



# **KAHBH Standard Operating Procedures And Training Manual**

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**Funding provided by**

**Kansas Department of Social and Rehabilitation Services, Topeka, KS**

**Kansas Department of Health and Environment, Topeka, KS**

*Version 1.2 (revised)  
July 2006*

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## Purpose and Scope of the KAHBH Training Operations Manual

This Kansas All-Hazards Behavioral Health Project Training Operations Manual is intended to be used in conjunction with the following SAMHSA/CMHS publication:

### ***Training Manual for Mental Health and Human Service Workers in Major Disasters***

DHHS Publication No. ADM 90-538

Substance Abuse and Mental Health Services Administration

Printed 2000

Author: Deborah J. DeWolfe, Ph.D., M.S.P.H.

Editor: Diana Nordboe, M.Ed.

Source: <http://www.mentalhealth.samhsa.gov/publications/allpubs/ADM90-538/Default.asp>

The sections of this KAHBH Operations Manual that follow provide a description of the purpose and scope of the trainings; however, the specific content of the trainings are based on the SAMHSA/CMHS Training Manual. The KAHBH Operations Manual will provide information that is specific to trainings in Kansas and supplemental information intended to expand the information provided in the SAMHSA/CMHS Training Manual. For the purposes of this Operations Manual, the reader will be referred to any information that is in the SAMHSA/CMHS Training Manual, rather than repeating information in this document.

## KAHBH Trainings

### ***Core Behavioral Health Training***

All KAHBH team participants will complete a 1 day (8 hours) Core Behavioral Health Training (“core training”). The Core Training will provide all participants, both mental health professionals and paraprofessionals, with background information related to all-hazards behavioral health and specific information unique to their roles and functions in all-hazards behavioral health response.

The core training was developed by the KAHBH Team in 2005 and was based on a thorough review of disaster mental health literature and national resources. The information contained in the Core Training is considered to be the “national standard” of knowledge in the field, based on the pool of information gathered by the team. The core training will be continuously reviewed and updated on an annual basis, in order to continue to provide current and relevant information.

The following outline describes the information provided in the KAHBH Core Training:

- DAY 1 (approx. 8 hours)
  - For ALL KAHBH Network Members
    - Module 1: An Overview of the Kansas All-Hazards Behavioral Health (KAHBH) Program
    - Module 2: The FEMA/SAMHSA Crisis Counseling Assistance and Training Program & the All-Hazards Response System

- Module 3: Disaster Classifications and Phases
- Module 4: Traumatic Reactions to Disasters
- Module 5: Providing Support During Disasters
- Module 6: KAHBH Community Outreach Teams: Structure, Procedures, and Documents
- Module 7: Considerations for Special Populations, Cultural Competence, and Ethical Issues

### ***Paraprofessional Training***

All non-behavioral health members/paraprofessionals will receive an additional ½ day (4 hours) training on basic crisis helping skills. Because paraprofessional team members will not have a mental health/counseling background, this training will provide them with background information in working with people in crisis, communication skills, issues related to confidentiality and ethics, and other basic helping skills.

The following outline describes the information provided in the Paraprofessional Training:

- The Role of the Helper
- Professional and personal boundaries
- Ethics, confidentiality, and dual relationships
- Communication Skills
- Challenges in Helping
- Diversity and multicultural awareness as a helper
- Helping in Crisis and Grief Situations

### ***Specialty Trainings***

The Specialty Trainings will provide network members with specialized training related to special/vulnerable populations. The trainings will be provided in ½ day (4 hour) trainings. At least 2 network members (1 mental health and 1 paraprofessional) from each region will receive specialized training in the following areas:

- Children (under age 18)
- Frail Elderly
- Developmentally and physically disabled
- Severe Mental Illness and People in active Substance Abuse Treatment
- People in Correctional Institutions
- College Students in dorms/away from home/Families/individuals relocated
- People with high traumatic exposure
- People in poverty and homeless
- Emergency responders involved in rescue/recovery
- Multicultural issues
- Farmers/Ranchers/Agricultural Workers/Rural Populations
- Other roles of men and women that may affect vulnerability

## Competencies

All KAHBH network members are expected to meet these core competencies upon completion of the KAHBH Core Training. These competencies are based on the Core Competencies for Public Health Professionals, adopted by the [Council on Linkages Between Academia and Public Health Practice](#) on April 11, 2001.

1. Identifies relevant and appropriate data and information sources
2. Obtains and interprets information regarding risks and benefits to the community
3. Recognizes how the data illuminates ethical, political, scientific, economic, and overall public behavioral health issues
4. Prepare and implement behavioral health emergency response plans
5. Advocates for public health/behavioral health programs and resources
6. Effectively presents accurate demographic, statistical, programmatic and scientific information for professional and lay audiences
7. Utilizes appropriate methods for interacting sensitively, effectively, and professionally with persons from diverse cultural, socioeconomic, educational, racial, ethnic, and professional backgrounds, and persons of all ages and lifestyle preferences
8. Identifies the role of cultural, social, and behavioral factors in determining the delivery of public health/behavioral health services
9. Develops and adapts approaches to problems that take into account cultural differences
10. Collaborates with community partners to promote the health/behavioral health of the population
11. Identifies community assets and available resources
12. Describes the role of government in the delivery of community behavioral health services
13. Identifies the individual's and organization's responsibilities within the context of the KAHBH Program and its core functions
14. Creates a culture of ethical standards within organizations and communities
15. Helps create key values and shared vision and uses these principles to guide action
16. Identifies internal and external issues that may impact delivery of essential public behavioral health services (i.e., strategic planning)
17. Promotes team and organizational learning

## Background and Overview

Source: <http://www.mentalhealth.samhsa.gov/publications/allpubs/ADM90-538/Default.asp>

Mental health intervention has become a valued dimension of immediate and long-term disaster response. Psychological recovery is recognized as a focus for relief efforts, along with repairing homes and rebuilding bridges. Emergency responders, disaster workers, and community members now receive mental health support following most large-scale disasters. Mental health professionals have readily stepped into the disaster milieu to provide counseling, debriefing, school interventions, case management, and consultation.

Legislative authority is given to the President under Section 416 of The Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988 (Public Law 100-707) to provide training and services to alleviate mental health problems caused or exacerbated by major disasters. The Act reads as follows:

*Crisis Counseling Assistance and Training. The President is authorized to provide professional counseling services, including financial assistance to State or local agencies or private mental health organizations to provide such services or training of disaster workers, to survivors/victims of major disaster in order to relieve mental health problems caused or aggravated by such major disaster or its aftermath.*

The Crisis Counseling Assistance and Training Program (commonly referred to as the Crisis Counseling Program) is managed by the Federal Emergency Management Agency (FEMA) in cooperation with the Center for Mental Health Services (CMHS).

### **Purpose of the SAMHSA/CMHS Training Manual**

While each disaster and community is unique, States face similar challenges as they mobilize the resources to provide post-disaster mental health services. Disaster mental health providers, program planners, and administrators must quickly acquaint themselves with "the basics" of disaster mental health to be able to design and deliver services that are effective. A primary purpose of this Manual is to present an overview of essential information including: how disasters affect children, adults and older adults, the importance of tailoring the program to fit the community, descriptions of effective disaster mental health interventions, and strategies for preventing and managing worker stress.

Another purpose of the Manual is to efficiently assist mental health administrators, planners, and disaster mental health trainers as they develop the training component of their crisis counseling project. Specific disaster mental health training is critical for all professional and paraprofessional personnel associated with a disaster mental health recovery program. This training can guide crisis counseling project development so that the wisdom gathered from 25 years of disaster mental health intervention is reflected in program services.



Crisis Counseling Programs typically reach out to human service agencies and organizations in the community. Examples of service provider groups are disaster relief workers, health care professionals, church crisis workers, senior center personnel, building permit inspectors, public assistance workers, food bank workers, day care staff, and agricultural extension employees. Crisis counseling staff provides educational presentations and materials on disaster mental health so that local human service workers are better equipped to serve their constituencies following the disaster.

### ***Why Special Training?***

Specific training is essential because post-disaster behavioral health services are significantly different from the work activities of most mental health professionals. A supportive conversation or a focused problem-solving session over a cup of coffee, at a feeding van, or at a town meeting are essential activities in disaster work. While a background in crisis intervention or critical incident stress is helpful, it does not prepare a mental health professional for the range of issues encountered in communities during the months following a disaster.

As public funding for mental health services has become primarily limited to serving those with serious and persistent mental illnesses, many mental health workers have become less experienced in dealing with the general population who may be coping with loss, disruption, and, in some cases, tragedy. Many outpatient psychotherapists, accustomed to the fifty-minute session in an office, find providing support services in people's homes or at shelters outside their comfort zone. While case managers for people with mental illness and geriatric specialists are skilled at accessing resources and providing services outside an office, they benefit from training on disaster issues. Disaster mental health training builds on each mental health professional's existing strengths and experiences and provides a framework and specific interventions appropriate to the disaster context.

Newcomers to disaster work are impressed with the "alphabet soup" of agencies, centers, and services (e.g., DFO, EOC, ARC, FEMA, VOAD, SBA). For most, the bureaucratic context of disaster relief work is new, almost like operating in a different culture. Training provides the big organizational picture of disaster recovery, so that mental health workers can navigate in the new environment and utilize available resources.

Crisis Counseling Programs typically find that paraprofessionals from the affected communities can be highly effective community outreach workers. When paraprofessional workers represent the groups they are serving, for example, older adults, people of color, or people from different ethnic or cultural groups, they often readily gain access. Although these individuals may be "natural helpers" or "peer counselors" with other groups, specific training on disaster and mental health issues facilitates their integration into the program. In addition to specific disaster mental health training, paraprofessionals benefit from training and practice with basic counseling skills.

Occasionally, States will provide disaster mental health training for disaster mental health workers only, and not include those who will be providing clinical supervision or

program administration. Disaster program experts emphatically concur that when all parties involved with a program have received training in disaster mental health, conflicts and misunderstandings that undermine program effectiveness can be avoided.

### ***Overview of Resources***

The SAMHSA/CMHS Training Manual focuses on what workers need to know to provide disaster behavioral health services, including sections on how communities and survivors respond to disaster, potential at-risk groups, and stress management for staff. Recognizing the necessity for service providers to quickly develop competency in a new context, topic presentations are focused and brief. The material included in the KAHBH Training Manual is intended to provide additional resources for KAHBH network members to enhance their training in responding to disasters and crisis events in Kansas.

## Crisis Counseling and Behavioral Health Treatment Similarities and Differences

### Source:

[http://www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/ccp\\_pg02.asp](http://www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/ccp_pg02.asp)

(Note: This section corresponds with *Module 5* of the KAHBH Core Training)

*Note: This is the second in a series of program guidance documents developed to ensure consistency in addressing key program issues in the Crisis Counseling Training and Assistance Program (CCP). The Federal Emergency Management Agency (FEMA) under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act funds the Crisis Counseling Training and Assistance Program. On behalf of FEMA, the Center for Mental Health Services (CMHS), Emergency Services and Disaster Relief Branch (ESDRB) provides technical assistance, program guidance and oversight.*

### **Purpose**

This program guidance outlines the similarities and differences between crisis counseling and behavioral health treatment in the context of the FEMA/CMHS Crisis Counseling Assistance and Training Program (CCP). It describes the scope and limitations of crisis counseling services and identifies key questions agencies and counselors should consider when deciding whether to refer an individual to mental health treatment services.

### **What is Crisis Counseling?**

For over twenty-five years, the Crisis Counseling Program has supported short-term interventions with individuals and groups experiencing psychological sequelae to large-scale disasters. These interventions involve the counseling goals of assisting disaster survivors in understanding their current situation and reactions, assisting survivors in reviewing their options, providing emotional support, and encouraging linkages with other individuals and agencies that may help survivors recover to their pre-disaster level of functioning. The assistance is focused upon helping disaster survivors cope with their current situation. Until there are contradictory indications, the program draws upon the assumption that the individual is capable of resuming a productive and fulfilling life following the disaster experience if given support, assistance, and information at a time and in a manner appropriate to his or her experience, education, developmental stage and culture.

The goal of crisis counseling is to assist individuals in coping with the psychological aftermath of the disaster, mitigate additional stress or psychological harm, and to promote the development of understanding and coping strategies that individuals may be able to call upon in the future. While always cognizant of those with special needs, the thrust of the Crisis Counseling Program since its inception has been to serve people responding normally to an abnormal experience. By serving such a broad spectrum of people, the program may encourage the use of mental health services by reducing discrimination and stigma associated with receiving them.

### **What is Behavioral Health Treatment?**

In contrast to the crisis counseling services provided through the CCP, mental health treatment, as typically defined within the mental health community, implies the provision of assistance to individuals for an existing pathological condition or disorder. In this

context, it involves providing a variety of interventions following the assignment of a diagnosis consistent with the most recent edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association or another similar assessment tool. This diagnosis is made following an evaluation and/or psychological testing by a licensed mental health professional. Typically, the mental health professional and client will discuss various treatment options and agree to certain interventions and treatment goals. Common interventions include the treatment of mental disorders, personality reconstruction, development of insight into a wide variety of historical and current life experiences, and resolution of unconscious conflicts. During treatment, the provider maintains a documented treatment plan and record. The mental health professional is licensed by the State and is protected by, and is subject to, a wide variety of legal matters including malpractice, informed consent to treatment, confidentiality, and patient/therapist privilege. Since the CCP does not provide "therapy" in the traditional sense, program managers and outreach workers should assume that their conversations with disaster survivors would not be considered "privileged" by a court of law.

The outline below provides a basic description of the differences between traditional mental health services and the Crisis Counseling Program. These key differences between traditional mental health practice and crisis counseling influence the way services are provided.

<b>"Traditional" Behavioral Health Practice</b>	<b>Crisis Counseling</b>
<ul style="list-style-type: none"> <li>▪ Is often office based.</li> <li>▪ Focuses on diagnosis and treatment of a mental illness.</li> <li>▪ Attempts to impact the baseline of personality and functioning.</li> <li>▪ Examines content.</li> <li>▪ Encourages insight into past life experiences and their influence on current problems.</li> <li>▪ Has a psycho-therapeutic focus.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Is primarily home and community based.</li> <li>▪ Focuses on assessment of strengths, adaptation of existing coping skills and development of new ones.</li> <li>▪ Seeks to restore people to pre-disaster levels of functioning.</li> <li>▪ Accepts content at face value.</li> <li>▪ Validates the appropriateness of reactions to the event and its aftermath and normalizes the experience.</li> <li>▪ Has a psycho-educational focus.</li> </ul>

\*Traditional behavioral health practice takes many forms. These descriptions are intended to provide examples for contrast rather than to describe the full range of traditional behavioral health practice.

### ***Use of Behavioral Health Professionals as Disaster Crisis Counselors***

Training and experience as a behavioral health professional in the traditional system does not guarantee that an individual will be an effective crisis counselor. While there are numerous examples of mental health professionals who have functioned exceptionally well as crisis counselors, there are also many examples of situations where this has not been the case. The most effective mental health professionals serving on crisis counseling teams have the following characteristics:

- They can assimilate a revised conceptualization of behavioral health services that is often different than their training and traditional function. (e.g. lack of diagnosis, interventions in very non-traditional settings, role ambiguity);
- They are comfortable working with paraprofessionals or trained nonprofessionals;
- They are able to incorporate crisis counseling theory and practice into the theoretical construct that usually guides their practice (e.g. psychoanalytical, cognitive/behavioral, insight oriented approaches).

### ***Scope of the Crisis Counseling Program***

The scope of the crisis counseling program includes the provision of crisis counseling services to individuals adversely affected by major disasters. In addition, it includes provision for training those hired by the crisis counseling programs and other community members who may deal with disaster survivors and would benefit from this type of knowledge. Training has proven to be a critical element of the program, particularly as it assists the crisis counselors in understanding the scope and boundaries of their roles as well as when it is appropriate to refer individuals to mental health treatment. Behaviors associated with generalized anxiety disorder; adjustment disorders, dysthymic disorder, substance abuse and perhaps eating and phobic disorders are commonly seen after a disaster. Yet, it is suggested that the Crisis Counseling Program coordinators train their outreach workers on how to approach individuals who may be experiencing such disorders. Asking the following types of questions may help clarify if the counselor should serve or refer the individual:

- Is the condition caused by or clearly exacerbated by the disaster?
- Is the crisis counseling staff able to perform an adequate assessment of this individual and assure that they can defend, in an adverse legal action, the appropriateness of crisis counseling as opposed to formal treatment, as the intervention of choice?
- Is the program's informal recording of contact notes adequate and appropriate (as opposed to a formal treatment record) in this case?
- Is the mental health system (of which crisis counseling is a part) the most appropriate and qualified to deal with this problem? Primary health care providers, substance abuse providers, social services, and protective services are examples of other service systems to which crisis counselors sometimes refer.
- Can the counselor appropriately respond to the needs of this person within the time, human resource, and skill limitations of the program?

To the extent that these questions are answered in the negative, referral is the recommended course of action. Clearly, making this type of assessment and possible referral takes time and appropriate supervision.

This program is intended to supplement State and local mental health (public and private) resources. It is expected that there will be individuals with needs that fall outside the scope and duration of the CCP. Cases that fall outside the scope of the Crisis Counseling Program should be referred to other agencies that provide mental health treatment. The criteria and methodology for referral should be well known

throughout the program and consistently applied by the crisis counselors. Supervisors should provide ongoing review of staff activities to assure that they are consistent with the scope and intent of the Crisis Counseling Program.

## **Kansas All-Hazards Behavioral Health (KAHBH) Network**

(Note: This section corresponds with *Modules 1 and 6* of the KAHBH Core Training)

The KAHBH Network will be responsible for performing a range of administrative functions that support the development of the crisis response infrastructure. These functions may be performed during any phase of the disaster but will be concentrated heavily on pre-disaster preparedness and future preparedness activities. In addition, the KAHBH Team will provide technical assistance and consultation to behavioral health providers and other primary care professionals in the state. In that role, the KAHBH Team will have primary responsibility for training related to crisis response and will perform the following functions:

- Organize and present crisis training events for professionals and community groups
- Assist with the development of Community Outreach Teams (COT)
- Train COT members
- Maintain a database of COT members
- Provide training, technical assistance and consultation to behavioral health providers and primary care responders
- Maintain a database of disaster-trained clinicians available to accept referrals, as needed
- Maintain a database of state speakers in the area of all-hazards behavioral health
- Prepare and distribute public information documents that address behavioral health aspects of disasters and terrorism
- Assist in the development of community needs assessments
- Evaluate trauma treatment and all-hazards behavioral health intervention techniques and recommend best practices, based on current literature

## ***KAHBH Team Structure***

The following is the list of functions performed by various KAHBH structure participants:

### ***Kansas Mental Health Authority***

#### **Qualifications**

- Knowledge of State behavioral health delivery system
- Knowledge of all-hazards behavioral health concepts and applications
- Knowledge of state emergency operations management
- Experience in behavioral health disaster response preferred, but not required

#### **Roles/Responsibilities**

- Serves as primary point of contact for emergency management activities related to all hazards behavioral health response by the Kansas Department of Emergency Management
  - Responsible for developing, implementing, and coordinating the KAHBH Response
  - Serves as the senior representative to the KDEM
  - Serves as staff at KDEM Command Center
  - Communicates all-hazards response activities to the Command Center coordinator
  - Supervises KAHBH State coordination
  - Collaborates with other state department and voluntary organizations involved in the all-hazards response
  - Coordinates needs assessment
  - Oversees the development, administration, and implementation of FEMA Crisis Counseling Program grant

*Kansas All-Hazards Behavioral Health (KAHBH) Team Coordinator*

Qualifications:

- Knowledge of State behavioral health delivery system
- Knowledge of all-hazards behavioral health concepts and applications
- Experience in behavioral health disaster response preferred, but not required

Roles/Responsibilities:

- Serves as second point of contact in KAHBH network for state emergency management activities
- Manages day-to-day operations of the all-hazards response
- Provides communication links to KMHA Coordinator
- Coordinates with local and regional all-hazards behavioral health response teams
- Develops policy and procedure manual for all-hazards behavioral health response
- Develops and provides orientation and training to Behavioral Health Network
- Develops Operations Manual for All-Hazards Behavioral Health Preparedness, Response, and Recovery Activities
- Directs the KAHBH response
- Assists in development of Community Outreach Teams
- Provides linkage to state and local responders during the pre-disaster and recovery phases
- Coordinates training, technical assistance, and consultation
- Develops and provides orientation to KAHBH staff
- Develops and maintains database of state network behavioral health responders
- Oversees development of community education materials
- Oversees the development, administration, and implementation of FEMA Crisis Counseling Program grant

*Community Mental Health Center (CMHC) Coordinators/ Community Outreach Team (COT) Leaders*

Qualifications

- Knowledge of all-hazards behavioral health concepts and applications
- Experience in behavioral health disaster response preferred, but not required
- Knowledge of local behavioral health resources
- Knowledge of the State behavioral health delivery system
- Professional background in a qualified mental health field.
- Selected on the basis of their leadership skills, expertise, training and previous disaster experience

#### Roles/Responsibilities

- Serves as local behavioral health liaison to local behavioral health contacts, county emergency service/disaster agents, local public health departments, and the KMHA and KAHBH coordinators
- Develops and maintains relationships with local emergency response entities in order to represent the COT Network with area emergency management
- Oversees the development of the KAHBH Network response teams
- Assures that all staff are appropriately trained in all-hazards behavioral health training
- Serves as leader of the local COT and assures coverage meets needs
- Provides input in the development/revisions of the KAHBH All-Hazards Behavioral Health Plan and Operations Manuals
- Manages and coordinates the day-to-day activities of the local COT
- Provides oversight and management of network members
- Advises state coordinators and network members regarding the planning and delivery of all-hazards behavioral health related services at the local level
- Coordinates CMHC all-hazards behavioral health response with appropriate community crisis providers
- Schedules periodic debriefing of staff in conjunction with state coordinators
- Conducts periodic meetings of the KAHBH Network members in their area
- Tracks all-hazards behavioral health related activities performed by local teams and reports to state coordinator(s)

#### *Community Outreach Teams (COT)*

- Consists of both behavioral health and non-behavioral health/paraprofessional members
- Provides all-hazards behavioral health interventions and supportive crisis counseling
- Provides outreach and advocacy to survivors, family members, and the community at large
- Provides consultation and technical assistance to local community groups
- Tracks crisis related activity performed by community teams and reports to command center
- Provides community education on all-hazards behavioral health issues through local organizations



### ***KAHBH State Network***

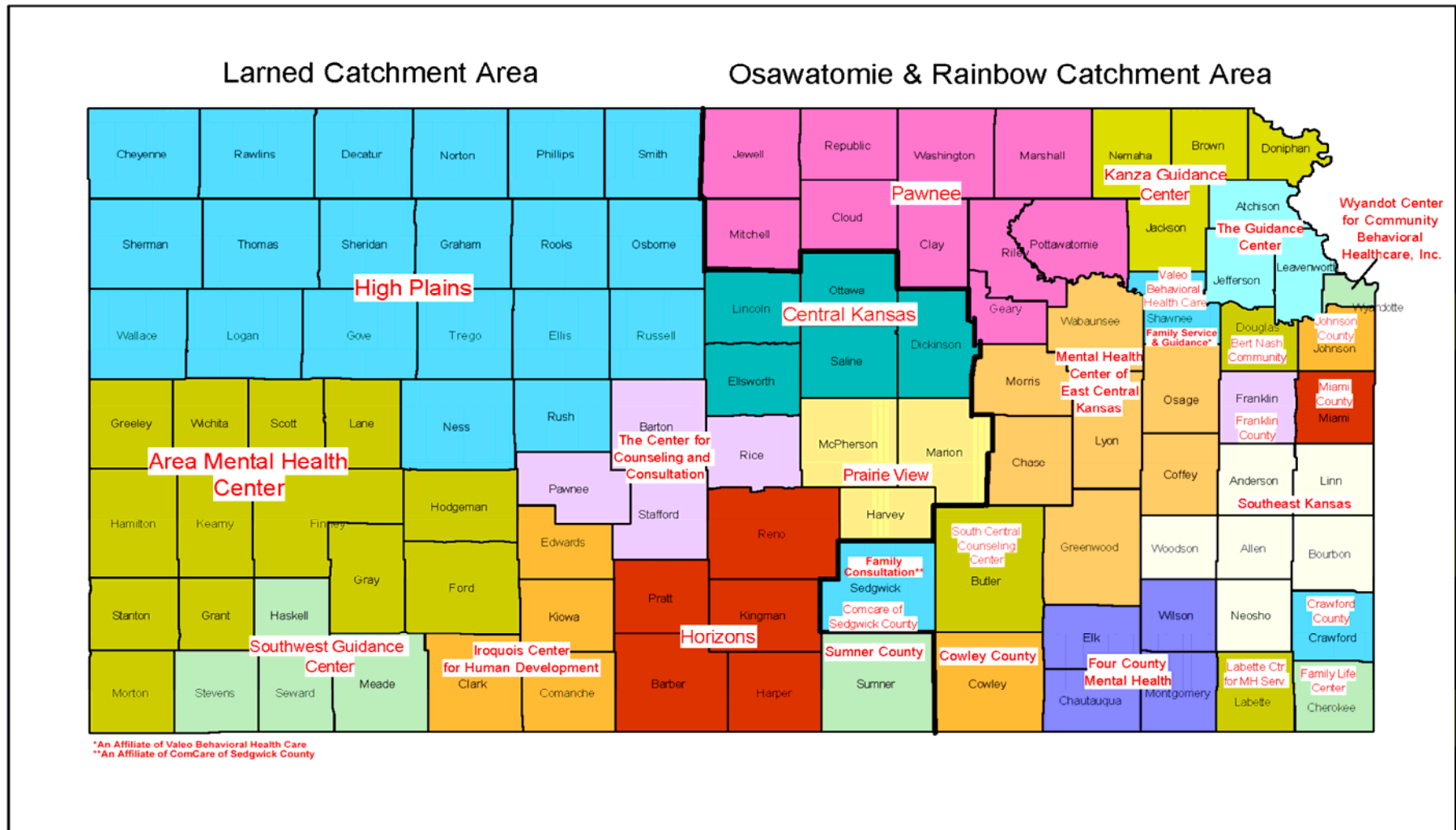
The limited availability of disaster behavioral health resources often leads to reliance on other supports for disaster behavioral health service such as primary health care providers, faith leaders, school personnel, and law enforcement. These professionals also may assume multiple roles in rural communities— crisis worker rescue squad member, crisis worker fire fighter, mayor, or community leader. The blurring of roles in small communities and rural areas creates challenges for work force identification and deployment in disaster and unique opportunities for cross-training, understanding, and risk communication. Organization of the KAHBH Network for disaster response occurs at the local level, creating Community Outreach Teams for local response.

The KAHBH State Network will provide behavioral health services directly to local communities during the acute and recovery phases of a disaster and will coordinate with local municipal and voluntary agencies. In Kansas, there are 27 Community Mental Health Centers and 2 affiliate organizations, based on the Kansas Mental Health Authority Community Mental Health Center (CMHC) Network (see Map on P. 69). The 27 CMHCs and the counties they serve are:

- 1) High Plains Community Mental Health Center  
Counties Served: CHEYENNE, DECATUR, ELLIS, GOVE, GRAHAM, LOGAN, \ NESS, NORTON, OSBORNE, PHILLIPS, RAWLINS, ROOKS, RUSH, RUSSELL, SHERIDAN, SHERMAN, SMITH, THOMAS, TREGO, WALLACE
- 2) Pawnee Mental Health Center  
Counties Served: CLAY, CLOUD, GEARY, JEWELL, MARSHALL, MITCHELL, POTTAWATOMIE, REPUBLIC, RILEY, WASHINGTON
- 3) Kanza Guidance Center  
Counties Served: BROWN, DONIPHAN, JACKSON, NEMAHA
- 4) The Guidance Center  
Counties Served: ATCHISON, JEFFERSON, LEAVENWORTH
- 5) Valeo Behavioral Health Care and Family Service and Guidance Center (Affiliate organization)  
County Served: SHAWNEE
- 6) Bert Nash Community Mental Health Center,  
County Served: DOUGLAS
- 7) Wyandot Center for Community Behavioral Healthcare  
County Served: WYNADOTTE
- 8) Johnson County Mental Health Center  
County Served: JOHNSON
- 9) Central Kansas Mental Health Center  
Counties Served: DICKINSON, ELLSWORTH, LINCOLN, OTTAWA, and SALINE
- 10) Mental Health Center of East Central Kansas  
Counties Served: CHASE, COFFEY, GREENWOOD, LYON, MORRIS, OSAGE, and WABAUNSEE
- 11) Franklin County Mental Health Center  
County Served: FRANKLIN

- 12) Area Mental Health Center  
Counties Served: FINNEY, FORD, GRANT, GRAY, GREELEY, HAMILTON, HODGEMAN, KEARNY, LANE, MORTON, SCOTT, STANTON, and WICHITA
- 13) Southwest Guidance Center  
Counties Served: HASKELL, MEADE, SEWARD, STEVENS
- 14) Iroquois Center for Human Development  
Counties Served: CLARK, COMANCHE, EDWARDS, and KIOWA
- 15) Center for Counseling and Consultation  
Counties Served: BARTON, PAWNEE, RICE, and STAFFORD
- 16) Horizons Mental Health Center  
Counties Served: BARBER, HARPER, KINGMAN, PRATT, RENO
- 17) Prairie View Mental Health Center  
Counties Served: HARVEY, MARION, and MCPHERSON
- 18) Comcare of Sedgwick County and Family Consultation Service (Affiliate organization)  
County Served: SEDGWICK
- 19) South Central Mental Health Counseling Center  
County Served: BUTLER
- 20) Sumner Mental Health Center  
County Served: SUMNER
- 21) Sunflower Centers of Kansas (previously: Miami County Mental Health Center)  
County Served: MIAMI
- 22) Cowley County Mental Health and Counseling Center  
County Served: COWLEY
- 23) Southeast Kansas Mental Health Center  
Counties Served: ALLEN, ANDERSON, BOURBON, LINN, NEOSHO, and WOODSON
- 24) Community Mental Health Center of Crawford County  
County Served: CRAWFORD
- 25) Four County Mental Health Center  
Counties Served: CHAUTAUQUA, ELK, MONTGOMERY, WILSON
- 26) Labette Center for Mental Health Services  
County Served: LABETTE
- 27) Family Life Center  
County Served: CHEROKEE

# State of Kansas Community Mental Health Centers



KAHBH Network local response will occur through Community Outreach Teams. Based on local communities, counties, or cities/towns in each CMHC area, Community Outreach Teams consist of all-hazards behavioral health specialists, including CMHC employees, other professionals, and paraprofessionals, who reside in or near the affected communities. Each CMHC will have a CMHC Coordinator/ Community Outreach Team (COT) Leader, who will coordinate response at the local level. The CMHC Coordinator will be a staff member of the local CMHC.

Each COT serves as back-up to local response efforts for other COTs in their geographic area and will normally be asked to deploy to other communities in their region (or to other regions) only if local resources are insufficient to address identified needs. In the event of a Presidentially declared disaster, all COT members in that region may be asked to deploy, or multiple KAHBH Network members might be deployed, depending on the scope of the disaster.

Participation in the KAHBH Network is entirely elective. Members will be multidisciplinary and will include behavioral health professionals and non-behavioral health professionals/ paraprofessionals.

### ***KAHBH Network Members***

The KAHBH Network is composed of behavioral health professionals and paraprofessionals indigenous to the community they serve from all areas of Kansas. All members are trained in the basics of all-hazards behavioral health and the SAMHSA Crisis Counseling Program. Their credentials and roles are explained below.

The KAHBH Network consists of behavioral health professionals who are employed by the local CMHC (CMHC employees), behavioral health professionals not employed by the CMHC but employed in the local communities (community professionals), and non-behavioral health crisis workers from the local communities (community paraprofessionals). Membership will be tracked by the KAHBH Coordinator, and CMHC Coordinators/COT Leaders will be provided with the names and contact information for potential responders in their local area. Community Outreach Teams may include only CMHC employees and/or a mix of CMHC employees and community professionals and paraprofessionals, depending on the availability of KAHBH responders in their local area.

### **Behavioral Health Professionals:**

#### ***Qualified Mental Health Professionals: CMHC Employees and Community-based***

There are five behavioral health professions recognized by the Center for the Mental Health Services of the Substance Abuse and Mental Health Service Administration that

are able to provide behavioral health services: psychiatry, psychiatric nursing, psychology, marriage and family therapy, and clinical social work ([www.mentalhealth.samhsa.gov](http://www.mentalhealth.samhsa.gov)). State licensure designates each of these professions as distinct and qualified to provide mental health treatment. The federal government recognizes these professions as the five core mental health fields, however, the term *Qualified Mental Health Professional* (QMHP) is not defined on the federal level. Each state decides which mental health professions are defined as QMHPs.

Kansas QMHPs are defined in the Kansas Care and Treatment Act for Mentally Ill Persons (KSA 59-2946). The Kansas Behavioral Sciences Regulatory Board recognizes QMHPs as physicians or psychologists who are employed by a mental health center or who are providing services under a contract with a mental health center, licensed masters level psychologists, licensed marriage and family therapists, licensed professional counselors, licensed specialist social workers or licensed master social workers, or registered psychiatric nurses ([www.ksbsrb.org](http://www.ksbsrb.org)). Each of these professionals is governed by its own state bylaws and its specific regional, state and/or national professional organization.

Within the KAHBH Network, QMHP members may include participants who are employed by the local CMHC as well as community professionals (e.g., private practitioners or employed by another agency). A QMHP who is employed by the CMHC will coordinate and supervise the local Community Outreach Team for the Crisis Counseling Program and may offer consultation and support to crisis counselors who are working with individuals with complex or difficult situations. A QMHP also may assess survivors to determine if their needs exceed the scope of the Crisis Counseling Program or may work directly with individuals, families, and groups whose problems are unusually challenging or complex. QMHPs still need training in understanding how crisis counseling with disaster survivors differs from traditional mental health or counseling practice. Essential skills include in-depth understanding about the normal human response to disaster and techniques for helping survivors integrate those experiences to ensure their return to pre-disaster levels of functioning.

**Psychiatrists.** Psychiatrists are trained as medical physicians and focus primarily on the Microsystems of patient care. The Microsystems of care attempts to heal the patient from within and with the assistance of medication. Psychiatrists are the only mental health professionals in all 50 states allowed to prescribe medications and medical treatments. They have completed three years of residency training in psychiatry following four years of medical school and a one-year internship. All psychiatrists are trained in psychiatric disorders and in pharmacotherapy, but not all have received training in psychotherapy. Psychiatrists specialize in the treatment of the persons with mental illness and usually do not treat the general population. They also are responsible for admission to and discharge from inpatient treatment for patients with a mental illness. The American Medical Association (AMA) governs them.

**Psychiatric Nurses.** Psychiatric nursing is a specialty area within the field of nursing. Psychiatric nurses, also called advanced practice registered nurses (APRN),

have a master's degree in psychiatric-mental health nursing ([www.apna.org](http://www.apna.org)). The American Psychiatric Nurses Association (APNA) governs them. These nurses assume the role of either clinical nurse specialist or nurse practitioner. Although nurses once functioned under the biomedical model, now they are more concerned with individual and family responses to health problems. Psychiatric nurses assess, diagnose, and treat individuals with psychiatric disorders. They also function as educators, consultants, and case managers. In some states, including Kansas, they have the authority to prescribe medications if they are licensed as Advanced Registered Nurse Practitioners working under a sponsoring physician ([www.ksbn.org](http://www.ksbn.org)). Before the advent of modern psychotropic drugs, psychiatric nurses spent a large portion of their time conducting therapy with mental health patients. However, now their primary responsibilities are to assess the patient, prescribe psychotropic drugs, monitor the patient for adverse side effects, and make necessary medication adjustments. Psychiatric nurses treat patients in the mental health unit of hospitals or in mental health centers.

**Psychologists. Clinical and Counseling psychologists** have doctoral level training and are governed by the ethical code of the American Psychological Association (APA). Clinical psychologists are making inroads toward having medication prescribing privileges. They are licensed to administer and interpret psychological tests, and they primarily place an emphasis on individual intrapsychic and behavioral issues, not on interpersonal ones. Clinical psychologists are licensed to diagnose and treat mental disorders. **Licensed Master's level psychologists (LMLP)** primarily provide counseling services for adjustment and emotional problems, either in individual sessions or in group settings. MLPs also conduct personality, intelligence and aptitude tests. In Kansas, they are required to work under the supervision of a clinical psychologist ([www.ksbsrb.org](http://www.ksbsrb.org)). MLPs can achieve the status of licensed clinical psychotherapist (LCP) by completing 4,000 hours of supervised clinical work and passing a licensing examination. Once they reach this level, they can then diagnose and treat mental disorders in private practice.

**Social Workers.** Clinical social workers with master's degrees or PhDs are particularly interested in identifying resources, coordinating services, and advocating for individuals, families, and communities. Clinical social workers are trained to provide short-term interventions. They examine the patient's macro system, meaning they look at the larger social context of an individual's life. They help people identify and use their strengths when dealing with crisis. Social workers function on interdisciplinary treatment teams. Their goal is to help maximize available resources and minimize the negative social and psychological consequences of disaster. Social workers utilize the biopsychosocial model of treatment and are governed by the National Association for Social Workers (NASW). Master's level social workers (MSW) in Kansas can achieve clinical status, which allows them to diagnose and treat mental disorders in private practice settings. A licensed specialist clinical social work (LSCSW) requires 4,000 hours of a supervised clinical experience and passing a clinical competency test ([www.ksbsrb.org](http://www.ksbsrb.org)).

**Marriage and Family Therapists.** Marriage and family therapists have a master's or a doctoral degree. MFTs work from a mesosystem framework, meaning they believe that the locus of responsibility for change lies within the interaction between the person and the person's family. Therefore, they are interested in the dynamic relationships within families and other systems, believing that whatever affects one member of a family or system, also impacts all the other parts of the family or system. MFTs function under the biopsychosocial model and are governed by American Association for Marriage and Family Therapy (AAMFT) ([www.aamft.org](http://www.aamft.org)). MFTs utilize systems theory, which emphasizes interpersonal relationships (rather than biological, intrapsychic, or societal processes) when addressing human distress. Licensed marriage and family therapists can achieve clinical status in Kansas by completing 4,000 professional hours, 1,500 that are direct client contact hours, and passing the national licensing exam. Clinical licensing allows MFTs to practice independently ([www.ksbsrb.org](http://www.ksbsrb.org)).

**Licensed Professional Counselors.** Master's level licensed professional counselors (LPC) and licensed clinical professional counselors (LCPC) have a foundation in human growth and development and promote career and life span development with individuals and groups. They help people make choices and develop themselves using cognitive and behavioral techniques ([www.counseling.org](http://www.counseling.org)). Licensed professional counseling is a relatively new profession and as such, it is not part of the core group of qualified mental health professions recognized by the federal government. However, Kansas includes LPCs as QMHPs. The counseling profession believes in the biopsychosocial model of care, but mostly focuses on intrapersonal development. Typically, LPCs are goal and action oriented. The profession's governing organization is the American Counseling Association (ACA).

Discipline	Education	Professional Organization	Theory / Model	QMHP Status	Exclusive Skills
Psychiatry	MD + Specialty	American Medical Association	Biomedical	YES	Treat medically, prescribe meds
Psychiatric Nursing	RN + Master's Degree	American Psychiatric Nurses Association	Biomedical + Biopsychosocial	Yes	Prescribe meds (if ARNP), treat medically (on psych unit)
Clinical Psychology	Master's Degree or PhD	American Psychological Association	Intrapsychic	Yes	Psych. testing and interpret results; psychotherapy
Social Work	Master's Degree	National Association of	Biopsychosocial	Yes	Advocate for and secure

		Social Workers			resources, psychotherapy
Marriage and Family Therapy	Master's Degree or PhD	American Association for Marriage and Family Therapy	Biosychosocial + Systems	Yes	Interpersonal relationship therapy
Licensed Professional Counselor	Master's Degree or PhD	American Counseling Association	Biopsychosocial	QMHP = YES; Core Gov't = NO	Career and lifespan development

Table 1: Comparison of QMHP Mental Health Disciplines

### ***Other Behavioral Health Professionals Employed by Kansas CMHCs***

The following behavioral health professionals also may be employees of local CMHCs and may be members of the KAHBH network:

- Bachelor's Level Social Workers
- Registered Alcohol and Other Drug Abuse Counselors
- Case Managers
- Attendant Care Providers
- Family Support Specialists

### **Community Paraprofessionals:**

The term paraprofessional refers to individuals who have a bachelor's degree or less or who are not human service professionals. They have strong intuitive skills about people or relate well to others. They possess good judgment, common sense, are good listeners, and are indigenous to the community. Paraprofessionals will engage in outreach crisis counseling and provide education, information, and referral services for individuals, families, and groups. Successful crisis counseling programs train paraprofessionals regarding the human response to disaster and methods for working with people who are experiencing the psychological consequences of disasters. Training should include the scope and limits of the program, the role of the crisis counselor, cultural considerations, ethical conduct, techniques for introducing crisis workers and the program, helping individuals understand their disaster experience,



record keeping, functional assessment skills, basic group process skills, and methods for guiding individuals in problem solving and setting priorities.

KAHBH Network Paraprofessional Members may augment the behavioral health response to disaster. Many of these responders already occupy natural helping roles within a community. They may be educators, human service professionals, or community crisis workers. Many will self-identify as wanting to be ready to respond or help if a disaster occurs. It is important to note that **even with the appropriate training, not everyone is suited for disaster response work**. Training in psychological first aid can be a first step toward building readiness. Pre-credentialing these crisis workers includes a requirement that they complete the KAHBH Core Training and an additional Skills Training for Paraprofessionals.

### ***Roles/Responsibilities of Paraprofessionals***

- Serve as an empathetic listener
- Provide education and outreach to community members about normal reactions to disaster
- Refer individuals to a professional for assessment if needed

Paraprofessional Members will not be trained or expected to perform any tasks in disaster response, which are best reserved for behavioral health professionals. Initial training will include psychological first aid principles, basic helping skills, an overview of disaster behavioral health, and when to refer to a professional.

### ***Inappropriate Tasks for Paraprofessional Responders to perform:***

- Functioning without supervision by a licensed professional
- Agreeing to or establishing long-term care or case management (implicit or explicit)
- Clinical assessment
- Evaluating, diagnosing, or using diagnostic terms (i.e., “you have...”)
- Giving advice about what to do
- Making any final decisions regarding behavioral health disaster services and/or referrals
- Minimizing reported symptoms
- Prescribing or dispensing drugs/medication
- Sharing certain types of information, i.e., fatalities
- Therapy/acting as a therapist
  - Emotional delving
  - Engaging in reprocessing of trauma
  - Debriefing

In summary, the KAHBH Network Community Outreach Teams will be unique to the communities they serve and may consist of the following membership groups:

- 1) Employees of the local CMHC, including Qualified Mental Health Professionals (psychiatrists, psychiatric nurses, psychologists, social workers, marriage and family therapists, and licensed professional counselors) and other behavioral

health professionals (LBSW, RAODAC workers, Case Managers, Attendant Care Providers, Family Support Specialists)

- 2) Qualified Mental Health Professionals in the community who are *not* employed by the CMHC
- 3) Community responders (i.e., community paraprofessionals) who are not trained as behavioral health professionals:
  - a. Public health professionals (doctors, nurses, administrators, etc.)
  - b. Emergency responders and other medical personnel
  - c. School principals, teachers, and health and counseling staff
  - d. Clergy and other members of the faith community
  - e. Employees of local agencies serving special/vulnerable populations, including children, elderly, people with disabilities, homeless, victims, multicultural groups, veterans, students and other groups unique to the community
  - f. Labor unions, businesses, and employee assistance personnel
  - g. Other potential members may include youth workers, hospice workers, students in training to be professional behavioral health practitioners, local service club members (e.g., Lions, Rotary), massage therapists, funeral home directors, senior citizen center workers, retirees, and others

KAHBH will work with the local American Red Cross, CISM network, and other groups to determine the possible scope and size of local deployment of their all-hazards behavioral health crisis workers. KAHBH Network members will be recruited for training and inclusion in the local teams. CMHC Coordinators/COT Leaders will help with member recruitment, gathering and maintaining member information for the KAHBH database, and member training.

### ***Key Characteristics/Abilities of KAHBH Personnel***

Disaster behavioral health work is not a vocation suited to all people. To complicate matters, individuals who perform well in the immediate stages of disaster may not possess qualities and skills necessary to provide services during the long term recovery stage. Often, once the community begins the long process of recovery, response personnel need different qualities and skills than were needed during the immediate response. Overall, key personal characteristics and abilities of those particularly suited for disaster work are:

- Mature
- Sociable
- Calm
- Knowledgeable about how systems work
- Flexible
- Tolerates ambiguity well
- Empathetic
- Genuine
- Shows positive regard for others
- Good listener

The recruitment and selection of KAHBH professional and paraprofessional network members will take into account the demographics of the disaster-stricken location (including ethnicity and language), and the phase of the disaster. Workers selected for disaster response and recovery work should not be so severely impacted by the disaster that their responsibilities at home or their emotional reactions interfere with participation as responders in the program, or vice versa.

It is recommended that network members:

- Be **indigenous** to the communities they serve, as they will be aware of issues in the community and not viewed as “outsiders” by disaster victims. Indigenous workers come from within the local community and are often part of the cultural or ethnic group receiving services. They are familiar to and recognized by community members. They may be community leaders or have a nurturing role in their communities. They may be behavioral health professionals already working in the community. Other examples of indigenous workers include retired persons, students and active community crisis workers. Indigenous workers may have formal training in counseling or related professions, or they may be paraprofessionals or professionals in other fields, as well.
- Possess **experience** working with various populations in need, including children, elderly, minorities, and disadvantaged. This expertise is invaluable in a disaster situation.
- Be capable of providing all-hazards behavioral health services through **non-traditional methods**. Working in a disaster may require public education activities, including public speaking at community meetings or local disaster-related events. Crisis counseling and all-hazards outreach work often is provided in victims’ homes, local restaurants, schools, or other informal places. Disaster workers should be able to function in these environments.
- Be **sensitive to cultural issues** and able to provide services that are culturally appropriate.

CMHC Coordinators/COT Leaders will identify, prescreen, select and train a cadre of community outreach workers who will be available for service in time of disaster. Potential crisis workers will complete an application and information form (See Appendix) that will be reviewed for appropriateness prior to an event. The KAHBH Coordinator will review and screen potential applicants for membership in the State network. The local CMHC Coordinators/ COT Leaders will select network members to work in local disasters.

Network members will be expected to complete required training, network orientation, member information form, and a statement of agreement. Spontaneous crisis workers may be screened and considered for an assignment in a non-direct service role during the immediate disaster phase and will be considered for KAHBH Network membership after the recovery phase of the disaster has ended.

## ***Brief Description of KAHBH Network Membership Requirements***

### **Training/Education**

Different forms of early intervention require different sets of skills, training, and background knowledge. Behavioral health practitioners are key professionals in this respect. In addition, many early intervention and follow-up activities may be delivered to trauma survivors by individuals who are specifically pre-trained in early intervention.

It is required that interested individuals not licensed as behavioral health practitioners complete the paraprofessional training program. Individuals who complete this training and any other required screening may be listed in a database of potential responders maintained by the KAHBH coordinator. Advanced behavioral health disaster response training is recommended for licensed/certified behavioral health professionals participating in the disaster response. For additional information on training, see the *KAHBH Training Operations Manual*.

### **Credentialing**

The KAHBH Coordinator will maintain a database of network members and copies of all members' professional licenses. Licensed/certified behavioral health professionals should always bring their professional license with them when they respond to a disaster. Behavioral Health Authorities and local emergency management agencies are urged to pre-credential community responders when possible. The local emergency management should coordinate this pre-credentialing and issue ID's suitable for local response needs to those who participate in trainings and are listed in the responder databases.

The American Red Cross involves separate credentialing and response system. Although KAHBH will coordinate with the American Red Cross Disaster Mental Health Services in responding to a disaster, the KAHBH Network will involve a community-based system of responders who provide direct outreach within their local area. As such, the credentialing and membership in the KAHBH Network, which may include ARC crisis workers as well, will be separate from the ARC network, which is exclusively clinically-licensed mental health professionals.

### **Community Outreach Team Leaders: Supervision of Responders**

Kansas recognizes that the initial phases of disaster response are intense and often chaotic, requiring supervisors to be skilled and experienced in disaster behavioral health work. For this reason, supervision of field work should fall to licensed behavioral health professionals, preferably with disaster response training and experience. Adequate clinical supervision of behavioral health disaster responders protects both service recipients and responders. Licensed behavioral health professionals with experience in

assuming clinical supervision roles should use the following guidelines to provide “adequate supervision” to behavioral health disaster responders:

- Be accessible to responders in the field
- Be available by phone or radio for immediate consultation, and availability on site for intervention or referral
- Limit the number of people in the field per supervisor to 5 teams of 2 people each if possible
- Require behavioral health responders to receive orientation prior to service and opportunities for debriefing following service
- Insist that behavioral health responders be deployed in teams – never solo
- Take time to know the strengths and limitations of the responders assigned for supervision
- Pair paraprofessional responders with licensed behavioral health members – use a “buddy system”
- Require that behavioral health responders identify themselves to survivors and those they are serving to allow the potential recipient of service to decline if desired
  - o Both licensed behavioral health responders and paraprofessionals should identify themselves “crisis counseling” crisis workers
- Work with administrative personnel to create reasonable working hours and conditions for those being supervised

Geographic areas without immediate access to licensed mental health experienced in disaster response should request the addition of such a responder as soon as possible. Community responders assuming a lead role in behavioral health responses in the interim should be cognizant of the guidelines listed above when actively deploying or supervising behavioral health responders immediately following a disaster.

The behavioral health response is part of an overall coordinated health response. Clinical supervisors should keep administrative personnel apprised of activities in the field through incident command structures. The clinical supervisors also may be in the field and can forward information to administrators about conditions, responses, and concerns that may contribute to the coordination of an overall response that more effectively meets the needs of those affected.

## Liability Issues

The Kansas All-Hazards Behavioral Health Plan is not a substitute for legal advice regarding liability. Efforts have been made to construct a system of deployment that maximizes protection from liability for community support workers. **There is no liability protection for community support workers who engage in illegal or unethical behavior while responding.** Workers are least liable when they: are part of a KAHBH Team activated by KMHA and KDEM, operate within the scope of their licensure or responsibility area, and are adequately trained and supervised in the field.

When an all-hazards event occurs, CMHC(s) in the affected area(s) will hire their COT responders, who will be employees of the CMHC; thus, each COT responder will be under the liability of the CMHC. Each CMHC will provide liability protection, based on their individual employee liability policy.

### **Requirements for KAHBH Network Participation**

- 1) All KAHBH Network members will complete the KAHBH Core Training.
- 2) The KAHBH Network will include behavioral health professionals who are employed by the local CMHC.
- 3) The KAHBH Network also may include Qualified Mental Health Professionals who are not CMHC employees but are employed in the local communities (i.e., “community professionals”), as well as non-behavioral health professionals from the local community (i.e., “community paraprofessionals”).
- 4) All KAHBH Network members who are “community paraprofessionals” will complete an additional training on basic helping skills in crisis counseling
- 5) All KAHBH Network members will have the opportunity to receive additional training in the following areas:
  - a. Children (under age 18)
  - b. Frail elderly
  - c. Developmentally disabled and physically disabled
  - d. People with severe mental illness and people in active substance abuse treatment
  - e. People in correctional institutions, college students in dorms/away from home, and other relocated families/individuals
  - f. People with high traumatic exposure
  - g. People in poverty and homeless
  - h. Women/girls in the area
  - i. Emergency responders involved in rescue/recovery
  - j. Multicultural issues
  - k. Rural populations, including farmers, ranchers, and agricultural workers

At least 2 members (1 CMHC employee and 1 community responder) in each CMHC Area will receive specialized training in each of these areas. Thus, Community Outreach Teams will have members trained in these specialty areas, but not all Community Outreach Team members will be trained in every area identified. Trainings are open to all members and members may choose to receive specialized training in more than one area. Even if network members have specialized training in these areas, they will be required to participate in the KAHBH Network Specialty Training in that area because of the special issues related to disaster work with these populations. These specialty trainings will be available via web-based training.

- 6) All KAHBH Network members will participate in at least one Core Refresher Training each year, which will be designed to provide updated information to

network members. These refresher trainings will be provided on-site initially and will eventually be available via web-based training.

- 7) All KAHBH Network members will sign an “Agreement to Participate.”

Community Outreach Teams will be responsible for providing a broad range of activities to individuals, groups, and communities affected by a disaster. The range of activities to be provided depends on the severity and phase of the disaster. In addition, certain activities are most likely to occur during the pre-disaster preparedness phase, like regional trainings and team recruitment and orientation activities. Potential activities may include the following:

Disaster Preparedness:

- Training
- Needs assessment
- Media and public information
- Linkages with local and statewide emergency response systems
- Network development and team recruitment

Disaster Response:

- Needs assessment
- Crisis intervention and counseling
- Case management and advocacy
- Community outreach and public education
- Emergency client movement
- Training
- Screening and preventive education
- Development of specialized disaster resources
- Coordination with other disaster resources

Recovery

- Brief supportive counseling
- Case management and advocacy
- Community outreach and public education
- Information dissemination
- Screening and assessment
- Support groups

Future Preparedness

- Evaluation of the KAHBH Response Plan
- Specialized training initiatives
- Research
- Prevention education

## **Establishment of Crisis Counseling Teams**

The KAHBH Coordinator or designee, with the assistance of KMHA Director, shall develop a mechanism for unaffected community mental health centers and hospitals to provide a list of staff who are on standby or available to report for immediate deployment to affected areas. Rosters and schedules shall be maintained by the KAHBH Coordinator regarding crisis counseling teams on standby and in the field documenting:

1. Names of crisis counselors;
2. Name of the referring community mental health center or state mental hospital;
3. Professional discipline or affiliation;
4. Clinical licensure
5. Clinical specialty (e.g., psychosocial rehabilitation, addictions, children and their families, crisis stabilization, deaf services, elderly, etc.);
6. Field assignment location;
7. Team leader's name;
8. Rotation dates into and out of the field;
9. Expected date of return to regular duty following each crisis counseling rotation;
10. Availability for subsequent rotations;
11. Debriefing plan and schedule.

## **Alternate Plan for Disaster Coordination**

In the event that the KMHA building in Topeka is incapacitated because of a disaster, the alternate behavioral health coordination site will be Kansas State University in Manhattan. Unaffected community mental health centers and hospitals shall coordinate deployment of personnel and assistance under the supervision of KMHA. Responses to Disaster

Source: <http://www.mentalhealth.samhsa.gov/publications/allpubs/ADM90-538/Default.asp>



## **Roles and Services within Crisis Counseling Programs**

Source: [http://www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/ccp\\_pg03.asp](http://www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/ccp_pg03.asp)

*Note: This is the third in a series of program guidance documents developed to ensure consistency in addressing key program issues in the Crisis Counseling Training and Assistance Program (CCP). The Crisis Counseling Training and Assistance Program is funded by the Federal Emergency Management Agency (FEMA) under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. On behalf of FEMA, the Center for Mental Health Services (CMHS), Emergency Services and Disaster Relief Branch (ESDRB) provides technical assistance, program guidance and oversight.*

### **Purpose**

This program guidance is designed to provide States with direction on the roles and services of the Crisis Counseling Program staff. A significant challenge in operating the FEMA/CMHS Crisis Counseling Assistance and Training Program (CCP) is to ensure that services are tailored to the unique issues in each disaster, while at the same time ensuring that basic program philosophy, concepts and requirements are understood and implemented consistently across the country. While there has been increased consistency in types and quality of services provided in recent years, there is still variation in the use of staff and service delivery models, particularly in communities that have little experience with the program.

### **Defining Outreach and Crisis Counseling**

Outreach, as it is used in the Crisis Counseling Program (CCP), is a method for delivering crisis counseling services to disaster survivors. It consists primarily of face-to-face contact with survivors in their own environments (i.e. homes, businesses, schools, places of religious worship) in order to provide disaster-related crisis counseling services. Outreach also may be conducted in Disaster Recovery Centers, shelters or community centers. Telephone contact with survivors is a common outreach method used by Crisis Counseling Programs during all phases of implementation. This includes calling individuals from lists of disaster survivors available from different agencies to establishing 24-hour crisis hotlines. While these are legitimate forms of contact, they do not constitute outreach, and should not constitute a significant portion of the crisis counseling services provided. Personal contact with survivors should be the dominant method of service delivery within the Crisis Counseling Program.

Crisis counseling is defined as a short-term intervention with individuals and groups experiencing psychological reactions to a major disaster and its aftermath. A key concept of the CCP is that most people experiencing a psychological reaction are responding normally to an abnormal situation.

For most disaster survivors, traditional office type psychotherapy is not necessary, nor appropriate. Crisis intervention, brief treatment, support groups and practical assistance are most effective. Behavioral health staff must have a working knowledge and skill in these several modalities. Ideally, the disaster behavioral health team should be

multidisciplinary and multi-skilled. Staff should be experienced in psychiatric triage, first aid, crisis intervention, and brief treatment. They should have knowledge of crisis, post-traumatic stress and grief reactions, and disaster psychology. Survivors are often reluctant to come to mental health centers for services. As a result, staff must be able to provide their services in non-traditional community-based settings. Prior disaster behavioral health training and experience are highly recommended. In situations of mutual aid where licensed professionals cross state lines to provide assistance in disaster, licensing in the impacted state may be waived under the Good Samaritan law. This issue should be investigated in instances of cross-state mutual aid.

Behavioral health responders should be well-acquainted with the functions and dynamics of the community's human service organizations and agencies. They should have experience in consultation, collaboration, and community education. Excellent communication, problem-solving, conflict resolution, and group process skills are needed, in addition to an ability to establish rapport quickly with people from diverse cultures and backgrounds.

Managers should pay careful attention to the state's scope of practice laws for various behavioral health professional disciplines. Individuals who provide formal assessment and counseling which fall into the definition of psychotherapy should be appropriately licensed and insured for professional liability.

### ***The Role of the Outreach Worker***

Sensitivity to the community's perception of behavioral health services is key in designing a successful Crisis Counseling Program. In designing a CCP, applicants should view "crisis counselors" and "outreach workers" as synonymous. Both should be providing crisis counseling services to survivors in a variety of locations through an outreach method of service delivery. It may be more acceptable to some communities for "outreach workers" to provide crisis counseling services; other communities may be quite comfortable with "crisis counselors" providing these services. Either reference, outreach worker or crisis counselor, is acceptable in describing the individuals who will be providing services. Throughout this guidance, "outreach workers" and "crisis counselors" will be used interchangeably.

The Community Outreach Team Members may be involved in the following outreach activities:

**1. Outreach:** Working in disaster-affected neighborhoods, mass care shelters, Disaster Application Center, or other community settings requires workers who are adept at such nontraditional behavioral health approaches as "spot consultations" and "over a cup of coffee" or "shoulder to shoulder" assessments and interventions.

**2. Public education and information:** Public education efforts require staff that is interested and effective in public speaking and

working with the media. The development of fliers and brochures requires good writing skills.

**3. Community liaison:** Establishing and maintaining effective liaison with community leaders requires individuals who understand and are effective in dealing with organizational dynamics and the political process. Working successfully in the "grass roots" community requires someone who understands the local culture, social networks, formal and informal leadership, and is effective in establishing relationships at the neighborhood level. Liaison activities might include everything from attending school or church gatherings, participating in neighborhood meetings, or providing disaster behavioral health consultation to government officials.

In general, crisis counselors provide:

- active and supportive listening;
- validation of the appropriateness of an individual's feelings and reactions;
- affirmation that such feelings and reactions are normal;
- education to survivors about ways to manage their distress and take care of themselves as they pursue recovery;
- assistance to survivors in determining their priorities and developing plans for meeting those priorities; and
- information and referral on disaster assistance and human service resources.

Crisis counselors do not:

- engage in case finding activities
- provide case management services
- create or implement emergency preparedness activities
- advocate in an adversarial manner
- engage in fundraising for disaster survivors
- provide childcare or transportation for disaster survivors

(For additional information refer to CCP-PG-04-00, "Case Management and Advocacy Within Crisis Counseling Programs")

### ***Phases of Crisis Counseling Services***

In the early phases of response and recovery, outreach workers may work in Disaster Recovery Centers (DRC), at shelters, mass care sites, water and relief distribution sites, or any location where survivors and/or emergency workers are gathering. They also will canvass affected areas to assess the relative impact of the disaster and seek out survivors in the community. In this phase of the disaster response and recovery,

counselors will often listen to survivors tell their stories and ventilate their frustrations. Survivors should be counseled about expected reactions, setting priorities, and developing plans for meeting their most critical needs. Counselors also may make judgments about the need for continuing contact with survivors.

In the middle phase of recovery, individuals will receive needed crisis counseling services at regular intervals in their homes or at a community-based site of the individual's choosing. Crisis counselors also provide community education services. These include participation in neighborhood and community meetings to educate people about the crisis counseling program and the normal reactions to disasters. Outreach workers often address church groups, civic organizations, and school related organizations such as Parent-Teacher Associations to provide education on disaster mental health issues and to promote the healthy use of these natural support systems. Counselors may collaborate with other community agencies to ensure comprehensive and coordinated services are provided; or they may educate other service providers on techniques to promote survivors' healing. Counselors also may train teachers, guidance counselors, and day care workers on methods for helping children cope with the disaster experience. People attending such presentations may either seek services or advise counselors about others who may need services.

In the final phases of the Crisis Counseling Program, outreach workers may become involved in assisting the community in planning anniversary events or memorial services and in creating a plan for ongoing community support. Crisis counselors should assess whether survivors need continuing behavioral health services and provide referrals when necessary. Individuals needing continued services should be referred to the traditional mental health programs in their community. Those who do not need continued services should be prepared by the outreach workers for the expected phase down and conclusion of the CCP. Program coordinators should prepare both the impacted community and the outreach workers for closure of the program by providing training on appropriate phase down activities. Linkages with existing agencies or service providers in the community should be established, as the final transition of the program to the community is particularly important.

COMMON CRISIS  
COUNSELING SERVICES

- Information
- Education
- Outreach
- Counseling
- Supportive listening
- Referrals
- Training
- Collaboration with other programs

Throughout the duration of the Crisis Counseling Program, outreach workers spend the majority of their time in the community. Through their outreach efforts, the workers determine who among the survivors may need crisis counseling services and begin to establish a relationship with them. When crisis counselors encounter survivors who have serious behavioral health problems that pre-date the disaster or who have developed a significant behavioral health problem as a result of the added stress of the disaster, they should refer the individual for more in-depth mental health services within their local community. However, assessment for referral to a behavioral health agency

for disaster-related emotional issues should not be a routine responsibility of crisis counselors.

## **Case Management and Advocacy within Crisis Counseling Programs**

Source: [http://www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/ccp\\_pg04.asp](http://www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/ccp_pg04.asp)

*Note: This is the fourth in a series of program guidance documents developed to ensure consistency in addressing key program issues in the Crisis Counseling Training and Assistance Program (CCP). The Crisis Counseling Training and Assistance Program is funded by the Federal Emergency Management Agency (FEMA) under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. On behalf of FEMA, the Center for Mental Health Services (CMHS), Emergency Services and Disaster Relief Branch (ESDRB) provides technical assistance, program guidance and oversight.*

### **Purpose**

This program guidance discusses advocacy and case management and clarifies the types of activities that are appropriate and inappropriate for implementation in the Crisis Counseling Assistance and Training Program (CCP). This guidance may be particularly helpful for Crisis Counselors who have prior experience, as case managers within the public health system because some commonly practiced advocacy and case management activities are not within the scope of the CCP.

### **Case Management and Advocacy within the Public Behavioral Health System**

Case management, in some form, is practiced in most public behavioral health agencies. While definitions and models vary greatly, case management typically involves coordination of client services to assure continuity of care and accountability for service provision. Within the public behavioral health system, advocacy is generally considered to be an important element of case management. Advocacy involves representation of the needs and interests of people with serious mental illnesses in order to obtain services, assure fair and reasonable accommodations for special needs, and promote opportunities for maximum independence in the community. Advocacy may include interpretation of client needs to providers, consultation and technical assistance in reducing and eliminating barriers, and assertive efforts to assure adaptations and accommodations. In some instances, advocacy can be an adversarial process directed toward forcing a system, resource or provider to serve the client.

### **Case Management and the Crisis Counseling Program**

The Crisis Counseling Program is funded by FEMA and administered by the Emergency Services and Disaster Relief Branch (ESDRB) of the Center for Mental Health Services (CMHS). Crisis counseling often includes assisting survivors in understanding the availability of other FEMA human services programs and the mechanisms for obtaining information regarding the status of their applications for assistance.

In many respects, the activities of crisis counselors may be similar to those of case managers in the public behavioral health system, especially to the extent that many

cases in the behavioral health system involve clients who require support from several community-based and governmental services. In addition, many crisis counselors have previous case management experience and are familiar and comfortable with that role. However, it is important to note that there are key differences between the disaster crisis counseling program and case management services. Not respecting these differences can lead to confusion and difficulties. Key differences between traditional case management activities and the services offered through the CCP are listed in the table below.

Case Managers	Crisis Counselors
Provide services to individuals who may have a serious and/or persistent mental illness or other disability of indefinite duration.	Provide services to disaster survivors who are assumed to have a high level of functioning.
Responsible and accountable for client or patient service provision.	Services provided do not require continuity of care.
Have the power to influence the provision of services for their client.	Empower the disaster victim to advocate for services needed.
Have long-term relationship with clients.	Have short-term relationships with disaster victims.

Crisis counselors may encounter disaster survivors who are seriously impaired. This impairment may result from a wide variety of sources including acute and chronic mental or physical illness, substance abuse, addiction, or a developmental disability. The magnitude of need and the compelling nature of a disaster victim's problems may incline the crisis counselor to assume a more central and expanded role than is appropriate. Crisis counselors should consult with their immediate supervisors before assuming any additional responsibilities for disaster survivors. It is entirely appropriate for crisis counselors to participate in activities designed to assure coordinated and comprehensive services to these individuals, but it is not appropriate for crisis counselors to assume the central role in the establishment or coordination of those services.

### ***Advocacy and the Crisis Counseling Program***

Advocacy has emerged to varying degrees in many crisis counseling programs. In its most controversial form, it has evoked the perception that some crisis counselors have represented or advocated for disaster survivors in their conflicts with other FEMA human services disaster programs. The focus of FEMA supported human services programs, including the CCP, is to assist survivors in organizing and accessing the disaster related resources that will help them achieve pre-disaster levels of functioning and equilibrium. In order to serve the wide variety of needs of disaster victims in the most efficient and cost-effective manner possible, each program addresses a different disaster recovery need. Learning to navigate the array of organizations and agencies offering disaster assistance becomes a central recovery task for disaster survivors. This experience can be overwhelming and frustrating for the survivor and can create additional trauma and stress. Survivor expectations often exceed the magnitude and speed of assistance FEMA is authorized to provide, and in turn they may view the process as cumbersome, slow and insufficient. Consequently, survivors may become

angry and may even feel that FEMA (and the FEMA staff with whom they come in contact) is unable to, or not interested in, assisting them. As a result, identifying the source of the disaster related stress and choosing the appropriate intervention could be complicated.

The purpose of the crisis counseling program is to help disaster victims recognize that, in most cases, their emotional reactions are normal and to develop coping skills that will allow them to resume their pre-disaster level of functioning and equilibrium. Allowing survivors to grieve their losses, enhancing coping mechanisms and developing skills are desired long-term outcomes of the CCP. Crisis counselors need to be knowledgeable enough about other resources to guide and direct the survivor to the appropriate sources for obtaining assistance or resolving problems. It is not appropriate or expected for the crisis counselor to become expert in the intricacies of other programs or to serve as an advocate for the survivor in obtaining services or resolving disputes. It is important to remember that the crisis counseling program is based upon assumed competence of disaster survivors. A key tenet of the program is the assumption that the vast majority of disaster survivors, given support and adequate information, are capable of appropriately representing themselves and resolving their own difficulties. Listed below are appropriate and inappropriate activities for crisis counselors.

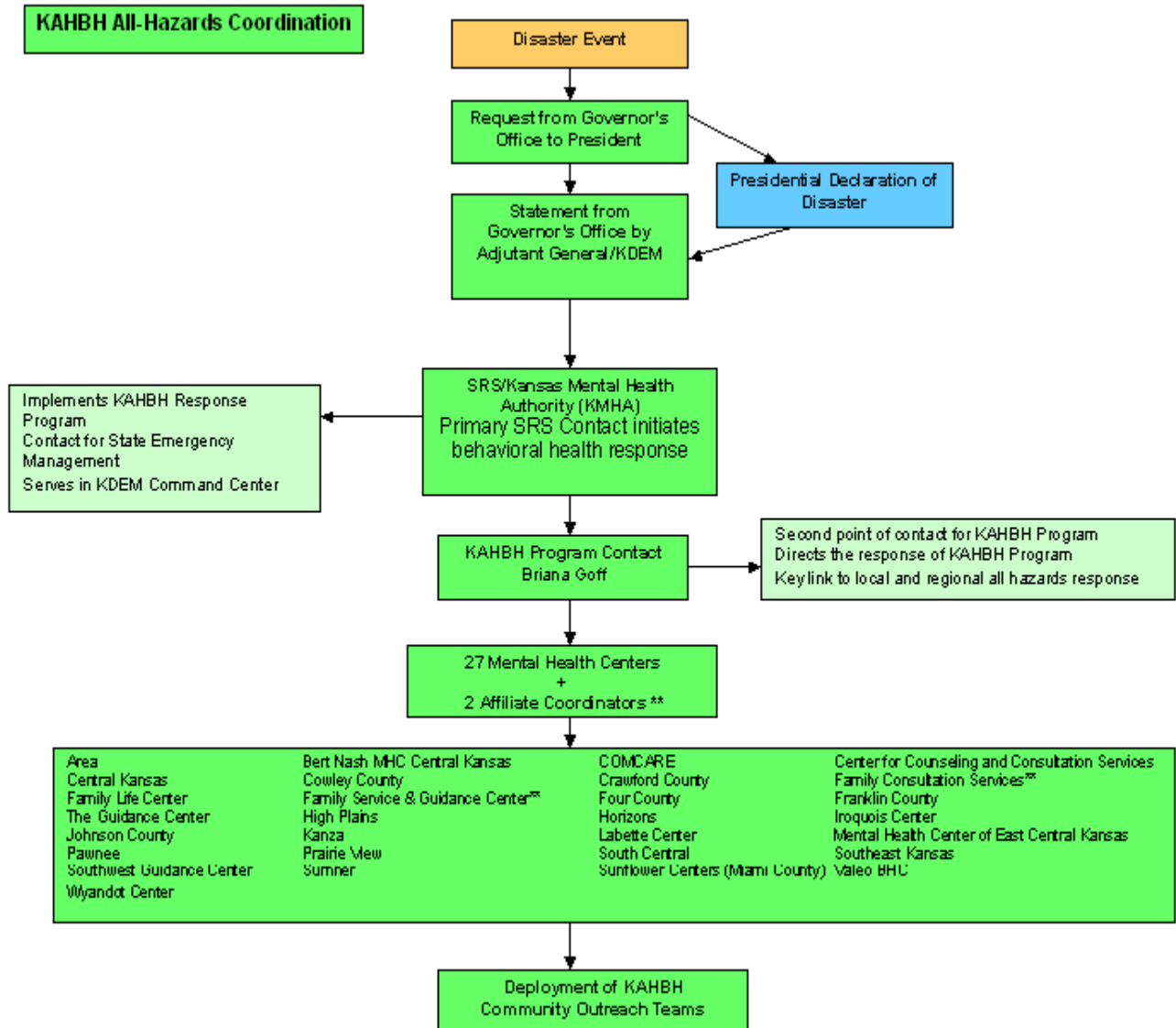
### ***Appropriate Activities for Crisis Counselors***

- Normalizing the disaster recovery experience by identifying and acknowledging that dealing with new and complex organizations is difficult and often stressful;
- Assisting survivors in organizing and prioritizing recovery tasks and external demands to reduce stress;
- Identifying normal reactions such as frustration and confusion, as well as defense mechanisms such as displaced anger;
- Establishing and maintaining current information about a wide variety of recovery resources in order to make efficient referrals;
- Assisting survivors in obtaining or maximizing skills such as communication, problem solving, conflict resolution, time management and stress management, to better enable them to work more effectively with recovery organizations;
- Representing the behavioral health perspective on "unmet needs" committees.

### ***Inappropriate Activities for Crisis Counselors***

- Assuming responsibility for representing a survivor to any organization;
- Advocating in an adversarial manner on behalf of a survivor;
- Becoming an expert on disaster relief and recovery programs outside the CCP;
- Becoming involved in the development of community resources for disaster relief;
- Creating or implementing emergency preparedness activities;
- Engaging in disaster relief fund raising activities for victims;
- Completing applications and appeal forms for disaster victims;
- Providing childcare services or transportation for disaster victims.

## Kansas All-Hazards Behavioral Health Response Structure





## **Disaster Classifications and Phases**

(Note: This section corresponds with *Module 3* of the KAHBH Core Training)

A survivor's reactions to and recovery from a disaster are influenced by a number of factors, some inherent and some malleable. These factors are depicted in the diagram below, and, as shown, contribute to recovery outcomes. The disaster event itself has characteristics, such as speed of onset or geographic scope, which generates somewhat predictable survivor responses. Each survivor has a combination of personal assets and vulnerabilities that either mitigate or exacerbate disaster stress. The disaster-affected community may or may not have pre-existing structures for social support and resources for recovery. Disaster relief efforts that effectively engage with survivors and the overall community promote recovery.

This section describes critical variables associated with each factor. The term "psychosocial" is often used to capture the breadth of effects of disaster on survivors. As shown in the diagram below, disasters unavoidably impact survivors both psychologically and socially. Disaster mental health program planners, administrators, and providers can more easily assess their own communities and design effective interventions when they have an appreciation for this "macro" view of interacting factors.

### ***Characteristics of Disasters***

Disasters are not uniform events. Each disaster, be it a flood, earthquake, hurricane, or human-caused disaster, has intrinsic unique elements. These elements have psychological implications for survivors and communities. The disaster characteristics discussed in this section are: natural vs. human causation, degree of personal impact, size and scope, visible impact/low point, and the probability of recurrence. Each of these, individually or collectively, has the potential for shaping and influencing the nature, intensity, and duration of post-disaster stress.

### ***Natural vs. Human Causation***

While there are divergent findings regarding whether natural or human-caused disasters produce greater overall psychological effects, there are clearly psychological reactions unique to each (Weisaeth, 1994; Rubonis & Bickman, 1991). In human-caused disasters such as bombings and other acts of terrorism, technological accidents, or airline crashes, survivors grapple with deliberate human violence and human error as causal agents. The perception that the event was preventable, the sense of betrayal by a fellow human(s), the externally focused blame and anger, and the years of prolonged litigation are associated with an extended and often volatile recovery period.

In true natural disasters, the causal agent is seen as beyond human control and without evil intent. For some, accepting mass destruction as "an act of God" is easier, whereas for others it can be more difficult. The world can temporarily seem to become unsafe with its potential for random, uncontrollable and devastating events (Yates, 1998).

In reality, there is a continuum between natural and human factors. Many disasters occur or are worsened through an interaction of natural and human elements (Green & Solomon, 1995). For example, damage from the natural event of flooding may be increased due to human factors such as inadequate planning, governmental policies, or faulty warning systems. An aircraft accident may result from an interaction of poor weather conditions and pilot error. Survivors experience reactions consistent with each dimension as they struggle with causal attributions.

### ***Degree of Personal Impact***

Researchers have consistently shown that the more personal exposure a survivor has to the disaster's impact, the greater his or her post-disaster reactions (Solomon & Green, 1992). Death of a family member, loss of one's home, and destruction of one's community exemplify high impact factors. In each of these, the intertwining of grief and trauma processes compound the effects and extend the duration of the recovery period for many survivors (Kohn & Levav, 1990). High exposure survivors experience more anxiety, depression, sadness, post-trauma symptoms, somatic symptoms, and, in some studies, alcohol abuse.

### ***Size and Scope of the Disaster***

As with the degree of personal impact, a dose-response relationship between community devastation and psychological impact exists. When entire communities are destroyed, everything familiar is gone. Survivors become disoriented at the most basic levels. Researchers have found higher levels of anxiety, depression, post-traumatic stress, somatic symptoms, and generalized distress associated with widespread community destruction (Solomon & Green, 1992).

When some fabric of community life is left intact (e.g., schools, churches, commercial areas), there is a foundation from which recovery can occur. Social support occurs more readily when community gathering places remain. Survivors are then more able to continue some of their familiar routines. Family roles of provider, homemaker, or student are more able to be fulfilled when structures and institutions remain.

### ***Visible Impact/Low Point***

Most disasters have a clearly defined end point that signals the beginning of the recovery period. After a tornado, hurricane, or wildfire has passed through an area, the community sees the total extent of resulting physical destruction and begins the recovery and rebuilding process. The disaster threat is over and healing can begin.

However, in contrast technological events like nuclear accidents or toxic spills are "silent" disasters and do not show visual damage or have an observable "low point." The health consequences of increased risk for cancer and birth defects continue for decades (Green & Solomon, 1995; Berren et al., 1989). This prolonged impact period with no clear end impedes the recovery process. Survivors suffer the effects of chronic stress and anxiety due to the extended period of anticipation, fear, and threat (Davidson & Baum, 1994).

The end point of the disaster can be ambiguous in some natural disasters as well. Although an earthquake has its major impact, the aftershocks keep survivors worrying that "the big one is yet to come." Slow moving, repeat flooding, and related landslides may continue for months through a period of heavy rains. While there is visual physical damage to be reckoned with, it may be weeks or months before survivors feel that the disaster is truly over.

### ***Probability of Recurrence***

When the disaster has a seasonal pattern, such as hurricanes or tornadoes, survivors are concerned they will be hit again before the season ends. During the low-risk portion of the year, communities rebuild. Vegetation grows back and visual reminders of the disaster diminish. At the one-year anniversary, the reminder that the area is potentially at-risk again causes disaster stress and hyper vigilance to resurface.

The immediate probability of recurrence is perceived as high following earthquakes and floods. The aftershocks following an earthquake or the increased risk of flooding due to ground saturation and damaged flood control structures following major floods keep many survivors anxious and preoccupied. In flood plain areas prone to repeat flooding, survivors can be kept in limbo regarding governmental buyouts, re-zoning, or the rebuilding of their homes as local, State, and Federal agencies address jurisdictional and legislative issues. This can be especially threatening and anger inducing when the next year's flood season approaches and decisions and/or repairs have not yet been made.

These five characteristics of disasters-natural vs. human causation, degree of personal impact, size and scope, visible impact/low point, and the probability of recurrence-contribute to dynamics that have potential psychosocial implications. These characteristics further define the disaster event portrayed in the diagram at the beginning of this section. Now, the discussion will shift to the survivor's characteristics that can mitigate or elevate disaster stress outcomes.

### ***Survivor/"Person" Characteristics***

A major disaster indiscriminately affects all who are in its path. Some disasters, such as a tsunami or landslide, may happen disproportionately to destroy wealthy people's shoreline or cliff-top view properties; whereas, another disaster, such as an earthquake or hurricane, may destroy poor people's structurally unsound housing. The disaster may affect thousands to millions of people in a densely populated urban area, or affect comparatively small numbers of people in a sparsely populated rural area.

Each survivor experiences the disaster through his or her own lens. The meaning the survivor assigns to the disaster, the survivor's inherent personality and defensive style, and the survivor's world view and spiritual beliefs contribute to how that person perceives, copes with, and recovers from the disaster. Experiences with losses or disasters may enhance coping or may compromise coping due to unresolved issues associated with those past events.

Having sufficient financial resources and being able to benefit from a social support network buffer the potentially devastating effects of a disaster and greatly assist the recovery process. An additional resilience factor includes the ability to tolerate and cope with disruption and loss. In contrast, vulnerability factors include preexisting health or emotional problems and additional concurrent stressful life events (McFarlane, 1996). In addition, cultural experience and ethnic background may facilitate or interfere with a survivor's ability to engage with disaster relief efforts.

Research findings are inconsistent with regard to the impact of gender and age on psychological outcomes. There is some indication that those in the forty to sixty age range may be more at risk because of the competing demands of child rearing, jobs, and caring for elderly parents (Green & Solomon, 1995). While single survivors may be more vulnerable than those who are married, increased marital conflict has been demonstrated following disasters. Refer to Section 3 for more information on the disaster reactions of potential risk groups.

### ***Disaster Relief Efforts***

When disaster relief efforts "fit" the community being served, survivors' access to assistance is enhanced. Information is available in native languages through print media, radio, and television. Relief workers are respectful of differences and work with trusted community leaders. Barriers are identified and addressed as every effort is made to connect survivors with resources for recovery.

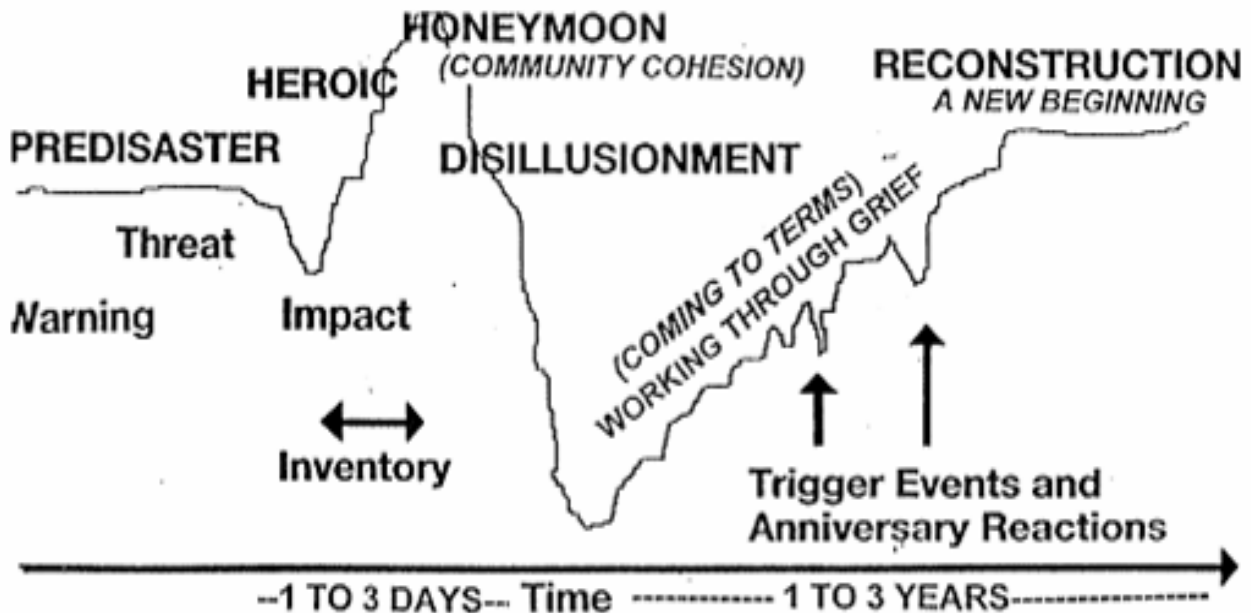
While the above description is a goal, relief efforts may fall short. Disaster mental health workers may identify survivor groups who are not receiving services or recognize incompatibilities between the relief operation and the disaster-affected community. When individual survivors are unable to access services because of their limitations, disaster mental health workers may assist the survivor with overcoming personal or institutional barriers.

The relationships depicted in the Phases of Disaster diagram (below) shift over time. The experiences and needs of survivors and the community are different in the first week following the disaster compared with those at three months. Disaster relief efforts, including mental health programs, must maintain awareness of and accommodate to the time-based phases of disaster response (Tassey et al., 1997).

### ***Phases of Disaster***

Both community and individual responses to a major disaster tend to progress according to phases. An interaction of psychological processes with external events shapes these phases. Examples of significant time-related external events are the closure of the emergency response phase, the damage assessment of one's personal residence, or receiving financial determinations. The following represents a compilation of phase lists developed by different disaster experts. These particular phases have been selected and described because of their relevance to disaster mental health planners and workers in providing ongoing disaster recovery assistance.

## Phases of Disaster



Source: Zunin/Meyers

### ***Warning or Threat Phase***

Disasters vary in the amount of warning communities receive before they occur. For example, earthquakes typically hit with no warning, whereas, hurricanes and floods typically arrive within hours to days of warning. When there is no warning, survivors may feel more vulnerable, unsafe, and fearful of future unpredicted tragedies. The perception that they had no control over protecting themselves or their loved ones can be deeply distressing.

When people do not heed warnings and suffer losses as a result, they may experience guilt and self blame. While they may have specific plans for how they might protect themselves in the future, they can be left with a sense of guilt or responsibility for what has occurred.

### ***Impact Phase***

The impact period of a disaster can vary from the slow, low-threat buildup associated with some types of floods to the violent, dangerous, and destructive outcomes associated with tornadoes and explosions. The greater the scope, community destruction, and personal losses associated with the disaster, the greater the psychosocial effects.

Depending on the characteristics of the incident, people's reactions range from constricted, stunned, shock-like responses to the less common overt expressions of panic or hysteria. Most typically, people respond initially with confusion and disbelief and focus on the survival and physical well-being of themselves and their loved ones. When families are in different geographic locations during the impact of a disaster (e.g., children at school, adults at work), survivors will experience considerable anxiety until they are reunited.

### ***Rescue or Heroic Phase***

In the immediate aftermath, survival, rescuing others, and promoting safety are priorities. Evacuation to shelters, motels, or other homes may be necessary. For some, post-impact disorientation gives way to adrenaline induced rescue behavior to save lives and protect property. While activity level may be high, actual productivity is often low. The capacity to assess risk may be impaired and injuries can result. Altruism is prominent among both survivors and emergency responders.

The conditions associated with evacuation and relocation have psychological significance. When there are physical hazards or family separations during the evacuation process, survivors often experience post-trauma reactions. When the family unit is not together due to shelter requirements or other factors, an anxious focus on the welfare of those not present may detract from the attention necessary for immediate problem-solving.

### ***Remedy or Honeymoon Phase***

During the week to months following a disaster, formal governmental and crisis worker assistance may be readily available. Community bonding occurs as a result of sharing the catastrophic experience and the giving and receiving of community support. Survivors may experience a short-lived sense of optimism that the help they will receive will make them whole again. When disaster mental health workers are visible and perceived as helpful during this phase, they are more readily accepted and have a foundation from which to provide assistance in the difficult phases ahead.

### ***Inventory Phase***

Over time, survivors begin to recognize the limits of available disaster assistance. They become physically exhausted due to enormous multiple demands, financial pressures, and the stress of relocation or living in a damaged home. The unrealistic optimism initially experienced can give way to discouragement and fatigue.

### ***Disillusionment Phase***

As disaster assistance agencies and crisis worker groups begin to pull out, survivors may feel abandoned and resentful. The reality of losses and the limits and terms of the available assistance becomes apparent. Survivors calculate the gap between the assistance they have received and what they will require to regain their former living conditions and lifestyle.

Stressors abound-family discord, financial losses, bureaucratic hassles, time constraints, home reconstruction, relocation, and lack of recreation or leisure time. Health problems and exacerbations of pre-existing conditions emerge due to ongoing, unrelenting stress and fatigue.

The larger community less impacted by the disaster has often returned to business as usual, which is typically discouraging and alienating for survivors. Ill will and resentment may surface in neighborhoods as survivors receive unequal monetary amounts for what they perceive to be equal or similar damage. Divisiveness and hostility among neighbors undermine community cohesion and support.

### ***Reconstruction or Recovery Phase***

The reconstruction of physical property and recovery of emotional well-being may continue for years following the disaster. Survivors have realized that they will need to solve the problems of rebuilding their own homes, businesses, and lives largely by themselves and have gradually assumed the responsibility for doing so.

With the construction of new residences, buildings, and roads comes another level of recognition of losses. Survivors are faced with the need to readjust to and integrate new surroundings as they continue to grieve losses. Emotional resources within the family may be exhausted and social support from friends and family may be worn thin.

When people come to see meaning, personal growth, and opportunity from their disaster experience despite their losses and pain, they are well on the road to recovery. While disasters may bring profound life-changing losses, they also bring the opportunity to recognize personal strengths and to reexamine life priorities.

Individuals and communities progress through these phases at different rates depending on the type of disaster and the degree and nature of disaster exposure. This progression may not be linear or sequential, as each person and community brings unique elements to the recovery process. Individual variables such as psychological resilience, social support, and financial resources influence a survivor's capacity to move through the phases. While there is always a risk of aligning expectations too rigidly with a developmental sequence, having an appreciation of the unfolding of psychosocial reactions to disaster is valuable.

### ***Key Concepts of Disaster Mental Health***

The following guiding principles form the basis for disaster mental health intervention programs. Not only do these principles describe some departures and deviations from traditional mental health work; they also orient administrators and service providers to priority issues. The truth and wisdom reflected in these principles have been shown over and over again, from disaster to disaster.

- No one who sees a disaster is untouched by it.
- There are two types of disaster trauma-individual and community.

- Most people pull together and function during and after a disaster, but their effectiveness is diminished.
- Disaster stress and grief reactions are normal responses to an abnormal situation.
- Many emotional reactions of disaster survivors stem from problems of living brought about by the disaster.
- Disaster relief assistance may be confusing to disaster survivors. They may experience frustration, anger, and feelings of helplessness related to Federal, State, and non-profit agencies' disaster assistance programs.
- Most people do not see themselves as needing mental health services following a disaster and will not seek such services.
- Survivors may reject disaster assistance of all types.
- Disaster mental health assistance is often more practical than psychological in nature.
- Disaster mental health services must be uniquely tailored to the communities they serve.
- Mental health workers need to set aside traditional methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully in disaster.
- Survivors respond to active, genuine interest, and concern.
- Interventions must be appropriate to the phase of disaster.
- Social support systems are crucial to recovery.

(CMHS, 1994; See Chapter 1, page 1, for more information.)

### ***Community Outreach***

Outreach approaches that offer practical assistance with problem-solving and accessing resources are key to a successful program. Returning to the diagram at the beginning of this Section, "disaster relief efforts," as shown, include disaster mental health services. It is essential that those services have the flexibility to engage with diverse individual survivors and the varied elements within the community. Programs should establish a vital presence early in recovery, developing creative strategies to meet survivors where they are and bring them forward in their recovery process.

Most people who are coping with the aftermath of a disaster do not see themselves as needing mental health services and are unlikely to request them. People reacting to disasters tend to have little patience with implications that they are in need of psychological treatment. This is why terms like "psychotherapy" or "psychological counseling" are often rejected and terms like "assistance with resources" and "talking about disaster stress" are more acceptable.

Survivors who will be using program services are, for the most part, normal, well-functioning people who are under temporary emotional stress.



Disaster mental health workers must go to the survivors and not wait and expect that the survivors will come to them (Cohen, 1990). This means being visible in the disaster-affected neighborhoods, often going door-to-door to check-in with residents to see if they want assistance. Establishing relationships with community gatekeepers like corner store owners, or local cafe staff is important for referrals of survivors in need. Attending community gatherings at churches, schools, or community centers is useful for connecting with local residents and providing disaster mental health information. Besides these outreach approaches, educational materials that describe and emphasize the normalcy of reactions are of great benefit for disaster survivors. Educational outreach through the media-television, newspaper, radio, and community newsletters-reaches survivors whom other means might not contact. Disaster Response and Recovery: A Handbook for Mental Health Professionals provides extremely useful and detailed information about community outreach in a range of settings (CMHS, 1994).

Disaster mental health workers are most likely to find people struggling with the disruption and loss caused by the disaster. Disaster-related psychological symptoms warranting diagnosis are rare (Ursano, et al., 1995). People vary in the ability to recognize their own needs and in comfort level with asking for help. They may, for example, feel that it is personally degrading to request clothing or to seek an emergency loan. This reluctance can usually be overcome by personal contact with a caring person, who has the correct information and encourages the seeking of assistance.

Above all, disaster mental health programs must actively fit the disaster-affected community. Salient dimensions for consideration include: ethnic and cultural groups represented, languages spoken, rural or urban locales, values about giving and receiving help, and who and what the affected groups are most likely to trust. Access and acceptance is gained more quickly when disaster mental health programs coordinate and collaborate with local trusted organizations.

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## Common Disaster Worker Stress Reactions

### **Psychological and Emotional**

- Feeling heroic, invulnerable, euphoric
- Denial
- Anxiety and fear
- Worry about safety of self and others
- Anger
- Irritability
- Restlessness
- Sadness, grief, depression, moodiness
- Distressing dreams
- Guilt or "survivor guilt"
- Feeling overwhelmed, hopeless
- Feeling isolated, lost, or abandoned
- Apathy
- Identification with survivors

### **Cognitive**

- Memory problems
- Disorientation
- Confusion
- Slowness of thinking and comprehension
- Difficulty calculating, setting priorities, making decisions
- Poor concentration
- Limited attention span
- Loss of objectivity
- Unable to stop thinking about the disaster
- Blaming

### **Behavioral**

- Change in activity
- Decreased efficiency and effectiveness
- Difficulty communicating
- Increased sense of humor
- Outbursts of anger, frequent arguments
- Inability to rest or "letdown"
- Change in eating habits
- Change in sleeping patterns
- Change in patterns of intimacy, sexuality
- Change in job performance
- Periods of crying
- Increased use of alcohol, tobacco, or drugs
- Social withdrawal, silence
- Vigilance about safety or environment
- Proneness to accidents
- Avoidance of activities or places that trigger memories

### **Physical**

- Increased heartbeat, respiration
- Increased blood pressure
- Upset stomach, nausea, diarrhea
- Change in appetite, weight loss or gain
- Sweating or chills
- Tremors (hands, lips)
- Muscle twitching
- "Muffled" hearing
- Tunnel vision
- Feeling uncoordinated
- Lower back pain
- Feeling a "lump in the throat"
- Exaggerated startle reaction
- Fatigue
- Menstrual cycle changes
- Change in sexual desire
- Decreased resistance to infection
- Flare-up of allergies and arthritis
- Hair loss
- Headaches
- Soreness in muscles

## Professional Self-Care

1. What do you value most about doing disaster mental health work?

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2. What are (or do you expect to be) the most stressful and the most rewarding aspects of disaster work?

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3. How do you know when you are stressed?

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4. How might your co-workers know when you are stressed?

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5. What can others do for you when you are stressed?

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6. What can you do for yourself?

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**Remember:** *You are a far less effective helper of others when you are not taking care of yourself.*

*Good teamwork means encouraging each other to manage stress.*

(Deborah J. DeWolfe, Ph.D., 1996)

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## **Stress Prevention and Management**

Source: <http://www.mentalhealth.samhsa.gov/publications/allpubs/ADM90-538/Default.asp>

Disaster mental health work is inevitably stressful at times. The long hours, breadth of survivors' needs and demands, ambiguous roles, and exposure to human suffering can affect even the most experienced mental health professional. The first "key concept" of disaster mental health states, "No one who sees a disaster is untouched by it." This combination of witnessing the disaster's destruction, working in an often chaotic environment, and having only limited resources available results in potentially stressful conditions.

These conditions require that planners and administrators integrate a comprehensive stress prevention and management plan into their mental health recovery programs. Too often, staff stress is addressed as an afterthought. Programs focus their efforts on survivors' "normal" reactions to traumatic events, and do not address the very same psychological processes that occur in staff as well. While disaster mental health work is personally rewarding and challenging, it also has the potential for affecting workers in adverse ways.

Preventive stress management focuses on two critical contexts: the organization and the individual (Quick et al., 1997). A disaster mental health program's organizational plan may initially be unclear or inadequate due to the rapid mobilization to address survivor needs. However, it is important that a functional plan and structure be developed quickly. Each worker providing services will be affected uniquely depending on his or her professional experience, personal history, and vulnerabilities. A pro-active approach for workers that teaches and encourages personal stress reduction strategies is essential. Adopting a preventive perspective allows programs to anticipate stressors and shape crises rather than simply reacting to them after they occur.

### ***Organizational Context***

Having an organizational structure and plan that builds in stress prevention can mitigate potential stress overload for staff. While these efforts may be time-consuming on the front end, the long-term benefits of reduced employee turnover and avoidance of thorny personnel issues, as well as increased productivity and program cohesion are well worth the efforts. The following five dimensions reflect necessary areas to address when designing a strong program that prioritizes organizational health:

- Effective management structure and leadership
- Clear purposes and goals
- Functionally defined roles
- Team support
- Plan for stress management

### ***Individual Context***

Psychologically healthy and well-balanced individuals are best equipped to implement and maintain an effective disaster mental health recovery program. Programs can build



in supports and interventions to ensure that the majority of their staff will be functioning in the "healthy and balanced" range. As community needs change over time, so will workers' stress management intervention needs. Listed below are four skill building areas to address when designing the staff stress management component of a program:

- Management of workload
- Balanced lifestyle
- Strategies for stress reduction
- Self awareness

### ***Stress Prevention and Management Methods***

The following charts present suggestions for organizational and individual stress prevention for immediate and long-term response time frames. Suggestions for the immediate response phase may be applicable for the long-term response phase as well. Approaches for eliminating and minimizing stressors and stress reactions are included. Since each disaster and mental health response has different elements, program planners will need to tailor the following to their own locale, resources, and disaster.

<b>Organizational Approaches for Stress Prevention and Management</b>		
<i>Dimension</i>	<i>Immediate Response</i>	<i>Long-term Response</i>
EFFECTIVE MANAGEMENT STRUCTURE & LEADERSHIP	<ul style="list-style-type: none"> <li>- Clear chain of command and reporting relationships</li> <li>- Available and accessible clinical supervisor</li> <li>- Disaster orientation provided for all workers</li> <li>- Shifts no longer than twelve hours with twelve hours off</li> <li>- Briefings provided at beginning of shifts as workers exit and enter the operation</li> <li>- Necessary supplies available (e.g., paper, forms, pens, educational materials)</li> <li>- Communication tools available (e.g., cell phones, radios)</li> </ul>	<ul style="list-style-type: none"> <li>- Full-time disaster-trained supervisors and program director with demonstrated management and supervisory skills</li> <li>- Clear and functional organizational structure</li> <li>- Program direction and accomplishments reviewed and modified as needed</li> </ul>
CLEAR PURPOSE & GOALS	<ul style="list-style-type: none"> <li>- Clearly defined intervention goals and strategies appropriate to assignment setting (e.g., crisis intervention, debriefing)</li> </ul>	<ul style="list-style-type: none"> <li>- Community needs, focus and scope of program defined</li> <li>- Periodic assessment of organizational health and service targets and strategies</li> <li>- CMHS Program Guidance guidelines integrated into service priorities</li> <li>- Staff trained and supervised to define limits, make referrals</li> <li>- Feedback provided to staff on program accomplishments, numbers of contacts etc.</li> </ul>
FUNCTIONALLY DEFINED ROLES	<ul style="list-style-type: none"> <li>- Staff oriented and trained with written role descriptions for each assignment setting</li> <li>- When setting is under the jurisdiction of another agency (e.g., Red Cross, FEMA), staff informed of their role, contact people, and expectations</li> </ul>	<ul style="list-style-type: none"> <li>- Job descriptions and expectations for all positions</li> <li>- Participating disaster recovery agencies' roles understood and working relationships with key agency contacts maintained</li> </ul>
TEAM SUPPORT	<ul style="list-style-type: none"> <li>- Buddy system for support and monitoring stress reactions</li> <li>- Positive atmosphere of support and tolerance with "good job" said often</li> </ul>	<ul style="list-style-type: none"> <li>- Team approach that avoids a program design with isolated workers from separate agencies</li> <li>- Informal case consultation, problem solving and resource sharing</li> <li>- Regular, effective meetings with productive agendas, personal sharing, and creative program development</li> <li>- Clinical consultation and supervision</li> <li>- In-service training appropriate to current recovery issues provided</li> </ul>

<b>Organizational Approaches for Stress Prevention and Management (Contin.)</b>		
<i>Dimension</i>	<i>Immediate Response</i>	<i>Long-term Response</i>
PLAN FOR STRESS MANAGEMENT	<ul style="list-style-type: none"> <li>- Workers' functioning assessed regularly</li> <li>- Workers rotated between low, mid, and high stress tasks</li> <li>- Breaks and time away from assignment encouraged</li> <li>- Education about signs and symptoms of worker stress and coping strategies</li> <li>- Individual and group defusing and debriefing provided</li> <li>- Exit plan for workers leaving the operation: debriefing, reentry information, opportunity to critique, and formal recognition for service</li> </ul>	<ul style="list-style-type: none"> <li>- Education about long-term stresses of disaster work and the importance of ongoing stress management</li> <li>- Program checklist including organizational and individual approaches and implementation plan</li> <li>- Plan for regular stress interventions at work and meetings (see next chart)</li> <li>- Extensive program phase down plan: timelines, debriefing, critique, formal recognition, celebration, and assistance with job searches</li> </ul>

<b>Individual Approaches for Stress Prevention and Management</b>		
<i>Dimension</i>	<i>Immediate Response</i>	<i>Long-term Response</i>
MANAGEMENT OF WORKLOAD	<ul style="list-style-type: none"> <li>- Task priority levels set with a realistic work plan</li> <li>- Existing workload delegated so workers not attempting disaster response and usual job</li> </ul>	<ul style="list-style-type: none"> <li>- Planning, time management, and avoidance of work overload (e.g., "work smarter, not harder")</li> <li>- Periodic review of program goals and activities to meet stated goals</li> <li>- Periodic review to determine feasibility of program scope with human resources available</li> </ul>
BALANCED LIFESTYLE	<ul style="list-style-type: none"> <li>- Physical exercise and muscle stretching when possible</li> <li>- Nutritional eating, avoiding excessive junk food, caffeine, alcohol, or tobacco</li> <li>- Adequate sleep and rest, especially on longer assignments</li> <li>- Contact and connection maintained with primary social supports</li> </ul>	<ul style="list-style-type: none"> <li>- Family and social connections maintained away from program</li> <li>- Exercise, recreational activities, hobbies, or spiritual pursuits maintained (or begun)</li> <li>- Healthy nutritional habits pursued</li> <li>- Overinvestment in work discouraged</li> </ul>

<b>Individual Approaches for Stress Prevention and Management (Contin.)</b>		
<i>Dimension</i>	<i>Immediate Response</i>	<i>Long-term Response</i>
STRESS REDUCTION STRATEGIES	<ul style="list-style-type: none"> <li>- Reducing physical tension by taking deep breaths, calming self through meditation, walking mindfully</li> <li>- Using time off for exercise, reading, listening to music, taking a bath, talking to family, getting a special meal to recharge batteries</li> <li>- Talking about emotions and reactions with coworkers during appropriate times</li> <li>- Cognitive strategies (e.g., constructive self talk, restructuring distortions)</li> </ul>	<ul style="list-style-type: none"> <li>- Relaxation techniques (e.g., yoga, meditation, guided imagery)</li> <li>- Pacing self between low and high stress activities, and between providing services alone and with support</li> <li>- Talking with coworkers, friends, family, pastor, or counselor about emotions and reactions</li> </ul>
SELF-AWARENESS	<ul style="list-style-type: none"> <li>- Early warning signs for stress reactions recognized and heeded (see following section)</li> <li>- Acceptance that one may not be able to self-assess problematic stress reactions</li> <li>- Over identification with survivors' grief and trauma may result in avoiding discussing painful material</li> <li>- Vicarious traumatization or compassion fatigue may result from repeated empathic engagement (Figley, 1995; Pearlman, 1995)</li> </ul>	<ul style="list-style-type: none"> <li>- Exploration of motivations for helping (e.g., personal gratification, knowing when "helping" is not being helpful)</li> <li>- Understanding differences between professional helping relationships and friendships</li> <li>- Examination of personal prejudices and cultural stereotypes</li> <li>- Recognition of discomfort with despair, hopelessness, and excessive anxiety that interfere with capacity to "be" with clients</li> <li>- Recognition of over identification with survivors' frustration, anger, and hopelessness resulting in loss of perspective and role</li> <li>- Recognition of when own disaster experience or losses interfere with effectiveness</li> <li>- Involvement in opportunities for self exploration and addressing emotions evoked by disaster work</li> </ul>

### ***Signs and Symptoms of Worker Stress***

Thus far, the focus of this section has been to describe methods for preventing and mitigating staff distress in a disaster mental health recovery program. The signs and symptoms of worker stress are also important to discuss, as early recognition and intervention are optimal. Educating supervisors and staff about signs of stress enables them to be on the lookout and to take appropriate steps. When programs emphasize stress recognition and reduction, norms are established that validate early intervention rather than reinforcing the more common (even though we know better) "worker distress is a sign of weakness" perspective.

## Common Disaster Worker Stress Reactions

### *Psychological and Emotional*

- Feeling heroic, invulnerable, euphoric
- Denial
- Anxiety and fear
- Worry about safety of self and others
- Anger
- Irritability
- Restlessness
- Sadness, grief, depression, moodiness
- Distressing dreams
- Guilt or "survivor guilt"
- Feeling overwhelmed, hopeless
- Feeling isolated, lost, or abandoned
- Apathy
- Identification with survivors

### *Cognitive*

- Memory problems
- Disorientation
- Confusion
- Slowness of thinking and comprehension
- Difficulty calculating, setting priorities, making decisions
- Poor concentration
- Limited attention span
- Loss of objectivity
- Unable to stop thinking about the disaster
- Blaming

### *Behavioral*

- Change in activity
- Decreased efficiency and effectiveness
- Difficulty communicating
- Increased sense of humor
- Outbursts of anger, frequent arguments

- Inability to rest or "letdown"
- Change in eating habits
- Change in sleeping patterns
- Change in patterns of intimacy, sexuality
- Change in job performance
- Periods of crying
- Increased use of alcohol, tobacco, or drugs
- Social withdrawal, silence
- Vigilance about safety or environment
- Avoidance of activities or places that trigger memories
- Proneness to accidents

### *Physical*

- Increased heartbeat, respiration
- Increased blood pressure
- Upset stomach, nausea, diarrhea
- Change in appetite, weight loss or gain
- Sweating or chills
- Tremors (hands, lips)
- Muscle twitching
- "Muffled" hearing
- Tunnel vision
- Feeling uncoordinated
- Headaches
- Soreness in muscles
- Lower back pain
- Feeling a "lump in the throat"
- Exaggerated startle reaction
- Fatigue
- Menstrual cycle changes
- Change in sexual desire
- Decreased resistance to infection
- Flare-up of allergies and arthritis
- Hair loss

(CMHS, 1994)

As with disaster survivors, assessment hinges on the question of "How much 'normal stress reaction' is too much?" Many reactions listed are commonly experienced by disaster workers with limited job effects. However, when a number are experienced simultaneously and intensely, functioning is likely to be impaired. Under these circumstances, the worker should take a break from the disaster assignment for a few hours at first, and then longer if necessary. If normal functioning does not return, then the person needs to discontinue the assignment.

Clinical supervisory support is essential when a disaster worker's personal coping strategies are wearing thin. Counseling support involves exploring the meaning for the worker of the disaster stimuli, prior related experiences and vulnerabilities, and personal coping strategies. Suggestions can be made for stress reduction activities. Usually, stress symptoms will gradually subside when the worker is no longer in the disaster relief environment. However, if this does not occur, then professional mental health assistance is indicated.

### ***Rewards and Joys of Disaster Work***

Most staff find helping survivors and their communities following a major disaster to be enormously rewarding. Disaster mental health workers witness both gut wrenching grief and sorrow and the power of the human spirit to survive and carry on. To assist people as they struggle to put their lives back together is fundamentally meaningful. At the close of the long-term mental health recovery programs, staff often describe their participation as the most challenging and personally satisfying of their careers.

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## **Disaster Reactions of Potential Risk Groups**

Source: <http://www.mentalhealth.samhsa.gov/publications/allpubs/ADM90-538/Default.asp>

(Note: This section corresponds with *Module 4* of the KAHBH Core Training)

Although there are many feelings and reactions people share in common following a disaster, there are also expressions that are more specifically influenced by the survivor's age, cultural and ethnic background, socioeconomic status, pre-existing physical, and psychosocial vulnerabilities. Disaster mental health workers are better prepared to design effective interventions when they have an understanding of how demographic and health factors interact with disaster stress.

This section describes groups commonly found within communities following a disaster and provides suggestions for disaster mental health interventions. Common issues, concerns, and reactions are also briefly presented in this section.

### ***Common Needs and Reactions***

First is a review of some thoughts, feelings, and behaviors common to all who experience a disaster:

- Concern for basic survival
- Grief over loss of loved ones and loss of valued and meaningful possessions
- Fear and anxiety about personal safety and the physical safety of loved ones
- Sleep disturbances, often including nightmares and imagery from the disaster
- Concerns about relocation and related isolation or crowded living conditions
- Need to talk about events and feelings associated with the disaster, often repeatedly
- Need to feel one is a part of the community and its disaster recovery efforts

## **Potential Risk Groups**

Each disaster-affected community has its own demographic composition, prior history with disasters or other traumatic events, and cultural representation. When disaster program planners review the groups impacted by a disaster in their community, consideration should be given to the following, as well as additional groups unique to the locale:

- Age groups
- Cultural and ethnic groups
- Socioeconomic groups
- People with serious and persistent mental illness
- Human service and disaster relief workers

The majority of survivors are resilient and with time can integrate their disaster experiences and losses and move on. However, survivors who have significant concurrent psychosocial, health, or financial problems are at greater risk for depression, anxiety, post-traumatic stress symptoms or an exacerbation of their pre-existing condition. When survivors have personally sustained severe disaster losses (e.g., death of a loved one, devastation of home and community), their reactions are more intensely expressed and over a longer period of time (Solomon & Green, 1992). This section includes a brief overview for each group. The disaster reactions described normally resolve over time with sufficient support and physical recovery. References for more detailed information are provided.

### ***Age Groups***

Each stage of life is accompanied by special challenges in coping with the aftermath of a disaster and age-related vulnerabilities to disaster stress. For children, their age and development determine their capacity cognitively to understand what is occurring around them and to regulate their emotional reactions. Children are more vulnerable to difficulty when they have experienced other life stresses in the year preceding the disaster, such as a divorce, a move, or the death of a family member or pet (Vogel & Vernberg, 1993). For adults, stress associated with family and home disruption, financial setbacks, and work overload predominate. For older adults, concerns regarding health, financial stability, and living independently become primary.

The age groups considered in this section are:

- Preschool (ages 1-5)
- Childhood (ages 6-11)
- Pre-adolescence and Adolescence (ages 12-18)
- Adults
- Older Adults

Reactions and problems vary depending upon the phase of the post-disaster period. Some of the problems discussed appear immediately; many appear months later.



### ***Preschool (ages 1-5)***

Small children view their world from the perspectives of predictability, stability, and the availability of dependable caretakers. Disruption in any of these domains causes distress. Preschool age children often feel powerlessness and fear in the face of a disaster, especially if they are separated from parents. Because of their age and small size, they are unable to protect themselves or others. As a result, they may feel considerable anxiety and insecurity.

In the preschool years, children generally lack the verbal and conceptual skills necessary to understand and cope effectively with sudden unexpected stress. They typically look to parents and older siblings as behavior models, as well as for comfort and stability. Research has shown that children's reactions are more related to how their family or caregiver is coping than the actual objective characteristics of the disaster itself (Green et al., 1991).

Children who have lost one or both parents are especially in need. Loss of a relative, a playmate, or a pet is also a disturbing event for children. They will need opportunities to express their grief. One of the major fears of childhood is abandonment, so children need frequent reassurance they will be cared for.

Preschoolers express their upset through regressive behaviors such as thumb sucking, bed-wetting, clinging to their parents, a return of fear of the dark, or not wanting to sleep alone. They often have sleep problems and frightening dreams. These problems are best understood as normal expressions of anxiety about the disruption of their familiar routines and previously secure worlds.

In the natural course of events, small children will try to resolve traumatic experiences by reliving them in their play activities. They may reenact the earthquake, flood, or tornado repeatedly. Children should be encouraged to verbalize their questions, feelings, and misunderstandings about the disaster so that adults can listen and explain. Relief of disaster fears and anxiety is attained through reestablishing the child's sense of security. Frequent verbal reassurance, physical comforting, more frequent attention, comforting bedtime rituals, and mealtime routines are helpful. As much as possible, young children should stay with people with whom they feel most familiar.

### ***Childhood (ages 6 - 11)***

School age children are developing the cognitive capacity to understand the dangers to family and environment inherent in disasters. They are more able to understand the disaster event and the mitigating role of disaster preparedness. This awareness can also contribute to preoccupation with weather and disasters, and fears about family members being killed or injured. School age children have a great need to understand what has happened and the concrete steps that they can take for protection and preparedness in the future.

Children often have special bonds with playmates or pets. When the disaster causes loss of significant others due to death or relocation, the child may grieve deeply. They

experience the full range of human emotions, but may not have the words or means to express their internal experience. Adults can assist children to express these powerful emotions through talking, play, art, and age-appropriate recovery or preparedness activities.

School age children also manifest their anxiety through regressive behavior. Returning to behavior appropriate for a younger age is trying for parents, but serves an initially functional purpose for the child. These behaviors include: irritability, whining, clinging, fighting with friends and siblings, competing with younger siblings for parents' attention, or refusing to go to school. Bedtime and sleep problems are common due to nightmares and fearfulness about sleeping alone or in the dark.

Sometimes children's behavior can be "super good" at home, because they are afraid of further burdening their parents or causing more family disruption. They may show disaster stress at school through concentration problems, a decline in academic performance, aggression toward classmates, or withdrawal from social interactions. Some children may have somatic reactions and seek attention from the school nurse for stomach aches, headaches, nausea, or other complaints.

### ***Pre-adolescence and Adolescence (ages 12 - 18)***

This age group has a great need to appear competent to the world around them, especially to their family and friends. They struggle with the conflicts inherent in moving toward independence from parents on the one hand and the desire to maintain the dependence of childhood on the other. Approval and acceptance from friends are of paramount importance. Adolescents need to feel that their anxieties and fears are both appropriate and shared by their peers.

Disaster stress may be internalized and expressed through psychosomatic symptoms such as, gastrointestinal distress, headaches, skin problems, or vague aches and pains. Sleep problems such as insomnia, night terrors, or sleeping excessively may signal internal upset. Adolescents may turn to alcohol or drugs to cope with their anxiety and loss.

Social or school problems may also occur. Acting out or rebellious behavior may involve fighting with others, stealing, or power struggles with parents. Other adolescents may express their distress through withdrawal from friends and family and avoidance of previously enjoyed activities. School performance may decline. When the disaster causes major destruction of home and community, an older adolescent may postpone the developmental step of moving away from home.

### ***Adults***

Adults are focused on family, home, jobs, and financial security. Many are involved with caring for elderly parents as well. Pre-disaster life often involves maintaining a precarious balance between competing demands. Following a disaster, this balance is lost with the introduction of the enormous time, financial, physical, and emotional demands of recovery. Children in the family are in special need of attention and familiar

routines, yet parents do not have enough hours in the day to accomplish all that is before them.

Over time, this stress overload can be manifested through physical symptoms of headaches, increased blood pressure, ulcers, gastrointestinal problems, and sleep disorders. Somatic reactions are especially present in those who are less able to experience and express their emotions directly. Cultural, gender-based, or psychological factors may interfere with emotional expression and seeking social support.

Emotional reactions often oscillate between numbness and intense expression. Anxiety and depression are common, as adults grapple with both anxiety about future threats and grief about the loss of home, lifestyle, or community. Anger and frustration about relief efforts abound, sometimes reflecting a displacement of the "less rational" anger that the disaster happened to them and was out of their control.

### ***Older Adults***

In the normal course of life, older adults typically have coped with losses prior to the disaster. They may have successfully adjusted to losses of employment, family, home, loved ones, or physical capabilities. For some, coping with these prior losses has strengthened resilience. For others, the prior losses may have worn down the individual's reserves and the disaster is an overwhelming blow (Norris et al., 1994). As a result of the disaster, irreplaceable possessions such as photographs or mementos passed on through generations may be destroyed. Pets or gardens developed over years may be lost. Mental health workers must recognize the special meaning of these losses, if they are to assist with grieving.

Older adults living on limited incomes tend to reside in dwellings that are susceptible to disaster hazards due to the location and age of the buildings. Because of financial limitations and age, they may not be able to afford the repairs to their homes. Leaving familiar surroundings is especially difficult for those who experience deficits in hearing, vision, or memory, because they rely on known environmental cues to continue living independently.

Many older adults fear that if their diminished physical or cognitive abilities are revealed, they risk loss of independence or being institutionalized. As a result, they may under report the full extent of their problems and needs. They may continue living in damaged or unsanitary conditions, because they do not have the physical strength, stamina, or cognitive organizational ability to undertake disaster clean up. Disaster mental health workers must carefully assess the range and full extent of problems in living faced by the older survivor. Often, concrete practical assistance for recovery, stabilization, and engagement with appropriate resources allows the older adult to continue living independently.

A larger proportion of older persons, as compared with younger age groups, have chronic illnesses that may worsen with the stress of a disaster, particularly when recovery extends over months. They are more likely to be taking medications that need to be replaced quickly following a disaster. While older adults may be in more need of multiple services for recovery, they are often especially reluctant to accept help and what they perceive as "handouts." Disaster mental health programs can more quickly gain acceptance when they work closely with known, trusted organizations and employ older adults as outreach workers.

### ***Cultural and Ethnic Groups***

Disaster mental health programs must respond specifically and sensitively to the various cultural groups affected by a disaster. In many disasters, ethnic and racial minority groups may be especially hard hit because of socioeconomic conditions that force the community to live in housing that is particularly vulnerable. Language barriers, suspicion of governmental programs due to prior experiences, rejection of outside interference or assistance, and differing cultural values often contribute to disaster outreach programs' difficulty in establishing access and acceptance. Communities that take pride in their self-reliance are reluctant to seek or accept help, especially from mental health workers.

Cultural sensitivity is conveyed when disaster information and application procedures are translated into primary spoken languages and available in non-written forms. Intense emotions are typically experienced and expressed in a person's language of origin, so outreach teams that include bilingual, bicultural staff, and translators are able to interact more effectively with disaster survivors. Whenever possible, it is preferable to work with trained translators rather than family members, especially children, because of privacy concerns regarding mental health issues and the importance of preserving family roles.

Cultural groups have considerable variation regarding views on loss, death, home, spiritual practices, use of particular words, grieving, celebrating, mental health, and helping. The role of the family, who is included in the family, and who makes decisions also varies. Elders and extended family play a significant role in some cultures, whereas isolated nuclear families are the decision-makers in others.

It is essential that disaster mental health workers learn about the cultural norms, traditions, local history, and community politics from leaders and social service workers indigenous to the groups they are serving. Program outreach workers and mental health staff are most effective when they are bilingual and bicultural. During the program development phase, establishing working relationships with trusted organizations, service providers, and community leaders is helpful. Being respectful, nonjudgmental, well informed, and following through on stated plans dependably are especially important for outreach workers.

### ***Socioeconomic Groups***

Many affluent, middle to upper middle class people live with a sense of security and see themselves as invulnerable to the devastation and tragedy associated with disasters. Because of their financial resources and life situations, they may have been protected from crises in the past, and have purchased insurance for "protection" in the future. They are more accustomed to planning and controlling life events, rather than unexpected overwhelming events controlling them. Shock, disbelief, self blame, and anger predominate in the hours and days following a major disaster, as the reality of losses, danger, and the work that lies ahead begins to sink in.

Higher income families may never have received assistance from social service agencies before. Accepting clothing, food, money, or shelter can be difficult and sobering. While they may need emergency assistance initially, they often do have social, financial, family, or other resources that engage quickly and buffer the disaster's impact.

Affluent families typically rely on known professionals for their support-their family physician, minister, or psychotherapist. Disaster mental health programs focus on educating local health care professionals and religious leaders about disaster stress, because these providers are most likely to encounter upper class survivors in need. *Psychosocial Issues for Children and Families in Disaster: A Guide for the Primary Care Physician* (CMHS, 1995) is an informative resource for training. Recovery programs can also coordinate disaster mental health counseling and support groups through these known and trusted entities.

In contrast, low-income survivors have fewer resources and greater pre-existing vulnerability when disaster strikes. While they may have developed more crisis survival skills than the more protected upper class individuals, they often lack the availability of support and housing from family and friends and do not have insurance coverage or monetary savings. Without these, the recovery process is even more arduous and prolonged, and sometimes impossible. Federal and State disaster assistance programs are designed to meet serious and urgent needs. The intent of these programs is not to replace all losses. Uninsured, poor families may have unmet needs and should be referred to non-profit disaster relief organizations and unmet needs committees. If they are renters, they may be faced with unaffordable increases in rent after landlords have invested money to repair their properties. They may be dislocated to temporary disaster housing that is undesirable and removed from their social supports. Relocation may make transportation and getting to appointments more difficult.

Faced with these multiple challenges and assistance that falls short of solving the problems before them, low-income disaster survivors can feel overwhelmed. For those with limited reading and writing abilities, obtaining accurate information and completing forms is difficult. Disaster mental health workers are most effective when they provide concrete problem-solving assistance that facilitates addressing priority needs. Workers must be knowledgeable about the full range of community resources available to people

of limited economic means and actively engage this resource network with those in need.

### ***People with Serious and Persistent Mental Illness***

Clinical field experience has shown that disaster survivors with mental illness function fairly well following a disaster, if essential services have not been interrupted. People with mental illness have the same capacity to "rise to the occasion" and perform heroically as the general population during the immediate aftermath of the disaster. Many demonstrate an increased ability to handle this stress without an exacerbation of their mental illness, especially when they are able to maintain their medication regimens.

However, some survivors with mental illness have achieved only a tenuous balance before the disaster. The added stress of the disaster disrupts this balance; for some, additional mental health support services, medications, or hospitalization may be necessary to regain stability. For individuals diagnosed with Post Traumatic Stress Disorder (PTSD), disaster stimuli (e.g., helicopters, sirens) may trigger an exacerbation due to associations with prior traumatic events.

Many people with mental illness are vulnerable to sudden changes in their environment and routines. Orienting to new organizations and systems for disaster relief assistance can be difficult. Program planners need to be aware of how disaster services are being perceived and build bridges that facilitate access and referrals where necessary. Disaster mental health services designed for the general population are equally beneficial for those with mental illness; disaster stress affects all groups. In addition, when case managers and community mental health counselors have a solid understanding of disaster mental health issues, they are able to better provide services to this population following a disaster. Responding to the Needs of People with Serious and Persistent Mental Illness in Times of Major Disaster provides a comprehensive discussion of planning, preparedness, and options for service delivery with this population (CMHS, 1996).

### ***Human Service and Disaster Relief Workers***

Workers in all phases of disaster relief, whether in law enforcement, local government, emergency response, or victim support, experience considerable demands to meet the needs of the survivors and the community. Typically, disaster workers are altruistic, compassionate, and dedicated people who occasionally have difficulty knowing when it is time to take a break from the operation. For many, the disaster response takes precedence over all other responsibilities and activities. The brochure, Prevention and Control of Stress Among Emergency Workers-A Pamphlet for Workers, is an excellent resource for both disaster relief workers and mental health providers (NIMH, 1987). This brochure highlights the importance of having a personal emergency preparedness plan, so that workers are assured that their families are safe while they devote themselves to disaster relief for the community.

Relief workers may witness human tragedy and serious physical injuries, depending on the nature of the disaster and their role. This contributes to the psychological impact of their work. In disasters in which there is a high level of exposure to human suffering, injuries, and fatalities, providing psychological support and interventions for workers is especially necessary. In addition, relief workers and first responders should be considered a target group for ongoing services during the course of the disaster mental health recovery program.

As some order returns to the community, many workers, particularly crisis workers, return to their regular jobs. However, they may attempt to continue with their disaster work. Over time, the result of this overwork can be the "burn-out" syndrome. This state of exhaustion, irritability, and fatigue creeps up unrecognized and can markedly decrease the individual's effectiveness and capability. These workers may be avoiding problems at home by working constantly. Disaster mental health workers should be on the lookout for workers whose coping resources have eroded due to their personal vulnerabilities and seemingly unrelenting workload. The next section in this manual, "Stress Prevention and Management," offers suggestions for identifying, educating, and intervening with those who may be having stress reactions and difficulty coping.

Disaster Reactions and Intervention Suggestions				
Age Groups	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
PRESCHOOL (1 - 5)	<ul style="list-style-type: none"> <li>- Resumption of bed-wetting, thumb sucking</li> <li>- Clinging to parents</li> <li>- Fears of the dark</li> <li>- Avoidance of sleeping alone</li> <li>- Increased crying</li> </ul>	<ul style="list-style-type: none"> <li>- Loss of appetite</li> <li>- Stomach aches</li> <li>- Nausea</li> <li>- Sleep problems, nightmares</li> <li>- Speech difficulties</li> <li>- Tics</li> </ul>	<ul style="list-style-type: none"> <li>- Anxiety</li> <li>- Fear</li> <li>- Irritability</li> <li>- Angry outbursts</li> <li>- Sadness</li> <li>- Withdrawal</li> </ul>	<ul style="list-style-type: none"> <li>- Give verbal assurance and physical comfort</li> <li>- Provide comforting bedtime routines</li> <li>- Avoid unnecessary separations</li> <li>- Permit child to sleep in parents' room temporarily</li> <li>- Encourage expression regarding losses (i.e., deaths, pets, toys)</li> <li>- Monitor media exposure to disaster trauma</li> <li>- Encourage expression through play activities</li> </ul>
CHILDHOOD (6 - 11)	<ul style="list-style-type: none"> <li>- Decline in school performance</li> <li>- Aggressive behavior at home or school</li> <li>- Hyperactive or silly behavior</li> <li>- Whining, clinging, acting like a younger child</li> <li>- Increased competition with younger siblings for parents' attention</li> </ul>	<ul style="list-style-type: none"> <li>- Change in appetite</li> <li>- Headaches</li> <li>- Stomach aches</li> <li>- Sleep disturbances, nightmares</li> </ul>	<ul style="list-style-type: none"> <li>- School avoidance</li> <li>- Withdrawal from friends, familiar activities</li> <li>- Angry outbursts</li> <li>- Obsessive preoccupation with disaster, safety</li> </ul>	<ul style="list-style-type: none"> <li>- Give additional attention and consideration</li> <li>- Relax expectations of performance at home and at school temporarily</li> <li>- Set gentle but firm limits for acting out behavior</li> <li>- Provide structured but undemanding home chores and rehabilitation activities</li> <li>- Encourage verbal and play expression of thoughts and feelings</li> <li>- Listen to the child's repeated retelling of disaster event</li> <li>- Involve the child in preparation of family emergency kit, home drills</li> <li>- Rehearse safety measures for future disasters</li> <li>- Develop school disaster program for peer support, expressive activities, education on disasters, preparedness planning, identifying at-risk children</li> </ul>



Disaster Reactions and Intervention Suggestions (Continued)				
Age Groups	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
PRE-ADOLESCENCE AND ADOLESCENCE (12 - 18)	<ul style="list-style-type: none"> <li>- Decline in academic performance</li> <li>- Rebellion at home or school</li> <li>- Decline in previous responsible behavior</li> <li>- Agitation or decrease in energy level, apathy</li> <li>- Delinquent behavior</li> <li>- Social withdrawal</li> </ul>	<ul style="list-style-type: none"> <li>- Appetite changes</li> <li>- Headaches</li> <li>- Gastrointestinal problems</li> <li>- Skin eruptions</li> <li>- Complaints of vague aches and pains</li> <li>- Sleep disorders</li> </ul>	<ul style="list-style-type: none"> <li>- Loss of interest in peer social activities, hobbies, recreation</li> <li>- Sadness or depression</li> <li>- Resistance to authority</li> <li>- Feelings of inadequacy and helplessness</li> </ul>	<ul style="list-style-type: none"> <li>- Give additional attention and consideration</li> <li>- Relax expectations of performance at home and school temporarily</li> <li>- Encourage discussion of disaster experiences with peers, significant adults</li> <li>- Avoid insistence on discussion of feelings with parents</li> <li>- Encourage physical activities</li> <li>- Rehearse family safety measures for future disasters</li> <li>- Encourage resumption of social activities, athletics, clubs, etc.</li> <li>- Encourage participation in community rehabilitation and reclamation work</li> <li>- Develop school programs for peer support and debriefing, preparedness planning, volunteer community recovery, identifying at-risk teens</li> </ul>
ADULTS	<ul style="list-style-type: none"> <li>- Sleep problems</li> <li>- Avoidance of reminders</li> <li>- Excessive activity level</li> <li>- Crying easily</li> <li>- Increased conflicts with family</li> <li>- Hypervigilance</li> <li>- Isolation, withdrawal</li> </ul>	<ul style="list-style-type: none"> <li>- Fatigue, exhaustion</li> <li>- Gastrointestinal distress</li> <li>- Appetite change</li> <li>- Somatic complaints</li> <li>- Worsening of chronic conditions</li> </ul>	<ul style="list-style-type: none"> <li>- Depression, sadness</li> <li>- Irritability, anger</li> <li>- Anxiety, fear</li> <li>- Despair, hopelessness</li> <li>- Guilt, self doubt</li> <li>- Mood swings</li> </ul>	<ul style="list-style-type: none"> <li>- Provide supportive listening and opportunity to talk in detail about disaster experiences</li> <li>- Assist with prioritizing and problem-solving</li> <li>- Offer assistance for family members to facilitate communication and effective functioning</li> <li>- Assess and refer when indicated</li> <li>- Provide information on disaster stress and coping, children's reactions and families</li> <li>- Provide information on referral resources</li> </ul>

<b>Disaster Reactions and Intervention Suggestions (Continued)</b>				
<i>Age Groups</i>	<i>Behavioral Symptoms</i>	<i>Physical Symptoms</i>	<i>Emotional Symptoms</i>	<i>Intervention Options</i>
OLDER ADULTS	<ul style="list-style-type: none"> <li>- Withdrawal and isolation</li> <li>- Reluctance to leave home</li> <li>- Mobility limitations</li> <li>- Relocation adjustment problems</li> </ul>	<ul style="list-style-type: none"> <li>- Worsening of chronic illnesses</li> <li>- Sleep disorders</li> <li>- Memory problems</li> <li>- Somatic symptoms</li> <li>- More susceptible to hypo- and hyperthermia</li> <li>- Physical and sensory limitations (sight, hearing) interfere with recovery</li> </ul>	<ul style="list-style-type: none"> <li>- Depression</li> <li>- Despair about losses</li> <li>- Apathy</li> <li>- Confusion, disorientation</li> <li>- Suspicion</li> <li>- Agitation, anger</li> <li>- Fears of institutionalization</li> <li>- Anxiety with unfamiliar surroundings</li> <li>- Embarrassment about receiving "hand outs"</li> </ul>	<ul style="list-style-type: none"> <li>- Provide strong and persistent verbal reassurance</li> <li>- Provide orienting information</li> <li>- Use multiple assessment methods as problems may be under reported (e.g., repeat observations, geriatric screening questions, discussion with family)</li> <li>- Provide assistance with recovery of possessions</li> <li>- Assist in obtaining medical and financial assistance</li> <li>- Assist in reestablishing familial and social contacts</li> <li>- Give special attention to suitable residential relocation</li> <li>- Encourage discussion of disaster losses and expression of emotions</li> <li>- Provide and facilitate referrals for disaster assistance</li> <li>- Engage providers of transportation, chore services, meals programs, home health, and home visits as needed</li> </ul>

## Age-Specific Interventions for Children in Disaster

<i>Age Group</i>	<i>At Home</i>	<i>At School or Other Organization for Children</i>
PRE-SCHOOLERS	<ul style="list-style-type: none"> <li>- Maintain family routines</li> <li>- Give extra physical comfort and reassurance</li> <li>- Avoid unnecessary separations</li> <li>- Permit child to sleep in parents' room temporarily</li> <li>- Encourage expression of feelings through play</li> <li>- Monitor media exposure to disaster trauma</li> <li>- Develop disaster safety plan</li> <li>- Draw expressive pictures</li> </ul>	<ul style="list-style-type: none"> <li>- Tell stories of disaster and recovery</li> <li>- Use coloring books on disaster</li> <li>- Read books on disaster and loss</li> <li>- Use dolls, puppets, toys, blocks for reenactment play</li> <li>- Facilitate group games</li> <li>- Talk about disaster safety and self protection</li> <li>- Absenteeism outreach to families and children*</li> <li>- Teachers, school nurses, and providers identify stressed children for assessment and referral*</li> <li>- In-service training on children and disaster*</li> <li>- School-based crisis hotline*</li> <li>- Provide educational brochure for parents*</li> <li>- Encouragement to eventually resume normal roles as students*</li> </ul>
ELEMENTARY AGE CHILDREN	<ul style="list-style-type: none"> <li>- Give additional attention and consideration</li> <li>- Set gentle but firm limits for acting out behavior</li> <li>- Listen to child's repeated telling of disaster experience</li> <li>- Encourage verbal and play expression of thoughts and feelings</li> <li>- Provide structured but undemanding home chores and rehabilitation activities</li> <li>- Rehearse safety measures for future disasters</li> </ul>	<ul style="list-style-type: none"> <li>- Free drawing after discussion of disaster</li> <li>- Free writing after discussion of disaster, complete a sentence exercise</li> <li>- Tell stories of disaster and recovery</li> <li>- Read books on disaster and loss</li> <li>- Role-play games about disaster</li> <li>- Create a play about disaster</li> <li>- School study or science projects to increase understanding and mastery</li> <li>- Talk about disaster safety, family protection, family preparedness*</li> <li>- Teach calming techniques (i.e., deep breathing, visualization)*</li> <li>- Field visit to disaster-affected area*</li> <li>- Small group or individual interventions for high risk children*</li> <li>- Group "debriefing" discussion to express and normalize reactions, correct misinformation, and enhance coping and peer support*</li> </ul>

<i>Age Group</i>	<i>At Home</i>	<i>At School or Other Organization for Children</i>
PRE-ADOLESCENTS AND ADOLESCENTS	<ul style="list-style-type: none"> <li>- Give additional attention and consideration</li> <li>- Encourage discussion of disaster experiences with peers, significant adults</li> <li>- Avoid insistence on discussion of feelings with parents</li> <li>- Suggest involvement with community recovery work</li> <li>- Encourage physical activities</li> <li>- Encourage resumption of regular social and recreational activities</li> <li>- Rehearse family safety measures for future disasters</li> </ul>	<ul style="list-style-type: none"> <li>- *All interventions starred above apply.</li> <li>- School programs for assisting community with recovery, helping others</li> <li>- Projects to commemorate and memorialize disaster gains and losses</li> <li>- Encourage discussion of disaster losses with peers and adults</li> <li>- Resume sports, club, and social activities when appropriate</li> </ul>

## Special Concerns of Older Adults in Disaster

**Reluctance to evacuate** – Research shows that older adults are less likely to heed warnings, may delay evacuation, or resist leaving their homes during disasters. Disaster planning and preparedness is especially critical with this group.

**Vulnerable housing** – Due to limited income, older adults tend to live in dwellings that are susceptible to disaster hazards due to the location and age of buildings.

**Fear of institutionalization** – Many older adults fear that if their diminished physical or emotional capabilities are revealed, they will risk loss of independence or institutionalization. They may under-report the full extent of their problems and needs.

**Multiple losses** – An older person may have lost their income, job, home, loved ones, and/or physical capabilities prior to the disaster. For some, these prior losses may build coping strength and resilience. For others, these losses compound each other. Disasters sometimes provide a final blow that makes recovery especially difficult.

**Significance of losses** – As a result of a disaster, irreplaceable possessions such as photograph albums, mementos, valued items, or sacred objects passed on through generations may be destroyed. Pets or gardens developed over years may be lost. The special meaning of these losses must be recognized to assist with grieving.

**Sensory deprivation** – An older person's sense of smell, touch, vision, and hearing may be less acute than the general population. As a result, they may feel especially anxious about leaving familiar surroundings. They may not be able to hear what is said in a noisy environment or may be more apt to eat spoiled food.

**Chronic health conditions** – Higher percentages of older persons have chronic illnesses that may worsen with the stress of a disaster, particularly when recovery extends over months. Arthritis may prevent an older person from standing in line for long periods of time. Problems with thinking and memory may affect the person's ability to remember or process information.

**Medications** – Older adults are more likely to be taking medications that need to be replaced quickly following disaster. Medications may cause problems with confusion or memory, or cause a greater susceptibility to problems such as dehydration.

**Hyper/hypothermia vulnerability** – Older persons are often more susceptible to the effects of heat and cold. This becomes critical in disasters when furnaces and air conditioning may be unavailable.

**Transfer and relocation trauma** – Frail adults who are dislocated without use of proper procedures may suffer illness or even death. Relocation to unfamiliar surroundings and loss of community may result in depression and disorientation.

**Delayed response syndromes** – Older persons may not react as fast to a situation as younger persons. In disasters, this may mean that deadlines for applications or eligibility timelines may need to be extended.

***Mobility impairment or limitation*** – Older persons may not be able to use automobiles or have access to public or private transportation. This may limit the opportunity to relocate, go to shelters, Disaster Recovery Centers, or to obtain food, water, or medications when necessary.

***Financial limitations*** – Because many older adults live on fixed and limited incomes, they can't take out a loan to fully repair their homes. They are unable to "start over" due to lack of money and time, as is more possible for younger people.

***Literacy*** – Older persons have lower educational levels than the general population. This may present difficulties in completion of applications or understanding directions. Public information targeting this group must be disseminated in multiple ways, including by non-written means.

***Isolation*** – Some older adults have limited social support systems and are not associated with local senior centers or churches. Their isolation may contribute to not learning about available resources. They may not have access to help with clean-up or repairs. Disaster outreach efforts should prioritize reaching these individuals.

***Crime victimization*** – Con artists target older people, particularly after a disaster. These issues need to be addressed in shelters, housing arrangements, and when contractors are being selected to repair homes.

***Bureaucracy unfamiliarity*** – Older adults often have not had experience working through bureaucratic systems. This is especially true for those who had a spouse who dealt with these areas.

***Welfare stigma*** – Many older persons will not use services that have the connotation of being welfare or a "handout." They may need to be convinced that disaster services are available as a government service that their taxes have purchased.

***Mental health stigma*** – Older persons may feel ashamed because they experience mental health problems, or they may be unfamiliar with counseling as a form of support. Psychological stress may be manifested in physical symptoms, which some find as more acceptable. Mental health services should emphasize "support," "talking," and "assistance with resources," and de-emphasize diagnosis or psychopathology.

(Deborah J. DeWolfe, Ph.D., 1995)

## **Resource Materials**

Diane Myers, R.N., M.S.N. Older Adults' Reactions to Disaster Handout. 1990.

U.S. Department of Health and Human Services. Action Plan of the Administration on Aging to Strengthen the Disaster Response Capacity to Serve Older People, 1994.

## Cultural Sensitivity and Disaster

Disaster mental health recovery programs must respond specifically and sensitively to the various cultural groups affected by a disaster. In many disasters, ethnic and racial minority groups may be especially hard hit because of socioeconomic conditions which force the community to live in low income, sub-standard housing that is particularly vulnerable to destruction. Language barriers, suspicion of governmental programs due to prior experiences, rejection of outside interference or assistance, and differing cultural values often contribute to disaster outreach programs' difficulty in establishing access and acceptance.

Cultural diversity includes social class, gender, race, and ethnicity. Each family or individual receiving disaster mental health services should be viewed within the context of their cultural/ethnic/racial group and their experience of being a part of that group. The degree and nature of acculturation is relevant, in that bicultural influences are manifested by variation within each group.

To be culturally sensitive and provide appropriate services, disaster mental health professionals must be aware of their own values, attitudes, and prejudices (we *all* have them), be committed to learning about cultural differences, and be flexible, creative, and respectful in our intervention and outreach approaches.

### Some Considerations When Establishing Contact With Ethnic Groups

***Language/degree of fluency in English and literacy*** – Program cultural sensitivity is conveyed when information is translated into primary languages and/or available in non-written forms. When English is a person's second language, emotions are frequently experienced and expressed in their language of origin. Use of trained translators, especially with mental health backgrounds, is preferable to family or neighbors because of issues of privacy and confidentiality.

***Immigration experience and status*** – The number of generations and years in the U.S., degree of acculturation, and citizenship status are relevant to consider when defining outreach strategies. Also, war, living conditions, and trauma in the country of origin as well as conditions of immigration may impact coping with the current disaster.

***Family values*** – Determine who is included in the "family." Often, elders and extended family members are considered part of the family unit and form the primary avenue of support. Learn who the family decision-makers are, what the relative roles of women and men, parents and children, and the older generation are. Establish who should be included in outreach or "counseling" sessions.

***Cultural values and traditions*** – Cultural groups have considerable variation regarding views of loss, death, grieving, property, home, rebuilding, religion, spiritual practices, mental health, healers, and helping. The disaster itself may be viewed as punishment, an act of God or other deity, or the result of another event or action.

## Suggestions for Intervention

- Learn from local leaders, social service workers, and community members from the cultural group about values, family norms, traditions, community politics, etc.
- Involve mental health staff and community outreach workers who are bilingual and bicultural whenever possible. Involve trusted community members to enhance credibility.
- Allow time and devote energy to gaining acceptance, be wary of aligning your efforts with agency/organizations that are mistrusted by the communities you're trying to reach. Take advantage of association with valued and accepted organizations.
- Be dependable, non-judgmental, genuine, respectful, well-informed, and credible to the community. Listen for verbal and non-verbal cues and modify efforts accordingly.
- Determine most appropriate and acceptable ways to introduce yourself and define your program and services to be culturally sensitive.
- Recognize cultural variation in expression of emotions, manifestation, and description of psychological symptoms, mental health problems, and view of "counseling."
- Provide community education information in multiple languages and via radio, TV, and church announcements if there is low literacy level.
- Focus on problem-solving and concrete solutions. Be action-oriented and empower clients through education and skill-building.
- Assist in eliminating barriers to help: interpret facts, policies, and procedures, provide advocacy and resource assistance in dealing with barriers.

(Deborah J. DeWolfe, Ph.D., 1993)

## Resource Materials

Diane Myers, R.N., M.S.N. and Josie Romero, L.C.S.W. Task Force on the Delivery of Services to Ethnic Minority Populations, American Psychological Association. *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations*. 1990.

Bolin, R. C. & Bolton, P. *Race, Religion and Ethnicity in Disaster Recovery*. Institute of Behavioral Science, University of Colorado, 1986.



Note: This section corresponds with Module 1 & 6 of the KAHBH Core Training.

## **BEST OR PROMISING PRACTICES**

### **Behavioral Health and Disaster**

Information on best or promising practices is emerging from ongoing research. The following recommendations on best practices will be updated as new information becomes available. Kansas adopts the recommendations resulting from the 2001 National Institute of Mental Health (NIMH) workshop to reach consensus on best practices in early psychological intervention for victims/survivors, excerpted here:

#### ***Guidance on Best Practice Based on Current Research Evidence***

Thoughtfully designed and carefully executed randomized controlled trials play a critical role in establishing best practices. There are, however, few randomized controlled trials of psychological interventions following disasters. Existing randomized controlled trial data, often from studies of other types of traumatic events, suggest that:

- Early, brief, and focused psychotherapeutic intervention can reduce distress in bereaved spouses, parents, and children.
- Selected cognitive behavioral approaches may help reduce incidence, duration, and severity of acute stress disorder, post-traumatic stress disorder, and depression in survivors.
- Early interventions in the form of single one-on-one recitals of events and emotions evoked by a traumatic event do not consistently reduce risks of later posttraumatic stress disorder or related adjustment difficulties.
- There is no evidence that eye movement desensitization and reprocessing (EMDR) as an early behavioral health intervention, following mass violence and disasters, is a treatment of choice over other approaches.
- Other practices that may have captured public interest have not been proven effective, and some may do harm.

In addition to the above recommendations, the following is recommended:

- Any psychological debriefings requested or undertaken under the KAHBH Plan will be voluntary on the part of participants
- The Kansas Critical Incidence Stress Management (CISM) Program has its own guidelines and operating procedures to serve the mental health needs of first responders and will follow those guidelines and will not be part of the KAHBH Response
- The number of responders activated should be enough to have a **consistent** presence at sites of intervention
- Behavioral health responders should spend adequate time at a site to ensure behavioral health needs are met

## **Substance Use/Abuse and Disaster**

Current research indicates that although alcohol and other substance use increases after a disaster, it increases only for those who had pre-existing substance use/abuse issues. In general, disasters do not appear to trigger new cases of substance use/abuse in survivors and first responder populations.

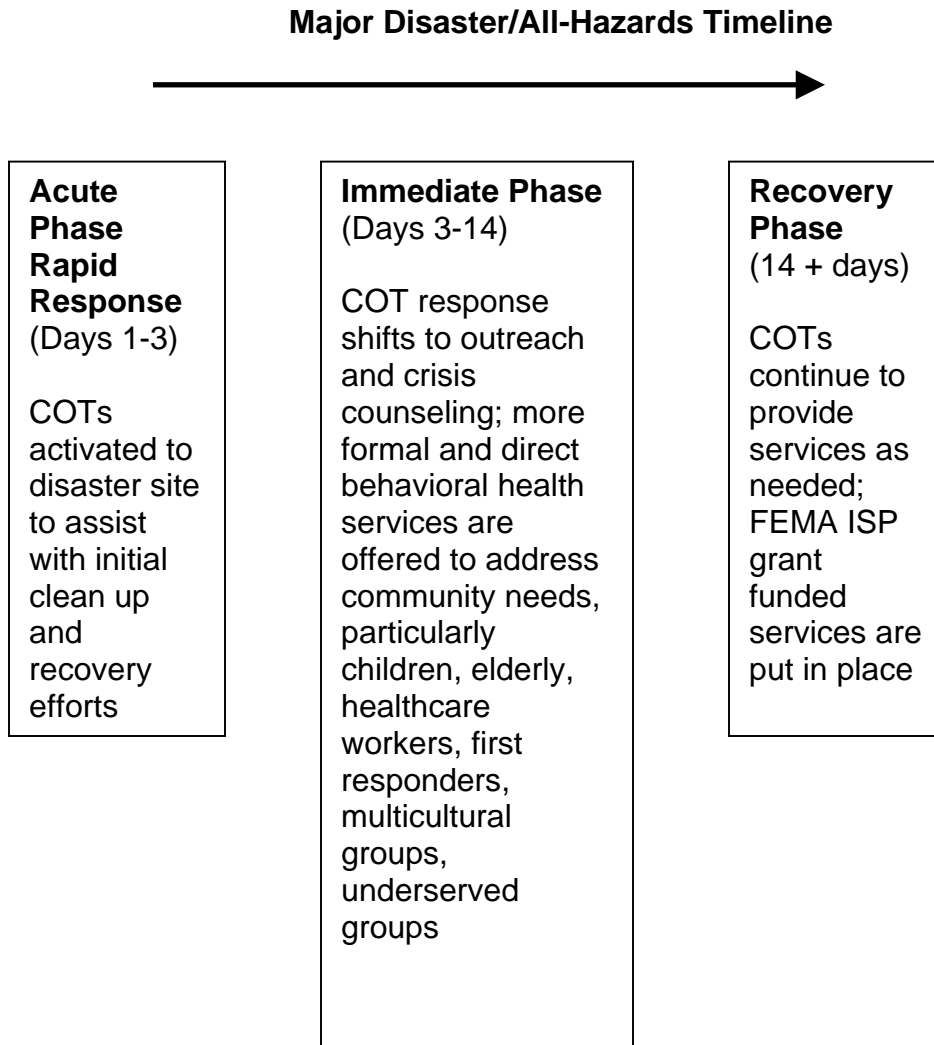
Following a disaster, these groups may require outreach and additional service provision from substance abuse professionals and support systems:

- Current clients of substance abuse treatment, detoxification, or methadone maintenance facilities to insure continuity of services;
- Past clients who were affected by the disaster, who may be at risk for relapse;
- Current substance abusers who are not in treatment;
- Users who normally do not have a problem with their substance use (social drinkers, for example), but who increase their substance use after a disaster
- First responders who use substances and are at increased risk for escalation of their substance use because of repeated exposure to emergencies and disasters

The KAHBH Network will include substance abuse professionals as part of the state response network.

## All-Hazards Behavioral Health Intervention Phases

During a major all-hazards event or Presidentially declared disaster, KAHBH Team and Community Outreach Teams will continually adjust their approach to the behavioral health needs of the affected community based on the rapidly evolving situation. The figure below depicts certain changes that we anticipate will occur as the situation unfolds:



### ***THE ACUTE PHASE: RAPID RESPONSE***

The KAHBH Program will be responsible for activating the KAHBH plan and the specific activities that are to be initiated.

The KAHBH Coordinator(s) will:

- 1) Receive and collate data from the Community Outreach Teams in the field.
- 2) Ensure that FEMA/State briefings are attended daily at the Disaster Field Office to obtain updated damage assessment information and report data from KAHBH activities.
- 3) Coordinate data collection from FEMA, American Red Cross, Kansas Department of Emergency Management officials, etc.
- 4) Prepare the Immediate Services and Regular Services grant applications in a Presidentially Declared disaster.

The CMHC Coordinators/Community Outreach Team Leaders will:

- 1) Be responsible to the KAHBH Team in carrying out the overall mission at the local level
- 2) While responsible to the KAHBH Team for their overall mission, report to the supervision of the local CMHC/hospital director or his/her designee on site.
- 3) Advise the team leaders about where and to whom to report at the disaster site.
- 4) Regardless of the office, division, CMHC or hospital, will be the point of contact for COT members for day to day direct supervision while in the field.
- 5) Have the authority and responsibility to return team members to their home base if, in the judgment of the Team Leaders, any team members are unable to carry out the necessary tasks for any reason.
- 6) Be responsible for summarizing contact data and reporting it daily to the KAHBH Coordinator

The KAHBH Network Members will:

- 1) Provide crisis counseling, debriefing, and support to survivors when the disaster exceeds the CMHC's or hospital's capacity to respond effectively.
- 2) Provide crisis counseling services to the survivors which include active listening, supportive counseling, problem definition and solving, information, education, referral, active or concrete assistance, advocacy, and reassurance.

- 3) Identify survivors whose response, needs, and history make them especially vulnerable to the stress of the event and subsequent mental health problems. More frequent and intense support is to be provided to these individuals.
- 4) Engage in providing services, community outreach, and interventions at non-traditional sites (e.g., “shoulder-to-shoulder” clean up, community centers, going door-to-door in affected neighborhoods, etc.)
- 5) Be responsible for documenting their contacts daily and reporting it to the CMHC Coordinator/Community Outreach Team Leader.

#### Community Outreach Team Structure:

- 1) Team leaders may organize their members into smaller teams for purposes of carrying out specific functions like debriefing responders; outreach; shelter and congregate site services, etc.
- 2) All teams will consist of 2 sets of paired teams (2 members on each team) providing services; no member will provide solo services, either on-site or within the community.
- 3) While team members may represent several CMHCs, they are under the direct supervision of the local CMHC/COT Leader and the Leader's designee(s) while in the field.
- 4) Although Team Leaders and members may come from different CMHCs or different areas, members of each COT go into the area together and complete their rotation together.
- 5) The make-up of teams will be multi-disciplinary and multi-cultural whenever possible.
- 6) The configuration of disciplines and specialties may vary depending on the phase of the response and the specific local needs.

#### Community Outreach Team Call-Up Procedure:

- 1) The initial response will be made by the KMHA and KAHBH coordinators
- 2) KMHA and KAHBH Coordinators will set in place a process for activating Community Outreach Teams in the affected area(s) by notifying the CMHC Coordinator/Community Outreach Team Leader of network members in their area
- 3) CMHC Coordinator/Community Outreach Team Leader will activate team members in the affected areas
- 4) All team members will report to the prearranged site for briefing, orientation, and assignment.
- 5) CMHC Coordinator/Community Outreach Team Leader shall have the authority to send members home when, in the judgment of the team leader, the member is unable to function in the interest of the whole team or the clients being served.

### Community Outreach Team Rotation:

**The following are provided as GUIDELINES for teams and team leaders.**

The following guidelines may vary depending upon the scope and nature of the disaster and varying needs and stresses as the response effort matures.

- 1) Team Leaders and members should serve in the field no longer than five (5) full and continuous days on site (inclusive of travel time) in a single rotation. On the final day, the outgoing team leader will brief the incoming team leader.
- 2) Team Leaders and members shall plan a reasonable amount of time for rest while in the field, but no less than eight (8) continuous hours in each twenty-four (24) hour period.
- 3) Each team is **required** to meet at the end of the day or shift and prior to assignment to shelters for the night, to share information, plan for the next day's work and emotionally process the day's activities together.
- 4) Team members and Leaders are **required** to leave the disaster area and return home for at least ten (10) full days before serving a subsequent rotation.
- 5) Team Leaders and members shall receive the next two (2) full scheduled working days off as Administrative Leave beginning the day after their return to their home and communities. The leave **must** be taken at this time. It cannot be considered Compensatory Time to be taken at a later date.

### KAHBH NETWORK DEBRIEFING PROCEDURES

Debriefing encompasses the exchange of information for purposes of planning and coordinating services, as well as, the need for all staff involved in the disaster to deal with the emotional effects of the experience. Debriefing is a specific clinical skill and only people trained in a debriefing model will be permitted to carry out this function.

#### Process Debriefing:

- While in the field, team members will process the day's activities and the plans for the next day with their team leader.
- While in the field, team leaders will check in daily with the DMH Disaster Response Team to process the day and to report their own and their team's challenges.

Post Rotation Debriefing:

- All employees who carry out field work in the affected area should have at least one debriefing session in their home community before returning for a subsequent rotation.
- Post rotation debriefing should be documented by a roster of those leading the debriefing and those attending the debriefing.
- The CMHC Coordinator/Community Outreach Team Leader should organize debriefing sessions for Network members responding in their area.
- Response workers may be debriefed within five to seven days of returning to their home facility or CMHC (these debriefings may occur during the employee's Administrative Leave period).
- Post-Response debriefing may be arranged as needed for each group of response workers.

***THE IMMEDIATE PHASE***

KAHBH Coordinators will continue the response activities that were initiated in the Acute Phase.

They will also be responsible for submitting applications for FEMA ISP and RSP grants for the continuing disaster response work.

***THE RECOVERY PHASE***

On-going recovery activities will be provided as needed and directed by KAHBH program coordinators. The KAHBH Program will be responsible for providing FEMA ISP and RSP grants administrative oversight.

# APPENDICES



## CHECKLIST

### PRIOR TO DISASTER:

1. Develop a behavioral health disaster plan that specifies responsibilities and functions of behavioral health personnel in time of disaster.
2. Pre-designate the members/location
3. Include multicultural, multi-language capability to reflect makeup of community
4. Update Census information in the plan to insure there is up-to-date information available about the people affected by the event.
5. Include special population workers (children, older adults, etc.)
6. Train behavioral health staff on the disaster behavioral health plan, roles, responsibilities, principles of disaster behavioral health practices, and stress management for disaster workers.
7. Orient team members in disaster mental health outreach techniques and disaster resources
8. Pre-designate site supervisors who can coordinate the behavioral health response at each site. These site supervisors will be licensed mental health professionals with previous disaster response experience. They will be able to orient responders to the current disaster and the types of information that is to be tracked throughout the response.
9. Train the team on personal and family disaster preparedness; Encourage all behavioral health staff to have family, school, and workplace disaster preparedness plans.
10. Provide the team with identification cards recognized by KDEM and local law enforcement officials
11. Have behavioral health supplies and materials pre-assembled in "kits" or "containers" for transport to shelter. These kits will be distributed to the team in advance or kept in an accessible location and will include the following:
  - a. Behavioral health brochures and fliers on common disaster reactions, ways to cope, and where to call for help (may leave blank space for disaster hotline numbers); in multiple languages, as needed
  - b. A current list of designated disaster contacts
  - c. A master copy of forms
  - d. A copy of the KAHBH Plan
  - e. Local resource directories
  - f. Pens, paper, necessary forms, clipboards and other supplies
12. Provide cellular phones or arrange with local amateur radio group to provide communication linkage
13. Complete simple data collection forms to track services delivered, funds expended, and to collect needs assessment data for FEMA and other available grants
14. Prepare sample public service announcements (PSAs), news articles, and sample interviews for radio and television; distribute as appropriate.
15. Identify and establish relationships with community agencies that will be key to successful outreach efforts: American Red Cross, schools, agencies serving special population

16. Identify special populations or groups in community likely to be vulnerable in disaster; outline outreach strategies and key resources for each group.
17. Train behavioral health staff in disaster roles, responsibilities, principles of disaster mental health practices, and stress management for disaster workers.
18. Participate in regular area and statewide disaster exercises and drills.

## **DISASTER RESPONSE:**

### **General Response**

1. Assess the situation and begin assembling information about the disaster
2. Get damage assessment information from KDEM as soon as it is available.
3. Assist local government in the assessment of behavioral health needs in the event of a large scale emergency or disaster
4. Note any high risk groups or special populations affected by the disaster and begin to estimate the size and extent of the behavioral health response needed
5. Employ assessment & tracking protocols recommended by the Center for Mental Health Services. Refer to the Crisis Counseling Program Data Collection Toolkit.  
Coordinate resources relevant to the behavioral health disaster response, building on local organization and requests. Coordination may include liaison work with groups such as:
  - American Red Cross
  - Emergency Management Agency
  - Public Health Departments
  - Hospitals and Medical Facilities
  - Educational institutions
  - VOAD (Voluntary Organizations Active in Disaster)
  - Private behavioral health and substance abuse providers
  - Public behavioral health and substance abuse providers
  - First responder groups
  - Utility companies deployed in clean up efforts
  - Federal resources that may be responding

### **Community Outreach**

1. Assess the situation and begin assembling information about the disaster
2. Get damage assessment information from Emergency Management as soon as it is available.
3. Assist local government in the assessment of behavioral health needs in the event of a large scale emergency or disaster
4. Note any high risk groups or special populations affected by the disaster and begin to estimate the size and extent of the behavioral health response needed

5. All personnel must wear official identification.
6. Establish chain of command and supervision from Emergency Operations Center to field staff
7. Establish a mechanism for communicating with staff in the field; provide staff with necessary communications equipment.
2. Brief staff regarding conditions in the field before deploying them to their assigned sites.
3. Ensure team coordination with other community resources, e.g., American Red Cross Disaster Services.
4. Provide staff with necessary supplies, including brochures on disaster worker stress management and self-care.
5. Determine safe routes to sites where workers will be assigned; provide escort of transportation for staff if necessary.
6. Arrange for food and shelter for staff in field, if necessary.
7. Deploy staff in teams of two or more.
8. Identify sites or shelters where groups of survivors are likely to gather (shelters, food kitchens, community centers, hospitals, schools, the morgue, standing in lines, at roadblocks, in neighborhoods, etc.)
9. Contact survivors via letters, phone calls, or door-to-door visits; provide informal assessment, education, support and resources
10. Establish and maintain contact with agencies, caregivers, key community members, and businesses used by survivors
11. Provide public education to community-at-large regarding common reactions, coping strategies, and where to call for help
12. Use print and electronic media for articles, interviews, public service announcements, paid advertisements, call-in, TV shows
13. Provide public speakers to civic groups, service clubs, PTAs, churches, etc.
14. Attend community gatherings and meetings, fairs, and other events; circulate and talk with survivors for informal assessment, education, support, and providing resources
15. Hang posters on bulletin boards, buses, bus stops, in clinics, waiting rooms, and other public places
16. Distribute brochures and fliers door-to-door, in shopping bags, on literature racks, in department, etc.
17. Train and educate community professionals, caregivers, and informal support systems of survivors regarding behavioral health aspects of recovery and how to help survivors
18. Consult with community professionals and caregivers to facilitate their work with survivors
19. Help community organization efforts among survivors or among informal resource groups
20. Help community organization efforts among survivors or among informal resource groups
21. In the field, observe staff for signs of stress; encourage good stress management practices.
22. Assign staff to work in teams on long-term recovery projects.

23. Provide regular, periodic debriefing or support groups.

### **On-Site Crisis Counseling Services**

1. Wear official identification.
2. Review and clarify behavioral health roles and responsibilities with on-site managers
3. Obtain briefing on conditions, tour the response site, become familiar with operation.
4. Assess population of survivors for special needs, e.g., children, older adults, mentally ill, specific ethnic groups, drug/alcohol dependents, individuals experiencing severe loss or trauma, language interpreter services.
5. Develop behavioral health staffing schedule according to needs.
6. Set up quiet area for behavioral health consultations, and drug/alcohol detoxification room if needed.
7. Consult with on-site manager as needed regarding location environment, needs of individual survivors, and stress management for staff.
8. Assist in establishing sources of information for shelter: Disaster Welfare Inquiry, newspapers, bulletin boards, briefings by emergency officials, brochures about resources, etc.
9. Assist in establishing activities to promote stress reduction for staff and disaster survivors, e.g., childcare, recreation, exercise, support and debriefing groups.
10. Circulate through the site and provide brief assessment, intervention, comfort, assistance, and follow-up for individual survivors and staff as needed.
11. Distribute brochures on behavioral health reactions of adults and children to disaster, self-help stress management suggestions, and where to call for additional help.
12. Provide staff support groups, stress reduction activities, brief supportive counseling services, and debriefings for staff and crisis workers.
13. Provide in-service training or consultation to staff about behavioral health issues pertinent to the population.
14. Keep accurate records of numbers of people seen, problems they were experiencing, and types of interventions given.
15. Maintain records of staff hours, supplies, and costs associated with their assignment.
16. Arrange debriefing by outside resource for behavioral health personnel at the end of shelter operations.
17. In the field, observe staff for signs of stress; encourage good stress management practices.
18. Assign staff to work in teams on long-term recovery projects.
19. Provide regular, periodic debriefing or support groups.

## **LONG-TERM RESPONSE ACTIVITIES**

1. Coordinate activities/liaison with other responding agencies
2. Seek membership on long-term needs groups that form in affected communities.
3. Gather and disseminate information that can help direct providers in their work with affected individuals and communities.
4. Coordinate local outreach and clinical services.
5. Assist local behavioral health providers in identifying additional resources that may be needed to meet their current clients' needs.
6. Provide information to providers about phases of recovery, normal reactions to stress and disaster, and planning for commemorative events.
7. If awarded, work with State coordinators to establish a FEMA Crisis Counseling Program. The following is an abbreviated list of some of the most pressing issues to be addressed in setting up this program:
  - Staffing
  - State service contracts
  - Program implementation
  - Service facilities
  - Equipment & supplies procurement
  - Service announcements (coordinate with State Public Information Officer)
  - Obtaining specialized training for staff and in-services staff
  - Documentation of process and service provision
  - Program evaluation
  - After action reports

## **POST-DISASTER**

1. Provide recognition to mental health staff for contribution to the disaster effort, including those who stayed at the clinic or office to "mind the store."
2. Arrange a critique for behavioral health staff to evaluate effectiveness of disaster operations.
3. Revise disaster plan, policies, procedures, and memoranda of understanding, based on recommendations from the critique.

## ORIENTATION OF DISASTER STAFF TO COMMUNITY ASSIGNMENTS

In addition to training, managers should be sure that an orientation to the disaster is provided to behavioral health staff before deployment. The following topics should be covered:

1. **Status of the disaster:** nature of damage and losses, statistics, predicted weather or condition reports, boundaries of impacted area, hazards, response agencies involved.
2. **Orientation to the impacted community:** demographics, ethnicity, socioeconomic makeup, pertinent politics, cultural mores, language requirements, etc.
3. **Local Community and disaster-related resources:** handouts with brief descriptions and phone numbers of human service and disaster-related resources. FEMA or the state Office of Emergency Services (OES) usually provides written fliers describing state and federal disaster resources once Disaster Application Centers (DACs) are opened. If available, provide them to all staff. Provide workers with a supply of behavioral health brochures or fliers to give to survivors, outlining normal reactions of adults and children, ways to cope, and where to call for help. For crisis workers or mutual aid personnel, provide a brief description of the sponsoring behavioral health agency.
4. **Logistics:** arrangements for workers' food, housing, obtaining messages, medical care, etc.
5. **Communications:** how, when, and what to report through behavioral health chain of command; orientation to use of cellular phones, two-way radios, or amateur radio crisis workers, if being used.
6. **Transportation:** clarify mode of transportation to field assignment. If workers are using personal vehicles, provide maps, delineate open and closed routes, indicate hazard areas; provide appropriate agency approved identification materials.
7. **Health and Safety in a disaster area:** outline potential hazards and safety strategies (e.g., protective action in earthquake aftershocks, flooded areas, etc.). Discuss possible sources of injury and injury prevention. Discuss pertinent health issues such as safety of food and drinking water, personal hygiene, communicable disease control, disposal of waste, and exposure to the elements. Inform of first aid/medical resources in the field.
8. **Field assignments:** outline sites where workers will be deployed (shelters, meal sites, etc.). Provide brief description of the setup and organization of the site and name of the person to report to. Provide brief review of appropriate interventions at the site.
9. **Policies and procedures:** briefly outline policies regarding length of shifts, breaks, staff meetings, required reporting of statistics, logs of contacts, etc. Give staff necessary forms and inform where to return forms.
10. **Self-care and stress management:** require the use of "buddy system" to monitor each other's stress and needs. Remind responders of the importance of regular breaks, good nutrition, adequate sleep, exercise, deep breathing, positive self-talk, appropriate use of humor,

"defusing" or talking about the experience after the shift is over. Inform workers regarding required debriefing to be provided at the end of each tour of duty in the field.

## **ORGANIZATIONAL SUPPORT FOR BEHAVIORAL HEALTH STAFF IN THE IMMEDIATE RESPONSE PHASE**

In the response phase during and immediately after impact of the disaster, the provision of certain supports for workers can help mitigate stressors and help workers to remain effective in their jobs. There are a variety of services such as communications, food, shelter, and supplies that are essential to "keep the organization going." In a large-scale disaster behavioral health operation, the organization must consider assigning a logistics coordinator to this function. The following should be considered:

### **Assistance with locating and checking on families**

When disaster strikes during work hours, employees' prime concern will be learning information about the well-being of their families. Worker anxiety will increase and efficiency will markedly decrease until such information is obtained. Some anxiety may be mitigated if workers have disaster plans at home, and know that their family members have the skills and supplies to take care of themselves. Nevertheless, staff will need information about the status of their families.

If workers do not have information about the well-being of their families, the organization should make every effort to help them in obtaining information. All agencies with disaster responsibilities should have a pre-established plan for how employees will check on their families if disaster strikes during the work hours. It has been suggested that each employee should have on file a regularly updated list of family members, addresses, phone numbers, and usual whereabouts during given hours of the day. Employees are strongly encouraged to establish a plan with their family members by which the family will make every effort to contact the workplace to report on family well-being. This is especially important in those situations where employee roles are essential and they may not immediately be able to leave the workplace.

If conditions allow, staff may be released to go home and take care of their families before reporting to duty for disaster response. In the situation where staff cannot be released (on an inpatient unit, for example), there are several options. When additional staff report for duty, staff can be released to check on families. Staff in less critical roles (clerical staff, for example) may be assigned to family locator functions, and may go into the community to check on families, conditions permitting. If phones are working, one line can be dedicated to family search activities.

### **Debriefing of behavioral health staff**

It is essential that disaster behavioral health workers begin to process their own emotions about the disaster before attempting to help survivors. It is strongly

recommended that a pre-deployment briefing or other group discussion of workers own reactions be conducted for workers before deployment.

### **Utilization of a team approach**

Whenever possible, behavioral health personnel should be assigned to work in teams of two. If there are not enough behavioral health workers to allow this arrangement, staff can often work in a team assignment with public health nurses, Red Cross workers, or other human service-type disaster responders. This ensures a system by which staff can serve as a check-and-balance for each other in assessing needs, making decisions, setting priorities, etc. in the chaotic disaster environment. It also provides staff with a "buddy system" for monitoring each other's stress level and providing support and encouragement.

### **Briefing**

Provide workers with as much information as possible about what they will find at the disaster site. This may involve a quick briefing before sending workers into the field, or a briefing for new staff as they arrive at the scene. This forewarning can help personnel gear up emotionally for what they may find.

### **Work related supplies**

Pens, paper, data collection forms, name tags, educational brochures on disaster stress reactions and stress management, and any other necessary supplies should be sent with workers to the worksite.

### **Official identification**

Official identification cards that are recognized by law enforcement will be necessary to enter the disaster site. In addition, name tags will be important once staff get to their assigned worksite. Most disaster survivors do not see themselves as needing behavioral health services, and may shy away from talking to staff who have name tags saying "psychologist" or "psychiatrist." Experience has shown that titles like "crisis worker," "crisis services," or "health services" are less intimidating to survivors.



## KAHBH Network Member Statement of Agreement

I understand that the Kansas Department of Social and Rehabilitation Services, Mental Health Authority, has established a statewide system to ensure the rapid and efficient deployment of personnel in the event of future disasters. I further understand that I will be serving on a Community Outreach Team (COT) to assist with response activities in the local region.

In the interest of serving as a COT member, I have attended the following training/orientation activities:

- 1) KAHBH Core Training
- 2) COT Formation Orientation Meeting

I agree to participate in annual special focus trainings/team maintenance activities and or disaster exercises/simulations, as required. I have received and read a copy of the "Kansas All-Hazards Behavioral Health Plan" and the related operations manuals.

I understand that I will be assigned as a member of the COT identified below, serving in that local region or other regions, as requested. I further understand that I have been assigned to the specialty sub-group identified below, although I may be called to serve other populations following an all-hazards incident.

I have provided the KAHBH Team with information about myself. In order to expedite immediate communication with me, I agree to the dissemination of this information to designees of the KAHBH Team for established communication protocols and to provide the KAHBH Team with accurate and timely notification of any changes to this information.

I understand that my participation as a member of the KAHBH Network is totally elective. I am under no obligation to respond to an all-hazards event or incident in the State. I can terminate my involvement in the network at any time. I further understand that my involvement in the network may be terminated by the KMHA or KAHBH Team at any time.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

Assigned to COT: \_\_\_\_\_

Specialty Assignment: \_\_\_\_\_

## Kansas All-Hazards Behavioral Health Program Member Information Form

First Name  
Middle Initial  
Last Name

Agency name:  
Job title:  
Work Street Address:  
City  
State  
Zip  
Work Phone:  
Work Fax:  
E-mail:

Home address:  
City:  
State  
Zip  
Home Phone:  
Cell Phone:  
Beeper:  
Other Phone:

Are you a state employee? \_\_\_Yes \_\_\_No  
If yes, name of state agency employed by:\_\_\_\_\_

Are you a licensed professional in Kansas? \_\_\_Yes \_\_\_No  
If yes, please answer the following:  
Credentials: \_\_\_\_\_  
Clinical License Number \_\_\_\_\_  
Please provide a copy of your current state professional license

Other Information:

Languages other than English that you speak fluently? Are you a TRAINED interpreter of the language(s)?

Please indicate the following areas in which you have experience or specialized training:

- ☐ Substance Abuse
- ☐ Multicultural Services
- ☐ Children's Services
- ☐ Women's Issues
- ☐ Sign Language Interpreter
- ☐ Trained interpreter of another language
- ☐ Abuse (physical, sexual, emotional)
- ☐ Elderly services
- ☐ Disability services
- ☐ Trauma/PTSD
- ☐ Veteran services
- ☐ Group counseling
- ☐ American Red Cross trained
- ☐ CISM Trained

Please indicate which of the following KAHBH SPECIALTY TRAININGS you would be interested in receiving (each one consists of approximately 4 hours of training):

- ☐ Children (under age 18)
- ☐ Frail elderly
- ☐ Developmentally disabled and physically disabled
- ☐ People with severe mental illness and people in active substance abuse treatment
- ☐ People in correctional institutions, college students in dorms/away from home, and other relocated families/individuals
- ☐ People with high traumatic exposure
- ☐ People in poverty and homeless
- ☐ Women/girls in the area
- ☐ Emergency responders involved in rescue/recovery
- ☐ Multicultural issues
- ☐ Rural populations, including farmers, ranchers, and agricultural workers

Are you willing to be on a KAHBH Call-up list during a disaster/emergency?

- ☐ Yes ☐ No

Are there any limitations for your involvement in a response?

Yes, County work area only \_\_\_\_\_

Yes, local or adjoining counties only \_\_\_\_\_

Yes, business hours only \_\_\_\_\_

Yes, evenings only \_\_\_\_\_

Yes, weekends only \_\_\_\_\_

Yes, other limitations \_\_\_\_\_

No, there are no limitations to my disaster response involvement \_\_\_\_\_

## ***KAHBH Core Training Supplemental Information***

This section provides supplemental information to the KAHBH Core Behavioral Health Training. The information includes a description/overview of the training, supplemental training information not contained in the SAMHSA/CMHS Training Manual, and handouts relevant to the Kansas All-Hazards Behavioral Health Team.

Intervention	Key Components
Basic Needs	Provide survival, safety, and security
	Provide food and shelter
	Orient survivors to the availability of services and support
	Communicate with family, friends, and community
	Assess the environment of ongoing threats
Psychological First Aid	Protect survivors from further harm
	Reduce psychological arousal
	Mobilize support for those who are most distressed
	Keep families together and facilitate reunions with loved ones
	Provide information and foster communication and education
Needs Assessment	Use effective risk communication techniques
	Assess the current status of individuals, groups, and/or populations and institutions/systems. Ask how well needs are being addressed, what the recovery environment offers, and what additional interventions are needed.
Rescue and Recovery Environment Observation	Observe and listen to those most affected
	Monitor the environment for toxins and stressors
	Monitor past and ongoing threats
	Monitor services that are being provided
	Monitor Media coverage and rumors
Outreach and Information Dissemination	Offer information/education and "therapy by walking around"
	Use established community structures
	Distribute flyers
	Host Web sites
	Conduct media interviews and programs and distribute media releases (National Institute of Mental Health, 2002)

## DISASTER RESPONSE: IMPACT ON STAFF

Disaster workers go through a series of emotional phases related to the nature of their jobs. At times, workers may feel "out of sync" with the reactions of survivors. This is especially common in the early hours and days of the disaster while workers are still making heroic efforts to organize and deliver services. At other times, mental health workers may closely identify with survivors and experience their emotions vicariously. While it is impossible to specify exactly what a given mental health worker will experience at any one point in time, the following are the usual disaster worker phases:

**Alarm phase.** This phase involves comprehending and adjusting to the news of the disaster, collecting and making sense of whatever facts and information are available, and gearing up to respond. In a warning period in which workers are waiting to see whether an event will materialize (a tornado watch, for example), they may experience vague feelings of anxiety, restlessness, and irritability. Post-impact, workers, like survivors, may initially feel shocked and stunned. An orientation or briefing for workers before they first enter the disaster area can help to prepare them for the conditions they may find, and can help to reduce some emotional shock.

**Mobilization phase.** Workers quickly recover from their initial shock and start developing and coordinating plans. Supplies, equipment, and personnel are inventoried and local community needs are assessed. Mental health center/hospital aid may be requested. Staff are selected and activated.

**Action phase.** Workers actively and constructively work at necessary tasks. There are two aspects to the mental health action phase (New Jersey Office of Emergency Management, Dec. 1991):

- A. **Response.** This phase occurs immediately before, during and after the impact. Mental health response activities may include staffing at shelters, first aid stations, meal sites, morgues, Emergency Operations Centers, or command centers. There is usually a high level of activity and often a high level of stress. Many frustrations may occur due to adverse conditions, lack of equipment, communication breakdowns, and the like. Nevertheless, workers proceed diligently and often heroically, frequently ignoring their own fatigue and injuries. During disaster operations that continue for more than a day or two, worker burnout can occur if needs for breaks, food, sleep, and stress management are ignored.
- B. **Recovery.** Short-term recovery includes activities intended to return vital life-support systems to more normal levels of operation. Psychological first-aid, crisis intervention, and defusing are short-term mental health recovery activities. Long-

term recovery activities are designed to return life to normal or improved levels. Long-term mental health recovery activities include outreach, consultation and education, individual and group counseling, community organization, advocacy, and referral to community resources. Mental health recovery services in the long-term may extend to or beyond the first anniversary of the disaster.

Recovery-phase disaster work has a slower pace and can be less immediately rewarding than early-phase response. Because disaster survivors do not usually seek out counseling services in large numbers, outreach and community education activities comprise a large part of recovery activities. Because of the lack of large numbers of clients, combined with the difficulty of evaluating effectiveness of outreach and education efforts, workers can lose heart and question the value of their work.

The emotional impact of disaster is especially strong for workers if contact with survivors is prolonged. Staffs identify with and sometimes take on the frustrations in their rebuilding efforts. Continuous exposure to survivors' stories of loss and grief can be painful for workers, and, if unrecognized, can play into an unconscious desire to avoid listening to painful material.

**Letdown phase.** This phase involves the transition from the disaster operation back into the normal routine of work and family life. It can be a difficult period for workers if feelings have been suppressed or denied during the action phase, and the feelings now begin to surface. In addition, workers may experience feelings of loss and "letdown" as they move out of the challenging disaster assignment and return to their usual activities.

## **WORKER STRESS REACTIONS DURING THE DISASTER**

The following are some list of common disaster worker stress reactions. They are provided to alert workers and supervisors to what stress reactions commonly occur, and to help them in determining if they are experiencing a problematic level of stress. Usually, the symptoms are normal in every way, and simply suggest a need for corrective action to limit the impact of a stressful situation. In some situations, stress symptoms may be delayed for weeks, months, or years following the event.

No clear-cut guide exists for how and when to know if workers are experiencing excessively high stress levels. One fact is clear: workers are usually not the best judges of their own stress, as they tend to become intensely involved in the disaster work. Therefore, a buddy system, where coworkers agree to keep an eye on each other's stress reactions, can be important.

### **COMMON DISASTER WORKER STRESS REACTIONS**

#### **PSYCHOLOGICAL/EMOTIONAL**

Feeling heroic, invulnerable, euphoric  
Denial  
Anxiety and fear  
Worry about safety of self or others  
Generalized anger  
Irritability  
Restlessness  
Sadness, grief, depression, moodiness  
Distressing dreams/unsatisfying sleep  
Guilt or "survivor guilt"  
Feeling overwhelmed and hopeless  
Feeling isolated, lost or abandoned  
Apathy, emotionally neutral  
Over identification with survivors

#### **COGNITIVE**

Memory problems  
Disorientation  
Confusion  
Slowness of thinking and comprehension  
Difficulty calculating, setting priorities, making decisions  
Poor concentration  
Limited attention span  
Loss of objectivity



Unable to stop thinking about disaster  
Blaming

## **BEHAVIORAL**

Change in activity levels  
Decreased efficiency and effectiveness  
Difficulty communicating  
Increased use of humor  
Outbursts of anger and/or frequent arguments  
Inability to get proper rest and feelings of being "let down"  
Change in eating habits: too much or too little  
Change in sleeping patterns  
Change in patterns of intimacy, poor sexual performance  
Change in job performance  
Periods of crying and depression  
Increased use of alcohol, tobacco, and other drugs to excess  
Social withdrawal, increased silence  
Vigilance about the safety of the environment  
Avoidance of activities or places that trigger negative memories  
Proneness to accidents and falls

## **PHYSICAL**

Increased heartbeat and breathing pattern  
Increased blood pressure  
Upset stomach, nausea, diarrhea  
Change in appetite, weight loss or gain  
Sweating or chills  
Tremors (hands, lips, facial area)  
Muscle twitching  
"Muffled" hearing  
Tunnel vision  
Feeling uncoordinated  
Headaches  
Soreness in muscles  
Lower back pain  
Feeling a "lump in the throat"  
Exaggerated startle reaction  
Fatigue  
Menstrual cycle changes  
Change in sexual desire  
Decreased resistance to infection through immune system suppression  
Flare-up of allergies and arthritis  
Hair loss

## PHYSICAL STRESS REACTIONS REQUIRING PROMPT MEDICAL EVALUATION

- Chest pains
- Irregular heartbeat
- Difficulty in breathing
- Fainting or dizzy spells
- Collapse
- Unusually high blood pressure
- Numbness or paralysis of part of body
- Excessive dehydration
- Frequent vomiting
- Blood in stool

## HOW TO KNOW WHEN STRESS REACTIONS BECOME A PROBLEM

Usually, worker stress reactions will diminish with practice of stress management approaches, the passage of time, the ability to talk about the event and its meaning, and the support of family, friends, and the worker's organization. Sometimes, the disaster or disaster work may be so stressful for the workers that symptoms do not seem to diminish on their own. The following are some guidelines for separating normal stress reactions from those that may be problematic:

**Duration:** the duration of a stress reaction will depend on the severity of the event, the meaning of the event to the worker, and the individual's coping mechanisms and support system. Stress symptoms related to the actual disaster usually subside in about six weeks to three months. Intense symptoms lasting longer may require professional assistance. Stress reactions related to the stressors of the disaster assignment can continue as long as the worker is in his/her disaster role. Careful attention should be paid to eliminating occupational stressors, providing organizational supports for workers, and building stress management strategies into the workplace. In addition, it is important to provide workers with anticipatory guidance about transition back into regular work roles and activities.

**Intensity:** This is a highly subjective criterion. However, any symptoms that seem acutely intense, disturbing, or out of control to the worker may require professional assistance. In particular, unusual physical reactions, visual or auditory hallucinations, extremely inappropriate emotions, phobic or panic reactions, antisocial acts, serious disorientation, or suicidal or homicidal thoughts should receive mental health assistance.

**Level of functioning:** Any symptoms that seriously interfere with an individual's functioning at work, at home, or in social relationships should be considered for mental health assistance.

## **Substance Abuse Services within Crisis Counseling Programs**

Source: [http://www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/ccp\\_pg05.asp](http://www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/ccp_pg05.asp)

*Note: This is the fifth in a series of program guidance documents developed to ensure consistency in addressing key program issues in the Crisis Counseling Training and Assistance Program (CCP). The Crisis Counseling Training and Assistance Program is funded by the Federal Emergency Management Agency (FEMA) under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. On behalf of FEMA, the Center for Mental Health Services (CMHS), Emergency Services and Disaster Relief Branch (ESDRB) provides technical assistance, program guidance and oversight.*

### **Purpose**

This program guidance is designed to clarify the role of the Crisis Counseling Program (CCP) in providing assistance for those who may abuse or are addicted to substances. In a number of disasters, there have been questions about the role of the crisis counseling program in providing "mental health treatment" to special needs groups, including providing "treatment" to people abusing substances. Confusion has occurred as a result of similar terminology in that services provided through the CCP are similar to what is often called "treatment" in the substance abuse field.

### **The Role of the Crisis Counseling Program**

The amount and kind of stress and trauma that individuals experience in a disaster will vary from person to person. However, experience has shown that many survivors may be vulnerable to adopting or resuming unhealthy coping strategies following a disaster. People may begin abusing substances, resume abusing substances, or engage in addictive behavior because they are overwhelmed by their disaster experience.

The purpose of the Crisis Counseling Program is to assist individuals in understanding that emotional reactions to a disaster are normal and to help them develop appropriate coping skills so that they can resume their pre-disaster level of functioning. The program also assists in the identification and referral of individuals who may need services outside the scope of the Crisis Counseling Program. The CCP has a responsibility to provide counseling and education for disaster related problems. Program staff cannot ignore survivors who are abusing substances (or are at risk of doing so) as they attempt to cope with the disaster. Yet, the program is not responsible for providing substance abuse treatment and should not operate 12-Step groups under its auspices. Crisis Counseling Program staff should refer individuals with difficulties requiring specialized expertise to treatment programs with trained and credentialed staff. Referrals may be made to detoxification and/or community-based recovery programs for individuals identified as substance abusers. In rare instances, the CCP might help to facilitate re-activation of recovery groups that may have been temporarily disrupted due to the disaster or whose members may have been dispersed because of the disaster. However, Crisis Counseling Programs are not designed to sponsor these efforts.

The State Mental Health Authority (responsible for overseeing the Crisis Counseling Program) should be in early and continuous contact with the State Substance Abuse Authority to assess needs and resources and to assure that planning and program operations following a disaster are coordinated. Early in the implementation of the CCP,

linkages should be made with local public and private substance abuse treatment programs to coordinate possible referrals. Community resources for detoxification, inpatient and outpatient treatment should be researched and the information made available to the crisis counselors. Assessment is one of the most important functions in addressing the problem of use, abuse or addiction with disaster survivors and is an appropriate function in the Crisis Counseling Program. Local substance abuse agencies and organizations, as well as the State Substance Abuse Agency, should be able to provide information on methods for assessment of substance abuse problems.

### **Staffing**

Crisis Counseling Programs are encouraged to consider including crisis counselors who are active in the 12-Step recovery community (e.g. Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA), Al-Anon and Ala-Teen, companion groups for friends and family) in their complement of staff. Members of the recovery community can be very helpful in the assessment and intervention process. They can educate crisis counselors about enabling behavior, ways to approach the individual who is in denial and provide sound guidance about the level of motivation in the substance abuser. Prospective crisis counselors who have a history of addiction should be drug free or "clean and sober" for two years before being considered for a counseling position. They should be sensitive to the cultural aspects of substance abuse as these will vary from one ethnic group to another and recovery groups will vary in the degree to which they welcome and accommodate diversity. The limits of the CCP with regard to substance abuse treatment should also be made clear to staff. Active members of the companion programs Al-Anon, Ala-Teen and Nar-Anon can be helpful in working with families of substance abusers, as post disaster substance abuse will often increase stress and tension in families. Crisis counselors with companion program experience can help families find healthy ways of coping with the substance abuse as they pursue their own emotional recovery from the disaster.

### **Intervention**

In the past, States have made requests to fund staffing for detoxification programs, substance abuse hot lines and support to relief workers in substance abuse treatment programs. The exclusion of these activities is based upon the determination that the services represent specialized treatment as opposed to disaster crisis counseling services; it is not based on an assumption that substance abuse issues predate the disaster. It is not appropriate for staff to engage in specialized treatment activities.

Substance abuse is one of the most difficult disorders to assess and treat. Denial, ethnic and cultural views, legal factors, and stigma all contribute to this difficulty. If assessment of an individual determines that a substance abuse problem may be present, then intervention, within the context of the CCP, begins with an exploration of what the disaster victim has done about the history and seriousness of the problem. If the person has experienced inpatient or outpatient treatment or has been in a 12-Step recovery program, re-establishing contact with these should be explored. Re-establishing contact is especially important if the person has a sponsor or a therapist. If the problem is new, the survivor should be strongly encouraged, in addition to

continuing involvement with the Crisis Counseling Program, to seek assistance from substance abuse resources in the local community. The crisis counselor may refer the individual to the appropriate program or agency. Most 12-Step recovery programs have a local, 24-hour hotline and referral number through which meeting times and places can be obtained. Members of AA and other 12-step recovery programs will often go out of their way to help a prospective member get to a meeting. Al-Anon and Ala-Teen programs are also widely available for family members.

### **Information and Referral Resources**

Adult Children of Alcoholics (AcoA)  
P.O. Box 3216  
Torrance, CA 90510  
(310) 534-1815  
<http://www.mentalhealth.org/scripts/redirect.asp?ID=1412>

Al-Anon Family Group Headquarters  
1600 Corporate Landing Pkwy  
Virginia Beach, VA 23454  
Information Line 800-344-2666  
National Referral Line 888-4AL-ANON (M-F, 8AM to 6PM EST)  
<http://www.mentalhealth.org/scripts/redirect.asp?ID=1878>

Alcoholics Anonymous  
P.O. Box 459  
Grand Central Station  
New York, NY 10163  
Phone (212) 870-3400  
<http://www.mentalhealth.org/scripts/redirect.asp?ID=1411>

AlaTeen  
P.O. Box 459  
Grand Central Station  
New York, NY 10163  
Phone (212) 870-3400  
<http://www.mentalhealth.org/scripts/redirect.asp?ID=1881>  
National Referral Line 888-4AL-ANON (M-F, 8AM to 6PM EST)

Center for Substance Abuse Prevention  
Rockwall II  
5600 Fishers Lane  
Rockville, MD 20857  
Phone (301) 443-0365  
<http://www.mentalhealth.org/scripts/redirect.asp?ID=17>

Publications: <http://www.mentalhealth.org/scripts/redirect.asp?ID=1882>

Center for Substance Abuse Treatment  
Rockwall II  
5600 Fishers Lane  
Rockville, MD 20857  
Phone (301) 443-5052  
<http://www.mentalhealth.org/scripts/redirect.asp?ID=18>

Children of Alcoholics Foundation  
33 West 60th Street, 5th Floor  
New York, NY 10023  
Phone (800) 359-2623  
[http://www.mentalhealth.org/\\_scripts/redirect.asp?ID=223](http://www.mentalhealth.org/_scripts/redirect.asp?ID=223)

Cocaine Anonymous  
3740 Overland Avenue, Ste C  
Los Angeles, CA 90034  
Phone (310) 559-5833  
[http://www.mentalhealth.org/\\_scripts/redirect.asp?ID=1883](http://www.mentalhealth.org/_scripts/redirect.asp?ID=1883)  
National Referral Line 800-347-8998

Nar-Anon Family Group Headquarters  
P.O. Box 2562  
Palos Verdes Peninsula, CA 90274  
Phone (310) 547-5800

Narcotics Anonymous  
PO Box 9999  
Van Nuys, CA 91409  
Phone (818) 773-9999  
[http://www.mentalhealth.org/\\_scripts/redirect.asp?ID=1884](http://www.mentalhealth.org/_scripts/redirect.asp?ID=1884)

## **HOW TO WORK WITH THE MEDIA**

### **The Public in Public Relations**

The first step in good public relations is to realize who the public is and what your responsibilities are. For local disaster coordinators, the “who” is multiple. The general public, private and public agencies, public officials, law enforcement officers and other disaster workers, and mental health professionals are among the “who” in your public relations campaigns. You must be sensitive to the fact that all groups of people in your community are your public.

What are your responsibilities? Your responsibilities cover two aspects of public information: (1) responding to requests and (2) assertive public education. Minimally, you must respond to requests for what is clearly public information. Any request can be taken as an opportunity to educate the public.

Assertive public education is the exiting part of your responsibilities. By not waiting for news to happen to you, you can control the overall impact of the news on your general public. You can prepare people for disasters, thus minimizing the physical and emotional damages that result from a disaster.

Exercise, even on the smallest scale, a public education “outreach” campaign within your local agency. To do that, develop, practice, and use the tools of good public relations.

### **The Relations in Public Relations**

The second step in developing good public relations is to develop contacts among the media people in your community. They, like you, want to support good programs, especially when they can get their jobs done at the same time.

Media professionals include: reporters and photographers, managing editors and radio/television program directors, sales staff, commentators and owners.

Know that media contacts have some clear expectations of you. Here are some helpful hints:

- ◆ Make sure you are the person authorized by your agency to speak for your program or agency. Confusion occurs when too many people try to serve as the spokesperson.
- ◆ Make it easy for reporters to contact you. Make sure that all reporters that cover your agency or program know your home and office telephone numbers and the name and number of one back-up person to call when you are unavailable. This is especially important in the hours and days immediately following a disaster.

- ◆ Know the deadlines of the newspapers and radio or television news shows. Plan ahead. Their deadlines are your deadlines.
- ◆ Media professionals appreciate news releases, public service announcements and other materials that are closely tailored to their specific needs. So, use the examples provided in this kit. They've been specifically written with the media in mind. Don't send carbon copies. Either send for the available material or reproduce it on a duplicating machine.
- ◆ Handle errors in stories carefully. Unless a reporter makes a serious mistake, no comment is usually necessary.
- ◆ If your story does not run, there may be many good reasons. It could have been thrown out at the last minute for something else of more value news wise. It is all right for you to ask if there was something wrong with the story--something that could be corrected in future stories.
- ◆ Express your appreciation every time you submit material, regardless of whether material is used.

### **What's News?**

News is anything the media chooses to print, film or broadcast as "news." But the choice is theirs, not yours. News is something that is at least slightly out of the ordinary for the media's audience. News is also anything enough people are interested in reading, seeing or hearing about for the media to be interested in handling--that is, in knowing what has happened, is happening or is going to happen.

In deciding what you think may be news, consider the audience you want to reach and in the interests you have available. At the same time, think about the duties you carry out. Many events related to your job, while ordinary for you, are newsworthy, exciting and unusual events for people outside your agency. At times, it may be appropriate to target your public education efforts toward a particular audience such as the school system.

Think in terms of two types of news--spot news and feature stories. Spot news is perishable news. It must be used soon to remain timely, perhaps just after a disaster strikes. A feature story can be used any time. It can be planned ahead and even be timed to meet the tornado or flood season or it may follow a man-made disaster such as an air traffic crash or chemical spill. A feature story is the human interest angle that gives the media's readers, viewers and listeners more than the surface facts. It's the human aspect of the story that creates feelings in the media's audiences.

If you are responsible for setting up an interview with a mental health professional or other disaster expert with a reporter, help set the climate for the interview. Reviewing the kind of questions that are likely to be asked will help the interviewee become



comfortable with the upcoming interview. Your notes for the newsperson should also contain a paragraph or so of general information about the interviewee and perhaps, other components of disaster planning and response.

### **Outlets for Your Disaster Information**

Since most of us rarely take more than one daily newspaper, we are inclined to look toward the major newspaper that we use as the only outlet for our news. But there are other outlets for your agency's stories.

Get a list of all publications in your area. Your county board of supervisors may have a list of news outlets in your area. These lists include local weeklies, trade papers and employee magazines, chamber of commerce, business and church publications and local shoppers. You'll be pleasantly surprised to know the size of readership of these outlets.

Anything that fits the small newspaper also fits the small, local radio stations. Make friends with them too. Besides news items, they often are hungry for talk show guests.

Obtain a media directory or make your own, listing these media in your county: daily and non-daily newspapers, radio and television stations, wire services, sheriff's offices, state highway patrol offices and other law enforcement agencies.

- ◆ Don't forget to give information or resource materials to local libraries either.

## **COMMON ACRONYMS**

**AA-** Alcoholics Anonymous  
**ABA-** American Bar Association  
**ACE-** Automated Construction Estimating  
**AD-** Associate Director  
**ADAMS-** Automated Disaster Assistance Management System  
**ALE-** Additional Living Expense  
**AOA-** Administration on Aging  
**ARC-** American Red Cross  
**ASCS-** Agricultural Stabilization and Conservation Service  
**ASD-** Acute Stress Disorder

**BFC-** Bill for Collection

**CBRNE-** Chemical, Biological, Radiological, Nuclear and High-Yield Explosives  
**CC-** Crisis Counseling  
**CCP-** Crisis Counseling Program  
**CDC-** Centers for Disease Control  
**CERT-** Community Emergency Response Team  
**CFR-** Code of Federal Regulations  
**CISD-** Critical Incident Stress Debriefing  
**CISM-** Critical Incident Stress Management  
**CMHC-** Community Mental Health Center  
**CMHS-** Center for Mental Health Services  
**CPI-** Consumer Price Index  
**CSA-** Core Service Agency  
**CSAT-** Center for Substance Abuse Treatment

**DAE-** Disaster Assistance Employee  
**DARIS-** Disaster Automated Reporting and Information System  
**DD-** Damaged Dwelling  
**DDC-** Disaster District Chairman  
**DEM-** Division of Emergency Management  
**DFC-** Disaster Finance Center  
**DFO-** Disaster Field Office  
**DH-** Disaster Housing  
**DHAP-** Disaster Housing Assistance Program  
**DHHS-** Department of Health and Human Services  
**DLS-** Disaster Legal Services  
**DHS-** Department of Homeland Security  
**DLSP-** Disaster Legal Services Program  
**DMH-** Disaster Mental Health  
**DOB-** Duplication of Benefits  
**DOL-** Department of Labor  
**DPS-** Department of Public Safety

**DPBRO-** Disaster Preparedness and Business Recovery Office  
**DRC-** Disaster Recovery Center  
**DRM-** Disaster Recovery Manager  
**DTAC-** Disaster Technical Assistance Center  
**DUA-** Disaster Unemployment Assistance  
**DV-** Disaster Victim

**EA-** Environmental Assessment  
**EMHTSSB-** Emergency Mental Health and Traumatic Stress Services Branch  
**EMI-** Emergency Management Institute  
**EMS-** Emergency Medical Services  
**EOC-** Emergency Operations Center  
**EOP-** Emergency Operating Procedure  
**ERT-** Emergency Response Team  
**ESDRB-** Emergency Services and Disaster Relief Branch  
**ESF-** Emergency Support Function  
**EST-** Emergency Support Team

**FCO-** Federal Coordinating Officer  
**FEMA-** Federal Emergency Management Agency  
**FHBM-** Flood Hazard Boundary Map  
**FIRM-** Flood Insurance Rate Map  
**FMHA-** Farmers Home Administration  
**FRP-** Federal Response Plan  
**FSR-** Final Statistical Report  
**FY-** Fiscal Year

**GAR-** Governor's Authorized Representative  
**GCO-** Grant Coordinating Officer

**HAZMAT-** Hazardous Materials  
**HHS-** Health and Human Services  
**HR-** Home Repairs  
**HS-** Human Services  
**HSO-** Human Services Officer

**IA-** Individual Assistance  
**ICS-** Incident Command System  
**IFG-** Individual and Family Grant Program  
**IFMIS-** Integrated Financial Management Information System  
**IMS-** Information Management Systems  
**IS-** Infrastructure Support  
**ISP-** Immediate Services Program

**KAHBH-** Kansas All-Hazards Behavioral Health Program

**KDEM-** Kansas Department of Emergency Management (a.k.a., KEMA)

**LAN-** Local Area Network

**LEDRS-** Livestock Emergency Disease Response System

**MOA or MOU-** Memorandum of Agreement OR Memorandum of Understanding

**MRAP-** Mortgage and Rental Assistance Program

**NACCT-** National Advisory Committee on Children and Terrorism

**NASMHPD-** National Association of State Mental Health Program Directors

**NEMIS-** National Emergency Management Information System

**NEPA-** National Environmental Policy Act

**NFIP-** National Flood Insurance Program

**NFIRA-** National Flood Insurance Reform Act of 1994

**NGO-** Non-Governmental Organization

**NIMS -** National Incident Management System

**NOGA-** Notice of Grant Award

**Non-PDD-** Non-Presidentially Declared Disasters

**NPS-** National Pharmaceutical Stockpile

**NPSC-** National Processing Service Center

**NTC-** National Teleregistration Center

**NVOAD-** National Voluntary Organizations Active in Disasters

**OEM-** Office of Emergency Management

**OEP-** Office of Emergency Preparedness

**OFA-** Other Federal Agencies

**OFM-** Office of Financial Management

**OGC-** Office of General Counsel

**OMB-** Office of Management and Budget

**OSD-** Operations Support Division

**OVC-** Office for Victims of Crimes

**PA-** Public Assistance

**PDA-** Preliminary Damage Assessment

**PDD-** Presidentially Declared Disaster

**PFT-** Permanent Full Time Employee

**PIO-** Public Information Officer

**PO-** Project Officer

**PP-** Personal Property

**PTSD-** Post Traumatic Stress Disorder

**QC-** Quality Control

**RAA-** Request for Allocation Advice

**RAU-** Rapid Assessment Unit  
**RD-** Regional Director  
**ROC-** Regional Operations Center  
**RP-** Real Property  
**RSP-** Regular Services Program

**SAMHSA-** Substance Abuse Mental Health Services Administration  
**SAP-** State Administration Plan  
**SBA-** Small Business Administration  
**SCO-** State Coordinating Officer  
**SEMC-** State Emergency Management Council  
**SERT-** State Emergency Response Team  
**SFHA-** Special Flood Hazard Area  
**SMHA-** State Mental Health Authority  
**SMP-** Stress Management Program  
**SOC-** State Operations Center  
**SOP-** Standard Operating Procedure  
**SSA-** Social Security Administration  
**SSI-** Supplemental Security Income

**UNC-** Unmet Needs Committee  
**USDA-** United States Department of Agriculture

**VA-** Veterans Administration  
**VOAD-** Voluntary Organizations Active in Disasters

**WHO-** World Health Organization  
**WMD-** Weapons of Mass Destruction

## ***DEFINITIONS***

**All-Hazard Emergency Operations Planning** - A step-by-step comprehensive planning approach to emergency management developed and recommended by the Federal Emergency Management Agency (FEMA) to address risk-based, all-hazard emergency operations planning.

**American Red Cross (ARC)** - The American Red Cross is a congressionally chartered, humanitarian organization, led by crisis workers, that provides relief to victims of disasters and helps people prevent, prepare for, and respond to emergencies.

**Acute Stress Disorder (ASD)** – Acute Stress Disorder, or ASD, is a psychological diagnosis used to explain extreme reactions to stress above what is often expected as a normal response to disaster.

**CBRNE** - Acronym for weapons of mass destruction: Chemical, Biological, radiological, Nuclear and high-yield explosives.

**Center for Mental Health Services (CMHS)** - Division of SAMHSA; a federal agency contained within the Substance Abuse and Mental Health Services Administration and the U.S. Department of Health and Human Services. This organization is mandated to adopt a leadership role in mental health services delivery and policy development. Further, CMHS has a specific interest in Disaster Mental Health and has created a branch specifically for this focus. CMHS disaster mental health programs are conducted by the Emergency Mental Health and Traumatic Stress Services Branch of the Federal Center for Mental Health Services (CMHS). In partnership with the Federal Emergency Management Agency (FEMA), this Branch of CMHS is responsible for assessing, promoting, and enhancing the resilience of Americans in times of crisis. The Branch disseminates mental health information about disasters and traumatic events in print and on the Internet.

**CSAT (Center for Substance Abuse Treatment)** – The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS), was congressionally mandated to expand the availability of effective treatment and recovery services for alcohol and drug problems.

**Community Emergency Response Team (CERT; pronounced 'sert')** – The Community Emergency Response Team (CERT) is collection of individuals who are trained in basic disaster response skills, such as fire safety, search and rescue, team organization, and disaster medical operations. CERT members can assist others in their neighborhood or workplace following an event when professional responders are not immediately available to help.

**Critical Incident Stress Debriefing (CISD)**-Debriefing for emergency responders. CISD is a technique that is specifically designed to assist others in dealing with the physical or psychological symptoms that are generally associated with trauma exposure. Debriefing, ideally conducted near the site of the event, allows those involved with the incident to process the event and reflect on its impact. This is a central component of Critical Incident Stress Management. **See CISM.**

**Critical Incident Stress Management (CISM)** - Includes individual counseling, CISD, education and follow-up. CISM is an intervention protocol, consisting of several elements, which

were developed specifically for dealing with traumatic events. This protocol is a formal, highly structured process for helping those involved in a traumatic event to share their experiences, vent emotions, learn about stress reactions and symptoms and receive referrals for further help if required.

**Crisis Counseling (CC)** – CC refers to the short term intervention that is focused upon assisting disaster survivors in understanding their current situation and reactions, mitigating additional stress, assisting survivors in reviewing their options, promoting the use of or development of coping strategies, providing emotional support, and encouraging linkages with other individuals and agencies who may help survivors recover to their pre-disaster level of functioning

**Crisis Counseling Assistance and Training Program (CCP)** – The Crisis Counseling Training and Assistance Program is funded by the Federal Emergency Management Agency (FEMA) under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. The purpose of the CCP is to support short term interventions with individuals and groups experiencing psychological sequelae to large scale disasters. The Federal Emergency Management Agency (FEMA) implements the CCP as a supplemental assistance program available to the United States and its Territories. FEMA counseling model used in presidential declared disasters to counsel survivors of the event.

**Department of Public Safety** - Parent organization of DEM (Division of Emergency Management).

**Disaster Cycle** - The disaster life cycle describes the process through which emergency managers *prepare* for emergencies and disasters, *respond* to them when they occur, help people and institutions *recover* from them, *mitigate* their effects, *reduce* the risk of loss, and *prevent* disasters such as fires from occurring.

**Disaster District Chairman** - DPS officer who will lead local response to an incident/disaster.

**Disaster Field Office** - FEMA disaster operations headquarters.

**Disaster Mental Health Services** - Brief stress management and mental health services designed to assist individuals and families return to normal functioning.

**Disaster Preparedness and Business Recovery Committee** - Ensures continuity of operations.

**Disaster Recovery Center** - On-site group of federal and state agencies that provide direct assistance to disaster applicants, established by the Federal Emergency Management Agency after a disaster to provide information and assistance to disaster survivors.

**Division of Emergency Management** - Governor's Division of Emergency Management responsible for mitigation, response and recovery efforts for the state

**Emergency** – As defined by the Stafford Act an "Emergency" means any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States.

**Emergency Mental Health and Traumatic Stress Services Branch (EMHTSSB) within SAMHSA/CMHS** - Through an interagency agreement with the Federal Emergency Management Agency (FEMA), the Center for Mental Health Services (CMHS), via the Emergency Mental Health and Traumatic Stress Services Branch (EMHTSSB), supports immediate, short-term crisis counseling, and ongoing support for emotional recovery for the victims of disasters. Natural and terrorist disasters may result in human trauma requiring specialized attention. In the wake of such disasters, the need for crisis counseling is just as important as cleaning up debris and reconstructing property. Qualifying Federal disasters include severe storms, forest fires, and incidents of mass criminal victimization. Support is provided in the form of grants to States for counseling outreach within Federal disaster areas and for the delivery of training to crisis counselors to provide crisis assistance after Federal relief workers return home. The program is known as the Crisis Counseling Assistance and Training Program (CCP) and is funded by (FEMA). On behalf of FEMA, CMHS provides technical assistance, program guidance and oversight. The services most frequently funded by CCP grants are: crisis counseling, education, and referral to appropriate agencies or mental health professionals. After the declaration of a disaster, States determine the need for crisis counseling services by compiling disaster data and conducting a mental health needs assessment of the disaster area. The State Mental Health Authorities (SMHA) must assess key indicators of disaster stress and determine the geographic, social, cultural, ethnic, and vulnerable populations for whom services should be provided. If existing State and local resources cannot meet the needs of those populations, the SMHA may choose to apply for a Crisis Counseling grant. Only a State or Federally-recognized Indian Tribe may apply for a CCP grant. States receiving these grants typically distribute the Federal funds to local mental health providers in order to hire additional staff to perform outreach and education on typical stress reactions and methods of reducing stress. Supplemental funding for crisis counseling grants is available to SMHAs through two grant mechanisms: (1) the Immediate Services Program (ISP) which provides funds for up to sixty days of services immediately following a disaster declaration; and (2) the Regular Services Program (RSP), which provides funds for up to nine months following a disaster declaration. While CMHS provides some technical assistance to Immediate Service Programs, the monitoring and distribution of funds remains the responsibility of FEMA. For the RSP, FEMA has *State Mental Health Authorities' Response to Terrorism* 69 designated CMHS as the monitoring authority; FEMA transfers funds to CMHS, which transfers the funds to the States. CMHS collaborates with FEMA to train State mental health staff to develop crisis counseling training and preparedness efforts in their States. Through an annual training, CMHS provides updates on the design and implementation of its crisis counseling projects and promotes State-to-State information exchange. CMHS also has developed numerous publications on working with, and supporting, disaster victims. All are available through SAMHSA's National Mental Health Information Center, by calling 1-800-789-2647, (TDD) 1-866-889-2647. **For more information contact: EMHTSSB/CMHS/SAMHSA, 5600 Fishers Lane, Parklawn Building, Room 17C-20, Rockville, MD, 20857, 301-443-4735 (p) 301-443-8040 (f) [www.mentalhealth.org](http://www.mentalhealth.org)**

**EOC (Emergency Operations Center)** – A central location where government at any level can provide interagency coordination and executive decision-making for managing response and recovery. A site designated to lead and control a disaster situation.

**EOP (Emergency Operations Plan)** – A document delineating roles and responsibilities of individuals and organizations for carrying out specific actions at projected times in an emergency situation. It describes lines of authority and organizational relationships and identifies steps to address mitigation concerns during response and recovery activities.



**Federal Coordinating Officer (FCO)** - FEMA officer who is in charge of the disaster field office and federal response/recovery efforts

**Federal Emergency Management Agency (FEMA)** - FEMA is a federal agency affiliated with the Department of Homeland Security (DHS) that reports to the President. FEMA is also the lead federal agency for disaster/emergency management. However, FEMA cannot direct a state or its agencies.

**First Responders** - Traditionally defined as Fire, Police, and Emergency Medical Services (EMS).

**Governor's Authorized Representative (GAR)** - During a disaster will be the State Coordinating Officer who will be working out of the disaster field office

**Hazard** – Any situation with the potential for causing damage to people, property or the environment.

**HAZMAT (Hazardous Materials)** – This refers to substances that are flammable, corrosive, reactive or toxic chemical, infectious biological (etiological) agent, or radioactive material. A hazardous material can be either a material intended for use or a waste intended to be treated or disposed of.

**Hazard Mitigation Services** - Funding for measures designed to reduce future losses to public and private property. In the event of a major disaster declaration, all counties within the declared State are eligible to apply for assistance under the Hazard Mitigation Grant Program. Some declarations will provide only individual assistance or only public assistance. Hazard mitigation opportunities are assessed in most situations.

**Individual Assistance (IA)** - Aid to individuals, families and business owners. The crisis counseling program is provided through this: *State Mental Health Authorities' Response to Terrorism* 68.

**Immediate Services Application** – The Immediate Services Application is an application for funding for Immediate Services Crisis Counseling Program; this must be submitted within 14 days of the Presidentially Declared Disaster and is eligible for individual assistance.

**Immediate Services Program (ISP)** - A 60-day crisis counseling program funded by FEMA. This is the initial phase of a Crisis Counseling Program, which includes screening techniques, as well as outreach services such as public information and community networking.

**Incident Command System (ICS)** – A management and process tool developed in California for use in complex disasters involving more than one jurisdiction, agency or response group. Originally used by First Responders to determine leadership and management structure in complicated disasters. All agencies responding to disasters should be trained in ICS. There is an online tutorial available at [www.fema.gov](http://www.fema.gov). An all-hazards, functional incident management system that establishes common standards in organization, terminology, and procedures and further provides a means (unified command) for the establishment of a common set of incident objectives and strategies during multi-agency /multi-jurisdiction operations while maintaining individual agency/jurisdiction authority, responsibility, and accountability. The ICS is a component of the National Interagency Incident Management System (NIIMS).

**Mass Casualty Event** - More than 1,000 residents residing in all 21 counties in New Jersey died in the World Trade Center attack. There was no local explosion or visible damage. These citizens simply disappeared from their communities, their cars remained at the train stations, they failed to pick up their children from daycare or school and they never walked through the front door of their homes again. They were victims of a *mass casualty* event as the horror unfolded at a specific point in time and the physical destruction ended within a few hours.

**Mass Exposure Event** - Consider the anthrax exposures through the Brentwood Postal Facility in Washington, D.C. and the Hamilton Postal Facility in New Jersey and their impact on the workers and communities are examples of mass exposure events.

**Mitigation** - Mitigation is the cornerstone of emergency management. It's the ongoing effort to lessen the impact disasters have on people's lives and property through damage prevention and flood insurance. Through measures such as building safely within the floodplain or removing homes altogether; engineering buildings and infrastructures to withstand earthquakes; and creating and enforcing effective building codes to protect property from floods, hurricanes and other natural hazards, the impact on lives and communities is lessened.

**Memorandum of Understanding (MOU)** – Formal written agreements delineating roles and responsibilities between the parties to the agreement.

**National Pharmaceutical Stockpile (NPS) Program** - Part of the Strategic National Stockpile (SNS). The mission of CDC's National Pharmaceutical Stockpile (NPS) Program is to ensure the availability of life-saving pharmaceuticals, antidotes and other medical supplies and equipment necessary to counter the effects of nerve agents, biological pathogens and chemical agents. The NPS Program stands ready for immediate deployment to any U.S. location in the event of a terrorist attack using a biological, toxin, or chemical agent directed against a civilian population. The NPS is comprised of pharmaceuticals, vaccines, medical supplies, and medical equipment that exist to augment depleted state and local re-sources for responding to terrorist attacks and other emergencies. These packages are stored in strategic locations around the U.S. to ensure rapid delivery anywhere in the country. Following the federal decision to deploy, the NPS will typically arrive by air or ground in two phases. The first phase shipment is called a 12-hour Push Package. "12" because it will arrive in 12-hours or less, "push" because a state need only ask for help—not for specific items, and *State Mental Health Authorities' Response to Terrorism* 70 "package" because the Program will ship a complete package of medical material—to include nearly everything a state will need to respond to a broad range of threats. Also available are inventory supplies known as Vendor Managed Inventory, or VMI packages. VMI packages can be tailored to provide pharmaceuticals, vaccines, medical supplies and/or medical products specific to the suspected or confirmed agent or combination of agents. A CDC team of five or six technical advisors will also deploy at the same time as the first shipment. Known as a Technical Advisory Response Unit (TARU), this team is comprised of pharmacists, emergency responders, and logistics experts that will advise local authorities on receiving, distributing, dispensing, replenishing, and recovering NPS materiel. For more information about the National Pharmaceutical Stockpile, contact the NPS Program at 404-639-0459.

**Non-Presidentially Declared Disasters (Non-PDD)** – A Non-PDD is a disaster or emergency of any magnitude, which does not receive a proclamation of Presidentially Declared Disaster.

**Post Traumatic Stress Disorder (PTSD)** - A psychiatric disorder caused by experiencing or witnessing a life threatening event that results in prolonged emotional distress. Posttraumatic

Stress Disorder, or PTSD, is a psychological disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged, and these symptoms can be severe enough and last long enough to significantly impair the person's daily life.

**Public Assistance** - Aid to public (and certain private non-profit) entities for certain emergency services and the repair or replacement of disaster-damaged public facilities.

**Preparedness** - Preparedness ensures that if disaster occurs, people are ready to get through it safely, and respond to it effectively. Whether you're an individual citizen, a crisis worker group or a government agency, preparedness means figuring out what you'll do if essential services break down, developing a plan for contingencies, and practicing the plan.

**Presidentially Declared Disaster (PDD)** – A PDD is any natural catastrophe (including any hurricane, tornado, storm, flood, high water, wind driven water, tidal wave, tsunami, volcanic eruption, landslide, mudslide, snowstorm, or drought) or, regardless of cause, any fire, flood, or explosion, which in the determination of the President, causes damage of sufficient severity and magnitude to warrant major disaster assistance under the Federal Disaster Relief Act. The PDD grant is intended to supplement the efforts and available resources of states, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering.

**Prevention** - Not all emergencies and disasters can be prevented. But there are some that can. For example, most chemical explosions and hazardous materials spills can be prevented. Many fires are also preventable, and fire prevention is an important objective of the United States Fire Administration (USFA). USFA engages in many activities to encourage fire prevention. Examples of its most important prevention activities are to educate the public on what to do to prevent fires (“install smoke detectors,” “use space heaters safely”) and help the fire and emergency medical services (EMS) providers conduct their own public education efforts.

**OEM** - Office of Emergency Management

**OEP** - Office of Emergency Preparedness

**Rapid Assessment Unit (RAU)** - A unit of the DEM that performs initial damage assessments following a disaster or emergency.

**Regular Services Program (RSP)** - A nine month crisis counseling program that is federally funded through CMHS. A Regular Services Program is a continuing portion of a Crisis Counseling Program designed to provide crisis counseling, community outreach, and consultation and education services to people affected by the disaster for the purpose of relieving continued emotional problems caused by the disaster. Funding is available for a period of 9 months beyond the 60 days of an Immediate Service Program for purposes of providing disaster crisis counseling services.

**Recovery** - The task of rebuilding after a disaster can take months, even years. Not only services and infrastructure, not only the facilities and operations, but the lives and livelihoods of many thousands of people may be affected. Federal loans and grants can help. Funds are used to rebuild homes, businesses and public facilities, to clear debris and repair roads and bridges,

and to restore water, sewer, and other essential services. Research shows that psychological interventions may be needed from three to five years following the impact.

**Response** - Begins as soon as a disaster is detected or threatens. It involves mobilizing and positioning emergency equipment; getting people out of danger; providing needed food, water, shelter and medical services; and bringing damaged services and systems back on line. Local responders, government agencies, and private organizations take action. Sometimes the destruction goes beyond local and state capabilities. That's when federal help is needed as well.

**Risk Reduction** - Viewed broadly, risk reduction is the goal of all mitigation efforts. FEMA reduces the cost and damage of flood disasters through the Federal Insurance Administration (FIA). The FIA partners with national insurance companies to provide affordable flood insurance, available nationwide. Communities become eligible for such insurance by enforcing floodplain management practices. As communities require individuals and businesses to comply with these guidelines, the risk of damage and injury is reduced.

**Robert T. Stafford Disaster Relief and Emergency Assistance Act** – Public Law 93-288, as amended (P.L. 100-707); an act intended to provide an orderly and continuing means of assistance by the federal government to state and local government in carrying out their responsibilities to alleviate the suffering and damage which results from disaster/emergencies.

**State Coordinator** - DEM employee who is federal counterpart at the disaster field office and in charge of the State's response.

**State Emergency Management Council** - Comprised of 33 state agencies that prepare for and respond to state declared emergencies.

**State Emergency Response Team (SERT)** - Team comprised of state agency representatives that are responsible for rapid deployment and immediate response to disasters and emergencies for the state

**State Operations Center (SOC)** - Emergency operations center for the state. Located at Department of Public Safety.

**Substance Abuse and Mental Health Services Administration (SAMHSA)** - Division of the US Department of Health and Human Services responsible for the Emergency Services and Disaster Relief Branch; created to focus attention, programs, and funding on improving the lives of people with or at risk for mental and substance abuse disorders.

**Terrorism** – As defined by the FBI, terrorism is the unlawful use of force against persons or property to intimidate or coerce a government, the civilian population, or any segment thereof, in the furtherance of political or social objectives.” This definition includes three elements: terrorist activities are illegal and involve the use of force, the actions are intended to intimidate or coerce, and the actions are committed in support of political or social objectives.

**The Disaster Declaration Process:** The Stafford Act (§401 and 501) requires that: “All requests for a declaration by the President that a major disaster or emergency exists shall be made by the Governor [chief executive] of the affected State.” A State also includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, and the Republic of the Marshall Islands. The Governor's request is made through the regional FEMA office. State, local, and

Federal officials conduct a preliminary damage assessment (PDA) to estimate the extent of the disaster and its impact on individuals and public facilities. The information gathered during the PDA documents the severity and magnitude of the event and is included in the Governor's request. Normally, the PDA is completed prior to the submission of the Governor's request. However, when an obviously severe or catastrophic event occurs, the Governor's request may be submitted prior to the PDA. Nonetheless, the Governor must still make the request and damage assessments are still conducted. Based on the Governor's request, the President may declare that a major disaster or emergency exists, thus activating an array of Federal programs to assist in the response and recovery effort. The determination of which programs are activated is based on the needs found during the joint preliminary damage assessment and any subsequent information that may be discovered. Federal disaster assistance available under a major disaster declaration falls into three general categories. However, not all programs are activated for every disaster.

**VOAD** (pronounced 'voh-ad'; **Voluntary Organizations Active in Disasters**) or **NVOAD (National Voluntary Organizations Active in Disasters)** – This is a nation-wide coalition that is comprised of individual member organizations that typically specialize in an aspect of disaster response. Different organizations often have different specialty areas, so that by working in concert, they are able to provide a range of services with little duplication.

**WMD** - Weapons of Mass Destruction.

## **Web Resources**

### **Government Agencies**

#### **Centers for Disease Control – Emergency Preparedness and Response**

[www.bt.cdc.gov](http://www.bt.cdc.gov)

The Center for Disease Control is a governmental organization that is charged with the task of protecting the health of the populace. This includes: agents of bioterrorism, chemical agents, radiation emergencies, mass trauma, natural disasters, and outbreaks of disease (i.e. SARS, Influenza, etc.)

#### **Federal Emergency Management Agency (FEMA)**

<http://www.fema.gov/>

An agency in Homeland Security, whose mission is to reduce loss of life and property and protect our nation's critical infrastructure from all types of hazards through a comprehensive, risk-based, emergency management program of mitigation, preparedness, response and recovery.

#### **FirstGov: America Responds**

<http://www.firstgov.gov/Topics/Usgresponse.shtml>

This site lists information on preparing for emergencies and disasters, information on chemical and biological weapons, safe travel tips, and a personnel locator.

#### **Guide to Citizen Preparedness**

<http://www.citizencorps.gov>

Citizen Corps, a component of USA Freedom Corps, was created to help coordinate crisis worker activities. It provides opportunities for people to participate in a range of measures to make their families, their homes, and their communities safer from the threats of crime, terrorism, and disasters of all kinds.

#### **National Institute of Mental Health - Information About Coping with Traumatic Events**

<http://www.nimh.nih.gov/healthinformation/traumaticmenu.cfm>

The National Institute of Mental Health conducts research not only on a wide range of mental health disorders, but also on the reactions that occur in a time of crisis or terror.

#### **Substance Abuse and Mental Health Services Administration**

##### **• Disaster Technical Assistance Center**

<http://www.mentalhealth.samhsa.gov/dtac/default.asp>

Established by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Disaster Technical Assistance Center (DTAC) helps SAMHSA ensure that our Nation is prepared and able to respond rapidly when events increase the need for trauma-related mental health and substance abuse services.

##### **• Emergency Services**

<http://mentalhealth.samhsa.gov/cmhs/EmergencyServices/after.asp>

This site provides tips for talking about disaster. Some materials are available in Spanish. Includes links to other relevant mental health information.

#### **U.S. National Library of Medicine**

<http://www.nlm.nih.gov/medlineplus/biodefenseandbioterrorism.html>

This MEDLINE Plus site provides links to information on dealing with emergencies and disasters.

**U.S. Department of Homeland Security – ready.gov**

[www.ready.gov](http://www.ready.gov)

**U.S. Food and Drug Administration**

<http://www.fda.gov/oca/sthealth.htm>

This site lists contact information for each State Health Agencies and links to their web sites.

**General Information About Psychological Responses to Emergencies**

**American Psychological Association Disaster Response Network**

<http://www.apa.org/practice/drnindex.html>

**American Red Cross**

<http://www.redcross.org/>

**Dart Foundation – PTSD Gateway to Post Traumatic Stress Disorder Information**

<http://www.ptsdinfo.org/>

This link service is a public Service of the Dart Foundation. It is a gateway to four nonprofit sites that offer PTSD information and resources.

**International Society of Traumatic Stress Studies**

<http://www.istss.org/>

The International Society for Traumatic Stress Studies provides a forum for the sharing of research, clinical strategies, public policy concerns, and theoretical formulations on trauma.

**National Center for Post-Traumatic Stress Disorder**

<http://www.ncptsd.org/>

The National Center for Post-Traumatic Stress Disorder is involved in multidisciplinary activities in research, education, and training related to PTSD.

**National Mental Health Association**

<http://www.nmha.org/reassurance/anniversary/index.cfm>

The National Mental Health Association has prepared several fact sheets for adults, seniors, children, individuals with mental illness, employers, and physicians on coping with war-related stress and terrorism. Many are also available in Spanish.

**Substance Abuse Mental Health Services Administration (SAMHSA)**

<http://www.samhsa.gov/>

SAMHSA is the Federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses. There are three centers: Center for Mental Health Services, Center for Substance Abuse Prevention and Center for Substance Abuse Treatment.

**Freedom From Fear**

[www.freedomfromfear.com](http://www.freedomfromfear.com)

**Resources for Faith Communities**

**American Academy of Experts in Traumatic Stress**

[www.aaets.org/arts/art82.htm](http://www.aaets.org/arts/art82.htm)

Article discusses roles of funeral, memorials, and spiritual fellowship for communities affected by disaster as well as the effectiveness of pastoral counseling.

**Church World Service**

<http://www.cwserp.org/training/>

This is the Church World Service disaster information for faith communities.

**National Center for Post-traumatic Stress Disorder – Spirituality**

[www.ncptsd.org/topics/spirituality.html](http://www.ncptsd.org/topics/spirituality.html)

This provides spirituality-related fact sheets, articles, videos, and website links.

**National Council of Churches USA**

[www.nccusa.org/nmu/mce/childrenterrorism.html](http://www.nccusa.org/nmu/mce/childrenterrorism.html)

Sponsored by the National Council of Churches, this site provides a short list of tips for talking to children about terrorism and also lists religious and secular resources for work with children.

**Resources for Families / Helping Children Cope After A Disaster**

**Center for Mental Health Services – Child and Adolescent Trauma**

<http://www.mentalhealth.org/child/childhealth.asp>

The Center for Mental Health Services sponsors this page on general topics related to child and adolescent mental health, including the Child Traumatic Stress Network and school violence prevention.

**Community Resilience Project – Children and adolescents**

- <http://www.communityresilience.com/Information/DisasterWhatTeensCanDo.htm>

A short fact sheet for teens that provides suggestions for coping after a disaster based on what was learned from working with teens affected by the 1995 Oklahoma City bombing.

- <http://www.communityresilience.com/Information/StressManagementforTeensbrochure.htm>

Defines stress for teens, how to recognize it, ways to manage stress and three helpful stress relief activities.

**American Academy of Child and Adolescent Psychiatry**

<http://www.aacap.org/publications/factsfam/disaster.htm>

Strategies for parents who are comforting children after a disaster. It explains that children must be allowed to talk about the frightening parts of the disaster and that their experience must not be minimized.

[www.aacap.org/publications/DisasterResponse/index.htm](http://www.aacap.org/publications/DisasterResponse/index.htm)

Fact sheets in English and Spanish.

**National Child Traumatic Stress Network**

<http://www.nctsnet.org/>

The mission of the National Child Traumatic Stress Network (NCTSN) is to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States.

**Substance Abuse and Mental Health Service Administration – Tips for Parents**

<http://www.mentalhealth.samhsa.gov/cmhs/TraumaticEvents/tips.asp#parents>



Parents will find articles to guide them in providing mental health support for their children related to the emotional impact of war.

**After the Disaster: A Children's Mental Health Checklist**

[http://www.fema.gov/kids/tch\\_mntl.htm](http://www.fema.gov/kids/tch_mntl.htm)

A checklist to assess a child's mental health status, following a disaster or traumatic experience.

**National Center for Children Exposed to Violence at the Yale Child Study Center**

<http://www.nccev.org/>

There is a link to Children and Terrorism that also has fact sheets on how parents and teachers can talk to kids.

**The Child Advocate**

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[http://www.childadvocate.net/help\\_children\\_cope.htm](http://www.childadvocate.net/help_children_cope.htm)

Printable booklet developed by the Penn State University Pediatric Trauma team to help parents and professionals deal with disaster and related issues. Can be used in schools, clinics and other settings.

**FEMA**

[http://www.fema.gov/kids/tch\\_mntl.htm](http://www.fema.gov/kids/tch_mntl.htm)

A checklist to assess a child's mental health status, following a disaster or traumatic experience.

**Resources for Educators**

**Community Resilience Project – Information for Parents and Children**

<http://www.communityresilience.com/InformationForParentTeacher.htm>

Provides links to fifteen other resource pages to support parents and teachers in helping children cope.

**National Center for Child Traumatic Stress**

[http://nctsnet.org/nccts/nav.do?pid=ctr\\_schl](http://nctsnet.org/nccts/nav.do?pid=ctr_schl)

This is a brief overview of child trauma and additional websites provided by the National Center for Child Traumatic Stress about trauma risk, normal reactions, best practices and other resources.

**Substance Abuse Mental Health Service Administration – Tips for Teachers**

<http://www.mentalhealth.samhsa.gov/cmhs/TraumaticEvents/tips.asp#teachers>

Teachers will find articles at this SAMHSA site giving them tips and suggestions for responding to children of different ages. Information also describes signs and symptoms that may indicate stress or fear in a child and coping strategies for dealing with fear and anxiety.

**North Carolina State University College of Agriculture & Life Sciences, Cooperative Extension Services**

[www.ces.ncsu.edu/depts/fcs/humandev/disas3.html](http://www.ces.ncsu.edu/depts/fcs/humandev/disas3.html)

Articles on Strategies for Parents and Teachers to help children handle disaster related anxiety.

**Special Populations and Needs**

**Administration on Aging: Disaster Assistance Resources**

[http://www.aoa.gov/eldfam/Disaster\\_Assistance/Disaster\\_Assistance.asp](http://www.aoa.gov/eldfam/Disaster_Assistance/Disaster_Assistance.asp)

For older persons who have been affected by a disaster—information about receiving financial assistance including Small Business Administration (SBA) loans. Available in English and Spanish.

**American Red Cross – Persons with Disabilities**

<http://www.redcross.org/services/disaster/beprepared/prep.html>

This is a link that provides guidance on disaster preparedness for persons with disabilities.

**National Center for PTSD – Substance Abuse**

[http://www.ncptsd.org/facts/disasters/fs\\_substance\\_disaster.html](http://www.ncptsd.org/facts/disasters/fs_substance_disaster.html)

This is a fact sheet prepared by the National Center for PTSD regarding substance abuse after disasters.

**National Organization on Disability**

<http://www.nod.org/>

**National Rural Behavioral Health Center**

<http://www.nrbhc.org/disaster.asp>

This is the National Rural Behavior Health Center rural disaster page

**Cultural Competence / Global**

**Federal Emergency Management Agency – Spanish Version**

<http://www.fema.gov/spanish/>

Agencia Federal para el manejo de emergencias.

**Massey University - Australasian Journal of Disaster and Trauma Studies**

<http://www.massey.ac.nz/~trauma/issues/1999-2/doherty.htm>

This article reviews cross-cultural counseling research including studies involving disaster victims and workers in other cultures.

**Project Liberty**

<http://www.projectliberty.state.ny.us/Resources/PLcultural.htm>

A site developed as part of Project Liberty, New York's crisis counseling program post 9/11. The page provides specific information about why cultural competence is important in disaster services, tips for crisis counselors for cross-cultural engagement and therapeutic alliances, and links to other related information.

**ReliefWeb**

<http://www.reliefweb.int/w/rwb.nsf>

ReliefWeb is an electronic clearinghouse for those needing timely information on humanitarian emergencies and natural disasters – designed specifically to help the humanitarian community improve its response to emergencies.

**CrisisWeb**

<http://www.crisisweb.org/>

This is the Web site of the International Crisis Group, a private, multinational organization committed to strengthening the capacity of the international community to anticipate, understand and act to prevent and contain conflict. Offers news and reports on unstable situations in various countries around the world.

### **Support in the Workplace**

#### **American Psychological Association - Workplace**

<http://www.apa.org/pubinfo/post911workplace.html>

A brief article developed by the American Psychological Association that describes effective practices for organizations to prepare their workforce for emotional aftermath of violence in the workplace.

#### **National Mental Health Association**

[http://www.nmha.org/reassurance/workforce\\_printpage.cfm](http://www.nmha.org/reassurance/workforce_printpage.cfm)

A brief overview of how employers can support their workforce in the aftermath of a terrorist attack. It includes specific key messages for communication to employees.

#### **Mental Health Services – Emergency and Disaster Relief Branch**

[www.mentalhealth.org/cmhs/EmergencyServices/index.htm](http://www.mentalhealth.org/cmhs/EmergencyServices/index.htm)

Web site provides information and best practices documents.

### **Bioterrorism Information**

#### **Centers for Disease Control - Anthrax**

<http://www.cdc.gov/od/oc/media/ga.htm>

Anthrax Update, Webcast and text (requires RealPlayer for video)

<http://www.bt.cdc.gov/Agent/Anthrax/Anthrax.asp>

Facts about Anthrax

#### **Disaster Epidemiology**

<http://www.cdc.gov/nceh/hsb/disaster/default.htm>

#### **U.S. Food and Drug Administration**

<http://www.fda.gov/cber/cntrbio/cntrbio.htm>

Countering bioterrorism

#### **U.S. National Library of Medicine**

<http://www.nlm.nih.gov/medlineplus/biodefenseandbioterrorism.html>

MEDLINE Plus Biodefense and Bioterrorism

#### **U.S. Postal Service**

<http://www.usps.com/news/2001/press/serviceupdates.htm>

Safety and security of the mail

### **General Information on Disaster Response, Terrorism and Trauma**

#### **American Psychological Association**

**APA Online: Disaster Response Network**

<http://www.apa.org/practice/drnindex.html>

A free mental health service to disaster victims and relief workers.

**Help Center: Managing Psychological Stress**

<http://helping.apa.org/daily/traumaticstress.html>

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Tips for recovering from disasters and other traumatic events and a list of additional resources and referrals.

**American Red Cross Disaster Services**

<http://www.redcross.org/services/disaster>

**Center for Mental Health Services (CMHS)**

<http://www.mentalhealth.org/>

Look for the link to the Emergency Mental Health and Traumatic Stress Services Branch.

**International Society for Traumatic Stress Studies**

<http://www.istss.org/>

Provides a forum for the sharing of research, clinical strategies, public policy concerns and theoretical formulations on trauma. Dedicated to the discovery and dissemination of knowledge and to the stimulation of policy, program and service initiatives that seek to reduce traumatic stressors and their immediate and long-term consequences.

**Coping with Traumatic Events**

<http://www.nimh.nih.gov/healthinformation/traumaticmenu.cfm>

**Relieving Trauma and Facts about Posttraumatic Stress Disorder (PTSD)**

<http://www.nimh.nih.gov/publicat/reliving.cfm>

A summary of posttraumatic stress disorder (PTSD) that includes statistics, treatment, and research findings

**National Mental Health Association**

<http://www.nmha.org/>

The National Mental Health Association is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. Site contains excellent disaster fact sheets.

**American Public Health Association**

[http://www.apha.org/public\\_health/state.htm](http://www.apha.org/public_health/state.htm)

Find state and local health departments with which to link.

**Research**

**International Critical Incident Stress Foundation, Inc. – Pastoral Care**

[www.icisf.org/articles/Acrobat%20Documents/Pastoral%20Care/Special%20Article%20Everly.p  
df](http://www.icisf.org/articles/Acrobat%20Documents/Pastoral%20Care/Special%20Article%20Everly.pdf)

This is a link to a brief article that describes approach to pastoral care in an emergency or disaster event. Also includes links to related mental health sites.

### **U.S. Census Bureau**

<http://www.census.gov/>

This is a link to the United States Census Bureau that provides a wealth of information regarding people (i.e. income, housing, population estimates), businesses (i.e. economic census, government, etc.), geography (Maps, etc.) and current events (i.e. recent news releases, etc). This site is often extremely valuable when writing grants and proposals.

### **Natural Hazards Center at the University of Colorado**

<http://www.colorado.edu/hazards/index.html>

The Natural Hazards Center at the University of Colorado is a national and international clearinghouse for information on natural hazards and human responses to hazards and disasters. Web site has general information, periodicals and listserves of the Center.

### **Crisis workers / Disaster Workers**

#### **National Voluntary Organizations Active In Disaster**

<http://www.nvoad.org/>

NVOAD coordinates planning efforts by many voluntary organizations responding to disaster. Member organizations provide more effective and less duplication in service by getting together before disasters strike.

#### **New York State Office of Mental Health**

<http://www.omh.state.ny.us/omhweb/crisis/crisiscounseling10.html>

This is the New York training outline for mental health professionals & nonprofessionals.

#### **Center for Mental Health Services – Disaster Worker Stress**

<http://www.mentalhealth.samhsa.gov/cmhs/TraumaticEvents/tips.asp#workers>

This site sponsored by SAMHSA focuses on managing job related stress and more for emergency workers and mental health workers. It also links to a catalogue of disaster-related and other mental health information that can be downloaded or ordered free of charge.

#### **Department of Homeland Security (DHS)**

<http://www.dhs.gov/dhspublic/display?theme=63>

The lead Federal agency inaugurated March 1, 2003 that combines 22 previously disparate domestic agencies into one department to protect the nation. The agencies are housed under four directorates: Border and Transportation Security, Emergency Preparedness and Response, Science and Technology, and Information Analysis and Infrastructure Protection.