DISASTER RESPONSE AND RECOVERY:

A HANDBOOK
FOR MENTAL HEALTH PROFESSIONALS

by

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KEY CONCEPTS OF DISASTER MENTAL HEALTH

This first chapter provides a synopsis of the major concepts
important to understanding how disaster mental health services must
differ from mental health programs in nondisaster times. The
knowledge has been acquired through both research and firsthand
experience of mental health administrators and practitioners who
have provided disaster mental health recovery services.

NO ONE WHO SEES A DISASTER IS UNTOUCHED BY IT

In any given disaster, loss and trauma will directly affect many
people. In addition, there are many other individuals who are
emotionally impacted simply by being a part of the affected
community. Myers (Hartsough and Myers, 1985) addresses the
extensive kind of personal and community upheaval which disaster
can cause:

     A disaster is an awesome event. Simply seeing massive
destruction and terrible sights evokes deep feelings. Often,
residents of disaster-stricken communities report disturbing
feelings of grief, sadness, anxiety, and anger, even when they are
not themselves victims. . . . Such strong reactions confuse them
when, after all, they were spared any personal loss. These
individuals find comfort and reassurance when told that their
reactions are normal in every way; everyone who sees a disaster
is, in some sense, a victim.

Even individuals who experience a disaster "second hand" through
exposure to extensive media coverage can be affected. This
includes children whose parents may lose track of how much disaster
material their children are seeing and hearing. Mental health
workers have, in essence, a whole population to educate about
common disaster stress reactions, ways to cope with stressors, and
available resources (Myers, 1991). Therefore, mental health
education about the effects of disaster, self-help interventions,
and where to call for additional help must be provided to the

community at large.

THERE ARE TWO TYPES OF DISASTER TRAUMA

In his study of the Buffalo Creek, West Virginia flood of 1972, sociologist Kai Erikson described two types of trauma that occur jointly and continuously in most disasters (1976). Disaster mental health services must take both types of trauma into consideration to address all of the needs of the community.

       Individual trauma is defined as "a blow to the psyche that breaks through one's defenses so suddenly and with such brutal force that one cannot react to it effectively."

       Collective trauma is "a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality."

Individual trauma manifests itself in the stress and grief reactions which individual survivors experience. Bolin and Bolton (1986) emphasize that collective trauma can sever the social ties of survivors with each other and with the locale. These may be ties that could provide important psychological support in times of stress. Disaster disrupts nearly all activities of daily living and the connections they entail. People may relocate to temporary housing away from their neighbors and other social supports such as church, clinics, childcare, or recreation programs. Work may be disrupted or lost due to business failure, lack of transportation, loss of tools, or a worker's inability to concentrate due to disaster stress. For children, there may be a loss of friends and school relationships due to relocation. Fatigue and irritability can increase family conflict and undermine family relationships and ties.

Collective trauma is often less "visible" to mental health clinicians trained to work with individuals. However, it is essential to identify and address collective trauma in disaster mental health programs. People will find it difficult, if not impossible, to heal from the effects of individual trauma while the community around them remains in shreds and a supportive community setting does not exist (Erikson, 1976). Thus, mental health interventions such as outreach, support groups, community organization, and advocacy, which seek to reestablish linkages between individuals and groups, are essential.

MOST PEOPLE PULL TOGETHER AND FUNCTION DURING AND AFTER A DISASTER, BUT THEIR EFFECTIVENESS IS DIMINISHED

There are multitudes of stressors affecting disaster survivors. In the early "heroic" and "honeymoon" phases there is much energy, optimism, and altruism. However, there is often a high level of activity with a low level of efficiency. As the implications and meaning of losses become more real, grief reactions intensify. As fatigue sets in and frustrations and disillusionment accumulate, more stress symptoms may appear (Farberow and Frederick, 1978). Diminished cognitive functioning (short-term memory loss, confusion, difficulty setting priorities and making decisions, etc.) may occur because of stress and fatigue. This can impair survivors' ability to make sound decisions and take necessary steps

toward recovery and reconstruction.

DISASTER STRESS AND GRIEF REACTIONS ARE NORMAL RESPONSES TO AN
ABNORMAL SITUATION

Most disaster survivors are normal persons who function reasonably
well under the responsibilities and stresses of everyday life.
However, with the added stress of disaster, most individuals will
usually show some signs of emotional and psychological strain
(Farberow and Frederick, 1978). Reactions include post-traumatic
stress and grief responses. These reactions are normal reactions
to an extraordinary and abnormal situation, and are to be expected
under the circumstances. Survivors, residents of the community,
and disaster workers alike may experience them. These responses
are usually transitory in nature and rarely imply a serious mental
disturbance or mental illness. Contrary to myth, neither
post-traumatic stress disorder nor pathological grief reactions are
rampant following disaster.

Green, Wilson, and Lindy (1985) emphasize that the post-traumatic
stress process is a dynamic one, in which the survivor attempts to
integrate a traumatic event into his/her self-structure. The
process is natural and adaptive. It should not be labeled
pathological (i.e., a "disorder") unless it is prolonged, blocked,
exceeds a tolerable quality, or interferes with regular functioning
to a significant extent.

Similarly, Myers, Zunin and Zunin (1990) point out that grief
reactions are a normal part of recovery from disaster. Not only
may individuals lose loved ones, homes, and treasured possessions,
but hopes, dreams, and assumptions about life and its meaning may
be shattered. Zunin and Zunin (1991) emphasize that the grief
responses to such losses are common and are not pathological
(warranting therapy or counseling), unless the grief is an
intensification, a prolongation, or an inhibition of normal grief.

Relief from stress, the ability to talk about the experience, and
the passage of time usually lead to the reestablishment of
equilibrium. Public information about normal reactions, education
about ways to handle them, and early attention to symptoms that are
problematic can speed recovery and prevent long-term problems
(Hartsough and Myers, 1985).

MANY EMOTIONAL REACTIONS OF DISASTER SURVIVORS STEM FROM PROBLEMS
OF LIVING CAUSED BY THE DISASTER

Because disaster disrupts so many aspects of daily life, many
problems for disaster survivors are immediate and practical in
nature (Farberow and Frederick, 1978). People may need help
locating missing loved ones; finding temporary housing, clothing,
and food; obtaining transportation; applying for financial
assistance, unemployment insurance, building permits, income tax
assistance; getting medical care, replacement of eyeglasses or
medication; obtaining help with demolition, digging out, and
cleanup.

DISASTER RELIEF PROCEDURES HAVE BEEN CALLED "THE SECOND DISASTER"

The process of obtaining temporary housing, replacing belongings,
getting permits to rebuild, applying for government assistance,

seeking insurance reimbursement, and acquiring help from private or voluntary agencies is often fraught with rules, red tape, hassles, delays, and disappointment. People must often establish ties to bureaucracies to get aid they can get nowhere else. However, the organizational style of the aid-giving bureaucracies is often too impersonal for victims in the emotion-charged aftermath of the disaster (Bolin, 1982). Munnichs (1977) has noted that "bureaucracy means impersonality in social relations, routinization of tasks, centralization of authority, rigid rules and procedures. . . ." To complicate the matter, disasters and their special circumstances often foul up the bureaucratic procedures even of organizations established to handle disaster (Bolin, 1982). Families are forced to deal with organizations that seem or are impersonal, inefficient, and inept.

Many individuals are unable to obtain the benefits for which they are eligible in a timely manner from the agencies involved. For individuals who felt competent and effective before the disaster, they may suddenly experience a serious erosion of self-esteem and confidence. Feelings of helplessness and anger are common (Farberow and Frederick, 1978). In response, mental health staff may assist individuals by reassuring them that this "second disaster" is a common phenomenon. They can reassure them that most people have difficulty wending their way through the bureaucracy. Simply hearing the phase "the second disaster" often brings a wave of relief to survivors, often with some welcomed laughter.

In addition, mental health personnel may need to help individuals to find constructive channels for their anger and frustration. This may involve helping them not to misdirect it (toward family, for example), nor to sabotage their own efforts by "blowing up" at the agencies trying to help them (Project COPE, 1983). Mental health staff may also help individuals by providing information about how specific agencies work. Survivor support groups are often very helpful in this regard, with individuals offering each other concrete advice and suggestions about how to deal with bureaucratic problems.

In addition, mental health may provide consultation or training to disaster relief agencies. The goal of such consultation is to influence programs toward maximum responsiveness to needs of disaster survivors. Mental health may also intervene directly with agencies on behalf of disaster survivors. Such advocacy may be case centered, seeking to benefit an individual client, or may be issue-centered, seeking to benefit a group of clients or the general population (Myers, 1990).

MOST PEOPLE DO NOT SEE THEMSELVES AS NEEDING MENTAL HEALTH SERVICES FOLLOWING DISASTER, AND WILL NOT SEEK OUT SUCH SERVICES

Many people equate "mental health" services with being "crazy." To offer mental health assistance to a disaster survivor may seem to add insult to injury--"First I have lost everything and now you think I'm mentally unstable." In addition, most disaster survivors are overwhelmed with the time-consuming activities of putting the concrete aspects of their lives back together. Counseling or support groups may seem esoteric in the face of such pragmatic pressures. Very effective mental health assistance can be provided while the worker is helping survivors with concrete tasks. For example, a mental health worker can use skilled but unobtrusive

interviewing techniques to help a survivor in sorting out demands
and setting priorities while they are sifting through rubble
together.

SURVIVORS MAY REJECT DISASTER ASSISTANCE OF ALL TYPES

People may be too busy with cleaning up and other concrete demands
to seek out services and programs that might help them. Initially,
people are relieved to be alive and well. They often underestimate
the financial impact and implication of their losses, and
overestimate their available financial resources. The bottom-line
impact of losses is often not evident for many months or,
occasionally, for years.

 The heroism, altruism, and optimism of the early phases of
disaster may make it seem that "others are so much worse off than
I am." For most people, there is a strong need to feel
self-reliant and in control. Some people equate government relief
programs as "welfare." For others, especially recent immigrants
who have fled their countries of origin because of war or
oppression, government is not to be trusted. Pride may be an issue
for some people. They may feel ashamed that help is needed, or may
not want help from "outsiders" (Farberow and Frederick, 1978).
Tact and sensitivity to these issues are important.

DISASTER MENTAL HEALTH ASSISTANCE IS OFTEN MORE "PRACTICAL" THAN
"PSYCHOLOGICAL" IN NATURE

Most disaster survivors are people who are temporarily disrupted by
a severe stress, but can function capably under normal
circumstances. Much of the mental health work at first will be to
give concrete types of help (Farberow and Frederick, 1978).
Mental health personnel may assist survivors with problem-solving
and decision making. They can help them to identify specific
concerns, set priorities, explore alternatives, seek out resources,
and choose a plan of action (American Red Cross, 1982). Mental
health staff must inform themselves about resources available to
survivors, including local organizations and agencies in addition
to specialized disaster relief resources. Mental health workers
may help directly with some problems, such as providing
information, filling out forms, helping with cleanup, locating
health care or child care, finding transportation. They may also
make referrals to specific resources, such as assistance with
loans, housing, employment, permits.

In less frequent cases, individuals may experience more serious
psychological responses such as severe depression, disorientation,
immobilization, or an exacerbation of prior mental disturbance.
These situations will likely require referral for more intensive
psychological counseling. The role of the disaster mental health
worker is not to provide treatment for severely disturbed
individuals directly, but to recognize their needs and help link
them with an appropriate treatment resource (Farberow and
Frederick, 1978).

DISASTER MENTAL HEALTH SERVICES MUST BE UNIQUELY TAILORED TO THE
COMMUNITIES THEY SERVE

The demographics and characteristics of the communities affected by
disaster must be considered when designing a mental health program

(Myers, 1991). Urban, suburban, and rural areas have different
needs, resources, traditions and values about giving and receiving
help. It is essential that programs consider the ethnic and
cultural groups in the community, and provide services that are
culturally relevant and in languages of the people. Disaster
recovery services are best accepted and utilized if they are
integrated into existing, trusted community agencies and resources.
In addition, programs are most effective if workers indigenous to
the community and to its various ethnic and cultural groups are
integrally involved in service delivery.

MENTAL HEALTH STAFF NEED TO SET ASIDE TRADITIONAL METHODS, AVOID
THE USE OF MENTAL HEALTH LABELS, AND USE AN ACTIVE OUTREACH
APPROACH TO INTERVENE SUCCESSFULLY IN DISASTER

The traditional, office-based approach is of little use in
disaster. Very few people will come to an office or approach a
desk labeled "mental health." Most often, the aim will be to
provide human services for problems that are accompanied by
emotional strain. It is essential not to use words that imply
emotional problems, such as counseling, therapy, psychiatric,
psychological, neurotic, or psychotic (Farberow and Frederick,
1978). Mental health staff may identify themselves as human
service workers, crisis counselors, or use other terminology that
does not imply that their focus is on pathology. Workers seem less
threatening when they refer to their services as "assistance,"
"support," or "talking" rather than labeling themselves as "mental
health counselors" (DeWolfe, 1992).

Mental health staff need to use an active outreach approach. They
must go out to community sites where survivors are involved in the
activities of their daily lives. Such places include impacted
neighborhoods, schools, disaster shelters, Disaster Application
Centers (DACs), meal sites, hospitals, churches, community centers,
and the like.

SURVIVORS RESPOND TO ACTIVE INTEREST AND CONCERN

They will usually be eager to talk about what happened to them when
approached with warmth and genuine interest. Mental health
outreach workers should not hold back from talking with survivors
out of fear of "intruding" or invading their privacy.

INTERVENTIONS MUST BE APPROPRIATE TO THE PHASE OF DISASTER

It is important that disaster mental health workers recognize the
different phases of disaster and the varying psychological and
emotional reactions of each phase. For example, it will be
counterproductive to probe for feelings when shock and denial are
shielding the survivor from intense emotions. Once the individual
has mobilized internal and external coping resources, they are
better able to deal with their feelings about the situation. During
the "heroic" and "honeymoon" phases, people who have not lost loved
ones may be feeling euphoric, altruistic, and optimistic rather
than bereaved. During the "inventory" phase, people are seeking
and discussing the facts about the disaster, trying to piece
reality together and understand what has happened. They may be
more invested in discussing their thoughts than talking about
feelings. In the "disillusionment" phase, people will likely be
expressing feelings of frustration and anger. It is not usually a

good time to ask if they can find something "good" that has
happened to them through their experience.

Most people are willing and even eager to talk about their
experiences in a disaster. However, it is important to respect the
times when an individual may not want to talk about how things are
going. Talking with a person in crisis does not mean always
talking about the crisis (Zunin and Zunin, 1991). People usually
"titrate their dosage" when dealing with pain and sorrow, and
periods of normalcy and respite are also important. Talking about
ordinary events and laughing at humorous points is also healing.
If in doubt, ask the person whether they are in the mood to talk.

SUPPORT SYSTEMS ARE CRUCIAL TO RECOVERY

The most important support group for individuals is the family.
Workers should attempt to keep the family together (in shelters and
temporary housing, for example). Family members should be involved
as much as possible in each others' recovery.

Disaster relocation and the intense activity involved in disaster
recovery can disrupt people's interactions with their support
systems. Encouraging people to make time for family and friends is
important. Emphasizing the importance of "rebuilding
relationships" in addition to rebuilding structures can be a
helpful analogy.

For people with limited support systems, disaster support groups
can be helpful. Scanlon-Schlipp and Levesque (1981) point out that
support groups help to counter isolation. People who have been
through the same kind of situation feel they can truly understand
one another. Groups help to counter the myths of uniqueness and
pathology. People find reassurance that they are not alone or
"weird" in their reactions. The groups not only provide emotional
support, but survivors can share concrete information and recovery
tips. They benefit from the guidance of other experienced
survivors. Besides the catharsis of sharing experiences, they can
identify with others who are recovering, and can begin to feel hope
for their own situation. Mental health staff may involve
themselves in setting up self-help support groups for survivors, or
may facilitate support groups.

In addition, mental health workers may involve themselves in
community organization activities. Community organization brings
community members together to deal with concrete issues of concern
to them. Such issues may include social policy in disaster
reconstruction, or disaster preparedness at the neighborhood level.
The process can assist survivors with disaster recovery by not only
helping with concrete problems, but by reestablishing feelings of
control, competence, self-confidence, and effectiveness. Perhaps
most important, it can help to reestablish social bonds and support
networks that have been fractured by the disaster.

SUMMARY

The above concepts illustrate some main differences between
disaster mental health services and mental health programs in
nondisaster times. Mental health administrators and service
providers have found these concepts essential to planning and
implementing successful disaster mental health recovery programs.

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SELECTION AND TRAINING
OF DISASTER MENTAL HEALTH STAFF

The skills and competencies required of disaster mental health workers are sufficiently different from typical inpatient/outpatient clinical practice to demand specialized selection and training. When a disaster strikes a community, it is ideal to have a cadre of mental health professionals with special training who can be quickly mobilized, oriented and deployed. If the impacted area does not have this capacity, then mutual aid agreements with communities having trained and experienced disaster mental health workers will be helpful in the chaotic times immediately following impact.

The purpose of this chapter is to assist mental health planners and administrators in selecting mental health staff for disaster assignments, and in establishing appropriate training programs to enable them to do their work effectively. Items for consideration in selecting disaster mental health staff are presented. The chapter then offers an overview of training issues, including practical aspects of rapid training and deployment, objectives of comprehensive disaster mental health training, and selection of appropriate trainers.

This chapter is not intended as a training manual per se. Many manuals and models for disaster mental health training already exist (Farberow and Frederick, 1978; Hartsough and Myers, 1985; Myers, 1990; American Red Cross, 1991). Similarly, the chapter does not seek to "train the trainer" in principles of adult education and methods of instruction. Many books and workshops are available on those topics.

PREDISASTER PLANNING

Much of the confusion and stress at the time of disaster impact can be eliminated when a mental health agency has a core of staff predesignated and trained as a disaster response team. Regular in-service training and participation in disaster exercises in the local jurisdiction can help to maintain and fine-tune skills. If resources allow, the team can respond to smaller crises that occur in the jurisdiction, so that staff will have some firsthand experience behind them if a large disaster strikes.

With the diminishing budgets of many community mental health programs, funds for training have become almost nonexistent. Training is considered a necessary and appropriate aspect of the Federal Emergency Management Agency (FEMA) Crisis Counseling programs, both in the Immediate Services and Regular Programs.

Mental health planners and administrators should include realistic training budgets in their grant applications.

SELECTION OF DISASTER MENTAL HEALTH STAFF

Disaster mental health work is not for everyone. This challenging and rewarding work requires that mental health professionals be flexible and socially extroverted. Despite altruism and a sincere desire to help, not all individuals are well-suited for disaster work. Whether designating and training disaster staff before or during a disaster, the mental health manager must consider several selection issues.

Ideally, selection of professional or paraprofessional staff should consider demographics of the disaster-affected population, including ethnicity and language; the personality characteristics and social skills of the staff member; the phase of disaster; and the roles the worker may play in disaster response and recovery efforts. Workers selected for disaster response and recovery work should not be so severely personally impacted by the disaster that their responsibilities at home or their emotional reactions will interfere with participation in the program, or vice versa. Many points that follow may seem obvious, but they are crucial in establishing effective response teams.

Demographics of the population

Managers should choose staff with special skills to match needs of the population. For example, staff with special expertise in working with children and the local schools should be included. If there are many elderly persons in the community, the team should include persons skilled in working with older adults.

Ethnicity and language

Survivors will react to and recover from disaster within the context of their ethnic background, cultural viewpoint, life experiences and values. Survivors with limited English-speaking skills may have difficulty communicating needs and feelings except in their native language. All aspects of disaster operations must be sensitive to cultural issues, and services must be provided in ways that are culturally appropriate.

For these reasons, it is essential that mental health staff be both familiar and comfortable with the culture of the groups affected by the disaster. It is highly desirable that they be fluent in the languages of non-English speaking groups affected. Ideally, mental health staff should include individuals indigenous to specific cultural groups affected by the disaster. If such staff are not immediately available, coordinators can recruit mutual aid staff with the required ethnic backgrounds and language skills from other community agencies or mental health jurisdictions for the immediate postdisaster phase. Indigenous personnel can be recruited and trained for the longer-term recovery work later.

Personality of staff members

A necessary quality for individuals participating directly in disaster is the ability to remain focused and able to respond appropriately. Disaster mental health staff must be able to

function well in confused, often chaotic environments. Workers must be able to "think on their feet," and have a common-sense, practical, flexible and often improvisational approach to problem-solving. They must be comfortable with changing situations, and able to function with role ambiguity, unclear lines of authority, and a minimum of structure. Many of the most successful disaster mental health workers perceive these factors as challenges rather than burdens. Initiative and stamina are required, as well as self-awareness and an ability to monitor and manage their own stress.

Workers must be able work cooperatively in a liaison capacity. They should be aware of and comfortable with value systems and life experiences other than their own. An eagerness to reach out and explore the community to find people needing help, instead of a "wait and treat" attitude, is essential (Farberow and Frederick, 1978). Workers must enjoy people and not appear lacking in confidence. If the worker is shy or afraid, it will interfere with establishing a connection (DeWolfe, 1992). Staff must be comfortable initiating a conversation in any community setting. Additionally, workers must be willing and able to "be with" survivors who may be suffering tragedy and enormous loss without being compelled to try to "fix" the situation.

The phase of disaster

In the immediate response phase of disaster, an "action orientation" is important. Workers who do well with the pace of crisis intervention do well in this phase. Personnel who have worked in emergency services in a local mental health center or a hospital emergency room are frequently well-suited to this phase of disaster work.

Some people cannot tolerate and do not function well when exposed to the sights and sounds of physical trauma. These staff should obviously not be asked to provide mental health services at the scene of injuries, in first aid stations, hospital emergency rooms, or morgues. This does not mean that they cannot be on the disaster response team, as there are many other roles they can play. However, involved personnel should openly discuss such issues during initial formation of the team, so individuals best suited to these roles can be predesignated.

Long-term mental health recovery programs, covering the period from about one month to one year postdisaster, are different in nature and pace from the immediate response phase. Mass care shelters and disaster application centers (DACs) are closed or closing, and locating disaster survivors is more difficult. Mental health workers need to be adept and creative with outreach in the community.

The results of outreach and education efforts are often hard to measure, as survivors traditionally do not seek out mental health services and there are few "clients" to treat and count. Clinically oriented staff accustomed to an office-based practice often question their usefulness and effectiveness. "Action-oriented" staff who thrived in the immediate response phase may not enjoy or function well in the longer-term recovery phase where patience, perseverance, and an ability to function without seeing immediate results are assets.

Roles and responsibilities of disaster mental health workers

Disaster mental health roles and responsibilities are diverse.
Thoughtful matching of worker skills and personalities to the
specific assignment can help ensure success of mental health
efforts.

    1.   Outreach: Working in neighborhoods, mass care shelters,
disaster application centers or other community settings requires
workers who are adept at such nontraditional mental health
approaches as "aggressive hanging out" and "over a cup of coffee"
assessments and interventions.
    2.   Public education: Public education efforts require staff
who are interested and effective in public speaking and working
with the media. Development of fliers and brochures requires good
writing skills.
    3.   Community liaison: Establishing and maintaining liaison
with community leaders requires someone who understands and is
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 network,
formal and informal leadership, and is effective in establishing
relationships at the neighborhood level. Liaison activities might
include everything from attending grange or church gatherings,
participating in neighborhood meetings, or providing disaster
mental health consultation to government officials.
    4.   Crisis counseling: For most disaster survivors,
prolonged psychotherapy is not necessary or appropriate. Crisis
intervention, brief treatment, support groups and practical
assistance are most effective. Mental health staff must have
knowledge and skills in these modalities.

Qualifications of professional disaster mental health workers

Ideally, the disaster mental health team should be
multidisciplinary and multiskilled. 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, so
staff must be able to provide their services in nontraditional
community-based settings. Prior disaster mental 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.

Staff should be well-acquainted with the functions and dynamics of
the community's human service organizations and agencies (Farberow
and Frederick, 1978). They should have experience in consultation
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 backgrounds.

Managers should pay careful attention to the state's scope of
practice laws for various mental health professional disciplines.
Individuals provide formal assessment and counseling which fall

into the definition of psychotherapy should be appropriately
licensed and insured for professional liability.

Qualifications of paraprofessional disaster mental health workers

Paraprofessionals can be excellent choices for outreach and
community workers, especially if they are familiar with the
community and trusted by its residents. They may be already
employed by a mental health, social service, health, or other
community-based agency, or they may be recruited from among
community residents. Characteristics and qualifications should
include the following (Collins and Pancoast, 1976; Farberow and
Frederick, 1978; Tierney and Baisden, 1979):

        1.   Possess at least some high school education (to
master information and concepts to be taught).
        2.   Are indigenous to the area, if possible.
        3.   Represent a cross section of the
community/neighborhood members with regard to age, sex, ethnicity,
occupation, length of residence in the community, etc.
        4.   Are motivated to help other people, like
people, and have sensitivity and empathy for others.
        5.   Are functioning in a stable, mature, and
logical manner.
        6.   Possess sufficient emotional and physical
resources and receive sufficient personal rewards to be truly
capable of helping.
        7.   Can work cooperatively with others.
        8.   Are able to work with people of other value
systems without inflicting their own value system on others.
        9.   Are able to accept instructions and do not have
ready-made, simplistic answers.
        10. Have an optimistic, yet realistic, view of
life, i.e., a "health engendering personality."
        11. Have a high level of energy to remain active
and resourceful in the face of stress.
        12. Are committed to respect the confidentiality of
survivors and are not inclined to gossip.
        13. Have special skills related to unique
populations (e.g., children or older adults, particular ethnic
groups) or useful to disaster recovery (e.g., understanding of
insurance, building requirements, etc.).
        14. Are able to set personal limits and not become
too involved with survivor recovery (e.g., understand the
difference between facilitating and empowering survivors as opposed
to "taking over" for the survivor).

WHY TRAINING?

Mental health professionals frequently assume that their clinical
training and experience are more than sufficient to enable them to
respond adequately in disaster. Unfortunately, traditional mental
health training does not address many issues found in
disaster-affected populations (FEMA, 1988). While clinical
expertise, especially in the field of crisis intervention, is
valuable, it is not enough. Mental health personnel need to adopt
new procedures and methods for delivering a highly specialized
service in disaster. Training must be designed to prepare staff
for the uniqueness of disaster mental health approaches.

Though disasters profoundly affect individuals, people rarely disintegrate and become incapable of coping with the situation. Nor does mental illness suddenly manifest in a full-blown florid state. Problems do appear and vary in nature and intensity (Farberow, 1978). However, most of the problems and postdisaster symptomatology are normal reactions of normal people to abnormal events. Few require traditional psychotherapy. Very few people seek out mental health assistance following disaster, and mental health staff who simply open the doors of their clinics to clients or patients will have little to do.

Because of this, outreach to the community is essential. Outreach is more than simply setting up decentralized clinical services in impacted areas, or sending out brochures advertising mental health services. Outreach also means mingling with survivors in shelters and DACs and meal sites and devastated neighborhoods. The key to effective outreach is the mental health worker's ability to establish rapport and to have therapeutic intervention with individuals in an informal, social context in which there is not a psychotherapeutic "contract."

In addition to the impact on individuals, a disaster is a political and bureaucratic event. Disasters profoundly affect the community and its social systems. Everyday resources for basic human needs may be destroyed or damaged. Transportation and communication may be disrupted. In a large-scale disaster, specialized emergency response and recovery agencies move into action and exert a significant influence on the postdisaster environment. Resources, structures, and individuals change as specialized response groups finish their jobs and move on and as new, grass-roots groups spring up. Mental health staff need to understand and be able to function effectively in a complex and fluid political and bureaucratic network.

Disaster mental health training will help staff to understand the impact of disaster on individuals and the community. It will provide information about the complex systems and resources in the postdisaster environment. It will also help staff to fine-tune clinical skills that are relevant and useful in disaster, and will aid them in learning effective community-based approaches.

Through videotapes, role play, and other exercises, training allows staff to experience vicariously the emotional climate of disaster recovery work. Sometimes, staff may decide they are not well suited to this type of work. Usually, the experiential aspects of the training will provide workers with some measure of "emotional inoculation" that will help them to anticipate the emotional aspects of the work. Training must also provide staff with awareness of the personal impact of disaster work, and with strategies for stress management and self-care.

BEFORE THE TRAINING

It is essential that disaster mental health workers begin to process their own emotions about the disaster before attempting to help survivors. While workers may talk about their own reactions during the training, training is not designed to be a debriefing. If workers come to the training with unmet needs related to their own feelings, the training will not be able to proceed effectively. A debriefing or other group format for discussion of workers'

reactions to the disaster should be conducted for workers before training. A trained facilitator who has not been directly involved in service delivery, yet thoroughly understands the demands of disaster work, should provide the debriefing.

LOGISTICS OF TRAINING IN THE MIDDLE OF A DISASTER

Immediately postimpact, mental health administrators may feel pressured to deploy their staff without delay. The urgency of disaster underscores the value of having a core team of staff trained in disaster response before a disaster occurs. If such a team is not in place, training must be conducted during the disaster response and recovery activities. This can require some juggling of schedules and personnel, but it has been done and remains essential to the success of the mental health response. Administrators and staff will need to shift from the pace of a regular work week to "disaster time" which often involves working 12 hour days and weekends.

In the urgency of immediate response, the timeframe required for a comprehensive disaster mental health training (2-5 days) is probably unrealistic. In addition, skilled trainers may not be instantly available. Such a comprehensive training may need to be postponed for a few days or weeks. In the short-run, the following suggestions will be helpful.

If possible, select disaster response staff with good crisis intervention and community relations skills, as these are the skills most transferable to the disaster situation. A trainer should ideally have disaster experience, but if one is not immediately available, an experienced crisis intervention worker can use materials from this book or other training materials to provide staff with basic training. The checklists at the end of most chapters will help staff in applying the information in the chapters. Initially, the chapters entitled "Key Concepts of Disaster Mental Health," "Providing Mental Health Services in a Disaster Shelter," and "Outreach Services Following Disaster" will be helpful for field-based staff. When Disaster Application Centers (DACs) open, the chapter on DACs will be helpful. The National Institute of Mental Health Training Manual for Human Service Workers in Major Disasters (Farberow and Frederick, 1978) provides essential information on phases of disaster, common stress reactions of adults and children, and suggested interventions. In an urgent timeframe, staff can read the materials and take them with them into the field. The National Institute of Mental Health Field Guide for Human Service Workers in Major Disasters is a reference guide for use by workers in the field.

Video training tapes may also be used until an experienced trainer can be engaged for comprehensive training. Appendix A lists training materials and videotapes.

Time allotted to this "basic" training may vary according to local circumstances, but if possible, at least a half-day should be devoted to training and orientation. In addition, at least one and a half to two hours should be set aside for debriefing of staff before the training.

Training may need to be repeated one or more times, so that staff can attend in "shifts" while other workers provide services. The

training may also need to be repeated as new personnel such as
volunteers, mutual aid, or extra-hire personnel come on board. On
the job training can be provided by linking inexperienced disaster
mental health workers with those who have had prior disaster
experience. Experienced workers may be part of a core team that
was trained predisaster, or they may be mutual aid staff who have
come from another jurisdiction to assist. An experienced worker
assigned to a team of new workers can provide on-scene
consultation, direction, and role modeling.

ORIENTATION OF DISASTER STAFF TO FIELD ASSIGNMENTS

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

        1.   Status of the disaster: nature of damages 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,
etc.
        3.   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 mental 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
volunteers or mutual aid personnel, provide a brief description of
the sponsoring mental health agency.
        4.   Logistics: arrangements for workers' food,
housing, obtaining messages, medical care, etc.
        5.   Communications: how, when, and what to report
through mental health chain of command; orientation to use of
cellular phones, two-way radios, or amateur radio volunteers, 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.
        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.
        10.   Self-care and stress management: encourage the

use of a "buddy system" to monitor each other's stress and needs. Remind 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 debriefing to be provided at the end of the tour of duty.

OBJECTIVES OF COMPREHENSIVE DISASTER MENTAL HEALTH TRAINING

Comprehensive training on disaster mental health should be provided for all staff and volunteers who will be involved in disaster response and recovery, including management and administrative personnel who will be closely involved. Training should be mandatory.

Effective disaster mental health training will provide participants with certain knowledge, skills, and attitudes that will enhance their effectiveness in the disaster setting. Because involvement with disaster mental health work requires a perceptual shift from traditional mental health service delivery, the acquisition of new skills and information is essential.

The objectives of a comprehensive disaster mental health training are to provide participants with the knowledge, skills, and attitudes that will enable them to:

     1.   Understand human behavior in disaster, including factors affecting individuals' response to disaster, phases of disaster, "at risk" groups, concepts of loss and grief, postdisaster stress, and the disaster recovery process.
     2.   Intervene effectively with special populations in disaster, including children, older adults, people with disabilities, ethnic and cultural groups indigenous to the area, and the disenfranchised or people living in poverty with few resources.
     3.   Understand the organizational aspects of disaster response and recovery, including key roles, responsibilities, and resources; local, state, and federal and voluntary agency programs; and how to link disaster survivors with appropriate resources and services.
     4.   Understand the key concepts and principles of disaster mental health, including how disaster mental health services differ from traditional psychotherapy; the spectrum and design of mental health programs needed in disaster; and appropriate sites for delivery of mental health services.
     5.   Provide appropriate mental health assistance to survivors and workers in community settings, with emphasis on crisis intervention, brief treatment, post-traumatic stress strategies, age-appropriate child interventions, debriefing, group counseling, support groups, and stress management techniques.
     6.   Provide mental health services at the community level, with emphasis on casefinding, outreach, mental health education, public education, consultation, community organization, advocacy, and use of the media.
     7.   Understand the stress inherent in disaster work and recognize and manage that stress for themselves and with other workers.

SELECTION OF TRAINER

The person or persons chosen to provide disaster mental health training should have knowledge, skills, and experience that will enable them to meet the above training objectives. Ideally, this should be someone who has worked in at least one actual disaster (preferably more). In addition, the individual should have a good understanding of principles of adult learning, and must have excellent training skills to promote learning of knowledge, skills, and attitudes.

Teaching disaster mental health involves working in the domain of emotions. Students often find that the material about disaster triggers deep feelings in themselves, and the trainer must be comfortable and skilled in group process and appropriate classroom discussion of emotions.

If a large group of people is being trained (over about 60), it is advisable to have more than one trainer to facilitate group discussion and skills practice. It is also possible to use trainers with different areas of expertise to teach various aspects of the material.

Training about ethnic groups affected by the disaster should ideally be done by individuals indigenous to the specific groups and familiar with conducting ethnic diversity training for majority culture groups.

Representatives of state, federal and voluntary agencies should provide training about their resources and programs. The intent is to familiarize mental health staff with programs to help them make effective referrals. At no time should mental health staff attempt to make determinations about individuals' eligibility for state or federal programs. Involving state and federal representatives in the training will also enhance the linkage and communication between mental health and the various programs. This part of the training can be arranged by contacting the Individual Assistance Officer (IAO) for the state Office of Emergency Services, the FEMA IAO at the Disaster Field Office, and the Voluntary Agencies (VOLAG) coordinator at the Disaster Field Office.

If a trainer is coming from outside the impacted area and is not familiar with the community, the mental health agency can help the trainer by providing him or her with background on the community and on the disaster. Census tract information, newspaper clippings or videotapes of the disaster will help the trainer to tailor the training to local characteristics and needs. The trainer should read the FEMA Crisis Counseling grant application if one has been written.

TRAINING TOPICS

The following topics are recommended for inclusion in a comprehensive disaster mental health training program:

     1.   Understanding Disaster and Disaster-related Behavior
               a.   Definition of disaster
               b.   Myths and realities of human behavior in
disaster
               c.   Factors affecting the psychological response of
individuals to disaster (factors related to the disaster, the
individual, and the social situation)

                    d.   "At risk" groups following disaster
                    e.   Phases of disaster
                    f.   Psychological, cognitive, behavioral, and
affective responses to disaster
                    g.   Differential assessment of normal responses vs.
those requiring intervention
        2.   Special Populations in Disaster: Issues and
Interventions
                    a.   Children
                    b.   Older adults
                    c.   People with disabilities
                    d.   The mentally ill
                    e.   Ethnicity and disaster
                    f.   People with previous traumatic experiences
3.   Roles, Responsibilities, and Resources in Disaster
                    a.   The disaster declaration process
                    b.   Chain of command among local, state, and
federal authorities
                    c.   Local, state, and federal mental health
programs
                    d.   Purpose and objectives of the FEMA crisis
counseling programs (if appropriate)
                    e.   Government and voluntary agency resources and
services for disaster survivors
        4.   The Disaster Recovery Process
                    a.   Loss and Grief
                    b.   Post-traumatic stress
                    c.   Interplay of individual recovery and community
recovery processes
        5.   Key Concepts of Disaster Mental Health
                    a.   Survivors' perception of needs
                    b.   Scope of community needs
                    c.   Milieu and time factors
                    d.   How effective disaster mental health
interventions differ from traditional psychotherapy
                    e.   Spectrum and design of mental health services
in disaster
                    f.   Sites for disaster mental health service
delivery
        6.   Effective Interventions with Disaster Survivors
        a.   Disaster preparedness
                    b.Crisis intervention
                    c.   Brief treatment
                    d.   Post-traumatic stress strategies
                    e.   Age-appropriate child interventions and school
programs
                    f.   Debriefing
                    g.   Group counseling and support groups
                    h.   Stress management techniques
7.   Effective Interventions at the Community Level
                    a.   Casefinding
                    b.   Outreach
                    c.   Mental health training
                    d.   Public education, including effective use of
media
                    e.   Consultation
                    f.   Community organization
                    g.   Advocacy
        8.   Disaster Work and Mental Health: Prevention and Control
of Stress Among Workers

                    a.   Sources of stress for workers (including mental
health workers)
                    b.   Stress management for workers before, during,
and after the disaster

Special consideration:

Paraprofessional staff without prior human service experience will
need training in communications and peer counseling skills before
attending the comprehensive disaster mental health training.
Topics should include the following:

     *Basics of crisis intervention
          *Establishing rapport
          *Active listening and responding skills
          *Attending to feelings
          *Interviewing techniques
     *Paraphrasing and interpretation
          *Cognitive reframing techniques
          *Nonverbal communication
          *Group dynamics
          *Helpful and unhelpful styles of assistance
          *When and how to refer to mental health
          *How to link clients with resources
               *Ethics (confidentiality, boundaries of relationship
with the client, etc.)
          *Legalities (duty to report to child protective
services,etc.)
     *Risk factors for suicide
          *Handling difficult situations

Close clinical supervision should be part of the organizational
structure. Training should provide peer counselors with
information regarding how and when to consult with their
supervisors and how and when to refer individuals. They should be
provided with specific indicators of when they are becoming
overinvolved with a client, and how to overcome this professional
vulnerability.

TRAINING FORMAT

Under ideal circumstances, a comprehensive disaster mental health
training will take from two to five days. The length of the
training will vary according to the disaster, the location, prior
experience of the staff, and the trainer.

To transmit the knowledge, skills, and attitudes encompassed in the
comprehensive objectives, a variety of instructional methods should
be used. Interactive teaching methods are important. Skills
practice that approximates the true disaster scene is crucial.
Exposure to scenarios and case studies that will challenge
participants to examine their own emotional responses to disaster
is also essential. A mix of methods such as didactic
presentations, reading, videotapes, self-awareness exercises,
discussion sessions, demonstrations, skills practice and supervised
field experience will help to achieve the training objectives.

TRAINING DURING LONG-TERM RECOVERY

As disaster response efforts are completed and longer-term recovery

efforts begin, there continue to be training needs for disaster
mental health workers.

If a FEMA Regular Program grant is sought and awarded for crisis
counseling services, new or additional staff may be hired for the
program. If they have not had a comprehensive disaster mental
health training program, such a program should be given or repeated
when staff are hired.

Besides the comprehensive training program, inservice training
and/or consultation should be provided at regular intervals.
Staff and supervisors working on long-term recovery efforts must be
attuned to training needs that may arise during the work. Some
needs are unique to a given disaster or locale. Such training, if
tailored to specific needs as they arise, can help staff to
overcome service-delivery barriers that they may encounter along
the way. Training always provides a welcome infusion of ideas and
gives a boost to staff morale. The Crisis Counseling grant
application should include funding for appropriate levels of
inservice training and consultation.

Staff may need in-depth training on a subject covered briefly in
the comprehensive training, or they may find that topics not
covered in the training are needed. Some common training needs and
interests seem to occur regularly in long-term recovery programs.
Examples include the following:

          * treatment of post-traumatic stress disorder
               * treatment of post-traumatic stress disorder and
alcohol abuse/dependence
          * interventions with complicated bereavement
          * advanced group dynamics
          * expressive therapies (art, music, writing) for use with
adults and children
          * advanced peer counseling for paraprofessionals
          * disaster and family issues
     * stress management interventions for survivors and workers
     * long-term recovery issues and interventions
          * outreach techniques for long-term recovery
               * the first anniversary: individual reactions and
community recovery events
     * community organizing at the neighborhood level
               * specialized topics important to understanding and
helping survivors, e.g., insurance issues, the city or county
permit   process, working with architects and contractors, and the
like
               * specialized topics pertinent to the local disaster
(e.g., floodplain management, seismic safety, hurricane warning
systems, etc.)
               * preparing for termination of the project:
termination of relationships with clients, referral of clients to
appropriate resources, notification of community regarding ending
of services

It is recommended that staff complete written evaluations of
training sessions as they occur. Evaluations provide useful
feedback to the trainer. They also provide information to managers
about the perceived usefulness of training. At the end of the
disaster recovery program, a critique of the training component of
the program is also useful. The FEMA crisis counseling program

final report can include the results of the critique as a way to help other projects with their training components. It should also be kept with the local disaster mental health plan as documentation of what was done for use in future disasters.

SUMMARY

Because the knowledge and skills required of mental health workers in disaster differ from those needed in nondisaster times, special attention should be given to selecting and training a disaster mental health team. The guidelines provided in this chapter can help mental health planners and administrators in selecting disaster team members and preparing them to be effective in this challenging and rewarding work.

CHECKLIST

SELECTION AND TRAINING OF DISASTER MENTAL HEALTH STAFF

PREDISASTER

_____ Select core group of disaster mental health staff

_____ Provide comprehensive disaster mental health training based on objectives and topics listed in chapter on "Selection and Training of Disaster Mental Health Staff"

_____ Provide regular in-service training and participate in disaster exercises at local level

DISASTER RESPONSE

_____ Provide disaster mental health training for all staff and volunteers who have not received prior training; initial training may be abbreviated until more comprehensive training can be arranged

_____ Orient staff to:

_____ Status of disaster situation

_____ Profile of the impacted community

_____ Community and disaster-related resources

_____ Logistics (food, housing, medical care)

_____ Communications

_____ Transportation/travel in disaster area

_____ Health and safety in disaster area

_____ Field assignment sites

_____ Policies and procedures

_____   Self-care and stress
management

_____   As soon as possible, provide
comprehensive disaster mental health training based on objectives
and topics listed in training chapter for all staff who will be
working on response and recovery who have not had prior training

DISASTER RECOVERY

_____   Develop training plan for staff who
will be working on long-term recovery program

_____   Include phase-appropriate
topics such as those suggested in training chapter

_____   Allow for consultation or
training in response to specific needs that may arise

_____   Provide expert consultation,
technical assistance, and regular debriefing sessions for staff
involved in long-term recovery program

POSTDISASTER

_____   Include staff in a critique of pre-
and postdisaster training.

_____   Keep written evaluation of training
and recommendations for the future; include in FEMA Crisis
Counseling program final report (if appropriate)

REFERENCES AND RECOMMENDED READING

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                                                       CHAPTER THREE

ORGANIZATIONAL ASPECTS OF DISASTER

INTRODUCTION

A disaster is a complex human, bureaucratic, and political event. Routine procedures and resources are not enough to manage the changes caused by a disaster. The number and type of responding groups, agencies, and jurisdictions increase monumentally, and relationships among organizations change. Alterations in traditional divisions of labor and resources increase the need for multi-organizational and multi-disciplinary coordination among all of the various responding participants. Without this coordination, resources may not be shared or distributed according to need. There may be insufficient communication and control, and a resulting duplication of effort, omission of essential tasks, and even counterproductive activity.

This chapter describes the roles, responsibilities, resources, and interrelationships of key private and governmental organizations involved in disaster management. To function effectively, it is essential that mental health agencies understand this complex organizational environment and system of resources. Clinical skills alone will not enable mental health to reach and serve the community of survivors in an effective way.

The chapter also describes the federal funding available to local mental health agencies in a presidentially declared disaster through Section 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. This funding can help mental health agencies in providing immediate response as well as longterm recovery services to survivors.

MANAGEMENT OF ROUTINE EMERGENCIES

In the United States, the management of day-to-day non-catastrophic emergencies is influenced by a national preference for local control. As a result, tasks are divided among a multitude of community organizations (public and private) and individuals, with roles and responsibilities determined by tradition, laws, contracts, and charters (Auf der Heide, 1989; Drabek, 1985; Drabek, 1987; Quarantelli, 1981). The allocation of tasks and of resources is fairly standardized and there is relatively little confusion (Auf der Heide, 1989). Community mental health agencies routinely interact in well-defined and understood relationships with other agencies such as social services, the schools, law enforcement, probation, and the like. In disaster, things change.

MANAGEMENT OF DISASTERS

The Federal Emergency Management Agency defines disaster as:

>"An occurrence of a severity and magnitude that normally results in deaths, injuries, and property damage and that cannot be managed through the routine procedures and resources of government. It . . . requires immediate, coordinated, and effective response by multiple government and private sector organizations to meet human needs and speed recovery" (FEMA, 1984).

A disaster differs from routine emergencies in that it cannot be adequately managed merely by mobilizing more personnel, equipment, and supplies. Disasters often create demands that exceed the capacities of single organizations, requiring them to share tasks and resources with other organizations that use unfamiliar procedures. As Auf der Heide (1989) has reported, disasters may cross jurisdictional boundaries. They change the number and structure of responding organizations, and may result in the creation of new organizations. They create new tasks, and engage participants who are not ordinarily disaster responders. Disasters also disable the routine equipment and facilities needed for emergency response.

The complexity of government in the United States compounds the difficulty of understanding "who does what" in disaster response. The 1982 Census of Governments found over 82,000 separate governments operating in this country. Such decentralization results in a lack of standardization in disaster planning and response, and complicates coordination in time of disaster (Auf der Heide, 1989).

In addition, organizations inexperienced in disaster often respond by continuing their independent roles, failing to see how their function fits into the complex, total response effort. Auf der Heide (1989) describes this as the "Robinson Crusoe syndrome" ("We're the only ones on the island").

This isolation occurs not just in response, but in planning as well. Too often, private sector groups and different levels of government may not have plans that realistically consider the roles and resources of other groups.

Because of the complexities and challenges of the disaster environment, key factors in an organization's effectiveness are flexibility and the ability to improvise. However, it is crucial for responding agencies to educate themselves about the roles and responsibilities of other local, state, and federal agencies in time of disaster. They must plan for disaster response based on a solid knowledge of the organizational environment.

PLANNING FOR MENTAL HEALTH'S ROLE IN EMERGENCY RESPONSE AND RECOVERY

A mental health disaster plan is essential to coordinating the mental health emergency response efforts with other emergency response organizations in time of disaster. It is strongly recommended that each state department of mental health have a mental health disaster plan which is a component of the state

emergency management plan. In many states, the governor mandates
a mental health disaster plan by executive order. Similarly, each
department of mental health, whether municipal, county, or
regional, should have a mental health disaster plan. The plan
should be a well-integrated component of the comprehensive
emergency management plan of the jurisdiction. Some states have
mandated this by legislation.

The purpose of the mental health plan is to ensure an efficient,
coordinated, effective response to the mental health needs of the
affected population in time of disaster. It will enable mental
health to maximize the use of structural facilities, personnel, and
other resources in providing mental health assistance to disaster
survivors, emergency response personnel, and the community
(California Department of Mental Health, 1989; New Jersey
Department of Human Services, 1991). The mental health disaster
plan will specify the roles, responsibilities, and relationships of
the agency to federal, state, and local entities with
responsibility for disaster planning, response, and recovery.

A mental health plan must also specify roles, responsibilities, and
relationships within the agency in responding to disasters (South
Carolina Department of Mental Health, 1991). The plan needs to be
organized so that it reaches each level and each component of the
agency. It must also identify the respective individuals (by
position) who are responsible for carrying out the functions.
Individuals should all have back-ups, preferably three deep.

Mental health services to disaster survivors must be provided in
community locations where survivors congregate, such as shelters
and meal sites. These sites are often operated by the Red Cross in
cooperation with social services or other organizations. In
long-term recovery, mental health efforts need to be integrated
with other human services to survivors. Because close
collaboration is necessary with these agencies, the mental health
disaster plan is often a component of, or an attachment to, the
social services/shelter plan. In some areas, mental health
agencies have found it beneficial to include in their plan a
Memorandum of Understanding (MOU) with the Red Cross, delineating
roles and responsibilities of the two agencies. Mental health
services to survivors may also be provided at hospitals, first aid
sites, and the coroner's office. Consequently, the mental health
plan requires coordination and integration with the emergency
medical plan, the public health plan, and the coroner's plan.

GOVERNMENT ROLES AND RESPONSIBILITIES IN EMERGENCY MANAGEMENT

Local government

The local level of emergency management consists of staff of cities
and counties. County staff are responsible for unincorporated
areas within counties, and may also function in a coordinating role
in a local emergency or state of emergency. Local ordinances and
resolutions establish local responsibilities for emergency
management, with each local program fitting into the state
emergency management organization. Local government has the
primary responsibility for emergency response, even when the event
overwhelms local government's capacity for effective response and
the state is called upon for assistance (Drabek and Hoetmer, 1991).

There is wide diversity in how local government carries out its emergency management functions. In most small cities, emergency management is the responsibility of an individual who performs the function as part of another job, such as city manager or fire chief. In counties, the responsibility is usually given to a full- or part-time emergency manager. Larger cities or counties are more likely to have a dedicated emergency management department with a small staff. The department may be an independent unit, or may be embedded in another unit, such as the fire department. Given the wide variation in political and organizational realities among local governments, there is not any standard design for local emergency management structure. However, Figure 1 provides a simplified organization chart of how many local emergency management units fit within local government.

It is the responsibility of the local emergency management unit to:

          1.   Identify all hazards that may pose a major threat to the jurisdiction, and develop hazard mitigation plans and programs to eliminate or reduce potential hazards.
          2.   Develop maps of areas within the jurisdiction that may be subject to disasters, for example, geologic hazards, flood plains, dam failure inundation areas, etc.
          3.   Work cooperatively with government and community organizations to develop and maintain up-to-date emergency plans that are consistent with the state plan and mutual aid agreements.
          4.   Coordinate with industry to develop industrial emergency plans and capabilities in support of local government plans.
          5.   Develop a training program for emergency response personnel, and an exercise program to test response capabilities.
          6.   Develop a public education program.
          7.   Develop and maintain emergency communication systems, including a system to alert key public officials and warn the public in the event of an emergency. Establish an emergency public information system.
          8.   Develop plans for meeting all conditions that could constitute a local emergency. Inventory personnel and material resources from government and private sector sources that would be available in an emergency. Identify and work with local officials to correct resource deficiencies.
          9.   Develop and supply an Emergency Operations Center (EOC) as a site for direction and control operations during an emergency.
          10.   Establish and maintain a shelter and reception and care system.
          11.   Develop continuity of government procedures and systems.
          12.   Assist in the establishment of mutual aid or cooperative assistance agreements to provide needed services, equipment, or other resources in case of an emergency.
          13.   Provide the county or state Office of Emergency Services (OES) with estimates of the severity and extent of damage resulting from a disaster, including dollar value of both public and private damage sustained as well as estimates of resource costs required to alleviate the situation.
          14.   Secure technical and financial assistance available to local jurisdiction through state and federal programs.

State government

State government plays a pivotal role in emergency management. It
is in a position to determine the emergency needs and capabilities
of its political subdivisions. In addition, it channels state and
federal resources to local government, including training,
technical assistance, and operational support in an emergency.

The authority and responsibility for emergency management at the
state level belong to the governor or his/her designee. While
state laws vary, the governor is typically given the powers or
options to do the following (Drabek and Hoetmer, 1991):

        1.   Suspend state statutes, rules and regulations.
        2.   Procure materials and facilities without regard
to limitations of existing law.
        3.   Direct evacuations.
        4.   Control entrance to and exit from disaster
area.
    5.   Authorize release of emergency funds.
        6.   Activate emergency contingency funds and
reallocate state agency budgets for emergency work.
        7.   Issue state or area emergency declarations and
invoke appropriate state response actions.
        8.   Apply for and monitor federal disaster and
emergency assistance.

Day-to-day emergency management responsibilities are generally
delegated by the governor to a lead agency in the state, usually
called the Office of Emergency Services. Various other state
agencies are mandated to carry out assigned activities related to
mitigating the effects of an emergency and to cooperate with each
other and other political subdivisions in providing assistance.
Figure 2 illustrates state emergency management functions under the
governor, and show state agencies with emergency management
responsibilities.

Drabek and Hoetmer (1991) list the responsibilities of the state
Office of Emergency Services as follows:

        1.   Prepare and maintain a comprehensive state
emergency plan and emergency management program.
        2.   Assign emergency functions to various state
agencies, and coordinate the activities of the agencies in
developing the state emergency plan.
        3.   Ensure that all personnel assigned specific
responsibilities in support of the state plan are adequately
trained and prepared to assume those responsibilities.
        4.   Support and facilitate local government
preparedness efforts, to ensure that disasters are handled at the
lowest government level; write standards and requirements for
county and municipal plans; and review and maintain a file of
current plans that are developed or updated under those standards.
        5.   Oversee the damage assessment process following
emergencies.
        6.   Administer and coordinate state resources
providing assistance requested by the county or affected area, and
request federal disaster assistance, if warranted.
        7.   Administer the state mutual aid system, with

regional or state staff assisting local emergency operations at the
request of local coordinators.
                8.   Maintain mutual aid agreements with adjoining
states.

When a disaster exceeds the local government's ability to respond
effectively, the state Office of Emergency Services activates
functions that are essential to a coordinated response in support
of the local jurisdiction (Drabek and Hoetmer, 1991). The specific
emergency support functions provided by the state in support of
local government may include the following (California Basic
Emergency Plan, 1989):

                1.   Management of emergency operations:
coordination, direction, and control of emergency operations,
usually at a State Operations Center (SOC) managed by the state
Office of Emergency Services (OES) director or designee;
communications; alert, warning, notification of people in
threatened areas; and situation reporting and damage analysis.
                2.   Fire and rescue operations: fire suppression,
fire safety, and search and rescue.
                3.   Law enforcement and traffic control:
enforcement of laws regarding evacuation, traffic control, access
control.
                4.   Emergency medical services: care and treatment
for the ill and injured.
                5.   Public health services: public health and
sanitation.
                6.   Coroner operations: collection,
identification, and protection of the remains of deceased persons.
                7.   Care and shelter operations: care for the
basic needs of evacuees and disaster service workers; registration
of all homeless, displaced, injured, and sick people; and shelter
and care to displaced survivors and disaster service workers
through emergency congregate care centers.
                8.   Movement operations: movement of people from
threatened or hazardous areas.
                9.   Rescue operations: search and rescue.
                10.   Construction and engineering operations:
maintenance or repair of roads, structures, or other public areas.
                11.   Resources and support operations: provision of
personnel, equipment, food, fuel, transportation, and utilities to
support operations.
                12.   Emergency public information: rapid
distribution of emergency instruction and accurate information to
the public during emergencies.
                13.   Technological services response: technological
response to hazardous material incidents; advice to the public of
protective measures.
                14.   Radiological protection: radiological
response, including monitoring radiation levels in the environment,
determining measures to minimize personal exposure, and
identification and management of fallout shelters.

Federal government

The basic role of the federal government in emergency management is
to protect life and property in a disaster and to assist state and
local governments in the recovery process.

By executive order, the president has assigned emergency
preparedness and operating responsibilities to certain federal
agencies, with overall responsibility assigned to the Federal
Emergency Management Agency (FEMA). Assignments are based on each
agency's regular functions and capabilities. Federal emergency
management includes the administration of natural disaster relief
programs and civil defense plans and programs.

In 1988, Public Law 93-288 was amended by Public Law 100-707 and
retitled as the Robert T. Stafford Disaster Relief and Emergency
Assistance Act. The Stafford Act provides the authority for the
Federal government to provide assistance to save lives and to
protect public health and safety and property as the result of
natural disasters and other incidents for which federal response
assistance is required. Crisis counseling for victims of
presidentially declared disasters is one of the assistance programs
authorized under the Stafford Act. The crisis counseling program
is discussed in more detail in a subsequent section of this
chapter.

The federal government recognizes local and state governments as
being in charge of emergency response operations. Federal
assistance under the provisions of the Stafford Act is supplemental
to state efforts. The president is authorized under the Stafford
Act to declare a "major disaster" or "emergency" for an area
affected by a disaster. This is done in response to a request by
the governor of the affected state, when state and local resources
are inadequate to respond effectively and to undertake recovery.
Once a presidential declaration has been made, FEMA may direct any
federal agency to help state and local governments directly.

Figure 3 illustrates the specific emergency support functions
(ESFs) of federal agencies.

AMERICAN RED CROSS ROLES AND RESPONSIBILITIES IN DISASTER

The American Red Cross was mandated by Congressional charter in
1905 to help meet the human needs created by disaster. This
mandate was reaffirmed by Congress in the Disaster Relief Acts of
1970 and 1974 (as amended, 1988) and in the published regulations
of the Federal Emergency Management Agency (FEMA) and a statement
of understanding between FEMA and the American Red Cross in 1982.
Thus, the Red Cross role in disaster is a legal mandate that it has
neither the authority nor the right to surrender (American Red
Cross, 1982). Nonetheless, the Red Cross receives no government
funding for its services, and relies solely upon voluntary
contributions.   In addition, local governmental responsibilities
and mandates are not superseded by Red Cross authority. The Red
Cross is responsible for providing emergency congregate and
individual care in coordination with local government and private
agencies. Figures 4 and 5 illustrate the responsibilities of local
government and the American Red Cross in disaster.

VOLUNTARY AGENCY RESPONSE IN DISASTER

Many volunteer organizations provide a response to disaster. These
responses are not mandated by law, but many individual
organizations include disaster response in their charters. Many
voluntary groups are members of the National Voluntary
Organizations Active in Disaster (NVOAD). In addition, existing

local groups, such as volunteer centers, may take on specific
responses to a local disaster. Spontaneous "grass roots" groups
also sometimes emerge to tackle unique situations for which no
organization has responsibility. Mental health should be alert to
and familiar with voluntary groups' response in disaster, as these
groups often provide human services that are not otherwise
available to survivors. Figure 6 illustrates the response of many
of the formal voluntary agencies.

The following list illustrates other voluntary groups and private
sector organizations who may be involved in disaster response:

Private hospitals
Physicians, nurses, pharmacists, other health professionals
Mental health professionals and agencies
Professional associations
Suicide prevention hotlines
Private ambulance companies
American Hospital Association
Private vendors of health supplies
National Association of Funeral Directors
Poison control centers
Veterinarians
American Humane Association
Volunteer search and rescue teams
Explorer Search and Rescue
Manufacturing plant fire departments
National Ski Patrol
Rescue Dog Association
Civil Air Patrol
Amateur radio organizations
Commercial radio and television stations
Private hazardous spill cleanup companies
Chemical Manufacturers' Association
     Railroad, airline, maritime, trucking, pipeline, petroleum,
mining, or chemical firms
American Society of Civil Engineers
National Association of Independent Fee Appraisers
National Association of Home Builders
Private building contractors
Heavy equipment owners and operators
Labor unions
AFL-CIO Department of Community Services
Private utility companies
Private colleges and universities
Childcare providers
National Restaurant Association
Private restaurants and food vendors
Veterans of Foreign Wars of the United States
American Legion
Service clubs
League of United Latin American Citizens
National Association for the Advancement of Colored People

THE DISASTER DECLARATION PROCESS

When disaster-caused needs exceed the resources of a jurisdiction
to respond, a declaration of increasing level of emergency may be
made. The following are the definitions of levels of emergency as
abstracted from several state emergency plans:

Local emergency

The declaration of a local emergency is made by the governing body
of a city or county when conditions of disaster or extreme peril to
the safety of persons and property exist within the jurisdiction.
A declaration is made when conditions are or are likely to be
beyond the control of the services, personnel, equipment, and
facilities of local government. Declaration of a local emergency
assumes that effective response will likely require the combined
forces of other jurisdictions. The declaration enables the
jurisdiction to use emergency funds, resources, and powers, and to
divert funds from other programs to cover emergency costs. It is
normally a prerequisite to requesting a gubernatorial proclamation
of a state of emergency.

State of emergency

The proclamation of a state of emergency is made by the governor
when conditions of extreme peril to the safety of persons and
property exist within the state. The governor makes the
declaration when conditions are or are likely to be beyond the
control of any single county, city and county, or city. A
declaration assumes that conditions may require the combined forces
of a mutual aid region or regions. The proclamation does the
following:

          *   Makes mutual aid assistance mandatory from
other cities, counties, and state agencies.
          *   Enables the state to use emergency powers
(suspend hindering regulations, make emergency purchases, redirect
monies allocated for different purposes).
          *   In some states, allows for state reimbursement
of local jurisdiction response, repair, and restoration costs
connected with the emergency and property tax relief for
damaged/destroyed private property.
          *   In some states, may make state housing loans
available to owners of damaged private residences.
          *   Is a prerequisite for requesting federal
recovery assistance.

If damage assessments find that the extent of damage merits a
presidential declaration, the governor submits a letter to the FEMA
regional director. If the FEMA regional director confirms the
governor's findings, a recommendation is submitted to the FEMA
director in Washington, D.C. The FEMA director then submits a
recommendation to the president.

Major disaster

The declaration of a major disaster is made by the president when
damage exceeds resources of state and local government and private
relief organizations. Under a major disaster declaration, two
types of federal assistance may be provided, as authorized under
The Stafford Act. Not all disasters include approval for both
types of assistance. A jurisdiction must be approved for
individual assistance to be eligible for a Section 416 Crisis
Counseling grant for mental health.

          Individual assistance to individuals and businesses may

include:

                         *   Temporary housing assistance
                         *   Low interest loans (individuals,
businesses, and farmers/ranchers)
            *   Individual and family grants
            *   Crisis counseling program

     Public assistance to state and local governments, special
districts and certain private nonprofit agencies may include:

                         *   Debris clearance
                         *   Repair/replacement of public property
(roads, streets, bridges, buildings)
                         *   Emergency protective measures (search
and rescue, demolition of unsafe structures)
                         *   Repair/replacement of water control
facilities (dikes, levees)

Emergency

The declaration of an emergency is made by the president and
authorizes specialized assistance to state and local governments to
meet specific needs. Assistance may include:

                    *   Emergency mass care
                    *   Search and rescue
                    *   Emergency transportation

Figure 7 illustrates the steps in the disaster declaration process.

Once a presidential declaration has been made, the FEMA director or
designee appoints a federal coordinating officer (FCO) as the
senior federal official who coordinates the administration of
relief activities in the affected area. The FEMA regional director
appoints a disaster recovery manager (DRM) to carry out the
responsibilities of the regional director in administering relief
programs. The governor appoints a state coordinating officer (SCO)
to coordinate state and local response efforts with those of the
federal government. The governor also appoints a governor's
authorized representative (GAR) to execute for the state all
necessary documents for disaster assistance, including
certification of applications for public assistance. The FCO, DRM,
and where possible, SCO and GAR work together in the disaster field
office (DFO). The DFO is a temporary office established in or near
the affected area for coordination and control of state and federal
response and recovery operations. Figure 8 illustrates the federal
programs represented in the DFO.

CRISIS COUNSELING PROGRAMS FOR VICTIMS OF PRESIDENTIALLY DECLARED
DISASTERS

This section of the chapter is adapted from the FEMA/NIMH
description of Crisis Counseling Programs for Victims of
Presidentially Declared Disasters (FEMA/CMHS, 1992).

Section 416 of the Stafford Act authorizes funding for mental
health services following a presidentially declared disaster:

          Sec. 416. 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 victims
of major disasters in order to relieve mental health problems
caused or aggravated by such major disaster or its aftermath.

Purpose and objectives

This crisis counseling program for survivors of major disasters
provides support for direct services to disaster survivors. A
training component in disaster crisis counseling for direct
services staff of the project and for training of other disaster
services workers may be included. This program has been developed
in cooperation with FEMA and the Center for Mental Health Services
(CMHS) within the Substance Abuse and Mental Health Services
Administration (SAMHSA).

The law was enacted and the program developed in response to the
recognition that disasters produce a variety of emotional and
mental disturbances that, if untreated, may become long term and
debilitating. Such problems as phobias, sleep disturbances,
depression, irritability, and family discord occur following a
disaster. Programs funded under Section 416 are designed to
provide timely relief and to prevent long-term problems from
developing.

Assistance under this program is limited to presidentially declared
major disasters. Moreover, the program is designed to supplement
the available resources and services of states and local
governments. Thus support for crisis counseling services to
disaster victims may be granted if these services cannot be
provided by existing agency programs. The support is not
automatically provided.

Terms and conditions of support

For any assistance an assessment of the need for crisis counseling
must be initiated by a state within 10 days of the date of the
presidential disaster declaration. There are two types of support:
Immediate Services Grants and Regular Services Grants. Monies for
both types of support come from FEMA.

Support for Immediate Services must be requested within 14 days of
the date of disaster declaration. Support may be provided for up
to 60 days after the date of the major disaster declaration. This
decision is made by the regional director of FEMA or his/her
on-site designee, the disaster recovery manager (DRM), after
consultation with the Emergency Services and Disaster Relief
Branch, Center for Mental Health Services (CMHS) within the
Substance Abuse and Mental Health Services Administration (SAMHSA).

Regular Services funding must be requested within 60 days of the
date of the disaster declaration. Support may be provided by the
assistant associate director of FEMA through SAMHSA, based upon the
recommendations of the FEMA regional director and the CMHS
Emergency Services and Disaster Relief Branch. The Regular Program
is limited to nine months except in extenuating circumstances when
an extension of up to three months may be requested.

Eligibility requirements

The law provides that financial assistance may be provided to
state, local, or private mental health organizations. A state
agency official is appointed by the governor to make all requests
for federal disaster assistance (i.e., the state is the official
applicant). This official is the governor's authorized
representative (GAR). Requests for funds under both the Immediate
and Regular Program must be made by the GAR. The recipient of
support may be a state agency or its designee.

Areas of special concern

In the development of a request for assistance, the applicant
should be aware of special concerns, such as:

                    -Specific attention should be given to high-risk
groupssuch as children, the frail elderly, and the disadvantaged;
                    -Prolonged psychotherapy measures are
inappropriate for this program;
                    -Maximum use should be made of available local
resources and personnel; and
                -Programs should be adapted to local needs,
includingspecial cultural, geographic, or politicalconstraints.

Disaster survivors are eligible for crisis counseling services if
they are residents of the designated major disaster area or were
located in the area at the time of the disaster. In addition, they
must (1) have a mental health problem which was caused or
aggravated by the disaster or its aftermath; or (2) they may
benefit from preventive care techniques (Federal Register, 1989).

Crisis counseling project staff or consultants to the project are
eligible for training that may be required to enable them to
provide professional disaster mental health services to eligible
individuals. In addition, all federal, state, and local disaster
workers responsible for assisting disaster victims are eligible for
training designed to enable them to deal effectively and humanely
with disaster survivors (Federal Register, 1989).

Application for Immediate Services

For Immediate Services, an application for funding in the form of
a letter of request should be submitted not later than 14 days
following the disaster declaration by the GAR to the FEMA disaster
recovery manager (DRM). An additional copy will be submitted to
the Emergency Services and Disaster Relief Branch, CMHS, by FEMA
for consultation in evaluating the need for Immediate Services and
the state's capability for providing the services.

The application for Immediate Services must include the state's
assessment of need, initiated within 10 days of the disaster
declaration. An estimate of the size and cost of the proposed
program is required. Specifically the state mental health
authority should address each of the following issues, for each
jurisdiction that is requesting funds:

Extent of Need: To justify initiation of a special mental health
program, the state must demonstrate that disaster-precipitated
mental health needs exist. One approach to doing so is presented
in Figure 9.

State Resources: A description of current capabilities and
additional disaster needs is required.

Program Plan: Plans for outreach, crisis counseling, referral,
consultation, and education should be outlined briefly. Staff
qualifications and training needs should also be included.

While the Immediate Services application is expected to address the
above issues, it is anticipated that requests will be brief, only
a few pages. A more comprehensive statement is expected of
applications for the Regular Services.

Attachment 10 illustrates the Immediate Services Program grant
request and approval paperflow.

Application for Regular Services

For Regular Services, a grant application must be submitted with
Public Health Service Form 424 not later than 60 days following the
disaster declaration. The GAR must submit the application to the
FEMA assistant associate director, through the FEMA regional
director, and simultaneously to the Emergency Services and Disaster
Relief Branch, CMHS.

The application for Regular Services must include:

     (1) Public Health Service Grant Application Form 424.
     (2) The disaster description including the type of disaster,
and its time, place, and duration.
     (3) Needs Assessment: Estimates of the total number of
individuals in need of direct services and the total number of
individuals in need of outreach and consultation and education, for
each service provider group. Population demographics.
     (4) Program Plan: Description of the manner in which the
needs of the affected populations will be met, types of services to
be offered and a rationale for each. The plan must reflect
attention to cultural, ethnic, or geographic needs or other special
factors indigenous to the area.
     (5) Staffing and Training: Delineation of the number and
kinds of staff required as well as specific training programs for
staff.
     (6) Resource Needs and Budget: Explanation of the extent to
which existing resources are unable to meet the needs of the
disaster affected population. The budget must be clearly tied to
the program narrative and contain both dollars requested and a
justification for individual budget items.

Figure 11 illustrates the Regular Program grant application and
approval paperflow.

A Workbook for Development of a Grant Application for the Regular
Program, other technical assistance materials, and information and
guidance on either of the two types of applications may be obtained
by contacting:

Emergency Services and Disaster Relief Branch
Division of Program Development, Special Populations and Projects
Center for Mental Health Services
5600 Fishers Lane, Room 18-101

Rockville, Maryland 20857
Telephone: (301) 443-3728

SUMMARY

This chapter has outlined the major roles, responsibilities, and
resources of the private and public organizations and agencies
involved in disaster response. It is essential for mental health
agencies to have an understanding of the basic roles of these
groups in order to function effectively in the complex
organizational environment of a disaster. In addition, the chapter
has described the funding available through Section 416 of the
Stafford Act to assist local mental health agencies in helping
disaster survivors with their emotional and psychological recovery.

GLOSSARY

ADAMHA   Alcohol, Drug and Mental Health Administration
ARC   American Red Cross
ASCS   Agricultural Stabilization and Conservation Service
CDRG   Catastrophic Disaster Response Group
CMHC   Community Mental Health Center
CMHS   Center for Mental Health Services
COE   Corps of Engineers (U.S. Army)
DAC   Disaster Application Center
DFO   Disaster Field Office
DHHS   Department of Health and Human Services
DOC   Department of Commerce
DOD   Department of Defense
DOE   Department of Energy
DOEd   Department of Education
DOI   Department of the Interior
DOJ   Department of Justice
DOT   Department of Transportation
DRM   Disaster Recovery Manager
EEO   Equal Employment Opportunity
EOC   Emergency Operations Center
EPA   Environmental Protection Agency
           ESF   Emergency Support Function
FCC   Federal Communications Commission
FCO   Federal Coordinating Officer
FDIC   Federal Deposit Insurance Corporation
FEMA   Federal Emergency Management Agency
FHLBB   Federal Home Loan Bank Board
FmHA   Farmers Home Administration
FRS   Federal Reserve Systems
GAR   Governor's Authorized Representative
GSA   General Services Administration
HQ   Headquarters
IAO   Individual Assistance Officer
ICC   Interstate Commerce Commission
IFG   Individual and Family Grants
IRS   Internal Revenue Service
MHA   Mental Health Agency
MOU   Memorandum of Understanding
NASA   National Aeronautics and Space Administration
NCS   National Communications System
NRC   Nuclear Regulatory Commission

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NVOAD     National Voluntary Organizations Active in Disaster
OES       Office of Emergency Services
OFA       Other Federal Agencies
OPM       Office of Personnel Management
SAMHSA    Substance Abuse and Mental Health Services Administration
SBA       Small Business Administration
SCO       State Coordinating Officer
SOC       State Operations Center
SSA       Social Security Administration
THA       Temporary Housing Assistance
          USDA United States Department of Agriculture
USPS      United States Postal Service
VA        Department of Veterans Affairs
VOLAGS    Voluntary Agencies
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CHAPTER FOU

THE ROLE OF MENTAL HEALTH
IN EMERGENCY MANAGEMENT
AND THE EMERGENCY OPERATIONS CENTER

COMPREHENSIVE EMERGENCY MANAGEMENT

In order to manage disasters predictably and efficiently, a concept called Comprehensive Emergency Management (CEM) has been developed. It applies mitigation, preparedness, response, and recovery activities to all types of hazards in a municipal/county/state/federal partnership.

Mitigation is any activity aimed at reducing or eliminating the
probability of a disaster. Zoning, land use management, and public
education are examples of mitigation activities. Inspection and
proper maintenance of mental health facilities are fire mitigation
activities.

Preparedness includes endeavors that seek to prevent casualties,
expedite response activities, and minimize property damage in the
event of an emergency. Pre-disaster training of a specialized
mental health disaster response team is an example of preparedness
activities.

Response activities occur immediately before, during and after an
emergency or disaster. Examples include search and rescue or
implementation of shelter plans. Mental health response activities
include providing mental health staff at shelters, first aid
stations, meal sites, morgues, or command centers.

Recovery includes short and long-term activities. Short-term
activities attempt initially to compensate for damage to a
community's infrastructure and quickly return its vital
life-support systems to operation. Short-term recovery assistance
includes providing temporary housing, welfare, and unemployment
assistance. Psychological first-aid, crisis intervention, and
shift-change defusing (mini-debriefings) are short-term mental
health recovery activities. Long-term recovery activities are
designed to return life to normal or improved levels. Repair of
buildings, roads, bridges, and activities to reestablish business
are examples. Long-term mental health recovery activities include
outreach, consultation and education, individual and group
counseling, support groups and referral/information services. Both
short and long-term mental health programs may be funded by a grant
from the Federal Emergency Management Agency (FEMA) in a
presidentially-declared disaster. The program is authorized by
Section 416 of the Disaster Relief Act, Public Law 100-707 (FEMA,
1988).

THE INTEGRATED EMERGENCY MANAGEMENT SYSTEM

The second concept that currently helps to define roles and
responsibilities of emergency management is the integrated
emergency management system (IEMS). Drabek and Hoetmer (1991)
point out that comprehensive emergency management (CEM) provides an
inclusive framework that encompasses all hazards and all levels of
government. It includes the four phases of mitigation,
preparedness, response, and recovery. IEMS shows how the framework
can be operationalized. It spells out the details of CEM. IEMS
requires that a community carry out a hazard and risk analysis.
The community then must assess its capabilities in the areas of
mitigation, preparedness, response, and recovery.   The shortfall
between existing and required levels of capability leads to the
development of a multiyear development plan. The plan usually
covers a five-year period so that projects can be properly
scheduled and funded, with annual work increments. Thus, IEMS
supports the development of emergency management capabilities based
on functions that are required for all hazards (e.g., warning,
shelter, public safety, evacuation, etc.) (FEMA, 1983).

PLANNING FOR MENTAL HEALTH'S ROLE IN EMERGENCY RESPONSE AND

RECOVERY

Emergency management is a complex process. Organizations such as police, fire, emergency medical, health, welfare, public works, public utilities, and other government and volunteer groups all have specific duties and responsibilities. During an emergency, these organizations must pool their resources and work together as a well-coordinated team to protect life and property. The success of emergency management efforts depends upon smooth, effective interaction and communication among the many members of the emergency team.

Organizations and individuals must clearly understand their roles for the process to function efficiently. This is achieved by clearly specifying and describing the functions, duties, and responsibilities of each organization. Interrelationships among organizations must be spelled out, and roles and responsibilities must be regularly tested through drills and exercises. In this way, possible problems can be addressed prior to emergencies (New Jersey Office of Emergency Management, Dec., 1991).

To ensure the coordination of mental health emergency response efforts with activities of other response organizations in disaster, a mental health disaster plan is essential. A mental health disaster plan should be incorporated into each state's general state emergency plan. In many states, a mental health disaster plan is mandated by an executive order of the Governor. Similarly, each municipal, county, or regional department of mental health should have a disaster plan which is a component of the comprehensive emergency management plan of the jurisdiction. Some states have mandated this by legislation.

The purpose of the mental health plan is to ensure an efficient, coordinated, and effective response to the mental health needs of the population in time of disaster. It will enable mental health to maximize the use of structural facilities, personnel, and other resources in providing mental health assistance to disaster survivors, emergency response personnel, and the community (California Department of Mental Health, 1989; New Jersey Department of Human Services, 1991). The mental health disaster plan will specify the roles, responsibilities, and relationships of the agency to federal, state, and local entities with responsibility for disaster planning, response, and recovery. In addition, it will specify roles, responsibilities, and relationships within the agency in responding to disasters (South Carolina Department of Mental Health, 1991).

The mental health disaster plan needs to be organized so that it addresses each level and component of the department. It must also identify the respective individuals (by position) who are responsible to implement the plan. Individuals should all have backups, preferably three deep.

Mental health services to disaster survivors are provided in community locations where survivors congregate, such as shelters and meal sites. These sites are usually operated by the Red Cross in cooperation with social services or other organizations. In long-term recovery, mental health efforts need to be community-based and integrated with other human services to survivors. Because close collaboration is necessary with these

agencies, the mental health disaster plan should be coordinated
with or attached to the social services/shelter plan. In some
areas, mental health agencies have found it beneficial to have as
part of their plan a Memorandum of Understanding (MOU) with the Red
Cross delineating the roles and responsibilities of the two
agencies. Mental health services to survivors may also be provided
at hospitals, first aid sites, schools and the coroner's office.
Therefore, the mental health plan should be closely coordinated
with the health plan, the schools' plan and the coroner's plan.

EXERCISES

The mental health disaster team should participate in the regular,
official disaster drills of the jurisdiction. The role of mental
health response in disaster is very new in some areas. Working
side-by-side with more traditional disaster response agencies will
increase the knowledge of mental health personnel regarding roles
of other disaster responders. In addition, it will increase the
knowledge of other disaster agencies regarding the roles and
capabilities of mental health in disaster. It will help to
establish mental health as a regular and essential part of the
response team.

In addition, if mental health has disaster responsibilities agreed
upon with specific agencies, such as the schools, special exercises
of the conjoint disaster response will be important. If mental
health has agreed to respond to incidents such as a school suicide
or other tragedy, mental health response to those scenarios should
be practiced before the event occurs.

THE EMERGENCY OPERATIONS CENTER

Serious emergencies or disasters require organizational
coordination and communication beyond that needed in more routine
situations. The Emergency Operations Center, or EOC, facilitates
this communication. The EOC is usually under the jurisdiction of
local government, with the jurisdiction's emergency management
office responsible for its maintenance and operation. If disaster
needs escalate beyond the capacity of local resources, the Governor
may be requested to declare a state level of emergency, at which
point state resources are made available to the local jurisdiction.
In this situation, a state EOC may be activated. An EOC is
activated, operated, and closed according to a preplanned set of
policies and procedures (Herman, 1982).

The EOC is usually a predesignated site or facility, equipped and
supplied before the need for its operation. It is located away
from the disaster scene, usually in or near governmental offices,
in order to have access to needed records and resources. Many
older EOCs are located underground, with construction designed to
protect the facility against radioactive as well as natural and
technological hazards. This is no longer perceived to be a need,
however, and most newer EOCs are built above ground. EOCs are
usually designed to be self-sufficient for a reasonable amount of
time, with provisions for electricity, water, sewage disposal,
ventilation, and security. Food storage, preparation, and serving
facilities are desirable, as well as a bunk room or cots for tired
personnel. The EOC may have different rooms and areas for
different functions. Figure 1 illustrates the EOC of the
Pennsylvania Emergency Management Agency.

Ideally, each organization has a clearly designated worksite with communication equipment and status boards for recording information pertinent to the organization's area of responsibility. For example, social service/shelter operations will maintain a status board listing sites of open shelters and numbers of occupants and staff.

The EOC differs from a command post in two respects. First, the EOC is not usually at the site of the event. A command post is a facility at the scene of an emergency or disaster where site operations are directed. There may be multiple sites of impact and multiple command posts, with each command post having direct communications with the EOC. Second, the EOC facilitates overall, system-wide coordination of response among many disaster organizations. It does not focus on detailed operations at specific sites.

Functions of the EOC

The functions of the EOC include information management, situation assessment, and resource allocation. More specifically, these functions include the following:

        1.   Providing a common location of operation for individuals having top management responsibilities during the response and early recovery phase; providing centralized direction and control.
        2.   Ensuring clear delegation of responsibility and authority and establishing a clear chain of command.
        3.   Serving as the single point for collection, evaluation, display and dissemination of information; ensuring that decision makers in the EOC and in the field have adequate and accurate information.
        4.   Coordinating personnel, supply, and equipment on a priority basis.
        5.   Communication and direction to external response agencies.
        6.   Assessing the need for additional assistance such as mutual aid or requests to the governor for state and/or federal assistance.
        7.   Ensuring that affected populations are evacuated and sheltered.
        8.   Monitoring the situation and relaying warnings to local officials and the public.
        9.   Providing accurate public information and rumor control.

The Incident Command System in the EOC

EOCs must have a system in place for carrying out their diverse responsibilities and activities. The strategy most commonly used is the Incident Command System (ICS). ICS is an on-scene emergency response system developed by the fire service and increasingly being integrated into other emergency organizations and private industry. It provides for basic direction and control, including decision making and coordination among multiple agencies (Drabek and Hoetmer, 1991). It provides a chain of command that adapts to emergency events both large and small. In addition, it provides a common management terminology during times of stress (Russell,

1991).

It is an organizational structure divided into four sections:
operations, planning, logistics, and finance. Planning involves
acquiring information on current and future situations. Operations
directs activities to reduce the immediate hazard and to maintain
and/or restore essential functions. Providing for all support
needs such as food, communications, medical supplies, and the like
is the responsibility of logistics. Finance tracks all costs. The
functions can be performed by separate individuals simultaneously,
or one individual can perform two or more functions (Russell,
1991).

Staffing of the EOC

A community's characteristics, the size and scope of the emergency,
and the phase of response will determine which individuals will
need to be in the EOC at any point in time. Those individuals who
are needed in the EOC in the early stages of the emergency might
not be the same people who will be needed during later stages. In
the early phases, the EOC will likely be operating 24 hours a day,
which requires coverage for multiple shifts.

Although local government has overall responsibility for disaster
response, a variety of other public, private, and voluntary
agencies might be represented. Groups commonly represented include
the following:

     1.   Elected officials and top appointed officials
     2.   Office of Emergency Services personnel
     3.   Public safety (local and state police, county
sheriff, fire, emergency medical services, 911 communications)
     4.   Public works
     5.   Public health
     6.   Mental health
     7.   Social service/shelter operations (including
public social services, American Red Cross, Salvation Army, etc.)
     8.   Coroner
     9.   Schools
  10. Public utilities
     11.   Public information officer
     12.   Amateur radio volunteers
  13. Resource procurement personnel
  14. Finance personnel
     15.Support staff
(food, janitorial, clerical, stress management)

EOC representatives may be of two types: those with emergency
decision-making responsibilities and those who serve a liaison
function with other agencies and jurisdictions. It is vital that
EOC representatives responsible for decision-making come from the
top levels of management, representing the top person or
second-in-command in their organization (Herman, 1982), or have
been authorized to make decisions on top management's behalf.
Coordination is hampered when representatives at an EOC lack the
full authority, knowledge, and experience to make command and
coordination decisions. Unfortunately, those assigned to the EOC
often represent middle management levels of their organizations.
Mid-level managers often do not have the authority or experience
required for emergency decision-making. It is essential that the

EOC representative have in-depth knowledge of the capabilities of his or her organization and how its resources can best be activated. Retrospective analyses of emergency operations have shown that each representative must have sufficient rank and authority to make immediate, high-level policy decisions (Auf der Heide, 1989). In a declared emergency, the local emergency ordinance can give mid-level managers the necessary authority.

The EOC will likely have one or more support staff who provide services and supplies that keep the organization running. These staff might provide clerical support, switchboard functions, food and beverages, maintenance and janitorial services, and stress management.

Ideally, each agency represented at the EOC will use a team approach to manage shift coverage and any unexpected leave of absence. Orderly rotation of personnel is essential for decreasing the probability of dangerous errors due to fatigue. In addition, a team approach acknowledges the value of rest and interdependency as characteristics of successful emergency management.

Shift change proceedures should ensure communication and continuity between shifts. New shifts should be briefed on operations of the prior shift. An action log can provide the in-coming shift with brief written documentation of decisions and activities of the prior shift.

ROLE OF THE MENTAL HEALTH REPRESENTATIVE IN THE EOC

Not all jurisdictions' emergency plans call for a mental health representative in the EOC. Most municipal jurisdictions do not have a mental health department. In many county and state jurisdictions, mental health is a division of a larger department, such as Health Services or Human Services. In these cases, emergency plans often call for the department head to be present in the EOC, and mental health, as a subordinate division, is not represented.

However, it is strongly recommended that emergency management plans include a decision-making representative of mental health in the EOC. Representation legitimizes the importance of mental health's role both in the EOC and in the community-wide recovery efforts, and ensures that mental health resources are used appropriately.

The mental health EOC representative should be an individual specifically knowledgeable in the field of disaster mental health. This individual must also have the authority to make key decisions, and must have access to the most accurate information available in order to deploy mental health resources most efficiently and effectively. This individual must also be aware of decisions and actions of other agencies with whom mental health must coordinate efforts. He or she must also have information about decisions of other organizations that may affect mental health operations. Examples include such things as road closures that will affect mental health's access to an area, or the opening of additional shelters that will require mental health staffing. In addition, mental health expertise may be important to other key decision-makers when there are mental health consequences of particular decisions or actions. For example, a decision to provide mass shelter in separate facilities for men and women will

violate the basic disaster mental health principle that families
are a key source of stability for individuals, and family units
should remain intact.

In the EOC, the mental health work station should be situated close
to representatives from public health, emergency medical services,
social services, the Red Cross, and schools. In some EOCs, these
functions work together at the same table or in a room designated
specifically for them. Mental health will also need to work with
with the coroner if there have been deaths, in order to ensure
outreach and emotional support to the bereaved and, in some cases,
to the coroner's staff. The disaster mental health plan may call
for mental health to provide support to first responders in the
field (fire, EMS, law enforcement). If so, the mental health EOC
representative should work in close coordination with first
responder representatives in the EOC to ensure that services are
delivered where needed.

The responsibility of the mental health representative is to make
decisions about priorities and resource allocation, in coordination
with other agencies represented. He or she will also serve as
advisor to the top official in charge of the EOC (usually the
County Administrative Officer or the Office of Emergency Services
Director).

The mental health representative in the EOC will be providing
overall direction of the disaster mental health response. His or
her responsibilities are executive in nature. They are designed to
develop, direct, and maintain a viable organization and to keep
that organization coordinated with other agencies, elected
officials, and the public. As outlined by Auf der Heide (1989),
these responsibilities include:

              1.   Organizing to meet the needs of the disaster.
              2.   Establishing disaster mental health response
objectives.
     3.   Setting priorities for work accomplishments.
              4.   Approving resource and personnel orders and
releases.
              5.   Approving public information outputs.
     6.   Coordinating with agencies and public officials.

In all but the smallest jurisdictions, the mental health system
will need a disaster services field coordinator who will function
outside the EOC, most likely at the mental health administrative
office or alternate location. It will be the responsibility of
this coordinator to manage the deployment of staff and provision of
services in the field according to the directives of the EOC
representative. This coordinator will be responsible for keeping
the EOC representative informed of mental health activities and
needs for personnel, supplies, and equipment. The field
coordinator will also feed information about conditions in the
field back to the EOC.

In a very large mental health organization, the EOC representative
and field coordinator may require additional coordinators for
planning and logistical functions. A planning coordinator collects
data and provides the coordinator and EOC representative with
information about the incident. Information includes status of
resources, status of situations, and estimates of future needs for

the coming days and weeks. The planning coordinator may also
conduct planning meetings, prepare alternative strategies, and
compile action plans. The planning coordinator collects data for
and may prepare grant applications to FEMA for a Disaster Crisis
Counseling Grant as authorized by PL 100-707, Section 416.

A logistics coordinator will handle the pragmatic aspects of
deploying personnel, equipment, and services in the field. This
includes providing the services that "keep the organization going"
such as communications, food, shelter, security, and debriefing for
mental health staff in the field. In addition, the logistics
coordinator ensures adequate facilities, supplies, service
equipment, and other resources needed by staff in the field to
conduct their business (Auf der Heide, 1989). In very large-scale
disasters, military support may be necessary to provide logistical
support.

Communication between the EOC and mental health staff in the field
may be hampered if phones are inoperable. Cellular phones may be
valuable in areas with this service. Mental health might also
consider establishing a cooperative agreement with amateur radio
("HAM") groups, who routinely provide disaster radio communications
for such groups as the Red Cross. With such an agreement, radio
operators at the EOC and key mental health locations could provide
the needed communication linkage.

MENTAL HEALTH SUPPORT IN THE EOC

The climate of the EOC

Drabek and Hoetmer (1991) state that "no kitchen generates the kind
of heat found in the EOC." The social and psychological context
within which life and death decisions are made generates pressure
that is immense.

There is the ever-present need to take immediate action to prevent
or alleviate human suffering and physical destruction. The
pressure is intensified by scrutiny of the media and public
officials. The pressures are increased by the shortage of time:
during disaster, decisions must usually be made quickly if they are
to have any effect at all.

The climate of the EOC is also influenced by limited, uncertain,
rapidly changing, and often conflicting information. Available
information tends to be partial and imperfect.

Priorities for action may shift rapidly as new information is
presented. The principal priorities for emergency management are
to minimize loss of life, personal injury, and property damage.
However, the actions that support these priorities may change
during the course of the event. For example, a levee may fail
during a river flood, endangering a different part of town. A
previously safe shelter may become damaged in earthquake
aftershocks, requiring the opening of a new shelter and the
movement of evacuees.

In addition, the EOC climate embodies the stress that arises from
overlapping lines of authority and responsibility.
Interorganizational relationships in disaster necessitate resource
sharing and collaborative dependence. If authority or

responsibility is unclear, performance may be slow when time
pressures are great and response demands are high. The potential
for conflict and frustration is high both in the EOC and in the
field.

Drabek and Hoetmer (1991) further describe some unique stresses
that affect emergency personnel in the EOC. Staff can literally
not move around much. They are often confined to a table or work
station and its communication devices. They receive information
about the entire scope of the disaster, no matter where it occurs.
Thus, they are acutely aware of the extent of loss and suffering.
They have no direct contact with disaster victims, and cannot look
an individual in the face and feel personally responsible for
providing help.

In essence, the EOC climate is high-pressured and emotionally
charged. The level of stress must be managed if reasonable and
effective decisions are to be made quickly. Training, planning,
and regular exercises or drills can prepare staff to function in
such an environment. In addition, a preplanned stress management
component provided by experienced disaster mental health workers in
the EOC can help personnel to manage stress so that it does not
interfere with functioning.

Stress management in the EOC

Besides the executive role of mental health in the EOC, a mental
health representative may provide a support function to EOC staff
by providing stress management interventions. This support may be
in observing, advising, and intervening with disaster-related
stress among the EOC personnel.

If the EOC is not too hectic, the decision-making representative
may wear two hats and provide this support. In disasters of large
size or long duration, however, the decision-making representative
will be too busy managing the mental health response to the
disaster to provide stress management services in the EOC.
Therefore, it is recommended that a mental health staff member(s)
skilled in stress management be assigned as support staff to the
EOC. Preferably, these individuals should have training and
experience in disaster mental health.

The role of mental health support staff must be understood by other
staff in the EOC. Ideally, the staff member should be introduced
and his/her role explained by the top official in charge of the
EOC. It is helpful for the mental health representative to write
the script for the EOC director, to ensure that the role is
appropriately and accurately defined. This communicates that the
role is seen as important and has the sanction of the person in
charge.

Ideally, managers who have EOC responsibilities in disaster should
have predisaster training regarding disaster worker stress
management. They should be aware of the common stressors affecting
managers of disaster and to the stress reactions they are likely to
experience. Stress management and coping strategies effective in
such a setting can be taught. Policies and procedures can be
established predisaster to mitigate stressors and to help personnel
in managing their own stress and fatigue. For example, the
recommended policy for rest breaks is one break every 2-4 hours.

It is recommended that shifts be no longer than 12 hours in
duration followed by 12 hours of time off. If possible, a full 24
hour day off should be scheduled after each 7-10 day shift of work.
These policies should be explained as proven standards that enable
personnel to function at a higher level of effectiveness for a
longer period. Covering these policies and procedures in
predisaster training can instill them as a normal part of the EOC
routine. It can also help to prevent personnel from feeling
unfairly singled out when a break is suggested during EOC
operations (Mitchell and Bray, 1990).

Mental health support staff will be concerned with two levels in
addressing the needs of EOC staff: (1) the individuals, and (2)
the environment.

Individual interventions

With individuals working in the EOC, the mental health role will be
that of an observer and advisor. The mental health representative
may be particularly helpful when other staff members' effectiveness
has become diminished due to fatigue and stress. Common signs to
observe for include cognitive difficulties such as confusion,
memory problems, difficulty making calculations or setting
priorities, and difficulty making decisions. People may become
moody, irritable, or lose their temper. Some individuals may have
physical symptoms such as headaches, back pain, and tense muscles.
All these are common human reactions in the abnormal situation of
a disaster. The mental health worker must assess these reactions
in the context of the situation.

Myers and Zunin (1992) suggest that perhaps the most effective
style of mental health intervention in an environment like the EOC
is that of informally "roaming" through the worksite. This
involves circulating through the work units and break areas,
chatting with people, providing brief interventions, giving ad-hoc
stress management education, assessing the environment for
stressors, and occasionally making an "appointment" to see a person
individually during a break. This has been called the
"over-a-cup-of-coffee" style of intervention, in which stress
management staff simply interact in a "therapeutic" manner with
personnel. It has been shown repeatedly that emergency-oriented
staff respond best to an informal structure in engaging in
interactions with stress management or mental health staff.

If a worker's stress is interfering with his/her functioning, or is
impeding the work of the group, a short break may be helpful in
returning the individual to a higher level of functioning. Fifteen
to thirty minutes in a room away from the stimuli of the work
environment, with some food, beverages and perhaps some brief
stress reduction activities, is often all that is needed. The
mental health worker should suggest a break to the worker, and
accompany the worker on his/her break if the worker does not
object. This must be coordinated with the EOC manager so that
coverage of the individual's functions can occur. Coverage for
short breaks may be carried out by individuals with similar EOC
functions (for example, one law enforcement representative covering
for another). In cases where urgent decisions must be made, the
break can always be interrupted.

Individual mental health interventions in this setting are to be

brief in nature and are intended to return the individual to their
role in the EOC. Ideally, a separate, private room should be
available for an individual intervention. If this is not
available, a brief walk outdoors or in a corridor may be used.
Interventions will focus on the immediate here and now, and may
include the following (adapted from Santa Barbara CISD Policies and
Procedures, 1991):

      1.   ASK what is happening with the individual now,
what is the worst part of the situation for them? what will help
right now?

      2.   LISTEN AND REASSURE the individual that the
feelings are normal under the circumstances. Offer supportive
comments. Try to provide for the worker's stated needs.

      3.   INFORM the worker that the purpose of the break
is to get them back to work as soon as possible.

      4.   SUGGEST STRESS MANAGEMENT strategies that might
seem appropriate, such as deep breathing, progressive relaxation,
gentle muscle stretching exercises, or "self-talk." Diversionary
activities such as playing cards or reading a magazine for a short
while may help. Food and beverage should be suggested if the
worker has not eaten for a while.

      5.   LET THE WORKER REST. After chatting with the
worker, the mental health worker should allow him/her some
"breathing space" for 15 to 20 minutes. When checking back on the
worker, mental health and the worker probably can determine whether
the worker is ready and able to return to their work station.

Occasionally, an EOC worker may be so fatigued or so distressed by
the situation that a decision should be made to release the
individual to go home. If the person is highly upset, the mental
health worker will want to be sure that the person has safe
transport home, and that someone will be with them at home
(Mitchell and Bray, 1990).

The mental health support staff in the EOC serve an advisory role
to the EOC director. They may make recommendations to the director
about individual staff members who may need to take a break or be
relieved of duty until they are more rested. However, mental
health staff have no authority to order any of these actions. That
authority rests with the individual next in command above the
affected staff member or with the EOC director.

Disaster personnel in the "heroic phase" of response are often not
aware of the effects of stress on their functioning. Specific
feedback about their performance may need to be given to convince
them that they need to rest. Often, workers may resist the
suggestion that they take breaks or that they need time off-duty
for rest. Workers may actually need to be ordered to take breaks.
This is best accomplished by pointing out that the worker's role is
vitally important, and that it is essential for him to rest in
order to return to functioning at his full potential.

Mental health support staff should circulate throughout the EOC and
regularly check with other EOC representatives about the welfare of
their field personnel. Department heads can be reminded about the
importance of policies concerning breaks, length of shifts, etc.
for field personnel. Mental health staff in the EOC should make
sure linkages between field personnel and field mental health staff
are in place to provide appropriate mental health support. Mental

health support staff should not overlook 911 operators (whether functioning in or near the EOC, or in another facility). Environmental interventions

The mental health support staff will work with the EOC director and/or other support staff to ensure that, as much as possible, the EOC environment considers the psychosocial needs of the workers. Consultation might concern the physical environment, staff scheduling, or support and stress management services for EOC personnel.

The EOC is the "nerve center" of disaster operations. By definition, it will be hectic and noisy. Situations change rapidly, and workers need to adjust continuously to new information and new crises requiring their attention. The mental health worker will observe the environment and its activities, and advise the EOC director of any suggestions that might reduce the stress level. Consultation might concern EOC layout, with suggestions for noise reduction, traffic flow, groupings of workers, and the like. A quiet room or space where workers can get away from the bustle of the EOC on their breaks should be suggested if one is not already designated. A separate room for individual mental health interventions is also desirable. Adequate lighting, communication devices, supplies, and the like can all reduce frustration of the workers.

The basic needs of food, clothing, and shelter must be accommodated. Regular and healthy meals, snacks, and beverages should be emphasized. Staff should avoid excessive sugar and caffeine. If staff will be "living" in the shelter, arrangements for showers and clean clothing should be made. Sleeping space should be made as comfortable and quiet as possible.

A major concern for EOC staff will be the well-being of their family members. Most disaster plans encourage personnel to do what is necessary to ensure the well-being of their families before reporting for disaster duty. This may not always be possible for the high-ranking officials designated to staff the EOC. Sometimes, disaster conditions themselves may prevent personnel from learning about the whereabouts and situation of their loved ones. If a mechanism is not in place to try to locate and learn the status of EOC personnel's family members, mental health staff should consult with the EOC director about the importance of this function.

An EOC support staff member may be assigned the sole responsibility of locating families, using suggestions of EOC personnel as to individual family members' possible whereabouts, and using whatever communication systems are available.

It is recommended that jurisdictions establish a policy urging family members to contact the work site by phone or by any other feasible means during the emergency. In addition, policy should require personnel to complete a chart or form with the likely whereabouts of their loved ones during various times of the day. As noted by Tranchina (1991), these policies can provide some reasonable means for organizations to assist in locating family members of staff during major emergencies or catastrophes. Knowledge of family status can help staff to perform their duties without the added burden of worrying about family members.

A major family concern for EOC representatives may be care of their children for the duration of their work responsibilities. The provision of childcare for EOC and other disaster personnel should be a high priority in order to allow personnel to function with as much peace of mind as possible. The city of Oakland, California, as part of the city Emergency Plan, provides childcare on a 24-hour basis for children of emergency response personnel, including those working in the EOC. Trained childcare workers watch children at a location near the EOC, where personnel can visit their children during breaks and time-off (Renteria, 1992).

Mental health staff may provide consultation to the EOC director about stress management interventions and activities for EOC personnel. Advice about scheduling of breaks and time-off may be important. Diversionary activities such as magazines, cards, or games can be provided for use during off-duty time. In a busy EOC during response to the Loma Prieta earthquake, a masseuse provided needed relief to knotted necks and shoulders.

The healing properties of humor should not be forgotten. Laughter can break tension and provide relief from stress. It is not unusual for disaster jokes and cartoons to surface soon after a disaster. Disaster worksites often become decorated with cartoons that help workers keep some perspective and "lighten up" a bit in the midst of a difficult situation. Humor must be used with some care, however, as people are highly suggestible under stress. Both workers and survivors can sometimes take things personally and may feel angry or hurt if they feel they are personally the subject of a joke.

Pamphlets or video/audio tapes on stress reduction exercises can be provided, and mental health staff may help in teaching these techniques to personnel on or off-duty. Stress management "mini-breaks" can be conducted onsite during lulls in activity or during staff meetings or briefings. In five to ten minute sessions, mental health staff can give brief talks on sources of stress, coping strategies, and stress management techniques (Myers and Zunin, 1992). They can then lead personnel through a few stress management techniques, such as deep breathing or stretching tense muscles.

Mental health may also plan or provide stress management interventions for personnel after a shift in the EOC, after the EOC is deactivated, or after an individual's role in the EOC has ended. Ideally, policies regarding these activities should be in place before the EOC is activated. Interventions and activities might include a shift-end defusing (mini-debriefing), a demobilization meeting for all personnel when the EOC is deactivated, a formal debriefing, a critique, and formal recognition of EOC staff's contribution to the disaster response.

A demobilization meeting may be provided for personnel when the EOC is shut down. Such a meeting is short in duration, about 30 minutes, and serves as a "transition" from the operation back into the world. Usually, information is given about stress and the typical signs and symptoms that people experience (Mitchell and Bray, 1990). Mental health staff emphasize stress management techniques such as eating well, getting rest and exercise, avoiding abuse of alcohol or drugs, and returning to a routine (Hartsough and Myers, 1985). Handouts on stress and its management may be

given out. The person in charge, in this case the EOC director,
can make closing comments, and thank personnel for their work
(Ventura CISD policies and procedures, 1990; Mitchell and Bray,
1990). The meeting may provide an opportunity for ventilation of
feelings, but usually people are anxious to go home, and no one is
required to talk.

If the work has been highly stressful or traumatic for EOC
personnel, a formal debriefing can be arranged for all EOC
personnel who wish to attend. A debriefing is a meeting, led by a
mental health facilitator with special training in the technique,
which provides an organized approach to the management of stress
responses in emergency services (Mitchell, 1983). The mental
health staff member who has been working in the EOC will probably
have become an "insider" to the EOC team. Debriefers should not
have been participants in the situation they are debriefing. An
outside facilitator should be used, and the EOC mental health
personnel may attend the debriefing as "debriefee."

Different from a debriefing, but often equally important, is a
critique of the operation. While a debriefing focuses on the
psychological and emotional responses of workers, a critique is a
meeting for analyzing and evaluating the effectiveness of the
operation and recommending changes in policy and procedures for the
future. Calling a critique is the responsibility of the EOC
director. Mental health may suggest and encourage a critique, and
may provide a facilitator. A critique can assure that the input of
all participants is heard, and can be helpful in bring closure to
the operation. A critique and debriefing should not be combined in
the same meeting, as the agendas are quite different (Hartsough and
Myers, 1985).

Following a disaster operation, formal recognition of the workers'
participation can be very meaningful. Individuals in the EOC have
usually worked long hours under grueling circumstances, and a
letter in the individual's personnel file or a certificate of
appreciation will be much appreciated. After the Loma Prieta
earthquake of 1989 and the Eastbay Firestorm of 1991, several
agencies chose to give lapel pins to their employees in recognition
of their service. Staff wore them proudly, and they were
appreciated much more than a certificate would have been (Renteria,
1992). EOC support staff and staff outside the EOC who "minded the
store" while EOC staff were away from their regular jobs should be
included in the recognition. In situations where not all personnel
are recognized, or where some agencies provide recognition and
others do not, there can be feelings of disappointment and even
dissent among personnel.

SUMMARY

Because the field of disaster mental health is highly specialized,
mental health jurisdictions should have disaster plans that are
thoroughly integrated with the comprehensive emergency management
plan of their jurisdiction. It is advisable that in a disaster of
any magnitude a mental health representative with decision-making
authority should be present in the EOC. Mental health staff can
also play a vital role in providing stress-management functions for
EOC personnel during and after EOC operations.

CHECKLIST
DISASTER MENTAL HEALTH IN THE EMERGENCY OPERATIONS
CENTER

PREDISASTER

_____ Develop a mental health disaster plan that specifies responsibilities and functions of mental health, and addresses interrelationships with other disaster response/recovery organizations

_____ Develop Memoranda of Understanding with American Red Cross and other agencies as necessary to delineate roles and responsibilities

_____ Develop line of succession of mental health staff trained and authorized to assume responsibility in the EOC

_____ Train designated mental health staff with EOC responsibilities regarding the EOC, its functions, and their role in it

_____ Provide mental health staff having EOC responsibility with identification cards recognized and approved by emergency management and law enforcement officials

Provide instructions on EOC activation and access procedures

_____ Participate in EOC functions in disaster exercises

_____ Have necessary mental health supplies preassembled at EOC

DISASTER RESPONSE

_____ Notify and/or activate mental health personnel with key responsibilities (field coordinator, planning coordinator, logistics coordinator)

_____ Put on identification; report to EOC

_____ Establish liaison, obtain briefing on conditions, and meet regularly with representatives from Red Cross, schools, social services, health services, the coroner, and others as appropriate

_____ Collect, assess, and display information regarding locations needing mental health staffing, available mental health resources, and mental health resources deployed

_____ Provide direction to mental health field coordinator regarding priorities for response, deployment of personnel and resources

_____ Transmit incoming and outgoing information between EOC and mental health field coordinator regarding field conditions

_____ Determine need for mental health mutual aid resources and forward request through appropriate channels

_____ Provide information to the community, through Public Information Officer (PIO) or other designated channels, regarding common psychological responses to disaster, stress management suggestions, and where to obtain mental health assistance

_____ Document all actions and decisions

_____ Provide or obtain mental health support for EOC personnel

_____ Provide consultation to EOC director regarding EOC environment, the importance of breaks and limited length of shifts, needs of individual personnel, and stress management in the EOC

_____ Ensure that EOC personnel are briefed by EOC director as to the role of mental health support staff in the EOC

_____ If not already taken care of, help with arrangements for food service; an area for breaks and/or recreation; a sleep area; showers; and a private area where brief individual intervention may take place

_____ Assist in establishing mechanism for EOC personnel to obtain information about location and welfare of their families

_____ Observe personnel for signs of stress and fatigue; circulate among personnel to provide support, brief intervention, stress management suggestions, and assistance as needed

_____ With agreement of EOC director, provide or arrange for demobilization for EOC personnel at the end of EOC operations

POSTDISASTER

_____ If conditions in EOC were highly stressful or traumatic for personnel, arrange for debriefing (with agreement of EOC director)

_____ Encourage and participate in critique of EOC operations; arrange for mental health staff to facilitate critique if appropriate

_____ Encourage recognition of disaster response roles of EOC personnel, including support staff and those outside the EOC who "minded the store" while EOC staff were away from their regular jobs

_____ Revise mental health disaster plan, policies, procedures as appropriate based onrecommendations in critique

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THE USE OF VOLUNTEERS
AND MUTUAL AID PERSONNEL
IN MENTAL HEALTH DISASTER RESPONSE

The mental health agency charged with disaster response services will be faced with having to staff and maintain its standard mental health programs as well. Because most publicly funded mental health programs are limited in size and budget, it is likely that additional staffing will be needed to manage both operations.

Because local government has overall responsibility for disaster response activities, in all likelihood the coordinating agency for disaster mental health response will be the county mental health agency. In some states the state department of mental health provides all mental health services in local jurisdictions, and will be in charge of disaster-related mental health services. In a few locales, there are city mental health agencies that assume responsibility for the mental health response within their boundaries following disaster.

Staffing can come from several sources. One option is for the mental health agency to hire additional personnel. Frequently, however, budget constraints do not allow this option without additional funding. In a presidentially declared disaster, an Immediate Services Crisis Counseling grant from the Federal Emergency Management Agency (FEMA) will pay for the hiring of additional staff. However, the local agency will not know if its grant application is funded until several weeks after the disaster. Therefore, in most circumstances, mental health must augment staffing from two other sources: (1) volunteers or (2) mutual aid personnel from other agencies or jurisdictions.

Volunteers are mental health professionals who have offered to help without reimbursement. They may be in private practice or employed by other agencies. Mutual aid personnel are professionals from other agencies who have accepted voluntary assignment through their agency. These "volunteers" continue to receive pay from their agency during their disaster assignment.

Reimbursement for both volunteers and mutual aid personnel salaries

may be recouped through the FEMA Crisis Counseling Immediate
Services grant if those costs are specifically requested and
approved in the grant. However, the local mental health agency
should be careful to emphasize that they cannot guarantee such
reimbursement at the outset. Volunteers and mutual aid entities
should be prepared to assume responsibility for their own salaries
and expenses.

Most states have a mutual aid system designed to ensure that
additional resources are provided to local jurisdictions whenever
their own resources are insufficient. The mutual aid system is
usually adopted by all counties, and creates a formal structure for
giving and receiving help. Cities and counties may request
assistance from each other or may request assistance through the
state Office of Emergency Services, which will help in the
coordination of resources from other counties, the state, and the
federal government.

Mutual aid agreements typically include assistance such as fire,
rescue, law enforcement, medical services, coroners, public works
and engineering. Mental health may or may not be included, either
as a separate entity or under medical services. Local mental
health agencies should learn whether they are covered in the state
mutual aid plan. If they are, it is critical to understand how to
request assistance through the chain of command.

If mental health is not part of the state mutual aid system, mental
health agencies will need to develop resources and systems for
obtaining additional assistance in time of disaster.

Preplanning can diminish the disorganization and stress that can
occur when attempting to meet disaster staffing requirements. The
effort to find, select, mobilize, organize, orient, train, deploy,
supervise, feed, shelter, debrief, disengage, and provide thanks
and recognition to a cadre of unknown personnel is a Herculean
task. For this reason, law enforcement, fire and emergency medical
service jurisdictions have developed mutual aid agreements as part
of their normal operating procedures. The midst of an emergency is
not the preferred time to be thinking through the logistics
involved.

PREDISASTER

The first step is for the local mental health agency to develop a
disaster mental health plan.   The plan should outline what
disaster-related services would be provided under what
circumstances. It is helpful to consider the different levels of
emergency that might occur. Such levels would include minor
involvement (a site-specific incident, e.g., suicide at a school),
mid-level involvement (larger scale event, e.g., a plant explosion
with many deaths), or large-scale involvement (e.g., a major
disaster). Some mental health jurisdictions will not have the
capability to respond to small or mid-level events, and will limit
their disaster plan to mobilizing only in case of major disasters.

The mental health agency should integrate its disaster plan with
the local emergency management plan. The local office of emergency
management may help mental health in developing formal mutual aid
or cooperative assistance agreements with other mental health
jurisdictions or groups. The mental health disaster plan should

have a predesignated position for coordinator of volunteer and
mutual aid resources.

Identification of potential disaster staffing requirements

The mental health plan should identify which services would most
likely be provided should a disaster occur, potential sites for
mental health service delivery, and the degree and duration of
staff involvement for each level of emergency.

It is equally important for mental health administrators to examine
which day-to-day responsibilities can be suspended or curtailed in
the time of disaster, and which activities are essential. For
example, some outpatients could conceivably be seen less frequently
during the disaster response, assuming they are fairly
well-functioning and not immediately impacted by the disaster.
This knowledge will help the mental health agency in making some
estimates about how much staffing can be provided to the disaster
response and how much mutual aid may be needed in any given
scenario.

Identification of potential tasks for mutual aid personnel

Mental health should identify which job tasks (both
disaster-related and day-to-day) can be delegated to a volunteer or
mutual aid worker. Potential jobs include the following:

        1.   Clerical support, including record keeping and
compilation of statistics, typing of the grant application,
answering phones, etc.
        2.   Development of educational materials
(brochures, public service announcements, etc.).
        3.   Assistance with coordination of services and
logistical support for mental health staff in the field. If
possible, the mental health agency should bring in a consultant or
mental health disaster coordinator who has managed a large-scale
disaster operation. This individual can provide assistance to the
local mental health disaster coordinator.
        4.   Assistance with grant writing.
        5.   Outreach and crisis counseling at community
sites.
        6.   Community support groups and debriefing groups
for survivors and disaster workers.
        7.   Training of mental health and other
professionals in disaster mental health principles and
interventions. Training should be provided by an individual with
a thorough understanding of disaster mental health concepts and
practices, and with experience in disaster.

Clear delineation of local mental health agency responsibilities

The local mental health agency must maintain control and integral
involvement in the field-based disaster response. There are
several reasons for this "hands on" involvement. First, it is
vitally important for ongoing needs assessment in the community.
Secondly, and of equal importance, local mental health staff need
to be visible and accessible to the locally impacted population.
Some continuity of staffing is essential for the community's trust
of the local mental health program. Otherwise, services are
delivered by individuals who disappear at the end of the immediate

emergency. Survivors feel "abandoned" and have to get to know a
new cadre of workers. The local mental health program or its
designee will most likely manage or provide the long-term recovery
program if a FEMA Immediate Services and Regular Program grant is
obtained following a presidentially declared disaster.

Local mental health staff know the demographics of the community,
including ethnic populations, social and economic age groups,
community needs, and formal and informal community resources.
Local mental health staff must make this knowledge available to
volunteers. Both local staff and volunteers play a vital role in
linking survivors with local resources.

Identification of volunteer resources

Before a disaster, mental health can assess the capabilities of
potential volunteer groups. It is possible to survey professional
associations (e.g., psychiatrists, psychologists, social workers,
psychiatric nurses, and clergy) and clinicians in private practice
to learn their interest, capabilities, and availability. Ideally,
a disaster mental health response should be multidisciplinary, so
as many groups as feasible should be contacted.

It is useful for mental health to have a ballpark estimate of what
resources any given organization could mobilize, if needed. A list
of suggested items for assessing capabilities of potential mutual
aid sources is included at the end of this chapter.

Typically, recruiting enough bilingual staff is difficult. Special
efforts should be made predisaster to identify both local and
out-of-county mental health personnel who can provide services in
those languages present in the community. The mental health agency
should identify personnel with signing capabilities for
communicating with hearing impaired individuals.

It is recommended that mental health agencies consider
prescreening, selecting, and training a cadre of individual
volunteers from the community who would be available for service in
time of disaster. Potential volunteers can fill out an application
that is reviewed predisaster. The mental health agency then makes
a decision regarding acceptance of the individual for the disaster
response team. The selected volunteers could then participate in
regular training and drills with the predesignated disaster
response staff from the mental health agency.

A list of recommended items to include on such a volunteer
application form is included at the end of this chapter.
Applications of those volunteers not immediately selected should
not be discarded, but kept on file in case additional volunteers
might be needed.

Once selected, it is suggested that volunteers sign a statement
with wording such as "I understand that my time/service is
volunteered and I will not receive compensation for such services"
(Project COPE, 1983). In addition, volunteers should sign any
usual forms which mental health requires, e.g., an oath of
confidentiality. If the mental health agency has a policy
regarding self-referral to private practice (e.g., requiring review
by a panel of clinicians or by the clinical director), volunteers
should sign a statement of understanding of the policy. Volunteers

can be issued official identification predisaster or at the time of
mobilization.

Identification of mutual aid resources

For mutual aid resources, mental health can contact public or
private mental health agencies within the community. Examples
might include Family Service agencies, Catholic Social Services,
Jewish Family Service, and public or private hospitals with mental
health resources and expertise.

Some communities may have a critical incident stress debriefing
(CISD) team in place. A CISD team is a collaborative effort
between mental health professionals and trained peers from
emergency service agencies (police, fire, emergency medical
services). The purpose of the team is to provide support services
to emergency workers in dealing with the traumatic or critical
incident stress associated with their jobs. A team can provide a
variety of postincident interventions, including critical incident
stress debriefing. Debriefing is a group intervention that helps
workers in coping with the intense thoughts, feelings, and
reactions that are common following a critical incident. Teams are
highly specialized to allow members to understand and intervene
appropriately with emergency personnel.

If a CISD team exists in the community, the local mental health
agency should meet with the team leader predisaster to clarify
roles and responsibilities during a disaster. Because there is not
always consistency on a national level regarding amount and type of
training of CISD teams, the mental health agency should clarify the
exact capabilities of the CISD team. The CISD team will likely be
the logical resource for providing postdisaster assistance to
disaster responders, so that mental health does not have to
duplicate the effort. If the CISD team wishes to provide services
to the civilian survivor population, however, they must obtain
additional training in disaster mental health interventions with
non-responder populations.

The American Red Cross is developing its own cadre of mental health
professional volunteers. The intention is to provide services
primarily to Red Cross workers, but services may be provided to
survivors as well in some situations. Disaster Mental Health
Services policies and procedures (American Red Cross, 1991), and a
Disaster Mental Health Provider's Course have been developed by a
Red Cross national task force. Once uniformly in place, the course
will help local Red Cross chapters to train volunteer mental health
providers who will be assigned a variety of roles at Red Cross
disaster service sites, including shelters.

Local mental health agencies should establish collaborative
relationships with the local Red Cross chapter predisaster. Local
mental health may also undertake mental health activities in the
shelters, in which case roles and responsibilities of the mental
health agency volunteers and Red Cross mental health volunteers
should be spelled out before a disaster. The local mental health
agency should also develop a referral procedure with the Red Cross
team. This will ensure the continuity of services to survivors
after the shelter operations close down and Red Cross mental health
volunteers are no longer active. A formal memorandum of
understanding between the local Red Cross chapter and the local

mental health agency is recommended.

In areas where Red Cross mental health services have been established, they are designed to supplement the local community mental health delivery system in time of emergency (American Red Cross, 1991). In communities where local mental health resources are limited, Red Cross may take a more active role in providing disaster mental health services. Red Cross mental health assistance does not extend beyond assessment of mental health status and needs, stress reduction, brief counseling, crisis intervention, referral, and follow-up recommendations (American Red Cross, 1991). The responsibility for services to individuals requiring more intensive or long-term care will rest with public or private sector mental health resources. Rapport and trust between mental health providers and disaster survivors are best established in the early phases of disaster. Therefore, local community mental health staff should be present in the disaster shelters even if Red Cross has its own cadre of volunteers.

In the event of a large-scale disaster adjacent counties will likely be affected. In this case mutual aid may be needed from outlying counties or jurisdictions. In such a scenario, it will be extremely useful if the state mental health agency has conducted a predisaster assessment of mutual aid mental health resources throughout the state for use in time of disaster. If it exists, such a state directory of mutual aid resources and procedures for procurement should be updated annually and distributed to all county mental health disaster coordinators.

Development of a volunteer/mutual aid resource list and formal mutual aid agreements

Once volunteer and mutual aid resources have been assessed, the mental health agency should develop and annually update a directory of resources. The resource directory should include the name, address, and telephone number of contact persons and their alternates. An additional copy of the list should be kept at the local Emergency Operations Center.

The local office of emergency management is responsible for establishing mutual aid or cooperative assistance agreements with jurisdictions that can provide needed services, equipment, or resources in case of an emergency. They can help mental health in developing formal mutual aid agreements with the resources that have been identified. In time of emergency, these mutual aid resources can be formally activated through the Emergency Operations Center at the local level.

Development of an integrated public/volunteer response team

Some mental health jurisdictions have a formal cadre of volunteer and mutual aid responders whom they recognize as part of the agency's disaster response team. The mental health disaster plan includes policies and procedures for the volunteer as well as the agency components of the team. Through the process of periodic meetings, training, and exercising of the response plan, team building takes place. When a disaster occurs, individual team members are not total strangers to each other. They have a common base of knowledge and skills, and have an accurate, realistic understanding of roles, responsibilities, and chain of command.

The cost associated with predisaster team involvement may be an
issue for some volunteers or potential mutual aid groups. Private
practice clinicians and agencies alike may have to forfeit
income-generating activities to attend disaster training and
drills. In addition, agencies will usually be paying their staff's
salaries during their participation. The benefit to these
agencies, however, is that their staffs are receiving valuable
training that is applicable to many crises, not only large-scale
disasters. Training is usually provided at the expense of the
mental health agency sponsoring the team. In addition, disaster
work is exciting and rewarding. For many mental health
professionals, predisaster involvement in disaster training and
exercises add a new and interesting facet to their work, with a
boost in staff morale as an immediate result.

Legalities and liabilities

Local mental health agencies should work closely with their risk
management officers to develop plans for using volunteers and
mutual aid personnel. It should be clearly understood by both the
mental health agency and volunteers who is responsible for workers'
compensation or disability coverage if a worker is injured on the
job. Also, it should be clear who is responsible for general and
professional liability coverage. Some jurisdictions deal with
these issues by having volunteers sign a volunteer contract, which
then formally brings them under the umbrella of the agency and its
insurance coverage. After the Coalinga, California earthquake of
1983, the Seismic Safety Commission recommended formal registration
of volunteers as civil defense workers so they would be covered by
workers' compensation policies (Seismic Safety Commission, 1983).
Formalized mutual aid agreements can help to avoid legal and
liability questions between agencies and jurisdictions.

Training and exercises

For a mental health disaster response to be appropriate and
effective, training is essential. It is recommended that mental
health agency personnel be trained conjointly with individuals
identified in the community who are likely to be volunteer or
mutual aid responders. This book's chapter on training covers
topics and issues important to training. An essential component of
the training should be the mental health disaster plan, including
activation of the disaster response team; when and where to report;
types of services to be provided; sites of service delivery; and
roles, responsibilities, and chain of command. Besides training,
regular exercises for practicing response actions and skills are
critical.

DISASTER RESPONSE

In the event of a moderate or large-scale disaster, mental health
will need to assign at least one individual as coordinator of
volunteer and mutual aid resources. Volunteers themselves can
sometimes help with some facets of this coordination.

Activation of mutual aid agreements

If formal mutual aid agreements are in place, they should be
activated by the mental health representative in the EOC, using

local government's official mutual aid procedures. While the
mental health volunteer coordinator will likely function from the
mental health office, rather than the Emergency Operations Center,
all volunteer recruitment and deployment should be coordinated with
the mental health representative in the EOC.

Identification of resources

If mental health has not identified potential volunteer and mutual
aid resources predisaster, the steps outlined above for identifying
resources will need to be followed. The volunteer coordinator will
immediately begin contacting individuals and agencies who can help.
A telephone tree can be used to contact other counties for
assistance. Several counties can be called and each is asked, in
turn, to contact several others. The mental health agency can put
out a call for volunteers via the media, through the local public
information officer, with procedures for where volunteers should
call or check-in.

In all likelihood, volunteers and mutual aid resources will begin
contacting the impacted mental health agency in person or by phone,
or will simply begin appearing at disaster sites such as damaged
neighborhoods or shelters.

Convergence of volunteers

The convergence of volunteers, well-meaning but often untrained or
unsuited to the job to be done, is a universal phenomenon in
disasters. Quarantelli (1965) points out that "whatever planning
is undertaken, it can rarely prepare for the quantity and quality
of volunteers that appear." The United States has a long and
vigorous tradition of volunteerism in the fire service, in
ambulance services, and in many social and philanthropic causes
(Auf der Heide, 1989; Dick, 1982). This altruism does not vanish
in the face of disaster. If anything, it becomes stronger
(Quarantelli, 1970; Dynes, 1970).

Organizations often have difficulty coordinating the efforts of
volunteer workers, especially if people have never worked together
before. Volunteers have varying skill levels, knowledge of
community resources, and in all likelihood are unfamiliar with the
organization's routines and operating procedures. Difficulties
with volunteers may be lessened if procedures are developed to
integrate them into the formal organizational response. Even if
mental health has a preexisting cadre of volunteers trained in
disaster response, the agency should be prepared to deal with the
convergence of additional volunteers.

Screening of spontaneous volunteers

One approach is to develop a check-in area where volunteers can
report and where an inventory can be made of their skills,
abilities, and experience. The check-in area might only be open
several hours a day, with hours posted and advertised. It is
important for security personnel at roadblocks to be aware of the
check-in areas for volunteers and to direct volunteers to these
locations.

Another approach is to screen volunteers by phone. Following the
1989 Loma Prieta earthquake, volunteer groups nationwide called the

California Department of Mental Health offering their assistance. The Department compiled the offers into an "Earthquake Emergency Resource List" which it updated and faxed daily to the mental health department in each impacted county. Counties then made their own requests for assistance directly to the persons on the list. The resource list included the name and title of the caller, phone number, agency they represented, resources available (numbers and types of staff, language capabilities, written materials, etc.), and whether they had been committed to a certain county. Local mental health agencies can duplicate this procedure by screening and logging offers of assistance. Resources can then be called upon as needed.

Individual volunteers will need to be screened for appropriateness of their knowledge, skills, and experience. While this is not easy in the midst of disaster response, it is possible. Spontaneous volunteers should be asked to fill out the same volunteer application form used for prescreened volunteers. The volunteer coordinator can then review the application and decide the appropriateness of the applicant.

Free lance volunteers

Most likely, there will be more than a few mental health volunteers who show up at disaster sites without any linkage to the formal mental health response. If mental health staff are already established at the site, they should talk with the volunteer(s) and clarify the roles and responsibilities of the mental health agency in directing and providing mental health services. Usually, the volunteers are well-intentioned and simply do not understand the organizational structure of disaster response. Once it is explained, they are usually happy to work within the existing structure.

In some situations, mental health volunteers will continue to work independent of the mental health agency.   This can cause confusion among disaster response organizations who may assume that the volunteers are part of the official local response. It can also result in conflict if an independent group of volunteers establishes itself as a service provider for a survivor group that is the responsibility of the local mental health jurisdiction. Sometimes, freelance volunteers with no prior experience or training attempt to participate in disaster response. During rescue operations at the Cypress Structure freeway collapse in Oakland, California after the Loma Prieta earthquake, many experienced disaster mental health workers, working for county mental health, were approached by volunteers. These inexperienced volunteers asked them if they had "any kind of guidelines for how to run a debriefing" before providing interventions for rescue personnel. In more than a few instances, mental health "volunteers" not under the umbrella of the official mental health response have engaged in practices of borderline ethics. Examples include handing out personal business cards, referring individuals to their private practice, and billing groups for services provided at the disaster.

For these reasons, it is critical that the local mental health agency maintains a directory of volunteers who are working under its auspices. The agency should have official identification cards for volunteers, which are recognized by law enforcement and

emergency management personnel. If a question arises in the field
about whether a mental health volunteer is representing the
official mental health agency, a check of identification or of the
official volunteer list should be made.

Deployment of volunteer and mutual aid personnel

Ideally, volunteers should work in teams with known coworkers. Of
course, this may not be possible for individual private
practitioners. Mutual aid agencies sending personnel, however,
should always try to send two or more individuals. Coordination of
volunteers can be enhanced if assignments are made keeping these
work groups in tact. This provides the workers a "buddy" system
for both support and stress management. In addition, it can
preserve the existing coordination and communication procedures of
intact groups. The quality of volunteers' contributions to
disaster activity is improved if their organizational structures
are kept in tact (Dynes, 1974).

For groups of workers coming from outside the disaster area, it is
advisable that each group be asked to commit to a tour of duty of
at least one week in length. When groups come into an area for
only a day or two, the time required to brief, train, and debrief
them significantly reduces their service time, and unnecessarily
taxes the volunteer coordinator's efforts.

Mental health will probably have to provide some help to mutual aid
staff in finding living accommodations in the area. At the very
least, a list of hotels and motels will be helpful to volunteers in
making their own reservations. The mental health volunteer or
logistics coordinator may take on the task of making hotel
reservations for personnel, but the job is enormous and is best
left to the volunteers.

Most emergency agencies using mutual aid in a large-scale disaster
use the concept of a staging area for briefing incoming staff and
demobilizing departing personnel. If a situation is urgent,
personnel will be sent immediately to the scene. Mental health is
rarely involved in lifesaving efforts, however, and utilizing the
staging area approach to deployment of volunteer teams can help to
simplify coordination.

For mental health's purposes, the staging area can be a large room
at the mental health agency or community meeting hall. Volunteers
should be told the time and day to report to the staging area for
field assignment and orientation prior to their deployment. No
volunteer is to report to their field assignment before attending
an orientation. An orientation can also be conducted in the field,
but orientating volunteers at numerous sites becomes time-consuming
and fragmented.

Volunteers need to know what to bring with them to their disaster
assignment, including whether they must provide their own
transportation for use in the field. If mutual aid workers are
providing their own transportation, they should be asked to bring
at least one vehicle for every two workers. This allows mutual aid
teams the mobility to cover numerous sites.

Mutual aid workers should bring personal supplies that will enable
them to be fairly self-sufficient once in the field. The chapter

on Support and Stress Management for Disaster Mental Health Staff
provides specific suggestions.

Orientation of volunteers

It is strongly suggested that mental health schedule no more than
one orientation session per day (preferably, two or three per
week). Volunteers can be oriented in large groups. If possible,
the orientation should be kept to under three hours. The chapter
on Selection and Training of Disaster Mental Health Staff includes
topics to be included in the orientation. Volunteers should sign
any necessary forms and be issued identification.

Training and supervision of volunteers

Volunteers selected for disaster response should ideally have prior
training and experience in disaster or large-scale crisis
intervention. Sometimes, however, volunteers without such
experience are the only staff available. In such situations,
"quick and dirty" brief training will be critical before deploying
volunteers. Every effort should be made to link inexperienced
volunteers with more experienced workers. A great deal of "on the
job training" can take place in the field. For instance, an
experienced outreach worker can show a new volunteer, by example
and discussion, effective techniques such as "working the floor" of
a disaster shelter or Disaster Application Center.

The mental health agency should provide more in-depth training as
soon as possible, utilizing an experienced disaster consultant or
trainer whenever possible.

A basic principle of mutual aid is that the responsible local
official in whose jurisdiction an incident has occurred shall
remain in charge of mutual aid personnel (California Disaster and
Civil Defense Master Mutual Aid Agreement, 1980). This also holds
true in supervision of volunteers. The local mental health agency
remains responsible for the supervision of volunteer and mutual aid
personnel in the field.

Working as a volunteer in a traumatized community

Following a disaster, relationships among survivors take on a
special power. There is a sense that "outsiders" cannot possibly
understand the survivors' reality, and a boundary may develop to
safeguard the traumatized community from harm and to promote
psychic healing. Lindy and Grace (1986) have termed this
psychosocial boundary the trauma membrane, which has meaning at the
intrapsychic, interpersonal, and community level. Like a newly
developing outer surface of an injured cell, the trauma membrane
forms to guard the inner reparative process of the organism and
protect it from noxious stimuli. The membrane seems to have early
permeability to anyone willing to help, but this boundary later
becomes tightly sealed and outsiders are allowed in only under
certain circumstances and functions.

Disaster response agencies in a traumatized community may,
themselves, develop a trauma membrane concerning helpful
"outsiders." The psychological issues of vulnerability,
helplessness, and need for control are as evident in agencies as
they are in individual survivors, and require equal respect and

sensitivity. The healing process involves reestablishing and maintaining a sense of control. As a result, a traumatized agency may develop ambivalence about wanting or not wanting help from outside resources. While agencies such as community mental health may recognize the need for outside assistance, they may experience ambivalence or outright distrust of volunteers "meddling in our disaster."

Mutual aid personnel coming into a traumatized community can be met with a confusing mixture of gratitude and resentment. Volunteers may experience scrutiny, ambivalence, double messages, and being pushed and pulled in different directions.

Early integration in the formal, local mental health response, before the trauma membrane closes, can enhance collaboration. It is essential for mutual aid personnel to respect local agency authority, control, and self-determination. If volunteers "jump in" and attempt to help without being well integrated into official local efforts, they will likely alienate local leadership and generate turf issues. Confusion often arises as to "who is providing services to whom," and there are often problems of continuity and unnecessary duplication. Such well-meaning but organizationally naive volunteers are often denied access to survivors because their activities are outside the official disaster response.

Recognizing and understanding the concept of the trauma membrane can help volunteers to avoid some pitfalls in gaining access to survivors and providing needed assistance to disaster stricken communities.

Disengagement, critique and debriefing

Workers should not be sent home from their disaster assignment without a formal process of disengagement. The simplest way to handle the logistics is for all outgoing personnel to report at an assigned time at the staging area. Staff should ideally be disengaged from their assignments in teams who worked together in the same field assignments.

The purpose of a formal disengagement process is to help workers in making the transition from the disaster assignment back to their homes and regular jobs. Details of the disengagement processes are included in the chapter on Support and Stress Management for Disaster Mental Health Staff.

It is common for volunteers and mutual aid personnel returning home to an area not affected by the disaster to experience a sense of isolation. They often feel that no one has seen what they have seen and no one understands what they have been through. It is helpful for workers to continue to talk to each other about their experiences and feelings. For workers who did not come to the disaster with a team of co-workers, it may be helpful for them to exchange phone numbers and addresses with their disaster colleagues for postdisaster support.

POSTDISASTER

Thanks and recognition

While disaster work is inherently exciting and rewarding, it can also be challenging, stressful, exhausting, and traumatic. For volunteers who have worked without pay, the work may cut into their personal budget. For workers "on loan" from mutual aid agencies, work piles up on their office desks while they are away. A sincere attempt by the host mental health agency to learn the first names of volunteers during their disaster stay pays immediate dividends in terms of feelings of recognition, self-esteem and a sense of personal appreciation. It is also extremely important for mental health to provide a thank-you to those who volunteered. Ideally, a letter of thanks should go to each worker. If this is not possible, a letter should go to each contributing agency with a request that each worker receive a copy. The letter of thanks should come from a high ranking official such as the county mental health director, the county administrator, or a member of the Board of Supervisors. If possible, a certificate of recognition with the volunteer's name on it should accompany the letter of thanks. Such "small" remembrances are always deeply appreciated by the volunteers who gave so much of themselves.

Incorporation of lessons learned

It will be helpful in future disasters to have a written chronology of events and lessons learned. It is advisable for the volunteer/mutual aid coordinator to write an after-action report, including what worked and what didn't. Appropriate input from critiques should be included.

Besides the after-action report, "lessons learned" should be incorporated into the mental health disaster plan, policies and procedures, with resulting changes communicated to staff in the next regular disaster training.

SUMMARY

The logistics of recruiting, deploying, supervising, caring for, and demobilizing a cadre of volunteers and mutual aid personnel can be very complicated. The task is best managed if planned for in advance, with an assessment of potential resources and, ideally, a preselected and trained team of volunteers. Even with a predesignated team, however, mental health will likely be faced with a convergence of spontaneous volunteers. This chapter outlines the issues and challenges that need to be addressed, with suggestions from mental health managers who have faced the challenge in the past.

ASSESSMENT OF POTENTIAL MUTUAL AID RESOURCES

        1.   How many personnel can be sent?
     2.   That are their capabilities, including:

                a.   Formal education, degree, license,
insurance.

                b.   Specialized training and experience
in disaster, crisis, traumatic stress, grief intervention.

                c.   .Ethnicity and language skills,
including signing.

d.   Skills with special populations
(children, families, older adults, people with disabilities,
emergency responders).

e.   Other special skills (first aid,
amateur radio operator, etc.).

3.   What types of services can they provide
(clerical support, development of educational materials, grant
writing, outreach, crisis counseling, support groups, debriefing
for survivors and workers, training)?

4.   How soon can they be available and what is the
estimated time of arrival?

5.   Can they be self-sufficient in arranging
transportation and housing in the disaster area?

6.   How long can they remain on temporary
assignment?

7.   Are they available without reimbursement?

ITEMS TO INCLUDE ON VOLUNTEER APPLICATION

1.   Name, address, phone number, message phone
number.

2.   Formal training.

3.   Licensure, license number and date of
expiration (xerox copy of license, if possible).

4.   Are they covered by malpractice insurance?

5.   Specialized training and experience in crisis,
disaster, trauma, grief or critical incident stress intervention.

6.   Other special skills or training.

7.   Experience with special populations (children,
older adults, people with disabilities).

8.   Hours and times available (if only a few hours
a day); can volunteer be available for disaster assignment of one
week's duration?

9.   Locations in which the person can work (e.g.,
areas of the county).

10. Types of service the person can provide (crisis
counseling for survivors; debriefing for workers; support groups;
outreach to schools; developing written materials; training, etc.).

11. A signed form stating "I understand that my
time/service is volunteered and I will not receive compensation for
such service." This item can be waived if a FEMA Crisis Counseling
Grant is being applied for and includes a budget for retroactive
reimbursement of volunteer/mutual aid personnel.

CHECKLIST
THE USE OF VOLUNTEERS AND MUTUAL AID PERSONNEL

PREDISASTER

_____   Identify potential staffing needs for
disaster response

_____   Identify potential roles for
volunteer/mutual aid personnel

_____ Specify mental health agency roles and responsibilities vis-a-vis volunteers and mutual aid personnel

_____ Designate position of volunteer/mutual aid coordinator in mental health disaster plan

_____ Identify potential volunteer and mutual aid resources and capabilities

_____ Develop, maintain, and annually update volunteer/mutual aid resource list

_____ Review legalities and liabilities of use ofvolunteers and mutual aid workers with agency attorney or risk management officer; institute necessary procedures

_____ Train local volunteers and mutual aid personnel (preferably, simultaneous with agency personnel)

_____ Exercise roles and responsibilities

DISASTER RESPONSE

_____ Activate disaster volunteer coordinator

_____ Call-up predesignated resources and identify new resources as needed

_____ Arrange for food, housing, transportation, supplies, security, and other logistical aspects of maintaining volunteers

_____ Set up check-in area and application process for spontaneous volunteers

_____ Designate staging area for orientation and deployment of volunteers

_____ Issue instructions to volunteers regarding time to report and location of staging area; issue instructions regarding personal supplies to bring

_____ Orient volunteers to:

_____ Status of disaster situation

_____ The impacted community

_____ Community and disaster-related resources

_____ Logistics (food, housing, medical care)

_____ Communications

_____ Transportation/travel in disaster area

_____ Health and safety in disaster area

_____   Field assignment sites

_____   Agency policies and procedures

_____   Self-care and stress management

_____   Have volunteers sign necessary forms; issue identification and name tags

_____   Provide training for volunteers in disaster mental health issues and interventions

_____   Establish and maintain clear chain of supervisory command and communication for volunteers

_____   Arrange for postassignment disengagement at staging area

_____   Disengage workers in teams, with coworkers from same assignment area

_____   Provide facilitator for postdisaster critique

_____   Provide trained, experienced facilitator for debriefing (separate from critique)

POSTDISASTER

_____   Provide letter of thanks and and recognition to individuals and groups who volunteered or provided mutual aid

_____   Compile after-action report on the volunteer/mutual aid operation and lessons learned

_____   Incorporate appropriate changes into disaster mental health plan or policies and procedures; communicate changes to staff

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                                        CHAPTER SIX

OUTREACH SERVICES FOLLOWING DISASTER

Published research and reports of disaster mental health programs
have underscored the importance of active outreach to the affected
population. The need for active outreach services following
disaster is premised on the following:

     *Most people do not see themselves as needing mental health
services following a disaster, and do not seek out such services.
Consequently, mental health staff must actively find and interact
with survivors in community sites where they are living, working,
and reconstructing their lives.

     *Everyone who sees a disaster is affected by it, including
people who are exposed through extensive media coverage.
Therefore, mental health education and intervention must be
provided to the community at large following a disaster.

CATEGORIES OF OUTREACH ACTIVITIES

Outreach can be categorized on two levels: microlevel outreach to
individuals or small groups, and macrolevel outreach to the
community at-large.

Microlevel outreach

Some disaster mental health outreach activities occur on a "micro" or individual level, entailing a face-to-face, telephone, or written interaction between mental health workers and specific individuals or small groups. Casefinding, letter writing, and door-to-door visits to survivors are some examples. The major goal of microlevel outreach is to find and make contact with survivors, assess their problems and needs, provide education about resources and coping strategies, and link them with needed assistance.

Cohen and Ahearn (1980) list the following as microlevel outreach objectives to individual survivors:

          *   Providing education and information about resources available to help reorganize their lives.
          *   Helping with identification of ambivalent feelings, acknowledging needs, asking for help, and accepting support.
          *   Helping with prioritizing needs, obtaining resources, and increasing individual capacity to cope with specific priorities identified.
          *   Providing opportunities to become engaged and affiliated.
          *   Providing a structured method of perceiving specific problems, self-observations, behavior, and powerful emotions through help in understanding, defining, and ordering events in the larger world.

Outreach to individuals may identify survivors who need mental health intervention. In such situations, outreach is a precursor to individual treatment.

However, outreach to individuals can be an effective, beneficial intervention in and of itself. Often, mental health workers in disaster recovery programs are discouraged by the fact that large numbers of "patients" do not materialize. They interpret this as meaning that their outreach activities have not been successful. In fact, outreach has a far larger objective than "advertising" services and bringing people in the clinic door for treatment. The educational aspect of outreach can promote and enhance healthy adaptation and coping. By providing survivors with anticipatory guidance about normal stress and grief reactions, stress management strategies, and information about resources, such outreach may actually prevent a survivor from needing mental health treatment.

Preventive outreach strategies may reduce survivors' anxiety and diminish the number of people needing clinical treatment. However, disaster mental health workers should be cautious not to "normalize" disaster stress reactions to the point of stigmatizing people who do feel the need to seek mental health assistance. The goal is to reassure survivors about the normalcy of common reactions. Simultaneously, educational interventions must help people to feel comfortable in seeking assistance if their reactions seem intense, go on for too long, or interfere with interpersonal relationships, work or school.

Macrolevel outreach

In more broad scale outreach, the mental health worker reaches out
through organizations or the community at-large. An example is
public education through the electronic or print media. Other
macrolevel outreach approaches include environmental or social
action interventions aimed at organizational, community, or
societal target points. Examples include consultation, training,
or advocacy. Such activities aim to influence policies,
procedures, legislation, organization of services, environmental
factors, or community attitudes and behavior that may impede the
emotional recovery of disaster survivors. Community organization
is another macrolevel form of outreach. It seeks to bring together
community residents to deal with specific problems of recovery. It
can increase a sense of environmental mastery and help to establish
or repair social bonds and support networks among affected
citizens.

CHARACTERISTICS OF SUCCESSFUL OUTREACH PROGRAMS

Early intervention and visibility

Disaster survivors often see their experiences as intensely
personal. They believe that their ordeal is something that cannot
be understood by someone who did not share the experience. By
arriving as early as possible in the disaster, mental health
workers see, hear, and often feel very similar things to the
survivors. A willingness by the mental health workers to engage in
whatever needs to be done (helping with cleanup, for example)
contributes to the early establishment of trust and credibility in
the eyes of survivors.

Borrowing from Freud, Lindy and Grace (1986) describe a survivor
network boundary that forms after disaster. This perimeter seeks
to safeguard traumatized members from harm and to promote psychic
healing. They have called this barrier the trauma membrane. While
the membrane includes early permeability to people willing to help,
it soon becomes tightly sealed. Outsiders are allowed in only
under certain circumstances. The concept of the trauma membrane
further reinforces the importance of early mental health
involvement in response activities. Acceptance must be attained
before the membrane closes to "outsiders."

Deployment of appropriate staff

Outreach staff have to be comfortable working in community-based,
nonclinical roles. They must be able to adapt to changing
situations, make independent decisions, and work without close
supervision (Peuler, 1988). They need to be action-oriented and
willing to do whatever needs to be done. Staff should be
comfortable with being outside and in the elements.

Workers must be comfortable and adept in striking up conversations
with people they have not met before, and have not come to them
seeking help. It is helpful if workers live in the community, as
they will have common knowledge, concerns, and topics of
conversation. Personality is important. Workers must enjoy people
and not appear lacking in confidence. They must project interest
and empathy.

It is helpful if workers wear comfortable clothes that blend into

the community. In a farming area, for example, boots and jeans
might be the appropriate attire. Clothing should be appropriate to
the weather, to the hazards, and to the job to be done.

There are some advantages for outreach workers to be older. They
have more life experience to draw from, especially if they come
from the community that was affected by the disaster. Secondly,
they are more frequently perceived as nonthreatening (DeWolfe,
1992). However, age and gender should be appropriate to the group
being served.

Workers should be comfortable and effective in making public
presentations, as they will often be called upon to give impromptu
talks about the emotional impact of disaster. They should have a
thorough awareness of community resources, and must be
knowledgeable about phases of disaster recovery. They should be
culturally sensitive and appropriate in their interventions. It is
also important for them to have a thorough understanding of the
stress inherent in disaster work. They must also possess the
knowledge and skills necessary to recognize and manage that stress
for themselves and with other workers.

Personnel who generally function well in outreach roles include
crisis workers, psychiatric emergency staff, case managers, mental
health nurses, social workers, and trained paraprofessionals.

Use of indigenous workers

Professionals and paraprofessionals from within local community
groups can be particularly effective as outreach workers.
Indigenous personnel are especially useful in providing services to
distinct ethnic and cultural groups. A thorough knowledge of the
cultures, cultural values, and cultural practices is essential to
providing appropriate interventions. In addition, when mental
health workers have been unable to penetrate the trauma membrane,
indigenous workers from within the membrane often can be identified
and trained to do outreach and education.

Paraprofessionals recruited and trained from within the local
population can often accomplish social support functions that
outside workers cannot. They are often more successful at
establishing a peer relationship and understanding the survivors'
style of life (Reiff and Riessman, 1965). These peer counselors
can play the role of a "friendly neighbor" who listens and provides
emotional support for people who would shun mental health because
of the associated stigma (Riessman, 1967; Solomon, 1986). In
addition, workers from the area will likely have an easier "in"
with the community. With a rural population, for example, a person
familiar with farming, animals, orchards, gardening, farm
equipment, and the price of manure will have some common topics
with which to begin a conversation (DeWolfe, 1992).

Trained indigenous staff are often uniquely able to develop
effective case-finding strategies. They can recognize survivors'
emotional and social needs, identify resources acceptable to the
population, and make effective referrals. Local workers can
adeptly use their status as a peer to transmit norms about
help-seeking (Solomon, 1985). In other words, survivors perceive
that seeking help is acceptable and sanctioned by his/her own group
members. Workers indigenous to particular community groups can

provide services within the context of the values, norms, systems, and politics of their community group.

Use of social network analysis

Social network analysis examines the interrelationships of individuals and groups in a community concerning exchange of resources, information, social obligations, economic resources, and kinship ties. A thorough community needs and resource assessment should be done, using social network analysis. This will identify problem areas and vulnerable, high-risk groups. It can also lead to a directory of available and appropriate services (Mathews and Fawcett, 1979).

For example, social network analysis may show that a neighborhood or social group attends church frequently. In such a case, mental health staff could use the clergy, church social groups, and church bulletins for distributing information about common reactions to disaster and about mental health resources.

Use of community caretakers and neighborhood leaders

In every community, there are informal leaders and "caretakers" who provide support, assistance, or material goods to the community. They are often in jobs or positions of social interchange that allow them to see a great deal of what goes on among community residents. These individuals may include hairdressers and bartenders, merchants, mail delivery persons, utility repair persons, contractors, etc. These important individuals can serve as "key informants" to mental health staff, identifying people in need and areas of community concern. In addition, they are major sources of information and referral for the individuals in their social network. Providing information about formal resources to informal caregivers has been found to increase the number of referrals these individuals make to social service agencies (Leutz, 1976).

Mental health staff can enhance the effectiveness of informal caregivers and community leaders. Training and consultation of community leaders can enhance their knowledge and skills in providing support to their own community. It is useful to provide them with consultation on the disaster-related psychological and health problems they may see in the community, as well as information about mental health and disaster resources.   Mental health staff can also give information about backup services for problems that are beyond the helping capacity of the informal support system (Cohen and Sokolovsky, 1979).

Recognition of phases of recovery and use of phase-appropriate outreach methods

Certain interventions will not work well during the early "heroic" and "honeymoon" phases, when people are generally feeling energetic and optimistic. To ask people to talk about their feelings if they are still denying the implications of their loss is probably ill-timed. A more phase-sensitive approach would be to help them with their immediate, practical concerns. People will likely be more open to talking about their thoughts and feelings a little later in the "disillusionment" phase. Then, much of the protective "numbness" has worn off. People are anxious, sad, tired,

irritable, frustrated, and discouraged. A thorough understanding
of the phases of disaster, as well as focused attention to the
phase that individual survivors are experiencing, is essential to
successful outreach.

Ethnic, cultural and linguistic appropriateness

Services need to be provided in a manner relevant to the ethnicity,
culture, and languages of the people. Literacy in English and in
the language of origin must be considered. Specific outreach
approaches must be tailored to people who do not read (public
meetings, radio programs in native languages, etc.). Different
ethnic groups have varying beliefs about asking for help, about
whom they see as helpers, whether they trust government programs,
and so forth. Ideally, mental health outreach staff should be
indigenous to the ethnic group they are working with. At minimum,
they should be well-trained in cultural values, practices, and
beliefs of the group they are serving. They must work through
trusted community groups and individuals.

Ability to identify and overcome barriers

Mental health workers need to identify barriers to reaching the
community. For example, distance, transportation, bureaucratic
procedures, or cultural insensitivities may get in the way of
mental health programs reaching the people, and may be in the way
of people seeking services. A technique that has been useful in
many mental health disaster recovery projects is to have staff
brainstorm at the beginning of their project about what barriers
might interfere with carrying out the project objectives. Staff
then also brainstorm about specific ways to overcome or eliminate
the anticipated barriers. By doing this at the front end of the
project, staff can eliminate some obvious barriers immediately. It
also helps to establish a "can do" attitude among staff. While
obstacles will occur from time to time, the project staff will find
ways to modify their approach so that the program can succeed.

Utilization of interventions perceived as nonthreatening and
nonstigmatizing

Mental health information, education, consultation, and even
clinical interventions are usually well-received when presented as
"normal" events that are familiar and nonthreatening to the
community. Community meetings, presentations, training, discussion
groups, written materials such as brochures, and information in the
media are examples.

OUTREACH TECHNIQUES AND RECOMMENDATIONS

The following outreach techniques and recommendations include
concrete, specific suggestions for mental health workers following
a disaster.

Casefinding and outreach to individuals

Always and in all places, mental health staff should informally be
collecting information that will help them to locate disaster
survivors. They should make every effort get the survivor's
original address, current address, phone number, and a message
phone number.

A useful approach is to obtain lists with names and addresses of survivors. Such lists may be available through FEMA, the Red Cross, Social Services, hospital emergency rooms, the coroner's office, Department of Public Works, the building permit department, the Chamber of Commerce, the Unemployment Department (Disaster Unemployment Assistance), and newspaper/media reports. Some of these groups may consider their lists to be confidential, but it is worth a persistent try. Education of the agencies about the importance of outreach and education may help. Reassurance that the lists will only be used for outreach conducted by the FEMA crisis counseling program is important. These lists can be used for sending outreach letters with brochures from the mental health recovery project. Such mailings can list common reactions to disaster, self-help suggestions, and the project's phone number. The lists can also be used for making outreach telephone calls or home visits.

Use of door-to-door visits can be one of the most effective outreach techniques. It is helpful for staff to work in pairs, because knocking on doors is often a foreign approach for mental health workers, and it may feel uncomfortable at first. In addition, the work can be discouraging for staff if people are not immediately receptive. A male-female team can alleviate suspicions as to motive of the team or safety for the resident (DeWolfe, 1992).

Following up a mailing provides a good "in." Dewolfe (1992) has illustrated how a mental health worker might approach going door-to-door or making a follow-up phone call. Workers can start out by asking if the person has received the mailing describing the program. Another way of starting is to say something like "Hi, I'm Ruth Williams from Flood Support Services and I understand that you were hit real hard by the floods right here. Do you have time to talk?" After that, the worker can go with whatever the person says first after the introduction. If it's anger about the flooding, then the worker can agree and support the person's anger and frustration. If it's children tearing up the house, the worker can talk about the challenges of parenthood. After establishing rapport, the subject of damages in the disaster can be discussed. "Can you tell me what happened? Did you have mud in your house? How deep was the water?" In the resulting discussion, the worker can assess how the person is coping and what their needs might be.

DeWolfe (1992) has also observed that often, people are more comfortable talking about how others are doing at first. Ask what kinds of stress reactions they see in the neighborhood. Ask how their children are doing. These are good openers to begin talking about psychological reactions and family coping.

Provide brochures and information about common reactions and things that can be helpful, as well as phone numbers of the mental health disaster recovery project and other resources. Ask them to pass the information along to anyone who may need it.

Identify people in the community who will be familiar with the needs in the community, and can serve as "key informants." These informants may be found in:

        *   key agencies and groups in affected neighborhoods

(health, social services, churches, schools, daycare providers, community groups, police, fire department, etc.);
       *   places where people congregate (thrift shops, restaurants or coffee shops, bars, grocery or liquor stores, etc.);

       *   other services familiar with the neighborhood (mail delivery personnel, public utility workers, building inspectors);
       *   businesses or offices that survivors frequent during their recovery (thrift shops; lumber yards; hardware stores; building permit departments).

Different people will emerge as key informants depending on the type of disaster and the phase of disaster. In early phases, such people may include Federal Emergency Management Agency (FEMA) and Red Cross workers, insurance adjusters, managers at hotels where survivors are temporarily living, demolition contractors, etc. Later, as people begin rebuilding, there will be planning department staff who issue permits, engineers, architects, contractors, building supply stores, and so forth. Still later, as rebuilding nears completion, survivors will be interacting with building inspectors, furniture stores, landscapers, and the like.

Key informants related to the type of disaster might include fire departments (wildfires), structural engineers (earthquakes), flood control engineers (floods), geologists (landslides) and the like.

Request an interview with key informants to find out the following: How do they see the stress level in this neighborhood? Are there any specific concerns they have? Are there any specific individuals or families they areconcerned about?

Workers should make regular visits to places where survivors may congregate, such as senior centers, recreation halls, food kitchens, and so forth. Community meetings are a good place to meet survivors. By "aggressively hanging out" workers can strike up conversations and actively make connections with individual survivors.

Outreach to the general community

Outreach to the community has two goals:

      1.   Public education aimed at helping the population to realize that most stress reactions they are experiencing are normal, and providing suggestions about how to reduce/cope with disaster-related stress.
      2.   Resource information about services that are available and where to call for help.

Effective community outreach strategies include:

      1.   Newspapers and community newsletters: articles, interviews, human interest stories, paid advertisements.
      2.   Radio and television: public service announcements; special programs on effects of disaster; interviews with mental health staff, community leaders, or disaster survivors;human interest stories; call-in shows.
      3.   Public speakers: to civic groups, service clubs, special interest groups, PTAs, churches, etc.

4.   Videotapes: for training and as an adjunct to
public speaking, to educate the public and to stimulate discussion.

5.   Posters: on bulletin boards, buses, bus stops,
in clinics, waiting rooms, other public places.
6.   Brochures and fliers: handed out door-to-door,
hung on doorknobs, in grocery bags, liquor stores, thrift stores,
places where survivors do business, literature racks in clinics and
doctors' offices, in government offices, in church bulletins,
Scouts handing them out on the street, etc. Caregivers, agencies,
and departments with whom survivors have contact can be given
brochures and asked to hand them out. Door-to-door distribution of
handouts providing public health information or mental health
information on stress management, will often provide an opportunity
to assess levels of emotional distress and provide information or
intervention.
7.   Books: especially for children, combining
information about the cause of the disaster and ways to be safe;
coloring; stories; games. Appendix A provides examples of books
developed as outreach materials.
8.   Community fairs and events: information booths
at fairs and festivals; games and activities for children and
adults; pencils or balloons with recovery project logo and phone
number.

Mental health training

The purpose of mental health training in the community is to
increase awareness within the community of the mental health
aspects of disaster recovery. This can generate a "ripple effect"
and maximize the mental health knowledge and skills available in
the recovering community. Training also develops skills, instills
confidence, fosters collaboration, and creates involvement in the
mental health efforts toward disaster recovery. Training can be
provided to mental health, human service professionals, and other
community caregivers.

In addition, citizens who provide a support system for survivors
can benefit greatly from education about the mental health aspects
of disaster recovery. These individuals include relatives,
friends, and neighbors. They often lack knowledge of common phases
of recovery, issues being dealt with in each phase, and normal
stress and grief reactions. People are often unsure about when and
how to offer their support. Friends of survivors often subscribe
to some commonly held myths about trauma and loss: "Talking about
it just keeps it all stirred up." "It's time to put the past
behind you and get on with your life." "Dwelling on it is morbid."
Education about the process of recovery and how best to support
survivors can strengthen the contribution of the informal support
system to the healing process.

Target groups and suggested topics of training include:

1.   Mental health professionals not involved in the disaster
recovery project, but who may be seeing survivors in their
practice.

Suggested topics include:

a.   Understanding disaster behavior and recovery

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        --definition of disaster
        --myths and realities of human behavior in disaster
        --factors affecting the psychological response
          of individuals and the community to disaster
        --"at risk" groups following disaster
        --phases of disaster (including stressors and
          reactions common in each phase)
   b.   Key concepts of disaster mental health
   c.   Special populations in disaster:  children,
                 older adults, people with disabilities,
specific ethnic groups
   d.   Clinical issues and interventions:
        --symptomatology and assessment of post-traumatic stress
and grief
        --stress management and self-help approaches
        --crisis intervention/brief treatment
        --support groups
   e.   Disaster assistance resources/agencies
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2.   Human service professionals and other caregivers:

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             --social services, child and adult protective
services
             --human needs centers
             --volunteer centers
             --special population programs (older adults'
services, drug and alcohol programs, parenting programs, services
   for specific ethnic groups, etc.)
             --health services  (physicians, nurses, public
health and  school nurses, emergency room personnel, emergency
medical technicians and paramedics)
             --schools, preschools, daycare providers, foster
parents
             --clergy
             --police and fire department personnel
             --disaster agencies: FEMA, Red Cross, Salvation
Army, other voluntary agencies active in disaster
             --"natural helpers"
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         Suggested topics include:

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             a.   Understanding disaster and disaster recovery
             b.   Special populations in disaster (children,
older
                  adults, disabled, ethnic populations)
             c.   Disaster stress symptomatology:  normal
reactions, and when and where to refer
             d.   Helpful skills and styles of relating to
disaster survivors (listening, problem-solving, crisis
intervention)
             e.   Self-help and stress management skills for
disaster survivors
             f.   Recovery resources
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    3.   Citizens who serve as support networks for disaster
survivors (friends, relatives, neighborhood groups, church groups,
etc.):

         Suggested topics include:

                a.   Phases of disaster recovery and common issues,
stressors, and needs in each phase
                b.   Ways to help: listening skills; what to do and
say that can be helpful
                c.   Resources and referrals: when, how, and where
to refer

Consultation

Consultation to community caregivers and agencies has a similar
goal to that of training. The purpose is to increase awareness of
the mental health facets of disaster recovery, and expand the
mental health knowledge and skills available to survivors in the
community.

The goals of consultation are:

        1.   To facilitate the work of other professionals
and caregivers in the mental health aspects of helping disaster
survivors.
        2.   To encourage other professionals, caregivers,
and programs to incorporate mental health principles and approaches
into their services.
        3.   To assist other professionals and caregivers in
linking disaster survivors with appropriate resources, including
mental health.

Cohen and Ahearn (1980) emphasize that mental health must first
establish trust and collaboration with agencies to whom it will be
consulting. Consultants need to understand the mission and methods
of the agency or individual to whom they are providing
consultation, and not threaten existing methodology. It is helpful
if mental health accepts referrals without delay. It is also
important to work out unrealistic expectations or perceptions of
what mental health can do.

Consultation may be of two types (Cohen and Ahearn, 1980):

        1.   Case-oriented: case consultation involving a
mental health professional assessing a client or providing
consultation about a client to a worker.
        2.   Program-oriented: consultation aimed at
influencing programs, administrative structures, and staff. Goals
include early detection and intervention with mental health
problems, increased coordination and linkage among programs,
decreased fragmentation of services, and making services as
responsive to needs of disaster survivors as possible. Issues
addressed in program oriented consultation will probably include
such things as program design and planning; administrative
structures; methods of service delivery; policies and procedures;
and recruitment and training of staff.

Community organization

Community organization is the process of bringing together
community members for defining and working to solve their own
problems (Ross, 1967; Taillie, 1969). Issues may include such
things as social policy in disaster reconstruction, disaster
preparedness at the neighborhood level, or other issues of
neighborhood concern.

While the content around which people organize may not be the usual arena for mental health, the process is uniquely tailored to help disaster recovery in the following ways:

1. It can help people deal with concrete problems of concern to them.
2. It can reestablish feelings of control, competence, self-confidence, and effectiveness that were weakenedby the disaster.
3. It can establish, reestablish, or strengthen social bonds and support networks that may have been fragmented by disaster.

An example of community organization common after many disasters is the organization of self-help networks for disaster preparedness. Citizens gather in a series of neighborhood meetings. They inventory and mitigate local hazards, such as clearing brush that is a fire hazard. They find resources in the neighborhood (skills such as nursing or firefighting; equipment such as CB radios or camping gear). They also survey household needs in a disaster, such as children home alone after school who would need care. Neighbors decide task assignments for neighbors usually home during the day, such as turning off utilities in the neighborhood, providing first aid, helping children who are home alone. They meet periodically to review and modify the plan (annually and as new neighbors move in). The groups hold periodic drills or practice sessions, often making them "fun" in the process (a potluck supper prepared and eaten without electricity or gas!)

Such groups have organized around emergency preparedness following floods, mudslides, earthquakes, and wildfires. Group members report a marked increase in people's sense of safety and well-being, confidence in their ability to act effectively in an emergency, and sense of support and teamwork among neighbors. Such community organizations also strengthen the bonds of social support among survivors. Many individuals report satisfaction in getting to know and work with their neighbors, and groups often expand their scope to work together on a variety of other neighborhood concerns (Garaventa, Martin, and Scremin, 1984).

Community organization techniques may also be used to mobilize informal resources within the community. For example, after floods and mudslides devastated Inverness, California in 1982, no formal agency in the community existed to help survivors with the grueling work of digging mud out of their basements and crawl spaces. This was a particular problem for frail elderly who were unable to perform the labor themselves. When this problem surfaced at a community meeting, young adults and teens organized a group they named the "Mole Patrol," which made its sole mission the digging out of mud. When the job was done many months later, the informal group disbanded.

Advocacy

Mental health staff may intervene with agencies or situations on behalf of their clients. Advocacy may be case centered, as when a mental health worker seeks to assist an individual client. For example, the worker may attempt to cut through red-tape or clarify a misunderstanding between a client and an agency.

Advocacy may also be issue-centered or group-centered, seeking to benefit a group of clients or the general population. When devastating floods hit agricultural areas of western Washington state in 1990, severely damaging crops. Migrant farm workers arriving from Texas six months later for the annual harvest season found very few crops to harvest. Many of the workers had not received any information that flooding had occurred. The workers faced lack of housing and the loss of jobs. By informing and educating representatives of various agencies about the unusual circumstances that the migrant population faced, mental health staff were able to influence service delivery to meet the unique needs of these families (Williams, 1992).

SUMMARY

Because the entire community is affected by a disaster, and because survivors generally do not seek out mental health resources, outreach will be a key component of a successful mental health disaster recovery program. Outreach will be to individual survivors and to the community as a whole. It may take the form of casefinding and outreach to individuals, public education, mental health training, consultation, community organization, and advocacy. Mental health workers will do well to incorporate the characteristics of successful outreach programs learned from prior recovery projects in order to successfully reach the affected population of survivors.

CHECKLIST
DISASTER MENTAL HEALTH OUTREACH

PREDISASTER

_____   Pre-designate an outreach team

_____   Include multicultural, multilanguage capability to reflect makeup of community

_____   Include special population workers (children, older adults)

_____   Train the team in disaster mental health outreach techniques and disaster resources

_____   Train the team on personal and family disaster preparedness; all team members have personal disaster kit (food, water, clothes, sleeping bag, cash, medications, hygiene supplies, flashlight etc.) in trunk of car

_____   Provide the team with identification cards recognized by emergency management and law enforcement officials

_____   Assemble supplies and equipment for immediate use by team (distribute to team in advance or keep in accessible location)

_____   Cellular phones or

arrangement with local amateur radio group to provide communication linkage

_____ Resource directory

_____ 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, if needed

_____ Pens, paper, necessary forms, clipboards

_____ Simple data collection forms to track services delivered, funds expended, and to collect needs assessment data for crisis counseling grant

_____Prepare sample public service announcements (PSAs), news articles, and sample interviews for radio and television

_____ Identify and establish relationships with community agencies that will be key to successful outreach efforts: American Red Cross, schools, agencies serving special populations

_____ Identify populations or groups in community likely to be vulnerable in disaster; outline outreach strategies and key resources for each group

DISASTER RESPONSE

_____ Identify sites where groups of survivors are likely to congregate (shelters, food kitchens, community centers, hospitals, casualty collection points, the morgue, standing in lines, at roadblocks, in neighborhoods, etc.)

_____ Connect with agencies providing direct services to survivors (American Red Cross, emergency medical services, law enforcement, fire department, public health department, etc.)

_____ Designate public information officer (PIO); provide media with information concerning normal reactions to disaster, ways to cope, and where to call for help

_____ Deploy outreach team to appropriate sites

_____ Take identification and supplies

_____ Meet with the person in charge at the site; clarify mental health roles and responsibilities

_____ Tour the site and assess mental health aspects and needs of site

_____ Consult with the person in charge at site regarding mental health aspects of environment,

individuals needing assistance, disaster worker stress management

_____ Use formal and informal "key informants" to provide information about needs of individuals or populations

_____ Utilize "aggressive hanging out" and "over a cup of coffee" method of informal assessment and intervention with survivors and workers

_____ Support and assist survivors with specific, tangible problems (locating family members, childcare, transportation, obtaining medical care, temporary housing, etc.)

_____ Educate and distribute brochures about normal reactions, ways to cope, where to call for help

_____ Refer to mental health clinical staff: peoplein acute psychiatric distress, those with extreme emotional responses, and those with exacerbations of prior psychiatric problems

_____ Utilize established chain of command within mental health to communicate to mental health representative in emergency operations center (EOC) about field conditions and needs for resources

_____ Complete data collection forms for fiscal tracking and needs assessment for grant application

DISASTER RECOVERY

_____ Identify individual survivors by using lists of people applying for assistance, damage reports, etc.

_____ Contact survivors via letters, phone calls, or door-to-door visits; provide informal assessment, education, support, and resources

_____ Establish and maintain contact with agencies, caregivers, key community members, and businesses used by survivors

_____ Provide public education to community-at-large regarding common reactions, coping strategies, and where to call for help

_____ Use print and electronic media for articles, interviews, public service announcements, paid advertisements, call-in shows

_____ Provide public speakers to civic groups, service clubs, PTAs, churches, etc.

_____ Attend community gatherings and meetings, fairs, and other events; circulate and talk with survivors for informal assessment, education, support, and

providing resources

_____ Hang posters on bulletin boards, buses, bus stops, in clinics, waiting rooms, and other public places

_____ Distribute brochures and fliers door-to-door, in shopping bags, on literature racks, in church bulletins, and via community groups (Scouts, fire department, etc.)

_____ Develop activity or coloring books for children

_____ Train and educate community professionals, caregivers, and informal support systems of survivors regarding mental health aspects of recovery and how to help survivors

_____ Consult with community professionals and caregivers to facilitate their work with survivors

_____ Help community organization efforts among survivors or among informal resource groups

_____ Advocate on behalf of clients or populations in appropriate situations where mental health issues or needs are involved

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CHAPTER SEVEN

PROVIDING MENTAL HEALTH SERVICES
IN A DISASTER SHELTER

OVERVIEW OF SHELTER FUNCTIONS

When disaster survivors are unable to remain in their homes and have no other temporary place to stay, mass care shelters may be established. These shelters are usually set up in suitable and safe buildings such as schools, churches, community centers, and the like. The American Red Cross usually establishes and runs shelters. In some local jurisdictions, governmental disaster plans

also assign responsibility for mass care to the Department of
Social Services (DSS). In such situations, a memorandum of
understanding usually exists between the ARC and DSS, outlining the
roles and responsibilities of each agency.

Most mass care shelters are run by the Red Cross. Therefore, it is
important for mental health staff to have some understanding of the
role and responsibilities of the Red Cross, and to understand the
basic functions provided within a Red Cross shelter. This section
will give an overview of Red Cross responsibilities and shelter
operations. However, it is highly recommended that mental health
staff who will be functioning in disaster shelters take the Red
Cross courses on Introduction to Disaster Services and Shelter
Management.

The American Red Cross was mandated by Congressional charter in
1905 to help meet the human needs created by disaster. Congress
reaffirmed this mandate in the Disaster Relief Acts of 1970 and
1974. The mandate is referenced in the published regulations of
the Federal Emergency Management Agency (FEMA). A statement of
understanding between FEMA and the American Red Cross was
established in 1982. Thus, the Red Cross role in disaster is a
legal mandate that it has neither the authority nor the right to
surrender (American Red Cross, 1982). Nonetheless, the Red Cross
receives no government funding for its services, and relies solely
upon voluntary contributions. Local governmental responsibilities
and mandates are not superseded by Red Cross authority.

Most disaster survivors seek temporary housing through their own
resources, such as family or friends, and the Red Cross estimates
that only between 20 – 30% of an affected population will seek
shelter in mass care facilities. Mass shelter is a short-term
response to provide temporary housing. Before mass shelters are
established, efforts are made to house families with friends or
relatives, or to place families in hotels. Families in mass care
shelters are assisted in moving back to their homes or to interim
housing as quickly as possible.

There will be variations in the problems of shelter residents and
the duration of their stay in the shelter based the type of
community. For example, there are differences to be found between
urban and rural shelters and their populations.

In urban areas, preexisting community problems can quickly manifest
in the shelter. For example, people who were homeless before a
disaster often turn to disaster shelters for temporary relief. In
the California Loma Prieta earthquake of 1989, many low-rent
housing units were destroyed, making it even more difficult for
both the pre- and postdisaster homeless to find temporary housing.
Drug and alcohol problems are common in urban shelters. Although
it is strictly against shelter regulations, it is not uncommon to
find individuals attempting to bring drugs and alcohol into the
shelters. Such illegal activity is the responsibility of security
and law enforcement. However, the behavior and health risks of
individuals who are "high," intoxicated, or having withdrawal
symptoms can become a problem for shelter management and shelter
mental health staff. The juxtaposition in a shelter of "street
people" with middle class homeowners, cultural groups without
connections or understandings, or gangs with outright hostilities
toward one another can contribute to anxiety and actual conflict.

In rural areas, the population may be more homogeneous. However,
the problem of finding long-term housing can be exacerbated by
scarcity of predisaster housing. In agricultural communities,
substandard housing is often rented to migrant or resident
agricultural workers. Because of the age and condition of the
housing, it often sustains serious damage, thus leaving low income
renters without any place to live. In the rural areas of Santa
Cruz and San Benito counties after the Loma Prieta earthquake, the
Federal Emergency Management Agency (FEMA) set up mobile home parks
to augment existing housing in the communities. Finding immediate,
short-term temporary housing for shelter residents so that mass
care shelters can be closed down is a serious challenge.

Red Cross volunteers assigned by the local Red Cross chapter
usually provide staffing for the shelter. Under ideal conditions,
staff include a shelter manager, nurse, family service worker (all
of whom have had Red Cross training specific to their role and
responsibilities), food supervisor, storekeeper,
janitor/maintenance staff. Shelter residents often voluntarily
help with various functions in the shelter.

The mass care shelter is usually a large facility such as a school
or church. The sleeping accommodations are usually in an area such
as a gymnasium, with dormitory-style rows of cots or mats for
sleeping. Areas are allocated for recreation (indoors or
outdoors), childcare, food service, and storage. There may be some
small rooms for office space and nursing services. There are also
bathrooms or port-a-potties. At any given point during a day, some
residents may be sleeping, some eating snacks, some talking, some
engaging in recreation. The noise level is usually high.

                AMERICAN RED CROSS DISASTER SHELTER SERVICES: AN
OVERVIEW

        Food includes preparation and serving of full meals and
snacks. If the shelter does not have cooking facilities, food may
be prepared and served elsewhere.
        Individual assistance includes services to families
withdisaster needs. Such assistance might include providing
information, interpreting disaster resources, making school
arrangements for children, assisting with transportation, and
helping families to find housing.
        Health services include preventing disease, protecting
health,first aid, and 24-hour medical and nursing supervision for
all shelter residents. Emotional support and crisis counseling
fall under the jurisdiction of health services, and may be provided
by Red Cross volunteers or by community mental health staff
assigned to the shelters.
        Sleeping accommodations provide residents with a place to
sleep.
        Recreation services are geared to relieving tensions
andimproving morale of all ages and groups housed in the shelter.

Childcare is often provided.
        Other activities include registration of all shelter
residents; administrative functions (staffing the shelter,
record-keeping, supply purchases); maintenance; communications and
public relations; and enforcement of safety, fire, and sanitary

regulations (American Red Cross, 1976, 1979).

RED CROSS AND MENTAL HEALTH SERVICES: RECENT DEVELOPMENTS

A new shelter role is being developed in some Red Cross
jurisdictions, that of disaster mental health provider. A Red
Cross national task force has developed Disaster Services
Regulations and Procedures for Disaster Mental Health Services
(American Red Cross, 1991), and a Disaster Mental Health Provider's
Course. Once in place, local Red Cross chapters can train
volunteer mental health providers who will be assigned a variety of
roles at Red Cross disaster service sites, including shelters.

It is essential that local community mental health agencies begin
to develop collaborative relationships with the local Red Cross
chapters before disaster strikes. Community mental health agencies
will want to provide staffing in the shelters. Shelters are one of
the best sites to establish early contact and rapport with
survivors. It is important that roles and responsibilities of
community mental health staff and Red Cross mental health
volunteers in shelters be clarified as much as possible before a
disaster. Planning between the two agencies should ensure
continuity of services for survivors after shelter operations close
down. A formal memorandum of understanding between the local Red
Cross chapter and the local mental health agency is recommended.
Appendix B contains a sample memorandum of understanding.

Red Cross mental health services are designed to supplement the
local community mental health delivery system in time of emergency.
Red Cross mental health volunteers will primarily provide services
to Red Cross workers and their families. Local mental health
agencies seek to serve the disaster survivors and other disaster
workers. In communities where local mental health resources are
limited, Red Cross may take a more active role in providing
disaster mental health services to survivors. Red Cross mental
health assistance never extends beyond assessment of mental health
status and needs, stress reduction, brief counseling, crisis
intervention, referral, and follow-up recommendations (American Red
Cross, 1991). The responsibility for services to individuals
requiring more intensive or long-term care will rest with public or
private sector mental health resources.

MENTAL HEALTH SERVICES IN DISASTER SHELTERS

Administrative issues

The mental health agency providing staff to the shelters has
responsibility for the clinical and administrative supervision of
the mental health staff in the shelters. This includes scheduling
and staffing levels. The Red Cross has full responsibility for
shelter management, and mental health must work in close
cooperation with Red Cross management. Red Cross staff must keep
mental health informed of shelter conditions or changes to allow
mental health to make staffing changes in a timely manner. If
difficulties arise in establishing a collaborative working
relationship between mental health and the shelter manager, the
mental health coordinator should speak with the Red Cross Health
Officer or other operations administrators if required.

The number and type of mental health staff needed at a shelter will

be decided by the size and characteristics of the shelter
population. For example, an urban poor population will likely have
a high prevalence of mental illness and substance abuse, which, in
turn, affect staffing. In large shelters, the settings become more
disorganized and chaotic, and the environment itself is likely to
cause stress. Probability guarantees that the larger the number of
shelter residents, the greater the likelihood that the population
will include individuals with psychiatric illness and/or acute
stress reactions. As a rule of thumb, the larger the shelter
population, the larger the number of mental health staff and the
more hours of coverage needed. In a large shelter, it is prudent
to attempt to provide twenty-four hour coverage for at least the
first forty-eight hours, or until it is decided that the need no
longer exists. If twenty-four hour on-site coverage is not
possible or not needed, round-the-clock consultation and crisis
response should be available. Ideally, staff should work no more
than a twelve-hour shift, with twelve hours on duty and twelve
hours off duty. Mental health administration should support their
staff in the shelters by scheduling adequate time off, regular
breaks, and the like.

The demographics and characteristics of the resident population
will dictate type of staff needed. Mental health should provide
staff experienced in working with special populations such as
children, older adults, the mentally ill, and people with
disabilities.

It is important that mental health staff be knowledgeable about the
various ethnic groups impacted by the disaster. There must be
staff who are fluent in languages of non-English speaking
survivors. All aspects of shelter operations must be sensitive to
cultural and ethnic issues, and services must be provided in ways
that are culturally appropriate. Food preferences, health care
practices, help-seeking behavior, desire for privacy versus
communality, and expression of emotions are but a few of the
culturally dependent values and behavior that must be considered in
establishing a shelter environment and providing shelter services.

If there is a high level of substance abuse in the sheltered
population staff with skills in drug and alcohol detoxification and
treatment should be present. Some shelters may have large numbers
of older adults, persons with medical problems, or persons with
prior psychiatric problems. In such a case, round-the-clock or
on-call staffing by a psychiatrist may be essential for
differentiating medical from psychological problems and for
prescribing medication.

The issue of administration of medications in the shelter should be
worked out in advance with Red Cross health services. There should
be no confusion or conflict over where this responsibility belongs.
Red Cross Health Services regulations assign the responsibility for
medications to Red Cross nurses. The medication orders come from
attending physicians or are based on Red Cross Medical-Nursing
Protocols that have been reviewed and preapproved by a physician.
Mental health and the Red Cross may agree that mental health is
responsible for prescribing and/or administering psychotropic
medications. If so, it must be determined if a local pharmacy is
available to fill prescriptions. If not, a supply of common
psychotropic medications and a secure method to store them should
be sent to the shelter.

The issue of whether individuals receiving psychotropic medications "belong" in the shelter may also need to be worked out between mental health and the Red Cross. If an individual's behavior is not disruptive, disturbing, or dangerous to other shelter guests, the fact that he or she is taking psychotropic medication should be of no more consequence than an individual taking medication for another health problem.

Mental health staff should be provided with a debriefing session following their tour of duty. For disaster assignment of longer than a few days' duration, debriefing may be provided at regular intervals as a stress management tool.

All disaster workers, including mental health personnel, should be trained to be as "self-sufficient" as possible in a disaster. However, certain logistical support services are necessary for workers in a disaster shelter. These include official identification, access to the disaster site, food and lodging, supplies, and so forth. The chapter on "Support and Stress Management for Disaster Mental Health Staff" addresses logistics.

The disaster shelter as a mental health worksite

The activities of mental health workers in a shelter will differ from their functions in a clinical setting in several ways. First, the work environment will be significantly different from the usual clinic or office environment. Even though there are structure, roles, responsibilities, policies and procedures in a shelter, conditions will likely seem chaotic. There are continuous requests, demands, questions, and interruptions. There is a lack of privacy and a high level of noise. It is easy for both staff and shelter residents to feel overwhelmed. Although the stress level in such a setting is high, most disaster survivors do not see themselves as needing mental health services. They rarely seek out staff at a mental health table or counseling room. Obviously, a traditional, clinical approach is neither possible nor appropriate. Staff need to feel comfortable circulating and making contact with individuals in the milieu. Disaster mental health staff have called this approach "aggressively hanging out," and it is an essential part of providing mental health services in a shelter.

The role of shelter mental health workers will be broad and diverse. They often report that their activities in a shelter seem more "practical" than psychological. This is due to the many concrete, pragmatic needs of the survivors at this phase of the disaster. For example, mental health staff may help family members in locating loved ones, in finding out information about damage to their homes, and in obtaining information about disaster recovery resources. Follow-through by mental health is critically important. Even if a worker is unable to obtain a requested piece of information, reconnecting with the survivor is important. Shelter residents already feel considerable loss of control, so workers' reliability can convey some much needed predictability.

Mental health staff may also assist in setting up the shelter environment, registering the residents, providing language translation, or making snacks if these activities need to be done. As the days pass in the shelter, residents generally become more bored, restless, and frustrated if their needs are not being

adequately addressed. The residents who remain the longest are
generally those with the fewest personal resources and, in some
cases, the fewest coping skills. Mental health should anticipate
these changes in mood and residents' needs as they progress into
the "disillusionment" phase of disaster. Mental health
interventions must be tailored according to current needs.

While flexibility in performing practical tasks is necessary,
mental health staff may also need to explain their mental health
skills and capabilities to shelter management. The manager may be
unfamiliar with what mental health personnel can provide within the
shelter. Commonly, roles and activities will develop in adaptation
to situations as they arise. The mental health worker may be
establishing collaborative relationships with other professionals
in the disaster environment with whom there are few collaborative
precedents, and roles may need to be flexible and negotiable
(Cohen, 1986). Sometimes, mental health workers may not be welcome
at a shelter. Under these circumstances, it will be necessary to
start by establishing roles and a collaborative relationship at the
Red Cross Operations Headquarters.

The disaster and the shelter environment will affect the disaster
workers themselves, including the mental health staff. An
important function for mental health staff in shelters is
monitoring staff stress, mitigating stressful situations when
possible, and encouraging physical health and stress management
practices. Mental health staff should work within the context of
a team in the shelter. Staff should work in pairs, which provides
a "buddy system" for monitoring stress and providing support and
assistance. Mental health staff should meet together at the
beginning and end of each shift to discuss mental health issues
that they should communicate to the next shift. These team
meetings are also a time for staff to "defuse" and talk about their
reactions and feelings from the shift.

There should be a coordinator of the mental health team who works
closely with the shelter manager and the shelter nurse or nursing
supervisor. The mental health coordinator may have valuable input
about mental health issues affecting residents and staff, about the
shelter environment, or about the psychological implications of
operations and activities. Therefore, the coordinator should
ideally be a part of all decision-making team meetings about the
operation of the shelter. However, this level of collaboration may
take time to achieve.

Mental health interventions in the shelter

Mental health services function at three levels in meeting the
psychosocial health needs of survivors and workers in the shelter:

    1.   Population
    2.   Environment
    3.   Individual

The first and second levels involve "macro" level interventions, or
interventions with systems. The third level involves "micro" level
interventions, or interventions with individuals. Most mental
health staff are more experienced in interventions at the micro
level. While all mental health interventions ultimately focus on
the needs of the survivors, the mental health worker must be

acutely aware of the interrelationship between the forces of the postdisaster systems. These include the disaster recovery programs and the authoritative structures that implement them (Cohen, 1986). These systems have a powerful effect upon the well-being of the survivors. Mental health workers can have an important role in influencing programs to make services as responsive to needs of disaster survivors as possible. He or she can also help programs to understand the mental health implications of programmatic and administrative decisions (Cohen, 1986). For example, in a large urban shelter after the Loma Prieta earthquake, a tentative decision was made to house men in a separate facility from women and children. This meant that intact families would be separated. When the tentative decision was communicated to shelter residents, the agitation and anger in the shelter rose dramatically. Mental health helped shelter management understand the importance of keeping families together, and the decision was reversed. This example illustrates that systems-level interventions in the shelter can be as important as individual interventions.

1.   Interventions with the population

There are two shelter populations that mental health staff will be concerned with: residents and staff (professional and volunteer).

Mental health staff must first assess the shelter population in order to plan appropriate care for various groups. They must anticipate possible mental health problems affecting the population and identify mental health staffing needs in the shelter. It is important that staff avoid committing to individual situations until a general assessment is done and priorities can be established for mental health activities.

Knowledge of the mental health status of the community from which the shelter population is drawn is essential in assessment. If the mental health worker is not familiar with the community where they are assigned, the team leader should obtain a briefing from shelter personnel or key informants in the community. Staff should have knowledge of the socioeconomic status and ethnic and cultural groups in the community. Health issues, the presence of any significant stressors, and the prevalence of any mental health problems in the community should be learned. Staff should know about any prior history of disasters or traumatic events in the community.

The impact of the disaster on the community and on particular neighborhoods or groups should be explored. Staff should have knowledge of the number of dead and injured and of the damages that have occurred. They should also be aware of trauma occurring as a result of the threat of death, frightening evacuations, exposure to dead and injured, or other traumatic circumstances. Children, the frail elderly, and people with preexisting stress or health problems may be at risk for mental health problems. Groups found most at-risk include those who:

            1.   have lost loved ones;
            2.   have lost homes;
            3.   have been injured or whose loved ones have been
injured;
            4.   have homes with major damage;
            5.   have lost jobs;

                    6.   have been exposed to traumatic sights, sounds,
or experiences.

Some assessment of the population can be done by surveying the
registration file. This will provide information on the number and
ages of children, the number and ages of elderly, and persons with
health problems. The predisaster addresses of survivors will tell
a worker whether residents of the shelter are from areas severely
impacted by the disaster.

Mental health staff should also interview the shelter manager to
learn whether the disaster has personally affected shelter staff
and volunteers. Sometimes, disaster workers plunge themselves into
their work without acknowledging the physical and emotional
implications of their own losses. While this may be functional in
the short-run, it will eventually take a toll on the worker These
workers should be recognized as at-risk for delayed reactions.

The mental health coordinator can obtain valuable information about
the shelter population by observing conditions during a tour of the
shelter. Important information can be obtained asking the shelter
manager and nurse for a report on shelter mental health conditions.
Mental health staff should ask about their general impressions,
mood and stress levels of residents and staff, specific problems,
individuals or families needing assessment, and any specific
concerns they may have. This should be done at the beginning of
mental health's involvement in the shelter, and at the end of each
shift. The report should then be passed on to incoming Red Cross
and mental health staff.

It is important for mental health staff to recognize that being
dislocated from one's home and belongings and being sheltered in a
mass care facility is extremely disorienting and stressful.
Survivors are often heroic in displaying courage and optimism.
However, they are also usually very stressed by the disaster and
the shelter environment.

If there are many children in the shelter, mental health should
provide child specialists among their staff. Parents in the
shelter will be tremendously stressed, and may not be as alert or
capable as usual in meeting the needs of their children. Mental
health can provide support and guidance to parents. In addition,
mental health can work with the Red Cross to ensure that childcare
is available to provide both children and parents with some
respite. The Church of the Brethren and other voluntary groups
often provide childcare in shelters in time of disaster. With some
support and consultation, shelter residents can provide group
childcare themselves.

Because of the lack of privacy in shelters, children may
occasionally be exposed to witnessing adults engaging in sexual
behavior. Also, when children are unsupervised, they may be
vulnerable to exposure to sexual abuse or exploitation. Mental
health should keep these circumstances in mind in observing and
intervening with the shelter population. In circumstances where
there is concern about child abuse or neglect, mental health staff
are required to report any instances of abuse that they observe or
seriously suspect. Red Cross staff may need consultation about
local reporting procedures.

Based on an assessment of the shelter population, mental health staff can implement actions to meet the mental health needs of the population as a whole. Such "macro" level interventions might include:

     1.   Arranging staffing and other resources to meet the needs of special populations in the shelter: children, elderly, specific ethnic groups.
     2.   Acquainting staff and residents with mental health resources in or near the affected area.
     3.   Providing debriefing and support groups to shelter residents, including age-appropriate therapeutic activities for children.
     4.   Providing handouts and posters about normal disaster stress reactions and helpful stress management strategies for children and adults.
     5.   Providing inservice training and consultation to shelter staff about mental health issues pertinent to the shelter. A topic might include identifying and meeting the needs of special populations. The phases of emotional reactions of survivors and workers during and after disaster can be helpful. Practical suggestions for communicating with disaster survivors might be needed. How to handle difficult situations such as intimidating or intoxicated residents, and establishing clear rules and structure to help contain the population may be important. When to refer to mental health and clear protocol for when to call law enforcement is essential.
     6.   Consulting with Red Cross leadership about stress management for shelter staff and volunteers; providing input regarding staff scheduling, breaks, and supportive services; arranging and providing staff support groups, stress reduction activities, and debriefings throughout the duration of the shelter assignment; providing brief supportive counseling services for individual staff or volunteers who are affected by the disaster or the stress of the job; and providing debriefing groups for workers at the end of their assignment in the shelter.
2.   Interventions with the environment

Mental health staff should work with the shelter manager and nurse to ensure that the shelter environment considers the psychosocial needs of both survivors and workers. Mental health staff may provide consultation or assistance about the following aspects of the shelter environment:

     A.   Space: Mental health staff can consult with the shelter manager about the layout of the shelter. While conditions may not be ideal, optimal allocation of space seeks to reduce noise and provide as much privacy as possible. Staff should ensure that families remain together. If there is discomfort or actual conflict among groups, they should be housed in separate areas, if possible. Some community space is important to promote social interaction, conversation, and recreation. Quiet space is important for individuals to find respite from the bustle of activity.

     Mental health personnel should also try to identify a quiet, private area or room that will belong to mental health alone. Here, staff may take fragile, decompensating, or acutely disturbed people who need to be separated from the stimuli of the setting or need some uninterrupted time with a mental health

worker.

B.   Information: Initially, residents will need
information about the location and well-being of loved ones. Red
Cross Disaster Welfare Inquiry services within the shelter may help
them, although this system is not usually functional until several
days into the disaster. Anything mental health staff can do to
assist people in locating loved ones is helpful. Often, survivors
are not thinking clearly under the stress of the situation, and
concrete problem-solving suggestions are valuable. Rumors are
rampant during the first days of disaster, and staff should remind
residents of the importance of waiting for "official" or verified
information.

People also need information about the changing disaster
situation, e.g., damages in various areas, road closures, projected
duration of evacuation, etc. All available methods of
communication should be provided to help them: television, radio,
newspapers, bulletins, newsletters, maps, and briefings by
emergency officials. However, mental health staff should also
observe to make sure that too much media intake does not add to the
stress of residents. For example, adults may become glued to the
television long after they have ceased to obtain new information.
Parents may also need to be reminded about the effects of too much
graphic television coverage on their children.

Once information on the impact of the disaster is known,
residents will need information on resources for recovery. The
most immediate need will be for information about temporary housing
resources. Posters, brochures, bulletin boards, and visiting
resource specialists from various disaster programs can provide
shelter residents with the information they need. In a
Presidentially declared disaster, most government and voluntary
agencies are grouped at a one-stop center called a Disaster
Application Center (DAC). Shelter residents will need information
about the purpose, location, hours, and resources of the DAC.

Educational materials on common reactions of adults and
children to disaster are especially important. Such information
will help to reassure people that most of their reactions are
"normal reactions of normal people to an abnormal situation."
Education can help to alleviate anxiety and will also provide
anticipatory guidance about reactions that may come up in the
future. Suggestions about stress management are also useful.
Educational materials should help people to recognize when stress
reactions exceed "normal" in intensity or duration, and where to
seek further support and assistance.

C.   Activities: Recreation, exercise, and large-muscle
activity, appropriate to age and health, can help to reduce stress
and improve the spirit in the shelter. Involvement in meaningful
activity can help residents of all ages to reestablish a sense of
control and purpose. Involving residents in shelter tasks, such as
serving meals, reading to children, or putting together a skit for
entertainment, can be helpful.

Childcare can provide therapeutic activities for
children. It also can help to reduce stress on parents who are
preoccupied with many postdisaster problems and decisions.

3.   Interventions with individuals

Because there may be many individuals in the shelter, the task of
identifying those at-risk or in need of mental health intervention
may seem formidable. Most individuals do not seek out mental
health assistance. It is critical, therefore, that mental health
staff actively outreach and "casefind." This is best accomplished
by having mental health staff circulating and "working the floor"
of the shelter, touching base with shelter residents and making
informal observations and assessments of individuals in need. This
method has been called "roaming" (Myers and Zunin, 1992). DeWolfe
(1992) has referred to this as the "over a cup of coffee" method of
informal intervention. Sitting at a mental health table or in a
counseling room will not provide mental health workers with the
contact and exposure necessary to make adequate assessments.

A survey of registration forms may suggest individuals with mental
health problems or at-risk for stress-related problems. In
addition, regular checks with the nursing station may help mental
health in identifying individuals with physical complaints that may
be stress-related. Shelter volunteers and residents themselves can
be used as key informants to help mental health staff to identify
persons in need. Mental health staff can ask such question "How do
you see the stress level in the shelter?" "Are there any specific
situations, individuals, or families you are concerned about?"

The priority for intervention should be individuals with acute
mental health needs. These may include individuals who have a
history of psychiatric illness and may be decompensating because
they have stopped taking medication. There may be people with drug
or alcohol problems who may go into withdrawal. There will likely
be individuals who are experiencing acute stress or grief reactions
related to the disaster. These individuals may be moved to a
counseling room or detoxification room, if one has been set up.
Psychiatric evaluation and medication may be provided if available
and appropriate. Transport to a psychiatric emergency or
detoxification unit may be arranged if necessary and available.
In most situations, medication should be avoided for individuals
experiencing acute grief or stress reactions. The exception is if
medication is deemed absolutely necessary to obtain some sleep or
short-term relief. Individual counseling and attention will
usually help to stabilize the client. If so, the individual can
probably remain in the shelter environment. Regular checks should
be made of these individuals for the duration of their stay in the
shelter. Regular checks will provide for assessment, support,
assistance with problem-solving, and reinforcement of coping
strengths.

Support groups can serve some useful functions in a shelter.
Survivors who attend such groups find reassurance that their
problems are not unique.   Also, they can give and receive
practical advice on the problems they face. Mental health staff
can provide group education about disaster stress reactions, stress
management, and resources. Groups provides a place to refer people
who could benefit from some regular contact with mental health. In
addition, they allow mental health staff to provide some
time-efficient, regular follow-up.

The environment of the shelter will affect the nature of the
interventions. Because of the noise and activity level in large

shelters, mental health staff do not have the luxury of a
controlled, clinical environment for making client observations.
In addition, the environment is not usually conducive to a private,
uninterrupted conversation. Mental health staff need to become
adept at making brief assessments and interventions, sometimes in
as little as five to ten minutes. Despite mental health's attempts
to follow-up with any given individual, people often leave the
shelter with little notice as their situation changes. An
experienced Red Cross worker once advised mental health staff,
accustomed to a practice of regular visits with clients: "Never
assume you will see an individual again. Treat each interaction as
though it's the only one you may have with them. Make it count."
Although this is a large order to carry out under adverse
circumstances, it is not at all impossible. The following are some
guidelines for mental health interventions with individuals in
shelters.

Observation: When circulating in the shelter, mental health
workers are wise to follow their instincts about individuals who
may be distressed. Body language and facial expression may say
much about what is going on for specific individuals, and can help
the mental health worker decide whom to select for interaction.

Active listening: While sensitive, active listening is important,
the shelter environment will make it difficult. Time pressures
will usually not allow for passive responding by the mental health
worker. Shelter residents are often in the denial or honeymoon
phase of reactions, and may feel happy just to be alive. They may
see others who seem much worse off than themselves. They are
likely to be reviewing the events mentally and trying to piece
facts together to inventory their losses. General questions such
as "How are you doing?" will likely elicit vague answers such as
"Fine." In addition, people in the early phase of disaster
response may not yet be ready to talk about their feelings. They
be uncomfortable or irritated with questions that probe for
feelings they are not ready to experience.

Structured conversation:

Most survivors respond positively to active interest and concern.
Gentle structuring of the conversation and alert, active listening
by the mental health worker can assist him or her to assess and
provide a therapeutic interaction with an individual in a limited
period. In their article on "Debriefing and Grief: Easing the
Pain," Myers, Zunin, and Zunin (1990) suggest the following format
for a brief therapeutic conversation:

        First, gather facts: Ask specific questions about the
individuals' losses, exposure to trauma, death of loved ones or
pets, injury to self or loved ones, health status, prior stressors,
coping skills, and support system. It is often helpful to ask
survivors what they know about themselves under stress: How are
they usually affected by stress? What positive things do they do
to cope? What ways of coping do they use that are not so helpful?

        Next, inquire about thoughts. The mental health worker
can explore three areas if time allows. First thoughts: "What was
the first thought you remember after the impact?" Current
thoughts: "What thoughts have you been having since you've been in
the shelter?" Repetitive thoughts: "Is there a thought that you

just can't get out of your mind?"

If there are indications that the person is thinking of suicide, it is essential to evaluate this possibility. Existence and lethality of a plan, availability of method, and previous suicidal history should be explored. Appropriate steps must be taken if a person is assessed to be a danger to himself or others. These steps may include not leaving the person alone, having them turn over the weapon or means, and transporting them to a psychiatric facility for safety and treatment. Involuntary treatment may be necessary if the person is a serious risk but is not willing to obtain treatment voluntarily. State law will govern who can legally apply a hold for involuntary treatment

Thoughts about what you need to do next: "What are the most important things for you to do today and tomorrow?" These questions will give the mental health worker a picture of the frame of mind of the survivor. They will also let the worker know how organized the person's thought processes are concerning setting priorities and problem-solving. Most people experience confusion and disorganization in the immediate postdisaster stage. They may need very concrete assistance in deciding a course of action in the face of all that confronts them. The mental health worker can help the person in listing necessary tasks, then setting priorities on the list. Alternatives and resources can be explored, and a plan of action decided upon.

Third, acknowledge feelings if they arise, but don't probe. Most people spontaneously begin talking about feelings as they share their thoughts. People may be experiencing confusion, fear, anxiety, anger, frustration, guilt, and grief. They may also be relieved to be alive, touched by the kindness of others, altruistic, and highly optimistic about recovery. Responses should acknowledge or validate feelings, but not seek to deepen or intensify survivors' emotional states. It may be clear that some people are in a level of denial about the impact of the disaster. However, it is important to remember that denial is a functional way for people to deal will the implications of the situation at a pace they can handle. Denial usually does not require intervention unless the individual is seriously out of touch with reality, or unless the denial is detrimental to the survivor, e.g., the person is turning away resources that he or she obviously needs.

Fourth, support and reassure. Usually, people's reactions are normal and common. However, most people need reassurance. This is the time to reinforce positive coping strengths and to provide suggestions or reminders about taking care of themselves, including using their support systems. A brochure on normal stress reactions in disaster and stress management suggestions can be helpful at this point.

Provide comfort. In the face of the overwhelming grief associated with disaster, gestures of comfort are a natural and meaningful form of communication. Most disaster mental health workers report using touch much more frequently in disaster than in their ordinary practice. A hug, a pat on the shoulder, a warm beverage to drink, or help in making up a cot may fill the gap when it seems there is nothing to say. Mental health staff need not fear a brief and appropriate show of emotion on their own part. Shared tears are often reported by survivors as a significant

communication of empathy and caring. However, workers must be
aware of their own feelings of powerlessness in the face of
overwhelming destruction and loss. They must be careful that their
attempts at providing comfort do not reflect more about how the
worker is feeling than being truly helpful for the survivor.

        Last, consider follow-up. Because of the sheer number of
people the mental health worker will have contact with, follow-up
with all individuals will not be possible. However, for those in
need of further assistance, a plan for intervention and follow-up
should be established. This may include referring the individual
to disaster recovery resources or to community mental health
services. If both the individual and the worker will be in the
shelter for a few more days, the worker may make plans to see the
individual daily, if needed and if time allows. Maintaining
contact means a lot to survivors who are struggling to put their
lives back together. It may be helpful for mental health staff to
keep a log of identified individuals who appear fragile. The log
can facilitate follow-up among shifts of workers. In the case of
individuals who would benefit from follow-up, the mental health
worker should obtain information about how the person can be
contacted in the future. People often move multiple times
following the loss of a home. Therefore, mental health staff
should obtain the name and phone number of a friend or relative who
can serve as a message center.

        Follow-up may also include recommending alternate
accommodations to the shelter manager and nurse when the stress of
congregate living may be significantly detrimental to the mental
health of a survivor (ARC, 1991). In such cases, the Red Cross can
attempt to find alternative temporary housing.

Because mental health services in disaster are non-traditional and
usually non-clinical in nature, mental health needs to pay close
attention to issues of privacy and confidentiality. Shelter
residents are, for the most part, not "clients." They have not
formally or informally agreed to enter a psychotherapeutic
relationship.

The point may arise in which a disaster survivor is divulging
information that is highly personal or sensitive in nature. At
this point, the worker should discuss confidentiality with the
person. At this juncture, a "shift" may occur, in which the worker
and person agree that a therapist/client relationship has been
established. It is at this point that the therapist should obtain
a release of information from the individual in order to share any
information with other agencies. Mental health staff may need to
explain the bounds of confidentiality to Red Cross workers who wish
to obtain information that the mental health worker cannot divulge.

Follow-up services will need to be arranged if additional
counseling for the shelter resident is indicated. The follow-up
may be with the mental health worker involved or with another
mental health provider. In the case where the mental health worker
is a volunteer from the private practice community, a policy should
be in place governing self-referral to private practice following
the disaster. Many agencies use a review process by the mental
health clinical director or peer review committee before a paid or
volunteer therapist can refer a client to their own private
practice.

Mental health staff should be sure to set up a charting system for people receiving psychiatric evaluation, medications, or intervention of more than a brief nature. In addition, accurate records should be kept of the numbers of people seen, problems they were experiencing, and types of interventions. Staff should keep accurate records of their time and expenses on the disaster job. These records are essential for obtaining mental health crisis counseling funds from the federal government in the event of a presidentially declared disaster.

As the shelter operation comes to a close, mental health staff should pay attention to the mental health needs of the workers disengaging from disaster work. They may provide debriefing for Red Cross personnel at the end of the tour of duty, if Red Cross does not have their own trained disaster mental health volunteers. Mental health should arrange debriefing for their own workers using an experienced disaster mental health debriefer who was not a part of the operation.

Following the shelter operation, mental health should make sure that their staff and volunteers are recognized for their contribution to the disaster effort. Workers who stayed behind at the office or clinic to "mind the store" should not be overlooked.

SUMMARY

Disaster survivors who seek refuge in a mass care shelter have usually endured both trauma and loss. They may have been evacuated from a hazard area. In many cases, they have suffered the damage or loss of their home. The shelter environment itself can be stressful for both survivors and staff. It is a setting to which mental health staff can contribute valuable knowledge and skills. This chapter has provided mental health staff with a brief orientation to the functions of a Red Cross Shelter. It has discussed the shelter as a mental health worksite. Administrative issues for mental health staff have been presented. The chapter has made suggestions for appropriate mental health interventions with the shelter population, the environment, and individuals.

CHECKLIST

DISASTER MENTAL HEALTH SHELTER OPERATIONS

PREDISASTER

_____   Develop a memorandum of understanding between mental health services and the local chapter of American Red Cross

_____   Train mental health staff on the disaster mental health plan, roles, responsibilities

_____   Cross-train mental health staff in Red Cross operations

_____   Provide mental health staff with identification cards recognized and approved by emergency management and law enforcement officials

_____ Have mental health supplies preassembled for transport to shelter, including mental health brochures in languages appropriate to the community's populations

_____ Clarify procedures with Red Cross for administering medications and record keeping in the shelter

DISASTER RESPONSE

_____ Put on identification

_____ Meet with shelter manager and nurse; review and clarify mental health roles and responsibilities

_____ Obtain briefing on conditions; tour shelter

_____ 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

_____ Develop mental health staffing schedule according to needs

_____ Set up quiet room for mental health consultations, and drug/alcohol detoxification room if needed

_____ Consult with shelter manager and nurse as needed regarding shelter environment, needs of individual survivors, and stress management for shelter staff

_____ Assist in establishing sources of information for shelter: Disaster Welfare Inquiry, newspapers, bulletin boards, briefings by emergency officials, brochures about resources, etc.

_____ Assist in establishing activities to promote stress reduction for shelter residents and staff, e.g., childcare, recreation, exercise, support and debriefing groups

_____ Circulate through the shelter and provide brief assessment, intervention, comfort, assistance, and follow-up for individual shelter survivors and staff as needed

_____ Distribute brochures on mental health reactions of adults and children to disaster, self-help stress management suggestions, and where to call for additional help

_____ Provide staff support groups, stress reduction activities, brief supportive counseling services, and debriefings for shelter staff and volunteers

_____ Provide in-service training or consultation to shelter staff about mental health issues pertinent to the shelter population

_____ Provide a summary report of mental health conditions and significant activities to each new shift of

mental health and Red Cross personnel

     _____   Set up a charting system for people receiving psychiatric evaluation, medications, or intervention of more than a brief nature

     _____   Keep accurate records of numbers of people seen, problems they were experiencing, and types of interventions given

     _____   Maintain records of staff hours, supplies, and costs associated with their shelter assignment

     _____   With agreement of Red Cross administration, provide debriefing for Red Cross personnel at the end of shelter operations (if other mental health resources are not providing the service)

     _____   Arrange debriefing by outside resource for mental health personnel at the end of shelter operations

POSTDISASTER

     _____   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"

     _____   Arrange a critique for mental health staff to evaluate effectiveness of their shelter operations

     _____   Revise disaster plan, policies, procedures, and memoranda of understanding, based on recommendations from the critique

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                    PROVIDING MENTAL HEALTH SERVICES
                    IN A DISASTER APPLICATION CENTER

OVERVIEW OF DISASTER APPLICATION CENTER FUNCTIONS

Following a major disaster, a wide range of local, state, federal,
and private disaster assistance programs is available to survivors.
Disaster assistance functions are those activities designed to help
a community back on its feet following a disaster. A major
objective of disaster recovery efforts is to inform individuals of
the assistance available to them and to make the process of
applying for aid as simple and easy as possible.

If a presidential declaration of a major disaster has qualified a
jurisdiction for Individual Assistance Programs under the Federal
Emergency Management Agency (FEMA), officials will set up one or
more disaster application centers (DACs) in the disaster area. A
DAC is a centrally located, "one stop" center where application can
be made for all programs. Personnel from all federal, state, local
and voluntary agencies that can provide disaster assistance are
represented in the DAC to provide assistance, information, advice,
and to take applications for specific programs. The centers are
kept in operation as long as the situation requires. In some
disasters, mobile teams are sent to help people in areas without
easy access to a DAC. Besides the on-site DAC services, FEMA also
provides teleregistration services, by which disaster survivors may
register for services by telephone and avoid having to visit a DAC.

DAC(s) usually open no sooner than the fourth day after the
president's declaration of disaster. This provides adequate time
to locate and set up a site, notify the public of the application
programs and DAC location, train DAC staff, and brief local
officials about DAC operations and procedures.

The DAC is set up as near as possible to affected areas and public
transportation routes. It is commonly located in a large,
well-known public facility such as school gymnasium, National Guard
armory, or community center. The size of the DAC and the number of
agencies participating will depend on the extent of the disaster,
the size of the community, and the capability of agencies to
participate. Usually at least ten to fifteen agencies will be
present.

Local officials are responsible for providing a facility and its
furniture, in addition to crowd control, security, janitorial
services, and first aid facilities. FEMA, state, and local DAC
staff provide their own office supplies, necessary forms, and
signs.

There are two DAC managers, a FEMA manager and a state manager.

They are jointly responsible for overall operations, including interior arrangements of furniture and equipment, coordinating agency programs, and providing liaison with the disaster field office (California Basic Emergency Plan, 1989). There are general reception staff and personnel for each program represented.

Most FEMA DAC managers and staff are "reservists" who work intermittently when disasters occur. They are often from outside the impacted area, and may have no preestablished relationship with regular FEMA staff in the region. Reservists might come to a disaster on the heels of a prior disaster. They may have worked long days for many weeks, with little or no rest between disasters. Additionally, these staff from outside the area are usually not familiar with the local community, its population, its needs, or its resources.

Often, FEMA will augment the reservist staffing by "borrowing" state or local government employees, by hiring local individuals, or by using volunteers. Thus, the mix of staff within the DAC may include experienced professional disaster workers as well as newly acquired "recruits."   Local DAC staff new to disaster work are usually unfamiliar with federal and state programs. They are trained in a "crash course" on site just before the DAC opens.

Local personnel staffing the DAC may themselves have suffered losses in the disaster, and may be in varying psychological and emotional states related to their own situation. In addition, newly recruited DAC staff are not aware of the stresses inherent in disaster work. Typically, they may not know the stress management and self-care techniques that could help them cope with the demands of the job.

DISASTER ASSISTANCE PROGRAMS

DACs provide survivors with access to federal, state, and local government programs as well as private and voluntary agency resources. The participation of local agencies and programs in the DAC is encouraged. Survivors often have pressing concerns about matters of local jurisdiction. For example, they may have questions about debris removal, restoration of utilities, zoning, permits to rebuild, and so forth. Some communities have developed their own programs to help disaster survivors, ranging from low-interest home repair loans to small business loans. These programs supplement or fill gaps in the federal and state programs. Voluntary agencies may provide childcare in the DAC. Local mental health agency staff and/or volunteers are present to provide crisis counseling and practical assistance to survivors, and to provide stress management support for DAC staff. Every effort is made to provide staffing with language skills and a sensitivity to the cultures of the impacted community.

The following are the most commonly offered programs in a presidentially declared disaster (California Basic Emergency Plan, 1989; FEMA, 1989):

Federal programs

        1.   Disaster Housing Assistance Program: FEMA provides assistance for any individual or family whose home has been made uninhabitable because of the disaster. Assistance may be

in the form of funds to obtain alternate rental housing, or to make essential repairs that are required to make the residence habitable.

2.   Individual and Family Grant Program: Grants may be available for eligible disaster victims to meet serious disaster related needs or necessary expenses that are not covered by other disaster assistance programs or insurance. The state administers the grants, with costs shared by FEMA and the state.

3.   Home/Personal Property Disaster Loans: Disaster loans through the Small Business Administration (SBA) are available to homeowners and renters for restoring or replacing disaster damaged real and personal property. Assistance for hazard mitigation to help prevent future losses to damaged property may be included. Interest rates vary, but are lower than prevailing bank loan interest rates.

4.   Business Disaster Loans: SBA loans are available to businesses to repair or replace destroyed or damaged business facilities, inventory, machines, or equipment. Assistance for economic injury may also be available.

5.   Disaster Loans to Farmers and Ranchers: The Farmers' Home Administration (FmHA) provides low interest loans to eligible farmers and ranchers (owners or tenants) for repair or restoration of disaster-damaged farm property. Loans are limited to the amount necessary to compensate for actual losses to essential property and/or production capacity.

6.   Other Agricultural Services: The Department of Agriculture provides cost-sharing grants for emergency conservation programs such as debris removal from crop/pasture lands, repairs to land/water conservation structures, and permanent fencing through the Agricultural Stabilization and Conservation Service (ASCS).

7.   Tax Assistance: The Internal Revenue Service (IRS) may allow casualty losses that were suffered on home, personal property and household goods to be deducted on income tax returns if they were not covered by insurance.

8.   Social Security Benefits: Assistance is available from the Social Security Administration (SSA) for expediting delivery of checks delayed by disaster and for assistance in applying for Social Security disability and survivor benefits.

9.   Veterans' Benefits: The Department of Veterans Affairs can expedite delivery of information about benefits, pensions, insurance settlements, and VA mortgage loans.

10.   Assistance from Financial Institutions: Early withdrawal of time deposits, without penalty, can be permitted by banks that are members of the Federal Deposit Insurance Corporation (FDIC), Federal Reserve Systems (FRS), or the Federal Home Loan Bank Board (FHLBB).

11.   Disaster Unemployment Assistance: This assistance may be available through State Employment Development Departments to provide payments to those out of work due to the disaster, including self-employed persons, farm workers, farm and ranch owners and others not covered under regular unemployment insurance programs.

State programs

1.   Consumer Protection: Counseling on consumer problems may be available through the State Department of Consumer Affairs and local Consumer Protection Agencies. Help may be provided for such situations as nonavailability of products and

services needed for reconstruction, price gouging, disreputable business concerns and practices, etc. The program may provide guidance on the availability of business and contractor services needed to support disaster relief programs.

   2. Social Services: The federal Disaster Food Stamp Program is administered through County Welfare Departments and the Individual and Family Grant Program.

   3. Housing and Community Development: This agency may help to provide sites and facilities for temporary emergency housing.

   4. Insurance Information: Assistance and/or counseling may be available on insurance problems and questions such as obtaining copies of lost policies, claims filing, expediting settlement, etc.

   5. Legal Services: State Bar Legal Services or local legal aid groups may provide free legal services, including legal advice and representation to low-income disaster survivors. Such services may include replacing legal documents, transferring titles, helping with contractor problems, doing will probates, and assisting with insurance difficulties and certain landlord related situations.

   6. Veterans Affairs: This department may assist individuals whose homes, businesses, or farms are financed under a state veterans' program.

   7. Tax Assistance: State taxing authorities may provide advice and assistance in obtaining tax relief for disaster losses.

   8. Mental Health Services: The State Department of Mental Health may provide advice and assistance to local mental health agencies in providing services to survivors. The Department assists local agencies in obtaining funds through the FEMA Crisis Counseling Program.

Local programs

   1. Temporary Housing: Assistance may be provided by city and county Housing Authorities.

   2. Tax Assistance: City and county tax assessment authorities may help survivors in obtaining tax relief.

   3. Consumer Protection: Advice and information may be provided by local agencies.

   4. Public Works Assistance: Local departments of public works coordinate debris removal.

   5. Social Services: In cooperation with the American Red Cross these local agencies may receive and distribute food and clothing and run temporary shelters. They administer the federal Disaster Food Stamp Program.

   6. Health Services: County or city health departments assist with disaster-related public health problems.

   7. Mental Health Services: County or city mental health agencies provide outreach, education, consultation, and crisis counseling to disaster survivors and disaster workers. They administer programs funded by the FEMA Crisis Counseling Program.

Private and voluntary programs

   1. Emergency Individual and Family Needs: Emergency food, clothing, shelter, supplies, medical assistance, and childcare are available to individuals and families in need because of the disaster. Voluntary relief organizations such as

the American Red Cross, Salvation Army, and church groups provide
this assistance.
        2.   Legal Assistance: Groups such as the American
Bar Association may offer legal assistance to families with
disaster-related problems.
        3.   Miscellaneous Services: Local "ad hoc" groups
may form to meet the unique needs of the community, such as
providing laundry service to a community without water.

The Disaster Field Office (DFO) in the affected area usually
distributes a federal/state "fact sheet" listing the disaster
assistance programs available for the specific disaster. The fact
sheet provides general guidelines on types of losses covered, loan
and grant amounts available, interest rates, and so forth. Phone
numbers for other important resources not present in the DAC are
usually included. Local mental health agencies should work through
the state's department of mental health to make sure that
appropriate local mental health phone numbers are included on the
fact sheet. In addition, mental health workers should obtain
copies of the fact sheet for their own information as well as for
giving to survivors.

THE DISASTER APPLICATION PROCESS

Each applicant at the DAC meets with a registrar who completes a
registration form to determine needs and eligibility. The
registrar then directs the applicant to the appropriate agencies
for information and assistance from specific programs.

Responding to each applicant and meeting the immediate needs of
survivors is a difficult, complex, and time-consuming task for DAC
workers. Survivors may be experiencing intense grief related to
their losses. They often are tired and irritable. Many have stood
in long lines to enter the DAC. Survivors may pose technical
questions for which inexperienced workers do not know the answers.
The resulting frustration and anger of the survivor are often
vented on the worker. In addition, the sheer volume of
applications that DAC workers take may be enormous. Three months
after the Loma Prieta earthquake, seventeen DACs in ten affected
counties had received over seventy-thousand applications for aid.
(Bay Area Regional Earthquake Preparedness Project, 1990).

While the application process may be stressful for DAC workers, it
can be even more stressful for applicants. Survivors come to the
DAC under great pressure from the day-to-day difficulties of the
disaster environment. Many have been living in a disaster shelter
or other temporary housing. They may be without clothes other than
what they were wearing at the time of the disaster or what they
have purchased or been given since. They are exhausted from work
and worry. Survivors have both tremendous needs for assistance and
a general lack of knowledge about the available programs.

Under such stress, individuals' ability to think clearly may be
impaired. They may have difficulty understand details, and their
memory may be poor. It may be hard to comprehend the massive
amounts of information being given. Often, required information or
verifications, such as insurance policies or income tax documents,
have been lost in the disaster. For many applicants, the process
of naming and counting their losses while filling out the
applications breaks through the numbness and denial that have been

protecting them from their grief. For many, it is in the DAC where their tears flow for the first time.

In addition, the long list of programs and their corresponding administering agencies and rules result in a complex process that can be difficult for even the most experienced bureaucrats to understand. For example, Individual Assistance programs provide both grants and loans. The Small Business Administration provides loans for homeowners (most people think it provides assistance to businesses). If an applicant is ineligible for a loan, they are referred to the Individual and Family Grant program, which provides eligible survivors with modest grants from FEMA and from the state. If an individual does qualify for a loan, they are not eligible for an Individual and Family Grant.

Furthermore, when coming to the DAC, most applicants are generally unaware of the limitations of disaster assistance programs. They have been assured by public officials and voluntary agencies that massive amounts of assistance are on the way. They do not realize that the process is not intended to cover all disaster-related losses. It simply provides survivors some aid in rebuilding homes and reestablishing businesses. All assistance in the form of a loan must be repaid. Survivors often suffer an additional shock when the limitations of assistance and the implications of those limits are made clear.

In addition, many survivors do not receive adequate information and accurate timelines regarding when they will receive financial assistance. Despite the best efforts of disaster assistance officials, the processing of large numbers of applications is complex and time-consuming. The process may be slowed while applicants struggle to replace documents necessary for verifying eligibility. Federal and state assistance programs use public funds for disaster recovery, and must therefore provide accountability for expenditures. All losses must be verified carefully. Although streamlining of the bureaucratic procedures could make the process less difficult, any use of public monies always carries with it the burden of justifying the expenditure. From the experience of the survivor who is applying for assistance, the process has been called "the second disaster." The application process often inadvertently plays a part in moving the survivor from the "honeymoon" disaster phase, characterized by general optimism, to the "disillusionment" phase, with its inherent frustrations and discouragement.

MENTAL HEALTH SERVICES IN DISASTER APPLICATION CENTERS

The Disaster Application Center as a worksite

The DAC work environment will be significantly different from the usual mental health clinic or office environment. There is a high level of activity and noise. There are many programs represented, each with its own work station, personnel, paperwork, and procedures. The sheer number of programs represented can appear overwhelming to survivors as well as to mental health or other workers who have never experienced a DAC before. The environment and the pressure of what it seeks to accomplish can cause stress for both applicants and workers.

Most disaster survivors will not seek out mental health staff who

are stationed at a counseling room or mental health table. As is
true in most disaster settings, mental health staff will need to
circulate and make contact with individuals in the milieu. A quiet
room where mental health staff can talk with applicants can be
useful for private conversations. A "mental health" table can
provide a place to display brochures, educational materials, and
other information about mental health recovery programs. Staff,
however, should not station themselves in the counseling room or
behind the table awaiting drop-in "clients."

The DAC can be a challenging environment for such interaction, due
to its highly structured function and procedures. Each distinctive
disaster assistance program is set up at a specific table.
Applicants move from table to table, being interviewed by workers
who help them in filling out the paperwork. Survivors are
goal-oriented and highly focused on the process. This is a vastly
different situation from a disaster shelter, where residents often
have time on their hands and are usually easy to approach and to
engage in conversation. Mental health staff will not want to
interrupt or interfere with the DAC application process. They will
need to pay careful attention to the environment so they can meet
survivors in a way that is supportive and not interfering.

A mental health team coordinator should be assigned to supervise
and coordinate mental health staffing at the DACs. In a large
disaster, there may be a coordinator for each DAC. The
coordinator's responsibilities include assessing the staffing needs
of the DAC and scheduling personnel accordingly. Of particular
importance is the inclusion of mental health workers with specific
cultural and language skills or skills with special populations,
such as children or the elderly.

It is essential that both the FEMA and the state DAC managers
understand and sanction mental health's role in the DAC. The
mental health coordinator should meet with both managers to explain
mental health's skills, capabilities, roles, and methods of
operating. The mental health team coordinator should explain the
same information to all DAC workers. DAC workers should be
oriented to how to use mental health appropriately. For example,
the importance of mental health "circulating" in the DAC, rather
than being positioned at a table like other programs, may need to
be explained. Mental health's capability in monitoring staff
stress and providing stress management interventions for DAC staff
should also be explained.
Occasionally, a DAC manager may not be amenable to mental health's
role in the DAC. The state mental health coordinator may need to
assist. He/she can work with the state Individual Assistance
officer and the FEMA Individual Assistance officer at the DFO to
pave the way for collaboration at the DAC.

The mental health team coordinator may have valuable input about
mental health issues affecting DAC applicants and staff, about the
DAC environment, or about other psychological aspects of
operations. Usually the mental health coordinator will be from the
local community. He or she may be of invaluable assistance to the
nonlocal DAC staff by providing consultation about the local
community and its resources. Consequently, it is ideal if the
coordinator is an integral part of the DAC management team, and if
mental health staff attend all regular staff meetings of DAC
personnel. However, this level of collaboration may take some time

to achieve.

Mental health interventions in the DAC

Mental health will have roles at three levels in meeting the
psychosocial needs of survivors and workers in the DAC:

          1.   Population
          2.   Environment
          3.   Individual

These three levels of intervention are described in detail in the
chapter on "Providing Mental Health Services in a Disaster
Shelter." To avoid redundancy, the reader should review the mental
health interventions described in that chapter, translating the
suggestions from the shelter to the DAC environment. The following
information pertains to mental health interventions specific to the
DAC.

     1.   Interventions with the population

Mental health staff will be concerned with two populations in the
DAC: survivors and staff.

Concerning survivors, mental health should be knowledgeable about
situations and issues affecting the mental health status of the
community, including the damages, losses, and types of trauma
inflicted by the disaster. They should be aware that survivors may
come to the DAC in moods ranging from optimism to grief, anxiety
and irritability. They should also be aware that survivors come to
the DAC with high expectations. Survivors also have an urgent need
for information and assistance. They often feel frustrated by the
paperwork, the need for documentation, the lack of answers to their
immediate questions, and the time that it takes to process their
applications. People may take out their frustration on DAC workers
who are doing their best to help them.

The population of the DAC changes from hour to hour as applicants
move through the process and go home and new applicants come in.
Mental health staff can assess the survivor population in the DAC
by maintaining frequent contact with DAC managers and staff. In
addition, mental health staff are unique among DAC workers, in that
they are not tied to a particular post. They can circulate through
the DAC, observing conditions and talking with applicants. In
effect, they can keep a finger on the pulse of the population.
Mental health will want to assess the needs of any "special
populations" in the DAC, to ensure that staffing and services
consider their special needs.

One special population in the DAC will be the children of
applicants. Mental health child specialists can help with this
population by involving themselves in childcare activities. They
may help with childcare or provide consultation to childcare
workers. If childcare is not being provided, the stress on parents
and workers increases dramatically as the children become bored and
fussy. Mental health might discuss the situation with DAC
management and assist in identifying local resources that could
provide this on-site childcare or recreation activities. Staff can
also help the child population by circulating through the DAC and
talking with parents with children, asking how the children are

doing, providing brochures about children's reactions, and providing consultation as appropriate.

Mental health should also be attuned to the needs of the elderly or people with disabilities who come to the DAC. Frail elderly or people with mobility, vision, or hearing impairment may have difficulty navigating the room, hearing what is being said, or reading fine print. In addition, they may not have the stamina to endure the long process involved. Mental health may work with DAC managers and staff to provide special assistance in such cases, such as assigning a volunteer to an applicant with visual impairment to help in filling out forms.

The mental health staff will also want to pay attention to special needs of particular ethnic or cultural groups coming to the DAC. Ideally, DAC and mental health staff should be able provide services in the language of the people coming for service, preferably having staff indigenous to the culture being served. If this is not possible, at the very least, translators should be available, with cultural sensitivity training provided to all DAC staff to familiarize them with the culture(s) of the population.

Mental health may offer consultation or training to DAC staff. Topics might include needs of special populations, or how to handle difficult situations (such as intense anger or intoxicated applicants). Inexperienced DAC staff may not be prepared for the intensity of emotion that is a "normal" reaction of survivors to the "abnormal" disaster situation. Some brief training by mental health about these normal reactions and when and how to refer to mental health can be helpful. Training about helpful and unhelpful styles of relating to disaster survivors can also provide staff with self-confidence about their ability to deal with survivors' normal but often intense emotional reactions. Training might include the art of listening, avoiding authoritarian or overprotective attitudes, not taking over too much responsibility, not minimizing the individual's feelings, avoiding false promises, and what to do if a person cries (American Red Cross, 1982).

If mental health is recognized as a trusted, integral part of the DAC team, they can provide support and advice to DAC management regarding staff stress management. They should specifically ask DAC managers to identify any staff who were personally affected by the disaster. They can then offer support and make sure that staff are not overlooking their own disaster-related needs because of their helping roles. It is also useful to know if any DAC staff came to the disaster directly from another disaster assignment, as these people may be at risk for fatigue, health problems, and burnout.

Because of their vantage point in circulating throughout the DAC, mental health staff are in an ideal position to observe staff functioning and provide advice to DAC management. Mental health may suggest stress management strategies such as breaks, regular meal times, limiting length of shifts, the need for time off, and the like.

If the population of applicants and workers is looking particularly fatigued or tense, a mental health worker can suggest a short, 2-3 minute "recharge" activity. This can be done in small groups or, in a small DAC, for the whole population at once. The mental

health worker simply announces to the group that she/he knows that
what goes on in the DAC can be stressful and fatiguing for
applicants and workers. The worker states that she/he is going to
lead them in a little stress management break. The worker then has
everyone stand up and leads them through some deep breathing and
gentle stretching for tense muscles. People may seem a bit shy at
first, but usually appreciate the attention and concern. The
activity always seems to greatly affect morale and physical
comfort. It is minimally disruptive to DAC activities, and may
even results in increased productivity. This type of group
intervention does take some boldness by the mental health staff.
It should have the approval of the DAC manager.

     2.   Interventions with the environment

Mental health should work with the DAC managers to ensure that the
DAC environment considers the needs of both survivors and workers.
Consultation may be provided regarding physical aspects of the DAC
space to reduce noise, ensure privacy, allow childcare and
recreation activities, encourage appropriate social interaction,
and so forth. Ideally, a quiet room should be available for mental
health counseling which requires privacy.

Mental health can ensure that survivors are obtaining information
they need regarding mental health resources for recovery. In
particular, mental health will want to make available informational
materials on common reactions of adults and children to disaster,
with suggestions for stress management, and information about where
to seek further support and assistance. Mental health workers can
display such information on posters and hand it out as they
circulate through the DAC. Information about mental health should
be included in any displays of brochures about disaster resources
and on the DAC "fact sheet" about resources.

The DAC managers are responsible for arranging such things as
refreshments, recreation, exercise, and childcare activities to
help reduce stress and improve the spirit in the DAC. These
activities are usually done by the Red Cross or other voluntary
agencies. However, if mental health staff have suggestions for
improvement or for additional activities, they should discuss their
ideas with the DAC managers.

     3.   Interventions with individuals

Because there are so many individuals in the DAC, the task of
identifying individuals at-risk or in need of mental health
intervention may seem quite difficult. Because most individuals
will not seek out mental health assistance, active outreach and
"casefinding" by mental health staff is critical. This is best
accomplished by having mental health staff circulate and "work the
floor" of the DAC, making informal observations and assessments of
individuals in need. Workers might interact with survivors in the
less structured areas of the DAC, such as in lines or waiting
rooms, refreshment areas, childcare sections, and so forth. They
may help with practical activities such as serving coffee, telling
stories to children, or providing language translation. These
activities provide concrete help as well as open the door to
informal "therapeutic" conversations.

In circulating throughout the DAC, mental health should use DAC

staff as key informants about specific survivors who might benefit
from interaction with mental health. If DAC personnel are familiar
and comfortable with mental health as part of the DAC team, DAC
staff can be important "gatekeepers" in helping mental health to
make linkages with survivors. An interviewer who is working with
a distraught client can informally summon a crisis counselor to the
table and introduce them to the client as a DAC team member who
specializes in working with disaster stress. The mental health
worker can then help with the application process, and/or can
arrange to speak further with the individual before they leave the
DAC. Similarly, mental health workers can "move in" to assist
with an interview when it appears that they might be of help to an
interviewer or a distressed survivor.

If helping survivors with the application process, mental health
should be very careful not to attempt to interpret eligibility
criteria to the individual. This is the responsibility of the
appropriate agency representative (FEMA, 1987). If the DAC staff
member cannot fully answer the individual's questions, they should
be referred to the appropriate DAC manager.

Mental health should maintain regular communication with the DAC
registrars, who will have contact with each individual coming into
the DAC. Mental health should provide the registrars with
consultation regarding situations that put individuals "at risk"
for mental health problems: those who have lost loved ones; have
lost homes; have homes with major damage; have lost jobs; or have
been exposed to traumatic sights, sounds, or experiences. They
should request that the registrars introduce them to any applicants
they may have concern about.

In circulating regularly through the DAC, mental health can chat
informally with DAC staff on their breaks or at their work stations
when business is slow, providing support, encouragement, and
self-care reminders. Mental health staff can also provide brief
supportive counseling services for individual staff affected by the
disaster or job stress. They may provide group debriefing services
for workers periodically and at the end of their assignment in the
DAC.

Specific interventions for use with individual survivors and
workers in the DAC are discussed in the chapter on "Providing
Mental Health Services in a Disaster Shelter."

SUMMARY

Disaster survivors who apply for services through a Disaster
Application Center are there because they have suffered losses of
various kinds. For many people, enumerating these losses during
the application process accentuates their grief. The DAC
environment itself can be stressful for both survivors and staff.
Mental health staff can contribute valuable knowledge and skills in
the DAC setting.

This chapter has provided mental health staff with a brief
orientation to the functions of a DAC. It has discussed the DAC as
a mental health worksite, and has made suggestions for appropriate
mental health interventions with the DAC population, the
environment, and individuals.

CHECKLIST

DISASTER MENTAL HEALTH OPERATIONS IN THE DAC

PREDISASTER

_____   Train mental health staff in disaster mental health plan, roles, and responsibilities

_____   Train mental health staff in organizational aspects of disaster, including federal, state, and voluntary response agencies, disaster assistance programs, and the function and organization of DACs

_____   Provide mental health staff with identification cards recognized and approved by emergency management and law enforcement officials

_____   Have mental health supplies preassembled for disaster response, including mental health brochures in all languages appropriate to the community's population

DISASTER RESPONSE

DAC mental health coordinator:

_____   Put on identification

_____   Meet with DAC managers; review/clarify mental health roles and responsibilities; explain the role of mental health to DAC workers

_____   Obtain briefing on DAC operations; tour DAC

_____   Assess population of survivors for special needs, e.g., children, older adults, specific ethnic groups, individuals experiencing loss or trauma

_____   Assess population of DAC workers for stress-related needs

_____   Develop mental health staffing schedule based on needs in DAC

_____   Manage logistical needs of DAC mental health staff (food, shelter, supplies, communication equipment, etc.)

_____   Arrange a quiet room for mental health consultations

_____   Consult regularly with DAC managers, registrars, and staff about needs of individual survivors and stress management for staff

_____   Provide summary report of mental health conditions and significant activities to each new

shift of mental health and DAC personnel

_____ Obtain statistical reports from mental health staff; provide statistical and cost reports to mental health management

_____ Arrange debriefing by outside resource for mental health personnel at the end of DAC operations

DAC mental health staff:

_____ Put on identification

_____ Circulate through DAC and provide brief assessment, intervention, comfort, assistance, and follow-up for DAC applicants and staff as needed

_____ Distribute brochures in appropriate languages on mental health reactions of adults and children to disaster, self-help suggestions, and where to call for help

_____ Provide stress reduction activities, brief supportive counseling services, and debriefings for DAC staff

_____ Provide inservice training and consultation to DAC staff about mental health issues pertinent to the population

_____ Provide DAC mental health coordinator with accurate records of numbers of people seen, problems they were experiencing, and types of interventions given

_____ With agreement of DAC managers, provide debriefing for DAC personnel on a periodic basis and at the end of their assignment in the DAC

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_____ Provide recognition to mental health staff for contribution to the disaster effort, including those who stayed at the clinic to "mind the store"

_____ Arrange a critique for mental health staff to evaluate the effectiveness of their DAC operations

_____ Revise disaster plan, policies, and procedures based on recommendations from the critique

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CHAPTER NINE

THE ANNIVERSARY OF THE DISASTER:
MENTAL HEALTH ISSUES AND INTERVENTIONS

An anniversary, by definition, is the recurrence of an event or the reawakening of feelings surrounding an event that took place in the past. An anniversary may also be a commemorative celebration of an important date.

Anniversary remembrances occur consciously and unconsciously, and are a part of our biology, psychology, history, and culture.

DERIVATION OF ANNIVERSARY REACTIONS

Biologically, all animals have a fine tuned awareness for signals of danger. Sights, sounds, smells, or other reminders of a threatening event usually evoke a memory of the threat and alertness for present danger. These sensitivities help to explain the "trigger reactions" of disaster survivors. Situation, sights, or sounds that remind people of the disaster experience can evoke a stress response. For example, earthquake survivors frequently become anxious when a truck rumbles by, rattling windows.

Besides having acute alertness for danger, animals including humans have an exquisite sensitivity to the changing of the seasons. Mating, nesting, foraging, and hibernating all take place in response to cues from the environment: changes in light/dark cycles, temperature, smells. Many ancient human traditions and rituals have evolved around times of the year or change of the season: rites of Spring, celebrations of the harvest, festivals of light in the darkness of the winter solstice. It is not surprising, then, that the normal stimuli associated with the "time of year" can evoke memories of an event, a heightened sense of anxiety, and reawakening of feelings associated with the event.

Many disaster survivors report restlessness and fear with the return of the season in which a disaster occurred. For example, when the annual storm seasons will likely bring anxiety to people who have survived a hurricane the previous year. A woman whose neighbor was killed in a massive mudslide reported ten years later that she still gets jitters when it rains (Johnson, 1992).

Psychological literature discusses "anniversary reactions" as the individual's response to unresolved grief resulting from significant losses (Cavenar, Spaulding, and Hammett, 1976; Pollock, 1970). From a psychodynamic perspective, Szekely (1978) describes the death of a close relative or friend or other "historic" event as leading to a modification of an individual's self-image. The change converts the event into a type of "monument" in the individual's personal history. These unconscious, timeless, and permanent self- and object-representations have a temporal character that is associated with feelings of longing or hopeful expectancy. Szekely describes two predisposing conditions for the generation of anniversary reactions: strain/trauma and unfinished mourning. Disasters in which individuals have experienced intense trauma and significant losses contain both predisposing conditions. For individuals who have experienced core losses, such as the loss of a loved one or the loss of a home and all the artifacts of one's history, mourning is still in progress at the one-year anniversary. It takes much longer than a few months to truly begin to make peace with the past and turn to the future. In their study of loss and mourning, Zunin and Zunin (1991) found that the lives of the bereaved may still be strongly affected a year and a half to three years later.

Some individuals may experience complicated or "pathological" bereavement with an intensification, a prolongation, or an inhibition of normal grief. In these cases, anniversary reactions can be used in clinical treatment as an opportunity to work through incomplete mourning (Cavenar, Spaulding, and Hammett, 1976; Pollock, 1970).

For normal people dealing with the abnormal situation of disaster, the anniversary can also provide an opportunity for emotional healing. By recognizing, allowing, and attending to the feelings and issues inherent in the anniversary reaction, an individual can make significant steps forward through the natural process of grief.

Formal recognition of anniversaries is part of human history and culture. Some anniversaries are of a happy nature: celebrations such as birthdays, weddings, historic events, and religious holidays. Anniversaries of such occasions prompt joyous memories and feelings. Some anniversaries are of a commemorative nature, in remembrance of tragic events or losses. Examples include the anniversary of a loved one's death or a day of honor for many who have died, such as Memorial Day.

Many cultures and religions have established traditions and rituals for grief and mourning, during which the first year is a formalized period of mourning. For example, Judaic law has established specific stages of mourning. There are guidelines for appropriate activities regarding marriage during the mourning period, the amount of grief to be shown, and the type of garments to be worn. In many cultures, the 1-year anniversary of the death ends the formal period of mourning.

Pollock (1972) hypothesizes that cultural mechanisms and traditions have been derived from the awareness of the intrapsychic needs of the individual. They arise from the need to achieve psychosocial equilibrium through institutional regulations. In other words,

religious and cultural belief systems regarding mourning and anniversary processes have evolved from the normal and natural psychological processes.

Similar to culturally prescribed response to major loss, most communities stricken by disaster develop formal mechanisms to commemorate the anniversary of the event for one or more years. Depending on the meaning of the event to the community, anniversary remembrances may continue to take place for many years. Survivors of the 1906 San Francisco earthquake still meet at 5:12 A.M. each April 18 to remember the anniversary.

DISASTER ANNIVERSARY REACTIONS

Not all disaster survivors experience anniversary reactions. However, many people do, and are troubled because they did not expect the reactions and do not understand them. It is important for disaster mental health personnel to be familiar with commonly experienced anniversary reactions in order to provide anticipatory guidance and public education about the normalcy of the reactions.

Frequently reported anniversary reactions among disaster survivors include the following:

Memories, dreams, thoughts, and feelings

At the anniversary of the 1985 Appalachian floods, an older woman reported that she simply couldn't keep her mind off the flood during the weeks approaching the anniversary. She reported remembering things she hadn't thought about for months. Parents may find their children suddenly talking about the disaster again. Adults and children alike may experience dreams about the disaster or other disturbing dreams.

For many people, the memory and feelings that occur on the anniversary are vivid. On the tenth anniversary of the 1982 flood and mudslide disaster in Marin County, California, fire Battalion Chief Brian Waterbury remembered the search operation he had led. For 25 hours firefighters near hypothermia searched in driving rain for a woman who was missing in the rubble of her mudslide-ravaged home. Looking back, the chief recalled the numbness that gripped his stomach when her body was unearthed. "The same mental pictures keep coming back, even though it's been ten years ago. It seems like it was almost yesterday to me. . . . I still have the vision, recall that feeling, the frustration of searching so hard, that feeling of hope, only to have it dashed at the end. There's still a certain amount of pain" (Johnson, 1992).

Grief, sadness, and regret

Individuals who lost loved ones frequently find that the anniversary of the death stimulates feelings of grief and pangs of longing. "She loved to ride her bicycle to the store and back with me. It would tickle her to death that she could outrun me," said a Hurricane Hugo survivor at the storm's anniversary. "But her bicycle's put up now. Nobody's been on it since she's gone." His youngest granddaughter had died in a fire sparked when Hugo's winds blew down power lines (Greene, 1990).

In their book on condolence, Zunin and Zunin (1991) include a

letter from Princess Alice written to her mother, Queen Victoria,
on the anniversary of the death of her father, King Albert.

                              Darmstadt,
                          December 11, 1866

     Beloved, precious Mama,

     On awakening this morning, my first thoughts were of you and
of dear darling Papa! Oh, how it reopens the wounds scarcely
healed, when this day of pain and anguish returns! This season of
the year, the leafless trees, the cold light, everything reminds me
of that time!

The grief associated with the loss of a home can also intensify at
the time of the anniversary. People living in temporary dwellings
may experience a rekindling of sadness over the loss of their home
and the lack of a permanent replacement.

Even people who have rebuilt their homes or found new dwellings to
rent frequently feel a sense of loss at the anniversary. One fire
survivor explained that their new home resembled the one they lost.
However, they would still go to certain parts of the house,
expecting to find what was there before. At the anniversary of the
fire, they particularly thought back on what was gone.

People who have been forced to relocate to another locale may
experience intense homesickness. "I miss the island terribly,"
said a survivor of Hurricane Hugo one year after the storm. He was
forced to move off Pawley's Island after the hurricane. "I don't
know the tides like I used to, and I miss seeing the moon every
night. And I miss the smell, and the changing seasons that were so
evident on the island" (Greene, 1990).

Besides memories and mourning of lost loved ones, homes, and
communities, people may also grieve for belongings they lost,
especially precious keepsakes they wished they could have saved.
At the anniversary of the 1990 Santa Barbara, California wildfire
one woman lamented that all she took with her as she escaped the
wind-whipped blaze were her bills. She deeply regretted not
picking up some cherished mementoes nearby. Family photographs,
bibles, baby books, a deceased son's military awards, a
grandfather's birth certificate, the family piano, 27 years of
Christmas decorations--these are the things people think about with
longing at the time of the anniversary. "A house is just concrete
and glass," observed a survivor at the one-year anniversary. "It's
the other stuff that has memories . . . those are the things that
you really miss" (Schultz, 1991).

For some survivors, life during the first year after the disaster
is simply too busy for them to grieve. One year after the 1989
Loma Prieta earthquake in California, many people expressed relief
at the waves of grief that were occasioned by the anniversary.
Many people reported having been so busy with the paperwork and
practicalities of rebuilding, they had not yet given themselves
time to "let down" and mourn their losses. After one year, things
were far enough along on a concrete level for them to take time to
deal with their feelings. "This is the first time since the
earthquake that I've been able to cry," said one San Francisco

resident as she wept at the one-year anniversary commemoration.
"I've been numb for so long" (Seligman, October 18, 1990).

Fear, anxiety, and stress

For many individuals, symptoms of fear and anxiety begin to recede
a few months after the disaster, only to resurface around the time
of the anniversary. Some report a resurgence of jumpiness,
startle responses, and vigilance about safety.

For individuals who were severely traumatized, the fear may not be
significantly diminished by the end of the first year, and the
anniversary rekindles it even more. One six year-old boy who
narrowly escaped the flames of the 1990 Painted Cave Fire in Santa
Barbara, California still panicked one year later every time he
heard a siren (Schultz, 1991). During Hurricane Hugo, a mother had
to tie her family to a high railing to keep them from being swept
away by rising floodwater. "I'm still scared," said her eight
year-old son, looking back a year later. "I almost drowned in that
storm. I just can't help it" (Greene, 1990).

Crisis counseling services in northern California experienced an
upsurge of calls in the week preceding and following the one-year
anniversary of the Loma Prieta earthquake. Many survivors reported
anxiety when traveling on bridges or under freeway overpasses.
"People still feel shaky; their nightmares are coming back,"
reported an Afterquake Project counselor. "They're not sure what
they can do. They feel more vulnerable" (Seligman, October 17,
1990).

Frustration and anger

The anniversary can also reawaken resentment and anger about the
disaster. One flood survivor remarked at the time of the
anniversary "I keep remembering things that weren't fair."
Survivors may remember the things that irritated them, the things
they lost, the time taken away from their lives, frustrations with
the bureaucratic aspects of the recovery process, impatience at the
slowness of rebuilding and healing. Many homes are still not
rebuilt at the first anniversary. Owners of nearly one-half the
structures destroyed in the 1990 Santa Barbara, California wildfire
had not submitted applications for permits to rebuild at the first
anniversary (Schultz, 1991). In the aftermath of the East Bay (CA)
Firestorm of 1991, only 12% of homes destroyed in the city of
Berkeley were under reconstruction at the one year anniversary and
none had been completed (Wee, 1992). A Red Cross worker commented
on the stress level in Santa Cruz, California a year after the Loma
Prieta earthquake: "The whole year has been very strange. People
realize a year has gone by and they are not fully recovered,
financially and spiritually" (Samuelson, 1990). For some people,
this anniversary-time reflection, is an impetus for people to seek
mental health counseling and support. Disaster mental health
programs often report an increase in calls for service at the time
of the anniversary.

Survivors may experience anger and resentment at the losses dealt
them, and at their real or perceived inability to rebuild their
lives or recoup their losses. A 91 year-old woman's apartment was
demolished in the 1989 Loma Prieta earthquake. Her husband of 50
years died shortly after that. She reflected at the one-year

anniversary: "My husband couldn't stand all this. It was too much
for him. The terrible shock, the loss of things, the terrible
problem of where to go next, and then to fill these empty rooms,
the furniture he had to seek out and try to buy and get here. Of
trying to replace everything, the lamps, the toaster, everything .
. . all nerve wracking. He had latent leukemia for three or four
years but he was doing very well and then the leukemia became
virulent . . . We were minding our own business. The earthquake
was not on our agenda . . . we lost everything" (Drewes, 1990).
One Santa Barbara fire survivor stated that he had many things on
his life agenda that he would have preferred doing that year other
than selecting toilets and bathroom fixtures for the house he was
rebuilding.

For one Santa Barbara couple, the one-year anniversary of the fire
brought up a sense of failure. They had disagreed about whether to
rebuild their home after the fire. She wanted to move away from
the area, while he insisted on rebuilding. One year later,
reconstruction was far behind that of their neighbors, primarily
due to ongoing differences between the man and his wife at every
stage of the reconstruction. Their relationship had deteriorated,
each blaming the other for creating problems. The woman felt
isolated, sad, and depressed. The man, who was retired, did little
besides work on the new home.

Avoidance

Many survivors welcome the cleansing tears, the commemoration, the
reflection, and the fellowship that the anniversary of the disaster
can offer. However, some survivors attempt to "ward off"
anniversary reactions by avoiding reminders and making efforts to
treat the anniversary as just an ordinary day. A young man who
lost his father in the collapse of the Oakland, California Cypress
Structure freeway after the 1989 earthquake was asked how he
planned to spend the day of the anniversary. "I see no sense in
celebrating an earthquake," he said (Chiang, 1990). Even if people
prefer to treat the anniversary as "just another day," it can be
useful to educate them about the common reactions that they or
their loved ones might encounter. Then, they will not be taken by
surprise or feel they are having a "setback" if reactions occur.

Reflection

Recovery from disaster takes place on many levels. It involves
rebuilding physically, emotionally, and spiritually. For most
people, the anniversary is a landmark point in the recovery
process. It takes time for humans to integrate an event of such
magnitude into their life experience. By the one-year anniversary,
enough time has passed for people to have developed some
perspective on the event and its place in their hearts, minds, and
lives.

Based on recollections of the disaster, survivors often confront
the haunting question "What would I do differently if I had to go
through it again?" They often do so in hopes their answers might
help others who confront such a situation. Unanimously, survivors
recommend preparedness planning. They discuss eliminating hazards
from the home and neighborhood environment. They emphasize
purchasing adequate insurance and recommend videotaping every room
in the house, including contents of drawers and closets, for

insurance purposes. Survivors warn of the importance of having
safety equipment and disaster supplies. They underscore the
importance of duplicating essential documents and photographs and
storing copies off-site. They agree on the importance of keeping
photographs and mementoes in one place in the home so they can be
easily evacuated. And they unanimously advise having a family plan
for evacuation and a designated site to meet each other if
separated.

Many people also reflect on ways in which, despite the losses and
trauma, their lives have changed for the positive. A disaster
causes a reassessment of values and beliefs. Many people can
recognize the challenges they have overcome, and acknowledge the
courage, stamina, endurance, and resourcefulness within themselves.
They often reflect with appreciation on the loved ones and friends
who have helped them through. Survivors may feel grateful for
deeper and more meaningful relationships. In reaching the
anniversary of the earthquake, people achieve an important
transition: that of seeing themselves no longer as "victims," but
truly as "survivors."

"It took away a certain part of my history and a certain part of my
life, and you just don't rebuild that in a year," said a survivor
of the 1990 Santa Barbara, California fire. But he also gained a
new perspective on himself and what is important in life in the
wake of the fire, he said. "It really got me to take a look at how
I was living my life before. It amplified some things that needed
correcting. It really turned my life around . . . Without the
fire, I wouldn't have half of what I have right now." A film maker
and artist by trade, he was inspired to create a video documentary
of the fire and its survivors. The video was shown at a local
theater on the anniversary of the fire as a benefit for the Red
Cross. It has since won two major awards.

Another survivor reflected on his neighborhood before and after the
disaster: "We weren't nearly as close before the fire," he said at
an anniversary block party on his street that had been destroyed.
While many homes were yet to be rebuilt, neighbors gathered and
reminisced as they ate cake decorated with rubble and a chimney
sending out colorful plumes of smoke. "This has been the best part
of the fire. The fences came down and we became friends," he said
(Malcolm, 1991).

The reflection occasioned by the anniversary often becomes a
landmark point in the recovery process. It allows people to
sharpen their perspective on the event and its place in their
hearts, minds, and lives. It allows people to look back over the
past year, recognizing how far they have come and the challenges
that have been surmounted. It is a time for survivors to look
inward, to recognize and appreciate the courage, stamina,
endurance, and resourcefulness of themselves and each other
throughout this process of recovery. It is a time for people to
look around and appreciate the loved ones and friends who have
helped them through the healing. It is also a time when most
people can look forward. In reaching the anniversary of the
disaster, most people recognize that they have achieved an
important transition: that of seeing themselves no longer as
"victims," but truly as "survivors."

ANNIVERSARY INTERVENTIONS AND ACTIVITIES

The goals of disaster anniversary mental health activities are as follows:

        1.   To educate survivors about common anniversary reactions.

        2.   To help survivors acknowledge and discuss issues and feelings still unresolved since the disaster or brought up the disaster anniversary.

        3.   To encourage survivors to view the anniversary as an opportunity for another step toward healing and closure of the disaster experience.

        4.   To allow survivors to reflect on changes in their lives since the disaster, to see the experience through the perspective of time, and to encourage a sense of mastery and survival.

        5.   To educate those not directly affected by the disaster about the reactions that may occur for survivors, and to encourage outreach and support to survivors.

Community education

Mental health programs should begin to plan for anniversary activities and interventions at least two months before the anniversary date, with more lead time if community activities such as commemorations, presentations, or conferences are planned.

The psychological and emotional impact of the anniversary may be quite intense and unexpected for survivors. Starting about a month before the anniversary, public education about anniversary reactions should begin. Anticipatory guidance, normalization and support can greatly diminish the anxiety involved with anniversary reactions. Education helps the survivor to understand that these "aftershocks" are not setbacks, but are natural and normal aspects of healing. Often, people feel embarrassed or uncomfortable about the intensity of their feelings around the time of the anniversary. They need reassurance that these feelings are normal. Mental health staff can emphasize the ongoing importance of people reaching out to each other to provide support and encouragement.

Education can also help people to plan for the anniversary and how they wish to spend the day. Encouraging people to talk about their memories as well as their present thoughts, feelings, and concerns about the disaster is helpful. It is also important for mental health to encourage people personally to recognize, articulate, and appreciate their own survival strengths and accomplishments. Although there may still be much physical and emotional rebuilding to be done, the survivors have made it courageously through a long and harrowing year. It is important to help people to look toward the future with realistic optimism.

The media is a useful tool for educating the public about anniversary reactions. At the anniversary of large scale disasters, the media usually rerun stories of the disaster. They usually provide a retrospective look at how far individuals and the community have come in their recovery in the year since impact. Media coverage of the disaster anniversary floods the area with images of the past as well as predictions for the future. Sometimes, media coverage may reactivate responses and feelings about the disaster, and it may be wise to limit exposure,

especially for young children. However, the media's interest in the anniversary provides a natural occasion for disaster mental health education. Mental health should utilize the opportunity to provide press releases, news conferences, or interviews about the psychological aspects of the anniversary.

Fliers and brochures can be developed and distributed to the public. They can provide information about common anniversary reactions and suggestions about ways to cope. They can also encourage people to see anniversary reactions as a step toward healing. In addition, special educational materials, consultation, and training can be provided for organizations serving survivors, such as churches, medical clinics, or disaster agencies. For example, written materials can be sent to schools and to parents with suggestions about commemorative activities for children. Appendix C provides an example of a manual to guide schools through commemorative disaster anniversary activities for students.

Crisis counseling and support groups

Disaster mental health crisis counseling programs often report an increase in calls to their hotline or intake phones in the weeks preceding and following the disaster anniversary. Many callers found that phone counseling, education, and support provided them with an understanding of their anniversary reactions, and the phone call was all that was needed. For others, the anniversary reactions provided an impetus to become involved in ongoing counseling.

People already being seen in individual counseling or support groups should be educated about common anniversary reactions and given the opportunity to discuss their thoughts and feelings about the anniversary. Sometimes, disaster support or recovery groups have conducted anniversary remembrances or activities, such as a special meeting, potluck supper, or memorial service. After a mudslide disaster where many homes were lost, one support group conducted a special "funeral" ceremony at the site of each group member's former home. The ritual provided a way to help individuals put their losses formally to rest.

Commemorative activities

The anniversary can generate mixed reactions of memory and grief, introspection and reflection, and relief and pride in having survived the first year. Many people choose to commemorate the anniversary of a disaster in personal or public activities or rituals.

Mental health can play an important role in encouraging these rituals and ceremonies, as they have an important healing power for survivors of a disaster. Public officials may ask mental health to help with the planning or carrying out of anniversary activities. In cases where no planning is taking place regarding the anniversary, mental health programs can provide leadership and consultation to individuals, groups, and public entities regarding appropriate anniversary activities to foster individual and community healing.

1.   Private commemoration: People may find themselves rethinking the day of the disaster--what happened, what they did, what they

didn't do. Many people find themselves reminiscing with friends or
family, telling "where we were when" stories about what happened to
them.

Many individuals who have experienced tragic loss choose to
remember the event in a very personal way. For those who lost
loved ones, they may visit the grave or a special place that they
had shared with the loved one. They may wish to write a letter or
poem to the person who is gone, especially if they feel there was
"unfinished business" in the relationship.

Some people are drawn to return to the site where their loss took
place. "It was so traumatic I didn't want to come back," said one
Loma Prieta earthquake survivor about the first anniversary. "But
I just thought I had to be there." She had been moving into an
apartment building which was reduced from four stories to one when
the quake hit. A handful of former occupants returned a year later
at precisely 5:04 p.m., the moment of the earthquake, to share
bottles of champagne and unforgettable earthquake stories. Among
them were the man who bulldozed their building, allowing them time
to retrieve valued possessions, and the Department of Public Works
supervisor who oversaw the demolition. "These people were a bunch
of survivors," he said. "There isn't anyone else I'd want to spend
the anniversary with." The mood was more somber at another site
nearby, where former residents brought flowers in memory of three
neighbors, including a 3-month-old baby, who lost their lives in
the quake (Walsh, 1990).

Numerous individuals made an anniversary hike to the epicenter of
the earthquake in the Santa Cruz mountains to privately reflect
upon the impact of the disaster on their lives. "This just seemed
like the best place to be to commemorate what happened last year
and how everybody's struggled, especially since it was an act of
nature," said one survivor (Dougan, 1990).

2.   Public commemoration: Mental health programs may provide
leadership or consultation to planning groups regarding appropriate
community commemorative activities. In addition, mental health may
be a participant in anniversary activities. Staff may serve as
speakers, may provide fliers and brochures, or may simply be
present to recognize and support survivors.

Most public events marking the anniversary of disaster have two
elements. These include commemoration of losses and recognition
and celebration of the human heroism, strength, and compassion that
are manifest in the recovery process. Public commemorations have
a way of moving survivors to tears, embraces and a joy mixed with
sadness that only the survivors of a disaster can truly comprehend
(Figueroa, 1990).

Commemorative events often involve a gathering at the scene of the
disaster or other appropriate place, such as a grave or memorial
site. Services may be conducted, speeches may be given, songs may
be sung, poems may be read. People may carry candles or flowers.
Commonly, there is a moment of silence at the exact time of impact.
Church bells may be rung. In remembrance of military deaths, taps
may be played. A memorial statue or plaque may be dedicated in
memory of those who died, or a tree may be planted.

Recognition of heroism and of the contributions of citizens is

usually given. At large-scale, community-wide events, the mayor or
other public officials may make speeches, thanking and giving
praise to those who have helped. The public is usually commended
for its hardiness and hard work, and for pulling together when it
mattered most. At the anniversary of the 1989 earthquake, the San
Francisco mayor spoke to a large group gathered for a commemoration
at the Ferry Building. The prominent flagpole atop the building
had been damaged and unused since the quake. "The lights went out
over this city, but the power of this community's spirit stayed a
shining light that the whole world saw. San Francisco never stood
taller." At 5:04 PM, the moment of the earthquake, the bells of
the clock tower sounded and an American flag rose on the flagpole
for the first time since the quake.

At the one-year anniversary of the Santa Barbara Painted Cave fire,
a videotape documentary of fire survivors' stories was shown at a
local theater. The evening was co-sponsored by the film producers
and the mental health Disaster Recovery Project. The event was
very moving for all who attended, and mental health staff provided
support and informal "debriefing" for individuals at the reception
following the film.

At anniversary functions, organizations and agencies often
recognize employees and volunteers for their contributions to the
disaster recovery efforts. Sometimes a much-deserved letter,
certificate, or memento of appreciation is given. After the Loma
Prieta earthquake, the Monterey, California Red Cross chapter
recognized its volunteers with individually inscribed certificates
saying "You have proven that there is one force as powerful as
Mother Nature: Human Nature."

Community activities

Besides commemorative functions, some communities sponsor other
activities to mark the anniversary and to focus on community
healing. Some communities have disaster preparedness fairs, with
demonstrations and information by fire departments, the Red Cross,
emergency service offices, and mental health. Art, photography,
and creative writing projects or contests focusing on the community
"then and now" have been held. At the one-year anniversary of the
Santa Barbara fire, a photography exhibit of the best photos from
the fire was held at the community art center. The Berkeley,
California Firestorm Recovery Project sponsored a community-wide
exhibit of children's art depicting the 1990 East Bay Fire. A
commemorative calendar entitled "Through Our Children's Eyes"
displayed some of the art works and talked about children's
healing.

At the ten-year anniversary of a northern California flood and
mudslide disaster, the community held a retrospective of photos,
slides, writings and memorabilia from the disaster. In addition,
there were a Firefighter Ball and formal presentations of awards to
disaster volunteers, given by the county Board of Supervisors and
the local chapter of the Red Cross.

Retrospective analysis

Often, formal meetings, conferences, or educational symposia may be
held at the time of the anniversary to examine issues and "lessons
learned" from the disaster. Emergency management or professional

groups with disaster responsibilities often hold such conferences.
Mental health disaster recovery programs may be asked to
participate in such programs. However, since disaster mental
health is a relatively new field, mental health programs may need
to proactively suggest inclusion of mental health perspectives in
such meetings.

Mental health agencies themselves may sponsor symposia to examine
various aspects of healing from disaster. At the one-year
anniversary of the 1991 East Bay Firestorm, the City of Berkeley
Mental Health Services and Alta Bates Medical Center co-sponsored
a conference on "Disaster: Psychological Response and Recovery"
which was attended by several hundred mental health professionals
from the impacted communities. Topics included patterns of
psychological response to disaster; mental health interventions
during and after the firestorm; intervention, expression and
research with children; psychological aspects of recovery from
physical injury; healing the healers; critical incident stress
debriefing; fire victims' dream journal study; and the
psychological impact of trauma on relationships.

The Counseling and Psychological Services branch of University
Health Service at the University of California at Berkeley
sponsored a similar event for faculty, staff, and students affected
by the fire. Entitled "When Traumas Happen: Recovery from
Individual and Community Disasters," the symposium provided
speakers and discussion on such topics as the effect of disasters
on individuals and communities; how relationships are affected by
trauma; issues in rebuilding cities after fires; personal recovery
from trauma; helping children recover from trauma; and storytelling
as a healing tool.

Termination of Crisis Counseling programs

At the time of the one-year anniversary of the disaster, most
Regular Program Crisis Counseling projects are ending. Staff may
feel guilt at "abandoning" the community by winding down the
project at a time when anniversary reactions have reawakened so
many feelings about the disaster. They will also be dealing with
their own feelings regarding the ending of the project and, for
some staff, the loss of a job. It is important to provide planning
meetings, debriefing, support and opportunities for staff to
express their feelings at this important time. It is also helpful
to provide them with consultation and supervision regarding
termination of services. Issues such as linkage of ongoing clients
with other resources must be discussed.

A formal critique discussing program successes, problems, and
lessons learned for the future can be an important part in bringing
closure to the program and planning for future disaster mental
health response.

SUMMARY

The anniversary of a disaster can reawaken a wide range of feelings
and reactions in the survivor population. These reactions can be
disturbing to survivors who do not anticipate them. This chapter
describes common anniversary reactions and how numerous survivors
experienced them. Anniversary interventions and activities are
discussed. The anniversary of the disaster is an important time

for individuals and the community. Mental health's leadership and
involvement in community activities at this crucial time can help
make the anniversary another step toward healing.

CHECKLIST

DISASTER ANNIVERSARY MENTAL HEALTH ACTIVITIES

PREDISASTER

_____   Include brochures, fliers, and
educational materials regarding anniversary reactions and
interventions in a library of disaster mental health materials

DISASTER RECOVERY

_____   Provide consultation and training to
disaster mental health staff regarding anniversary reactions and
appropriate interventions and activities

_____   Two to three months before the
anniversary, begin planning anniversary materials and activities

_____   Use the media to provide education
and normalization about anniversary reactions; use press releases,
news conferences, interviews, or articles and stories

_____   Develop and distribute fliers and
brochures about normal anniversary reactions and ways to cope

_____   Provide materials, consultation,
and/or training to organizations providing services to disaster
survivors, such as schools, churches, medical clinics, senior
service centers, disaster agencies

_____   Prepare switchboard or intake workers
for possible increase in disaster-related calls in the weeks
preceding and immediately following the anniversary

_____   Ensure that crisis counselors and
support group leaders provide anticipatory guidance and appropriate
anniversary-related interventions with clients

_____   Assist community groups in planning
and implementing appropriate commemorative programs or other
anniversary activities

_____   Participate in formal meetings,
conferences, or educational symposia

POSTDISASTER

_____   Conduct a formal critique of mental
health's role in anniversary-related activities

_____   Revise disaster plan, policies and
procedures based upon recommendations from the critique

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                    SUPPORT AND STRESS MANAGEMENT
                  FOR DISASTER MENTAL HEALTH STAFF

EFFECTS OF DISASTER ON MENTAL HEALTH WORKERS

To understand the effects of disaster on the mental health staff
who intervene, it is useful to underscore two of the key concepts
of disaster mental health:

No one who sees a disaster is untouched by it, including the
workers. The intensity of the emotional climate of disaster
demands that the worker continually confront and manage all kinds
of painful expressions of emotion (Cohen and Ahearn, 1980). Both
the subtlety and intensity of workers' reactions are reflected in
sociologist Kai Erikson's reaction to Buffalo Creek, West Virginia
when he first entered the community a year after a major,
devastating flood:

       I felt for a moment as though I were in the company of people
so wounded in spirit that they almost constituted a different
culture . . . the sense of being in the presence of deep and
numbing pain remained an important part of the emotional climate in
which this study was done. I was driving down Buffalo Creek late
that night when the storm that had been threatening all day finally
broke with mountain vengeance. I pulled over to the side of the
road near one of the several trailer camps on the creek and stayed
there as half the lights in the camp flashed on, children began to
cry, and small groups of men trudged out into the darkness to begin
a wet vigil over the stream. Something of the mood of that camp
reached across the creek to where I was parked, and I had to fight
off a compelling urge to drive away, to escape. I had been in the
hollow for only twelve hours (Erikson, 1977).

Disaster workers are normal persons who generally function quite
well under the responsibilities and stresses of their jobs.
However, exposure to traumatic stimuli and the demands of disaster
work may cause workers to show signs of emotional and psychological
strain. These reactions are normal under the extraordinary and
abnormal situation of disaster. Disaster stress and grief
reactions among workers are usually transitory in nature, and
relief from the stressors and the passage of time usually lead to
the reestablishment of equilibrium. However, education of workers
about normal stress reactions and the importance of stress
management on the job can help workers to anticipate and manage
their own reactions to the disaster.

WHEN A MENTAL HEALTH WORKER HAS SUFFERED LOSSES

There will be times when mental health staff themselves have
sustained direct losses from the disaster. There have been many
situations in which directly affected staff have heroically
participated in mental health response activities without letting

coworkers or supervisors know of their own losses. While this may
be part of an altruism that occurs after impact, it may put the
worker at real risk if personal, family, and financial needs are
not being attended to. Every mental health agency should find out
which of its workers have been directly affected in order to
support the worker and to make appropriate work assignments. The
organization can support its own workers by providing formalized
debriefing, crisis counseling services, and support groups for
those directly impacted staff.

The question usually arises about whether directly impacted mental
health workers can and should be involved in the mental health
disaster response. The answer is, "it depends." Initially,
impacted staff may need time off from work to attend to their own
affairs. Upon return to work, these employees may suffer from
postdisaster stress reactions such as poor concentration and
fatigue that may negatively influence their work performance.
"Light duty" assignments during periods of heavy personal stress
can be helpful, if they can be arranged. Sometimes, "business as
usual," with staff performing their regular functions and workload,
can provide a routine that offers structure and comfort.

Typically, impacted staff will feel a desire to be part of the
mental health response. Such a work assignment should be carefully
evaluated with the worker to learn how disaster work may affect
them on a personal level, and how their personal situation may
affect their disaster work. An important factor will be the
worker's ability to separate his or her own coping styles from
those of other survivors, and not to impose, consciously or
unconsciously, their own values and methods of coping upon others.
The ability to empathize with survivors may be enhanced by the
worker's own losses. However, the worker must be able to maintain
perspective and avoid the hazards of over-identification with
survivors. Taking too much control in a desire to help, playing
down others' crises, or avoiding listening to intense feelings
because it is too painful for the worker can be other pitfalls.

DISASTER WORK: PHASES FOR WORKERS

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. Postimpact, 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 community needs are assessed. Mutual aid may be requested. Staff move into action.

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):

        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. On 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.

        Recovery. Short-term recovery includes activities intended to return vital life-support systems to 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 (Hartsough and Myers, 1985). Staff identify with and sometimes take on the frustrations of the survivors who are struggling with setbacks and roadblocks 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 DISASTER

The following are some lists 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 (Mitchell, 1986; Selye, 1982). In some situations,
stress symptoms may be delayed for weeks, months, or years
following the event (Mitchell and Bray, 1990).

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.

Table 1 shows the common stress reactions that may occur for
disaster workers.

TABLE 1
COMMON DISASTER WORKER STRESS REACTIONS

PSYCHOLOGICAL/EMOTIONAL
Feeling heroic, invulnerable, euphoric
Denial
Anxiety and fear
Worry about safety of self or 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 disaster
Blaming

BEHAVIORAL
Change in activity
Decreased efficiency and effectiveness
Difficulty communicating
Increased use of humor

Outbursts of anger; frequent arguments
Inability to rest or "let down"
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, drugs
Social withdrawal, silence
Vigilance about safety of environment
Avoidance of activities or places that trigger memories
Proneness to accidents

PHYSICAL
Increased heartbeat, respirations
Increased blood pressure
Upset stomach, nausea, diarrhea
Change in appetite, weight loss or gain
Sweating or chills
Tremor (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

Table 2 provides a list of physical stress reactions that require
prompt medical evaluation.

TABLE 2

PHYSICAL STRESS REACTIONS REQUIRING PROMPT MEDICAL
EVALUATION
Chest pain
Irregular heartbeat
Difficulty breathing
Fainting or dizziness
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 worker that symptoms do
not seem to diminish on their own. The following are some
guidelines for differentiating 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,
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.

ORGANIZATIONAL SUPPORT FOR MENTAL 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 mental health
operation, the organization might 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 preestablished plan for how employees will check on
their families if disaster strikes during the work hours.

Tranchina (1991) suggests 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 mental health staff

It is essential that disaster mental health workers begin to process their own emotions about the disaster before attempting to help survivors. It is strongly recommended that a debriefing or other group discussion of workers' own reactions be conducted for workers before deployment.

Utilization of a team approach

Whenever possible, mental health personnel should be assigned to work in teams of two. If there are not enough mental 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 mental 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.

Access to disaster site

Besides appropriate identification, workers will need information
about safe routes to the work location, hazards to avoid, etc.
Sometimes, transportation and/or an escort may be necessary.

Food and shelter

If mental health staff are unable to live at home during their
disaster assignment, either because of distance or because of
hazardous travel conditions, it will be necessary to provide them
with shelter. It is preferable that staff have lodging in an area
separate from disaster survivors, to give staff a break from the
demands of the disaster when they are off duty. Shelter may be
available in local hotels or motels, depending on the severity of
damage in the disaster zone. Even in urban areas with many
facilities, however, available rooms fill fast with the influx of
disaster workers as well as survivors and other groups needing
temporary housing. Hotel accommodations may need to be made
outside the impact area, and workers may need to commute to and
from their field assignment.

For mutual aid mental health workers who may have come from outside
the local jurisdiction, the mental health agency will probably have
to provide some assistance in making hotel accommodations. At the
very least, a list of local hotels and motels will be helpful to
mutual aid personnel in making their own reservations. There are
logistical and psychological advantages for a given mutual aid team
to house all of its members at the same hotel, if room availability
permits. Defusings, debriefings, and practical aspects of team
coordination are made significantly easier.

If hotel or motel housing is unavailable, personnel may need to
sleep in churches, community centers, or official shelters. In
some situations, housing may be akin to "camping out." Personnel
should be knowledgeable of these conditions and should take
personal supplies, clothing, tents and sleeping bags. In South
Carolina after Hurricane Hugo in 1989, mental health staff at times
slept in buildings without windows or electricity. The state
Department of Mental Health provided public safety officers to
ensure the security of workers. Security will need to be
considered and planned for when conditions are primitive.

Food for workers may be available through local restaurants and
grocery stores. Sometimes, workers may need to eat at mass feeding
sites or mobile canteens set up by the Red Cross, Salvation Army,
or other groups. If workers will be depending solely on these
sources for their meals, the mental health agency should inform the
organization providing the meals to ensure that this arrangement is
acceptable and that there will be adequate food for workers.
Workers should take some food and water with them into the disaster
area as backup.

Communications

Staff should have a mechanism for communicating through the mental
health chain of command. They should be able to reach their
supervisor, and to transmit through the supervisor to the Emergency
Operations Center (EOC) pertinent information about conditions or
needs in the field. The field-based workers are often the "eyes
and ears" not only for the mental health agency, but for other
responding agencies as well. Workers may come across a previously
unknown hazard or need which should be communicated to the EOC.

Inoperable phone lines may hamper communications. Even if regular
telephones are functioning, field staff can benefit from the
convenience and security of having cellular phones, although some
rural areas do not have this service. Portable FAX machines and
their phones, as well as a laptop computer with modem can also be
useful. If such equipment is not available, however, a cooperative
agreement with amateur radio groups to serve as a communication
link may be necessary. Staff should not expect to communicate via
police or other emergency radio frequencies, as these will be busy
with emergency transmissions. Sometimes, communication may need to
be via messenger or runner.

Supervision

A clear chain of command should exist for workers in the field.
They should know who their supervisor is, and if the supervisor is
not always in the immediate area, how to communicate with him/her.
They should be instructed about what types of information should be
communicated to the supervisor.

In some situations, workers will be assigned to a site that is
under the management or command of another organization. A common
example is a Red Cross shelter. In such situations, workers are
expected to follow the rules and regulations of the host
organization, and to follow any criteria or guidelines that might
exist in a memorandum of understanding between that organization
and mental health. Logistical issues such as levels of staffing
and schedules of mental health workers at the site will need to be
worked out between the mental health supervisor and the site
manager. All supervision related to mental health issues, clinical
practices, policies and procedures, etc. is the responsibility of
the mental health agency supervisor.

The following suggestions may be helpful to supervisors in dealing
with disaster-related stress among mental health workers.

1.   Remember that early identification and intervention with
stress reactions is the key to preventing worker burnout. Review
stress symptoms with workers before they go into the field.
Provide handouts for workers regarding stress management and
self-care.

2.   Assess workers' appearance and level of functioning
regularly. It is not uncommon for workers to deny their own level
of stress and fatigue. For example, workers may say they are doing
"fine," but may be exhibiting multiple stress symptoms and appear
very fatigued.

3.   Try to rotate workers among low-stress, moderate-stress, and

high-stress tasks. Limit workers' time in high-stress assignments
(such as working with families identifying the deceased at the
morgue) to an hour or so at a time, if possible. Provide breaks
and personal support to staff in such positions.

4.   Ask workers to take breaks if effectiveness is diminishing;
order them to do so if necessary. Point out that the worker's
ability to function is diminishing due to fatigue, and that they
are needed functioning at full potential to help with the
operation. Allow the worker to return to work if he/she rests and
functioning improves.

5.   On breaks, try to provide workers with the following:
     * bathroom facilities
     * a place to sit or lie down away from the scene; quiet time
alone
     * food and beverages
     * an opportunity to talk with co-workers, if they wish

ORGANIZATIONAL SUPPORT FOR MENTAL HEALTH STAFF IN THE LONG-TERM
RECOVERY PHASE

For mental health personnel working in the long-term recovery
program, there are several supports that can make the work more
rewarding and effective.

Utilization of a team approach

In the long-term recovery phase, as in the immediate response
phase, utilization of a team approach can help to mitigate the
stressful effects of working in isolation. Whatever the size of
the long-term effort, the mental health agency should make every
effort to design the program so that there is a team of staff
participating. This is far preferable to having a "one person
operation" or having individuals from various agencies or offices
assigned to work in isolation.   Having a team of workers to meet
with, both formally and informally, can help to prevent erosion of
morale.

Perhaps most important, the team structure provides workers with a
system of peers who truly understand the nature and goals of the
work. To the population as a whole, and to mental health staff not
familiar with the process of disaster recovery, once debris is
removed and rebuilding begins, it is assumed that emotional
recovery has taken place. There may be little understanding of the
need for mental health support over the many months to follow.
Disaster mental health workers not functioning as part of a team
effort often feel isolated and unappreciated.

A team format for services also provides staff with both formal and
informal forums for supervision and peer consultation on difficult
cases or challenging community situations.

In-service training and consultation

Provision of in-service training regularly can give workers
knowledge and skills specific to long-term recovery issues. The
disaster mental health worker should remain current in his or her
knowledge of programs, services, and resources available to
disaster survivors. Periodic updates by representatives of key

recovery agencies, such as FEMA and the Red Cross, are useful. Certain topics can be anticipated, such as planning for the anniversary of the disaster. Other training needs unique to the particular disaster and community may be identified as the program proceeds.

Consultation from local or outside experts in disaster recovery can help staff in identifying and overcoming problems or barriers to effective service delivery. In addition, in-service training and consultation provide rewards for staff that have tangible positive effects on morale.

Stress management activities during long-term recovery work

The stress of long-term mental health disaster work is often less discernible than the intense and obvious stress immediately postimpact. Training on long-term stresses of disaster work and stress management strategies is important. Regular sessions set aside for staff to discuss the psychological and emotional impact of the work can be helpful in identifying and mitigating work-related stressors and in providing staff with peer support. Such meetings can be run in a peer-support group format or can be facilitated by an outside consultant.

Staff may need peer and supervisory reminders that there is "life outside disaster." The importance of good nutrition, rest, exercise, recreation, and participation in usual family and social activities should be underlined.

DISENGAGEMENT FROM THE DISASTER ASSIGNMENT

The ending of the disaster assignment, whether it involved immediate response or long-term recovery work, can be a period of mixed emotions for workers. Disaster work can be both stressful and rewarding. While there may be some relief that the disaster operation is ending, there is often a sense of loss and "letdown," with some difficulty making the transition back into family life and the regular job. Anticipatory guidance and an opportunity to talk about feelings and common transition dynamics can greatly help workers. There are several interventions that can provide education and help to ease the disengagement and transition process for workers.

"Defusing" is a spontaneous or organized staff meeting immediately after a shift or operation. It is an informal opportunity for staff to begin to talk about their experience in the disaster. It is usually kept short (no more than 30 to 45 minutes) (Mitchell and Bray, 1990) and can be led by any of the staff with group process skills. An outside facilitator is usually not necessary. Workers are usually asked "what was the worst part" of the shift or the work assignment, and allowed to ventilate and share feelings. Feelings are acknowledged but there is no probing or dwelling on feelings. The key is to keep the tone positive and supportive. Workers should not be criticized for how they feel or how they functioned. The meeting is not a critique of the operation. Team members should check on each other's well-being and provide support. Sometimes, a defusing may be all that is necessary for staff to deal with their feelings. In other cases, the need for a more thorough, formalized debriefing will become clear.

The purpose of a formal debriefing is to address the emotional and psychological impact of the disaster assignment on the worker. There is an added level of empathy, understanding, and peer support when the debriefing is conducted for a group of people who have worked together. A debriefing should be run by a mental health facilitator with experience in disaster and specialized training in debriefing techniques. While few outcome evaluations on the effect of formal debriefing have been conducted, participants usually report that it has a therapeutic effect. They report that debriefings help them to identify and talk about the feelings associated with the disaster assignment, provide "normalization" of their responses, and lend peer support. Debriefing serves an educational purpose, informing workers of the common stress and grief reactions, transition issues, and ways for them to cope. Handouts specific to disaster workers' reactions during and after disaster can be distributed.

For disaster assignments of any length, workers may need to talk about multiple stressful situations that they have experienced. Skilled facilitators can manage this specialized debriefing using a multiple stressor debriefing model (Armstrong, O'Callahan, and Marmar, 1991).

It is important to bring an ending, or closure, to the disaster job. A critique is a critical evaluation of how the operation proceeded. It is different and separate from a debriefing, which attends to the psychological and emotional impact of the work on personnel. A critique can result in positive changes in the disaster plan, policies, and procedures to improve mental health's approach in the next situation. A critique can also help workers to take pride and feel a sense of ownership in the operation. It helps them to see the positive effect of their efforts in the disaster.

Recognition of workers' participation in the disaster effort can mean a lot to staff and volunteers. Mental health staff appreciate a letter or certificate of recognition from the mental health director or the board of supervisors. A small souvenir from the project director, such as a picture, coffee mug or t-shirt, says in concrete terms how much the workers' involvement was appreciated. Workers who stayed behind at the regular worksite "minding the store" while disaster workers were in their special assignments should also be recognized for their essential contribution to the success of the disaster operation.

SELF-CARE FOR DISASTER MENTAL HEALTH WORKERS: ADVICE FOR BEFORE, DURING, AND AFTER DISASTER

Predisaster planning: prevention

Some of the most important stress management interventions for disaster workers take place predisaster. Preparation can help minimize the effects of stress when it occurs and can help individuals cope with stress in a more effective manner. The following are some useful predisaster interventions.

1.   Agency planning, orientation and training

Each mental health agency should have a disaster plan outlining worker roles and responsibilities in disaster. Training on the

mental health workers' disaster roles should be provided as part of workers' initial on-the-job orientation and ongoing in-service training. Specialized training in disaster mental health response can help staff to develop the skills necessary to their disaster roles. Education can also help to prepare staff for the stresses they may experience in their work. It can help to decrease their vulnerability and increase their effectiveness in dealing with job-related stresses when they occur.

2.   Predisaster personal emergency preparedness plans

Having a personal and family emergency plan will help individuals to cope with whatever emergencies may occur while they are at home. Every emergency worker should be familiar with hazards and potential emergencies inherent in the local geographic area, and should have contingency plans for self and family. This is important to the safety of the family and to the availability of the worker for disaster assignment. The more quickly things can be taken care of at home, the more quickly the worker can report to work with some worries about the family taken care of. Similarly, if the worker is at work when a disaster occurs, peace of mind and concentration will be enhanced if the worker's family is prepared and able to cope.

Every family emergency plan should include the following:

         *A home inspection to identify and eliminate hazards

         *A plan for different types of emergencies that might occur in the area, such as tornado, hurricane, earthquake, or hazardous materials spill; training for what to do before, during, and after each emergency

         *A home fire safety plan, including smoke detectors, fire extinguishers, and preplanned escape routes

         *An evacuation plan: what to take, where to go, where to meet or reunite

         *A plan to care for children, individuals needing assistance (the ill or those with disabilities), and pets in the event that adults cannot get home following disaster

         *Training of every capable family member in how to turn off utilities and in first aid

         *Prominent posting of emergency phone numbers

         *A plan for how family members will locate each other if separated at the time of disaster, e.g., an out of the area phone contact who can be called by all family members (long-distance phone lines often work when local lines are down)

Emergency supplies and equipment should include the following:

         *Food and water for 72 hours; include special diets, infant formula, and pet food

         *Portable radio, flashlight, and batteries

        *An adequate supply of prescription and over-the-counter
medications, eyeglasses, extra batteries for hearing aid, etc.

        *First aid kit and book

        *Personal hygiene supplies

        *Blankets or sleeping bags

        *Fire extinguisher

        *Sanitation supplies (plastic bags, bleach)

        *Alternate lighting: camping lantern, candles, matches

        *Safety equipment: hose for fire fighting, heavy shoes
and gloves, work clothes

        *Tools

        *Cooking supplies: charcoal, Sterno, camp stove

An abbreviated cache of supplies should be kept in the trunk of the
car, especially for those individuals with a long commute. A
cellular phone in the car is also a good resource.

A plan is of use only if all family members are familiar with it.
They should review it regularly, and hold practice "drills" of what
they would do in a variety of potential disaster situations.

Every family should be familiar with the disaster plan in the
children's school. Also, family members should know about the
disaster plans at the adults' workplace. In this way, families who
are separated at the time of disaster can have some peace of mind
knowing what plan exists to care for their loved ones.

It is a good idea to establish a mutual aid system within the
neighborhood. With a bit of preplanning, neighbors can arrange to
look out for and help one another in times of emergency, pooling
supplies and skills. Many neighborhoods develop emergency
preparedness plans as part of the Neighborhood Crime Alert network.
Such a mutual aid arrangement can give disaster workers more peace
of mind about their families' welfare.

In addition, every worker who might be called out on a disaster
assignment is wise to have an emergency bag prepacked. Supplies
should be tailored to the nature of the worker's likely assignment.
If the assignment will entail any length of time away from home,
the bag should include the following:

        *Clothes, including sturdy shoes and clothes for
inclement weather

        *Eyeglasses and medications (including over-the-counter
remedies for personal stress reactions--antacids, aspirin,
antidiarrhea medicine, etc.)

        *Personal hygiene supplies

        *Flashlight, portable radio, and batteries

        *Small first aid kit

        *Food and water (one gallon/day) for three days

        *Paper and pens, clipboard

        *Forms or supplies necessary to the worker's disaster
assignment

        *Sleeping bag

        *Cash and change for pay phones (these circuits usually
work when other phone lines are out of service)

        *Official identification to allow access into restricted
areas

        *A picture of one's family and at least one comforting
item from home

        *A good book, a deck of cards, crossword puzzles, etc.

Excellent materials on home emergency preparedness specific to a
given geographic location are available from local chapters of the
American Red Cross, local Offices of Emergency Services, or the
regional office of the Federal Emergency Management Agency.

Interventions during the disaster

The following are suggestions for mental health staff for
management of stress while working on a disaster operation.

1.   Request a briefing at the beginning of each shift to update
yourself and coworkers on the status of things since your last
shift. This can help you gear up for what you may be encountering
during your shift.

2.   Develop a "buddy" system with a coworker. Agree to keep an
eye on each other's functioning, fatigue level and stress symptoms.
Tell the buddy how to know when you are getting stressed ("If I
start doing so-and-so, tell me to take a break"). Make a pact with
your buddy to take a break when he or she suggests it, if the
situation allows.

3.   Encourage and support coworkers. Listen to each other's
feelings. Don't take anger too personally. Hold criticism unless
it's essential. Tell each other "You're doing great" and "Good
job." Give coworkers a pat on the back. Bring each other a snack
or something to drink.

4.   Try to get some activity and exercise. Gently stretch out
muscles that have become tense.

5.   Eat regularly. If not hungry, eat frequently, in small
quantities. Try to avoid excessive sugar, fats, and caffeine.
Drink plenty of liquids.

6.   Humor can break the tension and provide relief. Use it with
care, however. People are highly suggestible in disaster

situations, and survivors or coworkers can take things personally and be hurt if they feel they are the brunt of "disaster humor."

7.   Use positive "self-talk," such as "I'm doing fine" and "I'm using the skills I've been trained to use."

8.   Take deep breaths, hold them, then blow out forcefully.

9.   Take breaks if effectiveness is diminishing, or if asked to do so by your supervisor. At a minimum, take a break every four hours.

10. If possible, limit the length of shifts you are working to twelve hours maximum. A twelve-hour shift should be followed by twelve hours off duty.

11. Use a clipboard or notebook to jot things down. This will help compensate for the memory problems that are common in stressful situations.

12. Try to keep noise to a minimum in the worksite. Gently remind others to do the same.

13. Try to avoid unnecessarily interrupting coworkers when they are in the middle of a task. Think twice before interrupting.

14. Let yourself "defuse" at the end of each shift by taking a few minutes with coworkers to talk about your thoughts and feelings about the day.

15. When off duty, enjoy some recreation that takes your mind off the disaster. Draw on supports that nurture you. This may include friends, meditation, reading, or religion.

16. Pamper yourself in time off. Treat yourself to a special meal, get a massage, or take a long bath.

17. If needed, give yourself permission to spend time alone after work. However, don't totally withdraw from social interaction.

18. Get adequate sleep. Learn relaxation techniques that can help you fall asleep.

19. On long disaster assignments, attend periodic debriefing or worker support groups to talk about the emotional impact upon yourself and coworkers. Use stress management programs if they are available. If such programs are not offered, try to get them organized.

20. On disaster assignments away from home, remember the following:

        *Try to make your living accommodations as personal, comfortable, and homey as possible. Unpack bags and put out pictures of loved ones.

        *Make new friends. Let off steam with coworkers.

        *Find local recreation opportunities and make use of them.

       *Remember things that were relaxing at home and try to do them now; take a hot bath or shower, if possible; read a good book; go for a run; listen to music.

       *Stay in touch with people at home. Write or call often. Send pictures. Have family visit if possible and appropriate.

       *Avoid excessive use of alcohol and caffeine.

       *Keep a journal.

Interventions after the disaster

The following suggestions may be useful for workers in the first hours, days, and weeks following a disaster.

1. Attend a debriefing if one is offered. Try to get one organized if it is not offered.

2. Request a critique if you or others are feeling the need to critically evaluate how the operation went. Looking at how things went and what could be changed next time around can help to bring a sense of "closure" to the disaster response.

3. Talk about feelings as they arise, and listen to each other's feelings. Try alternative forms of expression besides talking: art, writing, music.

4. When listening, try to keep war stories to a minimum. It is not helpful to hear that someone else has gone through something worse.

5. Don't take anger too personally. Anger is a common feeling after a disaster, and it sometimes gets vented at coworkers inadvertently.

6. Recognition is important. Give coworkers appreciation and positive feedback for a job well done.

7. Eat well and try to get adequate sleep in the days and weeks after the disaster. Avoid excessive use of alcohol or caffeine.

8. Practice relaxation and stress management techniques. Recreation and exercise are helpful.

9. Try to reestablish your normal routine.

10. Be aware that you may experience some "letdown" when the disaster operation is over.

11. If you have been away from home on a disaster assignment, your family may have expectations and needs that differ from your needs when you get home. Try to anticipate the problem and negotiate your respective needs carefully.

12. You may experience mood swings after the disaster, where you change from happy to sad, tense to relaxed, outgoing to quiet, wanting to talk about the disaster to not wanting to talk about it. These mood swings are normal and natural and will pass with time.

13. Allow yourself some time alone if you feel the need. However, don't totally withdraw from others.

14. Avoid becoming distracted, reckless, or accident-prone.

LIFE AFTER DISASTER

                     "Who are you?" said the
                     Caterpillar . . . .

                     "I--I hardly know, Sir, just at
                     present," Alice replied rather shyly,
                     "at least I know who I was when I
                     got up this morning, but I think I
                     must have been changed several
                     times since then."

                     Lewis Carroll
                     Alice's Adventures in Wonderland (1960)

Being involved in a disaster can change a person in innumerable ways. Working in a disaster recovery project engages mental health workers in activities that may be intensely meaningful as well as stressful. Workers' experiences may be both very positive and very painful. After a disaster response or recovery project, it is not unusual for staff to feel some ambivalence about giving up their disaster roles. Staff often feel that their lives have been changed by their experience, but have not had time to reflect on how they have been changed. They may feel a sense of loss that the project is over, and concern about what their future employment may be. They may finish the project in a state of physical and emotional fatigue, and may feel relief that the project is ending. The mixture of relief and sadness can be confusing. It is helpful for mental health staff to remind themselves about the concept of transition and the transformation it entails.

Bridges (1980) describes transition as involving four components:

            1.   An ending, involving loss and letting go.
            --disengagement
            --disidentification
            --disenchantment
            --disorientation
      2.   A period of confusion or distress.
      3.   A period of working through and making sense of feelings.
      4.   A new beginning.

It can help mental health staff in making the transition from disaster work to life-after-disaster if they reflect on a few questions. If the disaster work has been of a short duration, these questions can be used as part of a post-operation debriefing. If staff have been engaged in long-term recovery work, discussing these questions in a group meeting a few weeks before the end of the project can help to prepare them for the transition.

      1.   What will I be leaving behind when the disaster operation ends?

Positives?

Not so positives?

2.   What do I anticipate my transition will be like as I leave the disaster operation and go on to life after the disaster?

What difficulties do I have with these types of transitions?

What helps me with transitions?

3.   In what ways have I been changed by working in this disaster?

Is there anything unfinished for me about my experience in the disaster?

Is there anything I need to do before or after leaving to help bring closure to the experience?

4.   Where am I going from here?

What am I taking with me from this experience?

What we call the beginning is often the end.
And to make an end is to make a beginning.
The end is where we start from.

T.S. Eliot (1940)

Parts of this chapter have been adapted from:

Prevention and Control of Stress Among Emergency Workers: A Pamphlet for Workers. Rockville, Maryland: National Institute of Mental Health, 1987.

Prevention and Control of Stress Among Emergency Workers: A Pamphlet for Managers. Rockville, Maryland: National Institute of Mental Health. 1987.

Hartsough, D.M. and Myers, D.G. Disaster Work and Mental Health: Prevention and Control of Stress Among Workers. Rockville, Maryland: National Institute of Mental Health, 1985.

                          CHECKLIST
          SUPPORT AND STRESS MANAGEMENT FOR DISASTER MENTAL HEALTH
WORKERS

PREDISASTER

                          Develop a mental health disaster plan that specifies responsibilities and functions of mental health personnel in time of disaster

                _____   Train mental health staff in disaster

roles, responsibilities, principles of disaster mental health practices, and stress management for disaster workers

_____ Participate in disaster exercises

_____ Strongly encourage all mental health staff to have family, school, and workplace disaster preparedness plans

_____ Prepare or obtain brochures on disaster worker stress

_____ Provide mental health staff with identification cards recognized and approved by emergency management and law enforcement officials

_____ Purchase or designate supplies and equipment to be used in time of disaster

DISASTER RESPONSE

_____ Support and assist mental health staff in locating their families

_____ Brief staff regarding conditions in the field before deploying them to their work sites

_____ Provide staff with necessary supplies, including brochures on disaster worker stress management and self-care

_____ Establish chain of command and supervision from Emergency Operations Center to field staff; brief staff

_____ Establish a mechanism for communicating with staff in the field; provide staff with necessary communications equipment

_____ Arrange for food and shelter for staff in field, if necessary

_____ Determine safe routes to sites where workers will be assigned; provide escort or transportation for staff if necessary

_____ Be sure all staff have official identification

_____ Deploy staff in teams

_____ Ensure team coordination with other community resources, e.g., American Red Cross Disaster Health and Mental Health Services

_____ In the field, observe staff for signs of stress; encourage good stress management practices

DISASTER RECOVERY

_____   Assign staff to work in teams on long-term recovery projects

_____   Provide regular in-service training and consultation
                         to staff

_____   Provide regular, periodic debriefing or support groups

_____   Observe staff for signs of stress and burnout; encourage good stress management practices

POSTDISASTER

_____   Provide debriefing by a trained facilitator for staff at the end of the disaster assignment

_____   Engage staff in a critique of the disaster operation or project

_____   Provide recognition to staff who participated in disaster operation as well as those staff who "held down the fort" by covering regular work assignments

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