subject headings (e.g., key people, referral numbers, phone numbers back home, contacts, things to do, etc). Compile your own resource directory, photocopying the yellow pages listing mental health agencies, etc.

Defuse regularly:

- An important stress management strategy is to talk with another mental health professional toward the end of each day about any emotional reactions you may have experienced in the course of the day's work. Perhaps there was something someone said that stands out, or something you witnessed. Having a colleague to share your experience with is beneficial in and of itself and will give you an objective monitor of your level of stress.

Call home regularly:

- Stay in touch with loved ones - call home regularly. Share your emotions with family.

Closures:

- Lastly, we suggest that time be set aside to say good-bye to the people who were important to you.

After an Assignment

Returning home:

- When returning home, remember to express gratitude to those who have covered your usual responsibilities and expect to feel "out of sorts" for a while —the intensity and meaningfulness experienced during disaster work cannot be matched back home. Though your presence may be highly valued in the field, you most likely will not receive the same level of appreciation by colleagues.
- Expect an adjustment period of a week or two as you may experience mild depression and a physical let-down. This is a common reaction and will pass. If, however, it continues for more than two weeks, we suggest talking with your supervisor about it.

Obstacles to Self-Care

Despite a general awareness of the importance of self-care, it remains common to encounter fellow disaster mental health workers' resistance to taking breaks, particularly to taking an afternoon or day off to rest. Certain values and beliefs often held by helpers may may actually interfere with self-care. For example:

"It would be selfish to take some time to rest"

"Others are working around the clock, day after day; I should too"

"I should be strong enough to work all the time"

"Needs of survivors are more important than the needs of helpers"

"I can contribute the most by working all the time"

Thus, barriers to self-care come from the demands of the disaster environment, but also from attitudinal barriers on the part of some disaster workers.

Because an exhausted disaster worker is at risk to perform less well, become irritable, and solve problems less ably, it is important for helpers to re-examine their attitudes and, when on assignment, be alert to these obstacles to self-care.

Section VI – Disaster Mental Health Services: The Big Picture

Whether you are an administrator or a clinician, it is necessary to have a rudimentary understanding of who is doing what, how disaster services become operational, and where service sites are likely to be established. The complexity of government in the United States compounds the difficulty of describing "who does what" in disaster. More than 82,000 separate government systems operate throughout the country in the absence of nationally integrated standard operating procedures for disaster planning and response. Numerous federal and state agencies are charged with the authority and responsibility to provide disaster services. In addition, the American Red Cross and many non-government agencies have a cadre of volunteers who provide disaster mental health services.

During the immediate aftermath of a disaster, it can be difficult to determine the scope or mission of each of the agencies responsible for providing mental health services. The architecture for a systematic, coordinated, and effective response is continually reshaped by real-world contingencies. Moreover, the vertical and horizontal multiorganizational emergency response network causes variable levels of interagency coordination. Higher levels of cooperation and coordination prior to disaster are directly related to response effectiveness (Drabek, 1992). Furthermore, each disaster becomes a political event and the political issues related to "who is in charge" are factors with implications for survivors, planners, and responders.

This section provides an introduction to the big picture with the objective of increasing your effectiveness and ability to contribute to the delivery of coordinated care. More specifically, becoming familiar with how the system mobilizes, who's who, and the array of disaster mental health resources will enable you to more effectively educate survivors, coordinate your activities with other responders, and communicate with other disaster mental health clinicians and officials. You and your team may have limited contact with from other disaster mental health agencies; nonetheless, if responding to a community-wide disaster, you will be operating within context of the National Disaster Medical System, the disaster declaration process, the Federal Response Plan, and potentially the Federal Crisis Counseling Program for disaster survivors.

NATIONAL DISASTER MEDICAL SYSTEM

NDMS is an inter-agency program that provides the United States with a nationwide medical mutual aid system. The NDMS is designed to care for as many as 100,000 victims of any incident that exceeds the medical care capability of an affected State, region, or Federal health care system. NDMS is a cooperative effort between four Federal agencies:

- Department of Health and Human Services
- Department of Defense
- Department of Veterans Affairs
- Federal Emergency Management Agency

The system may be activated in three ways:

- In the event of a peacetime disaster, the Governor of an affected state may request Federal assistance under the authority of the Disaster Relief Act of 1974.
- A state Health Officer may request NDMS activation by the Secretary of Department of Health and Human Services.
- When military casualty levels exceed the capabilities of the Department of Defense and the Department of Veterans Affairs medical facilities, the system may be activated by the Assistant Secretary of Defense.

Three primary functional elements comprise NDMS:

- Medical response:
  - Disaster Medical Assistance Teams (DMATs) - include mental health personnel
  - Clearing-Staging Units (CSUs)
  - Medical Support Units (MSUs)
  - Medical supplies and equipment
- Patient evacuation:

  Patients that cannot be cared for locally will be evacuated to designated locations throughout the United States.
- Hospitalization:

  NDMS has a network of hospitals spanning the major metropolitan areas of the country. Network hospitals accept patients in the event of emergencies.

Currently, all NDMS coordinating centers are military medical treatment facilities or Department of Veterans Affairs Medical Centers.

DISASTER DECLARATION PROCESS

Not every disaster requires federal assistance. Typically, before the Federal Emergency Management Agency (FEMA) and other federal agencies provide assistance to state and local governments, the state's governor must request assistance and the President must then make a declaration of major disaster or emergency.

1. Contact is made between the affected state and the FEMA regional office. This contact may take place prior to or immediately following the disaster.
2. If it appears that the situation is beyond state and local capacity, the state requests FEMA to conduct a joint Preliminary Damage Assessment (PDA). Participants in the PDA will include FEMA, other federal agencies, and state and local government representatives.
3. Based on the PDA findings, the governor submits a request to the President through the FEMA Regional Director for a disaster declaration.
4. The FEMA Regional Office submits a summary of the event and a recommendation based on the results of the PDA to FEMA headquarters, along with the Governor's request.
5. Upon receipt of these documents, FEMA Headquarters senior staff convene to discuss the request and determine the recommendation to be made to the President.
6. FEMA's recommendation is forwarded to the White House for review.
7. The President makes a declaration of disaster.

Disaster declaration process

Incident
↓
Local government responds
↓
State responds
↓
Governor requests President to declare major disaster/emergency
↓
FEMA Regional Director confirms Governor's findings
↓
Regional findings and recommendations to the President
↓
President declares a major disaster/emergency
↓
FEMA Associate Director appoints FCO and designates eligible areas
↓
Disaster Program Implemented

FEDERAL RESPONSE PLAN

The Federal Response Plan (FRP) describes the planning assumptions, policies, concept of operations, and organizational structures by which twenty-seven federal departments and agencies mobilize resources and conduct activities to augment state and local response efforts following a domestic disaster. The FRP uses a functional approach to operationalize the types of federal assistance under twelve Emergency Support Functions (ESFs):

ESF #1 - Transportation
ESF #2 - Communications
ESF #3 - Public Works and Engineering
ESF #4 - Firefighting
ESF #5 - Information and Planning
ESF #6 - Mass Care
ESF #7 - Resource Support
ESF #8 - Health and Medical Services
ESF #9 - Urban Search and Rescue
ESF #10 - Hazardous Materials
ESF #11 - Food
ESF #12 - Energy

Each ESF is headed by a primary agency, which has been selected based on its authorities, resources and capabilities in the particular functional area.

Mental health services fall under ESF#8, the Health and Medical Services Annex. Federal assistance provided under ESF #8 is directed by the Department of Health and Human Services (DHHS) through its Executive Agent, the Assistant Secretary for Health, who heads the U.S. Public Health Service.

All federal assistance is provided to the affected state under the overall coordination of the Federal Coordinating Officer appointed by the Director of the Federal Emergency Management Agency (FEMA) on behalf of the President.

FEDERAL, STATE, LOCAL, NON-PROFIT, AND VOLUNTEER AGENCIES OFFERING DISASTER MENTAL HEALTH SERVICES

Federal Agencies

Federal Emergency Management Agency (FEMA)

FEMA is the principal agency within the Federal Government for dealing with emergencies affecting the United States in peacetime and war. FEMA is responsible for coordinating emergency activities through all levels of government (i.e., Federal, state, and local), and the private sector of the nation. Other primary FEMA responsibilities include:

- Assessment: Assessing national mobilization capabilities and developing concepts, plans, and systems for management of resources in a wide range of national and civil emergencies.
- Resource Identification: Identifying shortages of natural, industrial, or economic resources that could constitute a threat to national security.
- Plan & Program Development: To protect the population, key government offices, and the industry of the United States.
- Mitigation: Prevention, risk reduction and effects limitation.
- Preparedness: Policy, planning, programs, training, and education.
- Response: Active coordination of scene activities during an emergency.
- Recovery: Restoring affected areas to normalcy.

The Director of FEMA reports to the President and works closely in emergency management matters with the National Security Council, the Cabinet, and the White House staff. There are 10 FEMA regional offices.

During the period immediately following a major disaster or emergency requiring Federal response, primary agencies, directed by FEMA, take action to identify requirements, and mobilize and deploy resources to the affected area to assist the state in life-saving and life-protecting response efforts.

A Federal Coordinating Officer (FCO) is appointed by the President to coordinate the Federal activities in each declared state. The FCO works with the State Coordinating Officer (SCO) to identify overall requirements, including unmet needs and evolving support requirements, and coordinate these requirements with the ESFs. The FCO also coordinates public information, Congressional liaison, community liaison, outreach

and donations activities, and facilitates the provision of information and reports to appropriate users.

The Catastrophic Disaster Resource Group (CDRG), composed of representatives from all departments and agencies under the Plan, operates at the national level to provide guidance and policy direction on response coordination and operational issues arising from FCO and ESF response activities.

FEMA Crisis Counseling Program

To meet the mental health needs of survivors following a Presidential-declared disaster, FEMA provides funding for crisis counseling programs through provisions of the Stafford Act. Funds for crisis counseling, training, public information, and education services are available only when states can document that needs exist which cannot be met with state and local resources. The needs assessment under the crisis counseling program must demonstrate that disaster-precipitated mental health needs are significant enough that a special mental health program is warranted which cannot be provided without federal assistance. A grant application is required for all states applying for funds for post-disaster crisis intervention programs under the "Immediate Services" and the "Regular Program" types of grants. Staff of the Emergency Services and Disaster Relief Branch (ESDRB) of the Center for Mental Health Services are available to assist in the preparation of the grant applications. The grant application requires the submission of Form 424 (Part I of Public Health Service grant application form 5161-1 - the other parts of Form 5161-1 are not required for the crisis counseling program). Other information for developing an application for crisis counseling services for disaster victims is available from the Emergency Services and Disaster Relief Branch (ESDRB).

Needs Assessment

Two methods of assessment are suggested: use of indicator data and the use of key informants.

Indicator Data Method[7]

- Estimation of average number of persons per household in each service provider area of state
- Estimation of the number of directly impacted households in service provider area (e.g., number of dead, hospitalized, non-hospitalized injured, homes destroyed, homes with major damage, homes with minor damage, disaster unemployed)

[7] Suggested sources of data include American Red Cross, FEMA, state and local governments, state Employment Services, and the Department of Labor.

- Estimation of the total number of individuals in need of services (prevalence rates for different types of loss have been developed to represent the percent of persons expected to be in need of mental health services).
- Estimation of outreach, consultation, and education needs · description of population demographics (high risk groups: children, frail elderly, the disadvantaged, ethnic groups).

Key Informant Method

The key informant approach to needs assessment is based on the assumption that certain persons in the community know the community well enough to be able to estimate both mental health needs attributable to the disaster and needed resources. Key informants can be surveyed to estimate a) specific groups impacted by the disaster; b) gaps and problems in existing services; and c) resources required to meet the needs resulting from the disaster.

Types of key informants:

- Gatekeepers: Professionals such as public health nurses, school nurses, social workers, clinicians, school teachers and administrators, clergy, and disaster workers.
- Administrators and directors of service organizations.
- Influential leaders: County commissioners, mayors, judges, school board leaders.

Program Plan

The program plan section of the grant application should describe the proposed service delivery mechanisms to meet the mental health needs of the impacted population as estimated by the assessment procedures. Crisis counseling programs services generally include outreach, consultation, individual crisis counseling, referral, and education services. In addition to the description of proposed services, the plan should include a budget, a description of organizational structure, staffing and training requirements, job descriptions, facility and equipment requirements, and the process of record keeping and program evaluation. The budget must be tied to program elements and present sufficient detail about the fiscal resources necessary to administer the program.

Individuals, families, farmers, and businesses are eligible for federal assistance if they live or own a business in a county declared a Major Disaster Area, incur sufficient property damage or loss, and, depending on the type of assistance, do not have the insurance or resources to meet their needs.

Public Health Service (PHS)

PHS is the principal health agency of the Federal government. It is responsible for promoting and assuring the nation's health through research into the causes, treatment, and prevention of disease.

PHS is made up of eight agencies and the Office of the Assistant Secretary for Health.

1. Agency for Health Care Policy and Research
2. Agency for Toxic Substances and Disease Registry
3. Center for Disease Control and Prevention
4. Food and Drug Administration
5. Health Resources and Services Administration
6. Indian Health Service
7. National Institutes of Health
8. Substance Abuse and Mental Health Services Administration

PHS is the lead agency for ESF #8, directing the provision of the federal government health and mental health resources to fulfill the requirements identified by the affected state/local authorities having jurisdiction. Included in ESF #8 is overall public health response, and triage, treatment and transportation of victims of disaster, and the evacuation of patients out of the disaster area, as needed, into a network of military services.

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA is the lead mental health agency of the Public Health Service. SAMHSA provides assistance with assessing mental health needs; providing mental health training materials for disaster workers; assisting in arranging training for mental health outreach workers; assessing the content of applications for Federal crisis counseling grant funds; and address worker stress issues and needs through a variety of mechanisms.

Center for Mental Health Services (CMHS)
Emergency Services and Disaster Relief Branch (ESDRB)

CMHS promotes mental health and the prevention of the development or worsening of mental illness by helping states improve and increase their mental health services. CMHS is organized into several divisions including the Division of Program Development, Special Populations, and Projects. Within this division, the ESDRB works with FEMA to administer the Crisis Counseling Program described earlier. Often the programs are given names by local authorities (e.g., Project Heartland following the Oklahoma City Bombing; Project Recovery following the midwest flooding; Project COPE following the Loma Prieta Earthquake, to name just

a few of the many programs funded). In general, these crisis counseling programs provide a range of psychoeducational services for individuals who live and work in disaster areas including one-to-one counseling, outreach services, family / and or childrens' programs, and programs for other special populations. In addition, they offer disaster mental health training to local mental health professionals. Typically, the federal Crisis Counseling Programs are funded for 9-15 months following the disaster. Staff of the ESDRB travel to the site of major disasters and assist state and local mental health agencies in needs assessment, training, and program design. Throughout the period of funding, ESDRB staff provide program consultation and monitoring.

Following a major disaster, early phase disaster mental health workers can inform and assure survivors that a counseling program will be established for them to receive additional support and information.

Disaster Medical Assistance Teams (DMATS)

DMATs are operationalized by PHS to assist in providing care for ill or injured victims at the site of a disaster or emergency. Each DMAT is made up of a volunteer group of about 30 professionals that include physicians, nurses, technicians, and other allied personnel who train together as a unit. Each DMAT has a sponsoring organization (e.g., medical center, public health agency, local Red Cross chapter). When NDMS is activated, DMATs receive, hold, and support patients in patient collection areas when evacuation is necessary. DMATs can provide triage, medical or surgical stabilization, and continued monitoring and care of patients until they can be evacuated to locations where they will receive definitive medical care. Specialty DMATs can also be deployed to address mass burn injuries, pediatric trauma, chemical injury or contamination, etc. In addition to DMATs, active duty, reserve, and National Guard medical units for casualty clearing / staging and other missions are deployed as needed. Mental health and medical care specialists may be provided to assist state and local personnel.

Department of Veterans Affairs (VA)

The VA healthcare system, the largest healthcare system in the world, provides primary and specialized care and related medical and social support services for veterans. A member of the Presidential Cabinet, the VA is Congressionally-mandated to serve as a support agency in the Federal Response Plan. Three programs within the VA healthcare system are involved with disaster response:

1. Emergency Management Strategic Health Care Group
2. National Center for Post-Traumatic Stress Disorder
3. Readjustment Counseling Service

Emergency Management Strategic Health Care Group (EMSHCG)

With headquarters at the VA Medical Center in Martinsburg, West Virginia EMSHCG coordinates it activities through four regional offices and 37 area emergency offices. EMSHCG serves as the emergency medical contingency facilitator for the Department of Veterans Affairs, providing technical guidance, support, management and coordination necessary to conduct programs ensuring health for eligible veterans, military personnel, and the public during Department of Defense contingencies and natural, human-made, and technological emergencies. EMSHCG works closely with DHHS, DOD, and FEMA to develop national plans, policies, and directives to support NDMS.

National Center for PTSD (NC-PTSD)

The NC-PTSD was mandated by the U.S. Congress in 1984 under Public Law 98-528 to represent the Department of Veterans Affairs in carrying out multidisciplinary activities in research, education, and training related to stress and trauma.

The NC-PTSD Executive Division is located at the VA Medical Center in White River Junction, Vermont, with six additional Division offices located at VA Medical Centers in Boston, MA; Honolulu, HI; Menlo Park, CA; and West Haven, CT.

NC-PTSD disaster mental health specialists have developed a training curriculum to prepare VA mental health, social work, nursing, and chaplaincy professionals to provide emergency response services at their local VA and in their local community. The curriculum also is designed to identify select groups of VA DMH specialists in various regions of the country, and to prepare them to provide the highest quality services in conjunction with the national disaster response system at the site of major disasters.

Readjustment Counseling Service

RCS was established under DVA, VHA, by U.S. Congress in 1979 under PL 96-22 to assist Vietnam-era veterans and their families in dealing with stress reactions and disorders as a result of the veterans' involvement in Vietnam. That mission has been expanded to include veterans of WWII, Korean, post-Vietnam conflicts, and veterans who have been sexually assaulted during military service.

RCS locates its Headquarters in Washington, D.C. There are seven area offices with 206 community-based Vet Centers with sites in each of the 50 states and Puerto Rico, the Virgin Islands, and Guam. Vet Center staff are professionals who have been specifically trained and are skilled in dealing with mental health issues related to stress and trauma.

Trained RCS staff have provided disaster mental health services in communities stricken by disasters such as hurricanes, earthquakes, floods, train wrecks, etc. RCS has also worked in collaboration with NC-PTSD in offering disaster mental health training programs.

VA Collaborative Disaster Mental Health Program

NC-PTSD and RCS are jointly developing a nationwide system for training a cadre of VHA/RCS clinicians as DMH specialists. The trainings are the first step in ongoing consultative guidance provided by a NC-PTSD/RCS DMH Executive Team, which will ensure each DMH team's continuing readiness by supporting team members before, during, and after disaster deployments.

The establishment of the VHA/RCS DMH response network represents a significant step toward the development of a truly proactive and integrated national DMH response system, in collaboration with other key disaster response organizations.

State Agencies

The governor appoints a State Coordinating Officer (SCO) to coordinate the state and local efforts with those of the federal government. To date, the 50 states do not have a universal disaster mental health organization chart. A few states have a designated state disaster coordinator within their respective departments of mental health.

State Mental Health Departments

State mental health departments have the responsibility to apply for crisis counseling assistance and training funding The Immediate Service Grant provides funding to pay for non-federal mutual aid assistance received by the state and the Regular Service Grant provides federal funding to run special mental health programs to communities affected by disaster. Assistance under these programs is limited to Presidential-declared major disasters.

Local Mental Health Services

County Mental Health Services:

County mental health agencies, the primary sponsors of disaster crisis counseling programs, almost exclusively serve individuals with severe and chronic mental illness as part of their everyday mission. Following a disaster these agencies must shift their services to assist people without mental illness who are responding normally to an abnormal situation. They must also maintain the care of their regular clientele, who often experience an exacerbation of symptoms during the aftermath of a disaster. Community mental health staff generally require special disaster-related training to be able to respond rapidly and efficiently. Additional staff are often needed to manage regular on-going services, immediate disaster response activities, and the crisis counseling program.

Mutual Aid:

Mutual aid (additional staffing) may come from both the non-profit and private sector. Most states have a mutual aid system designed to supplement individual county resources when a county's own resources are insufficient (e.g., fire, rescue, law enforcement, medical services, coroners, public works, engineering). However, mental health services may not be part of a state's mutual aid system. If not, it is strongly recommended that action be taken to include mental health services in the state plan to ensure organized rapid deployment of trained disaster mental health personnel when needed.

Non-profit agencies (e.g., Catholic & Jewish Family Services) may provide needed resources, and volunteers are generally, but not always, licensed private practitioners wanting to donate their time.

The Immediate Service Grant serves as the primary resource of funding for reimbursement of mutual aid. The Regular Service Grant is the funding mechanism for on-going crisis counseling programs and training.

Non-profit Agencies

American Red Cross Disaster Mental Health Services (ARC DMHS)

Under a 1905 Congressional charter, the American Red Cross is mandated to meet human needs created by disaster by providing emergency congregate and individual care in coordination with local government and private agencies. A private, charitable corporation, ARC is designated as a federal agency for purposes of the Federal Response Plan.

The first priority of ARC Disaster Mental Health Services is to promote effective disaster recovery efforts by helping ARC workers manage stress related to their disaster work. The provision of mental health services to disaster victims and local mental health providers are the second and third priorities.

The disaster mental health program is being developed at both the national and local levels. Extensive networking is being conducted with professional associations to inform their membership of the Red Cross DMHS program and their opportunity to become involved. Statements of Understanding have been signed with American Psychiatric Association, American Psychological Association, National Association of Social Workers, and the American Association of Marriage and Family Therapy. These understandings facilitate interagency cooperation and increase the number of available mental health professionals for local and national assignments.

Local Red Cross chapters are developing and incorporating disaster mental health response plans in their chapter disaster plan. Chapters are encouraged to network with community agencies and individual providers to coordinate services and obtain agreements that provide pro bono services to disaster victims and workers to be utilized in the chapter's response to local disasters. When disasters occur that are beyond the response capabilities of a local chapter, the national organization provides assistance with personnel, materials, and financial resources. The Disaster Services Human Resources System (DSHR) is the national personnel inventory that tracks individual disaster workers. From this system, volunteers are recruited to respond to these large disasters. To become a DSHR member, licensed mental health professionals must meet ARC training requirements and be available for a minimum of a 12 day operational assignment. Any mental health professional interested in becoming a volunteer should contact his or her local chapter of the American Red Cross.

Non-profit Agencies

Many non-profit agencies have disaster/trauma mental health teams or associate professionals who respond to disasters.

University and Colleges

Medical schools
Departments of psychology, social work, nursing

Religious Groups

Ananda Marga
Church of the Brethren
Christian Reformed World Relief
Lutheran Church of America
National Catholic Disaster Relief Committee
National Catholic Conference and Catholic Charities
The Salvation Army
Seventh Day Adventists
Southern Baptist Convention
United Methodist Church Committee
Volunteers of America

Miscellaneous Agencies

American Association of Marriage and Family Therapy (AAMFT)
American Psychiatric Association (APA)
American Psychological Association (APA)
Green Cross
International Association of Trauma Counselors (IATC)
International Critical Incident Stress Foundation (ICISF)
International Society for Traumatic Stress Studies (ISTSS)
National Association of Social Workers (NASW)
National Organization for Victim Assistance (NOVA)

Appendix A – List of Acronyms/Abbreviations

AAMFT	American Association of Marriage and Family Therapy
APA	American Psychiatric Association
APA	American Psychological Association
ARC	American Red Cross
CDRG	Catastrophic Disaster Response Group
CISD	Critical Incident Stress Debriefing
CISM	Critical Incident Stress Management
CMHS	Center for Mental Health Services
DFO	Disaster Field Office
DHHS	Department of Health and Human Services
DMAT	Disaster Medical Assistance Team
DMHS	Disaster Mental Health Services
DMORT	Disaster Mortuary Team, National Disaster Medical System
DOD	Department of Defense
DSHR	Disaster Services Human Resources System
DWI	Disaster Welfare Inquiry
EICC	Emergency Information and Coordination Center
EMS	Emergency Medical Services
EMSHCG	Emergency Management Strategy Health Care Group
ERT	Emergency Response Team
ESDRB	Emergency Services and Disaster Relief Branch
ESF	Emergency Support Function
FAA	Federal Aviation Administration
FCO	Federal Coordinating Officer
FEMA	Federal Emergency Management Agency
FRP	Federal Response Plan
IATC	International Association of Trauma Counselors
ICS	Incident Command System
ICISF	International Critical Incident Stress Foundation
ISTSS	International Society for Traumatic Stress Studies
JIC	Joint Information Center
JIS	Joint Information System
MADD	Mothers Against Drunk Driving
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MRE	Meals Ready to Eat
NASW	National Association of Social Workers
NC-PTSD	National Center for Post-Traumatic Stress Disorder
NDMOC	National Disaster Medical Operations Center
NDMS	National Disaster Medical System
NDMSOSC	National Disaster Medical System Operations Support Center
NFDA	National Funeral Directors Association
NIMH	National Institutes of Mental Health
NOVA	National Organization for Victims Assistance
NVOAD	National Voluntary Organizations Active in Disaster
PA	Public Affairs
PAO	Public Affairs Officer
PDA	Preliminary Damage Assessment
PHS	U.S. Public Health Service
PIO	Public Information Officer
PTSD	Post-traumatic Stress Disorder
RCS	Readjustment Counseling Service
RD	Regional Director
REC	Regional Emergency Coordinator
S	Staging Area
SAMHSA	Substance Abuse and Mental Health Services Administration
SAR	Search and Rescue
SCO	State Coordinating Officer
SOP	Standard Operating Procedure
VA	Department of Veterans Affairs
VHA	Veterans Health Administration, Department of Veterans Affairs

Appendix B – Resources*

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* Reprinted with permission of the American Psychological Association Task Force on the Mental Health Response to the Oklahoma City Bombing.

Internet Resources

The number of resources available on the world-wide web is voluminous.
Here are a few key web sites related to disaster.

American Red Cross	http://www.crossnet.org/
Federal Emergency Management Agency	http://www.fema.gov/
Knowledge Exchange Network	http://www.mentalhealth.org/
National Center for PTSD	http://www.dartmouth.edu/dms/ptsd/
Natural Hazards Center	http://www.Colorado.EDU/hazards/

Appendix C – PTSD Screening Protocol for Primary Care Settings

1. In general, would you say that your health is: ___Excellent ___Very Good ___Good ___Fair ___Poor

2. Have you received health care:	Now, at the VA	In the Past, at the VA	Now, Outside the VA	In the Past, Outside the VA
For depression, anxiety, nerves or PTSD?	o	o	o	o
For alcohol or drug use problems?	o	o	o	o

Would you like more information about VA services providing care for **physical health** problems? **YES** o **NO** o

Would you like more information about VA services providing care for depression, anxiety, nerves or PTSD? **YES** o **NO** o

Would you like more information about VA services providing care for alcohol or drug use problems? **YES** o **NO** o

3. Have you ever witnessed or had a terrible experience that most people never go through, like a serious accident, a natural disaster, a violent crime, being sexually assaulted or raped, or being in a military warzone or in combat? **YES** o **NO** o

Did you ever have a military or civilian experience that caused you serious injury or made you believe you might die? **YES** o **NO** o

4. In the past month, have you : a. Repeatedly remembered these experiences when you did not want to? **YES** o **NO** o

b. Had repeated dreams or nightmares about these experiences? **YES** o **NO** o

c. T**hought about these experiences when you didn't want to, or been bothered by repeated, disturbing *memories*, *feelings*, or *dreams*?** **YES** o **NO** o

d. Tried hard not to think about these experiences, or avoided situations, conversations, people, or feelings that reminded you? **YES** o **NO** o

e. Often felt extremely unsafe, on-guard, watchful when you didn't need to be, or jumpy and easily startled? **YES** o **NO** o

f. Felt emotionally numb (unable to feel most feelings) or detached from your relationships, activities or surroundings? **YES** o **NO** o

5. How much of the time during the past month:	All the Time	Most of the Time	A Good Bit	Some of the Time	A Little	Not at All
a. Have you felt calm and peaceful?	o	o	o	o	o	o
b. Have you felt downhearted and blue?	o	o	o	o	o	o
c. Have you been a very nervous person?	o	o	o	o	o	o
d. Have you been a happy person?	o	o	o	o	o	o
e. Have you felt so down in the dumps that nothing could cheer you up?	o	o	o	o	o	o

6. Did you ever drink alcohol? ___NO—Please stop here. Thank you. ___YES—Please continue and answer these questions:

a. Have you felt you ought to cut down on drinking?	o Yes, in the past month	o Yes, at some time in my life	o No, never
b. Have people annoyed you by criticizing your drinking?	o Yes, in the past month	o Yes, at some time in my life	o No, never
c. Have you felt bad or guilty about your drinking?	o Yes, in the past month	o Yes, at some time in my life	o No, never
d. Have you had a drink first thing in the morning to steady your nerves or get rid of a hangover (an "eye-opener")?	o Yes, in the past month	o Yes, at some time in my life	o No, never

Appendix D – 2-Day Training General Outline

NATIONAL CENTER FOR PTSD
DISASTER MENTAL HEALTH SERVICES
2-Day Training – General Outline

Learning Objectives

Participants will be able to:

a) assess the impact of disaster on individuals, disaster workers, organizations, and communities;

b) assess the factors associated with adaptation to disaster-related trauma;

c) identify at-risk groups and individuals in the wake of disaster;

d) target specific interventions to match the needs of specific at-risk groups and individuals in each phase of disaster impact (i.e., on-scene, early post-impact, and restoration phase);

e) identify essential advanced operational guidelines for applying disaster mental health interventions, including defusing, debriefing, death notification, and ritual and psychoeducational interventions;

f) identify the essential advanced operational guidelines for disaster mental health worker stress management;

g) understand the pertinent issues involved in forming and operating a VA disaster mental health team;

h) apply an overview knowledge of the Federal Response Plan to defining the disaster mental health team's and practitioner's liaisons to other disaster response organizations.

Training Content and Schedule

DAY 1

8:30 - 8:45 Instructor and Participant Introductions; Course Overview

8:45 - 9:15 The VA National Disaster Mental Health (DMH) Initiative
- Training/certifying a cadre of VISN-based joint VAMC/RCS (DMH) teams
- The role of RCS in VA'S DMH response

9:15 - 10:00 Disaster Mental Health Key Principles
- Lecturette: Key principles for intervention and phases of disaster

10:00 - 10:15 Break

10:15 - 10:45 Off-site Intervention
- **Video; Role Play Service Center simulation**

10:45 - 11:15 Group Discussion Of Role Play

11:15 - 12:00 Disaster Mental Health Settings And Clinical Guidelines
- **Lecturette: Settings: Working in a disaster service center, shelter, community**
- **Lecturette: Clinical Guidelines (How to structure assessment and interventions in large group settings; 6 step guide to defusing)**

12:00 - 1:00 Lunch

1:00 - 1:30 Clinical Guidelines (continued)

1:30 - 2:15 Adult Reactions to Disaster
- Video: "Beyond the Ashes:" Survivor and worker accounts

2:15 - 3:00 Debriefing
- Overview, rationale, and components

3:00 - 3:15 Break

3:15 - 4:15 Instructor Debriefing Demonstration With 8-10 Participants

4:15 - 5:00 Group Discussion: Debriefing The Debriefing

DAY 2

8:30 - 9:00 Participant Responses To Day 1 And Input To Agenda For Day 2

9:00 -10:00 Participant Skill Building Exercise: Defusing
- Instructor-coached 6-step guide to defusing VA personnel following critical incident

10:00 - 10:15 Break

10:15 - 11:15 Group Discussion: Defusing Exercise

11:15 -12:00 Children's Reactions To Disaster
- Video: "Children and Trauma"

12:00 - 1:00 Lunch

1:00 - 1:30 Leadership Issues

1:30 - 2:15 The Big Picture: National Disaster Medical System
- Lecturette and Video: Who's who, Federal Response Plan, and disaster declaration process

2:15 -3:15 DMH Team Development
- Lecturette: Establishing and maintaining a DMH team

3:15 - 3:30 Break

3:30 - 4:15 Disaster Mental Health Worker Stress Management / Self-Care
- Lecturette: Stress management / Self-care before, during, and after an assignment

4:15 - 4:30 Closure Discussion and Course Evaluations

Appendix E – References and Recommended Reading

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