

RESILIENT COMMUNITIES GUIDEBOOK

**For Bioterrorism and Other Public Health
Emergencies: A Mental and Behavioral
Health Wellness Model and Guide**

PART ONE:

**BACKGROUND AND GENERAL
INFORMATION**

**HRSA, Special Programs Bureau,
Division of Health Care Emergency Preparedness
April 2004**

**Resilient Communities Guidebook
For Bioterrorism and Other Public Health Emergencies:
A Mental and Behavioral Health Wellness Model and Guide**

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PART ONE:

BACKGROUND AND

GENERAL

INFORMATION

PART ONE
(Contains Sections 1 & 2)

**SECTION 1: INTRODUCTORY MATERIAL TO DISASTERS AND
TERRORISM**

Since people who work in the disaster preparedness field come from different professional backgrounds and have different scopes of interest, this first section will provide an overview of disasters and terrorism and the mental health impact.

WHAT IS A DISASTER?

“ ... A sudden event that has the potential to terrify, horrify or engender substantial losses for many people simultaneously.”

Fran Norris, Ph.D.
National Center for PTSD and Georgia State University
PTSD Research Quarterly, Spring 2002

“A disaster is an occurrence such as a hurricane, tornado, flood, earthquake, explosion, hazardous materials incident, war, transportation accident, mass shooting, fire, famine, or epidemic that causes human suffering or creates human need that the victim cannot alleviate without assistance.”

- *Training Manual for Mental Health and Human Service Workers in Major Disasters, 2nd Edition.* U.S. Department of Health and Human Services, 2000.

DISASTER FACTS: (The Realities of Disaster Behavioral Health Services)
(from SAMHSA All Hazards Regional Training)

- No one who sees a disaster is untouched by it (firsthand and secondhand victims)
- There are two types of disaster trauma
 - Individual trauma – causes stress and grief reactions
 - Collective trauma – damages the bonds of the social fabric of the community; increases fatigue and irritability, which can increase family conflict and damage family ties
- People pull together during and after a disaster
- Stress and grief are normal reactions to an abnormal situation
- Expectable emotional reactions occur in response to problems in daily living
- Disaster relief can become a second disaster
- People typically do not seek mental health counseling services
- Survivors reject help – “Others need it more than I need it.”
- Mental health services are “practical” rather than “psychological”
- Services need to be tailored to community norms

- Supportive systems are crucial to recovery
- Interventions must be consistent with the phase of the disaster

The following information is primarily adapted from the National Mental Health Association's *Blueprint for Responding to Public Mental Health Needs in Times of Crisis*.

Effective Mental Health Disaster Response

Effective mental health disaster response requires coordination between a number of system components or “players”, including government agencies, private organizations and stakeholder groups at the state, regional, and local levels.

Public health, hospitals and State Emergency Management Agencies need to make sure they are aware of who the mental health “players” are, as well as other agencies that have a role in mental health preparedness.

All of these “players” need to coordinate and integrate their disaster preparedness plans, with the overarching goal of incorporating them into the State Emergency Response Plan.

FEDERAL AGENCIES AND PROGRAMS THAT INTERACT IN TIMES OF CRISIS

Department of Homeland Security (DHS) - was established after the events of 9/11. This agency's mission is to prevent terrorist attacks within the United States, reduce America's vulnerability to terrorism, and minimize the damage from potential attacks and natural disasters. **FEMA (Federal Emergency Management Agency)** falls under DHS. FEMA is responsible for helping communities respond to, plan for, recover from and reduce the negative effects of disasters. In areas where the President has declared a disaster, FEMA funding is available through an immediate services grant to support disaster mental health services for 60 days from the disaster declaration date. After this 60-day period, a State may also apply for a regular services grant, which can be used to fund crisis counseling services for up to 9 months from the disaster declaration date.

Department of Health and Human Services (DHHS) - Within DHHS, there are a number of agencies involved in disaster response:

Substance Abuse and Mental Health Services Agency (SAMHSA)

The Center for Mental Health Services (CMHS) is housed within SAMHSA. Its Emergency Services and Disaster Relief Branch (ESDRB) works with FEMA to provide technical assistance, training for state and local mental health personnel,

grant administration and program oversight. This initiative is known as the **Crisis Counseling and Training Program (the “Crisis Counseling Program or CCP)**. The CCP is implemented as a supplemental assistance program available through FEMA. The Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1974 authorizes FEMA to fund mental health assistance and training activities in areas in which the President has declared a disaster. In addition, CMHS jointly administers the **Safe Schools/Healthy Students** program with the U.S. Department of Justice and the U.S. Department of Education. This program is designed to help schools address the anxiety children may experience in response to local, state or national crises.

Within the Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency with primary responsibility for mental health disaster preparedness.

SAMHSA Disaster Technical Assistance Center (DTAC)

Additionally, SAMHSA has a Disaster Technical Assistance Center:

Address: 7735 Old Georgetown Road, Suite 400, Bethesda, MD 20814.

Toll free number is 1-800-308-3515, fax 1-800-311-7691

E-mail: DTAC@esi-dc.com

For BT Coordinators : To access their services, contact your State Mental Health Disaster Coordinator (See appendix)

Key features of DTAC :

1. Preparation - SAMHSA DTAC assists the U.S. and its Territories with “all-hazards” disaster response planning. They support collaboration between mental health and substance abuse authorities, Federal agencies, and non-governmental organizations (NGOs). SAMHSA DTAC provides consultation to review disaster plans, conducts research on “new” threats, and brokers knowledge and support. In addition, the SAMHSA DTAC Web site offers valuable resources and will host Webcasts and online training events on topics relevant to disaster preparedness and response.

2. Response - Contact SAMHSA DTAC staff for assistance in identifying:

- Suitable publications
- Psychoeducational materials
- Expert consultants

SAMHSA DTAC staff members also provide technical assistance in the grant application process.

3. Communication - They maintain a contact database of State/Territory mental health commissioners, substance abuse directors, and disaster coordinators, as well as a roster of Federal agencies and NGOs involved in disaster and trauma research and/or service delivery. SAMHSA DTAC produces the *Dialogue*, an electronic, quarterly field communication highlighting Center activities and resources relevant to the field. The

SAMHSA DTAC Web site will host an ongoing forum in which disaster coordinators can communicate and share ideas.

4. Resources - Full-time, dedicated technical assistance (TA), publications, and logistics personnel staff the Center. SAMHSA DTAC houses a collection of materials, including those developed by crisis counseling programs and peer-reviewed literature. TA Specialists ensure that resources are current. They also are working to develop new resources to address gaps in the disaster mental health and substance abuse literature.

Centers for Disease Control and Prevention (CDC) – The CDC plays a wide variety of roles with respect to emergencies and disasters. It supports research, provides public information and educational materials, and interacts closely with State health authorities on a variety of public health issues. CDC addresses issues related to health consequences (including mental health) in preparing for and responding to terrorist incidents, especially those involving radiological, chemical, and biological agents. CDC is a central player in federal disaster relief response efforts and has included mental health content in requests for State public health bioterrorism applications.

www.cdc.gov

Health Resources and Services Administration (HRSA) – HRSA administers the Bioterrorism Hospital Preparedness Program (BHPP) under its Division of Health Care Emergency Preparedness (DHCEP), in collaboration with the Assistant Secretary for Public Health and Emergency Preparedness, and coordinated with other entities that assist State and local health entities with bioterrorism preparedness. The mission of the National Bioterrorism Hospital Preparedness Program is to ready hospitals and supporting healthcare systems to deliver coordinated and effective care to victims of terrorism and other public health emergencies. HRSA oversees cooperative agreements with 62 public health departments of States, territories, municipalities and Pacific nations. These awards are for the development and implementation of regional plans to improve the capacity of the healthcare system, including hospitals, emergency departments, outpatient facilities, emergency medical services (EMS) systems and poison control centers, to respond to incidents requiring mass immunization, isolation, decontamination, diagnosis and treatment (to include mental health), in the aftermath of terrorism or other public health emergencies.

www.hrsa.gov/osp

Administration for Children and Families (ACF) – ACF has a lead role in serving a number of populations with special needs in times of emergency, including people with developmental disabilities and their families and those who receive a variety of social services through state agencies. They also have a special interest in refugees and family violence.

www.acf.dhhs.gov

Center for Faith-Based and Community Initiatives – is attempting to ensure involvement and proper integration of the resources of the faith community in disaster or emergency response services.

www.hhs.gov/fbci

Administration on Aging (AoA) – provides leadership, technical assistance, and support to the National Aging Network of State and territorial Units on Aging, Area Agencies on Aging, tribal organizations, service providers, adult care centers, caregivers and volunteers.

www.aoa.dhhs.gov

Department of Justice (DOJ) Office for Victims of Crime (OVC) has authority to access the Federal Victims of Crime emergency reserve fund to assist victims of terrorism and mass violence. These funds can be used for mental health treatment services for victims and their families. Crisis response grants are also available within 0-9 months to help individuals cope with trauma related to the incident.

www.ojp.usdoj.gov/ovc click on “Help for victims”, then click on “Terrorism and Mass Violence”

Department of Education (DoE) - Through the Project SERV (School Emergency Response to Violence) program, the Federal DoE provides funding and crisis response experts to states, districts, and schools that have urgent needs that result from violence. These grants may be used for a wide range of services, including counseling. Although such grants are typically provided for school-related violence, they are also available in response to crises affecting states and communities that inevitably affect schools.

www.ed.gov/programs/dvppserv

Department of Defense provides information about services geared toward military families, and the agencies that provide them, on the Internet. If a military installation is nearby, it is likely that they will have mental health providers trained in disaster response.

www.mfrc-dodqol.org/Enduring_Freedom Click on “Helping Families Cope”

Department of Veterans Affairs (VA) – operates the National Center for Post-Traumatic Stress Disorder, which works to prevent or decrease post-traumatic stress disorder (PTSD) and other adverse consequences of trauma. The center’s website provides extensive information regarding trauma research, services and training. The VA also operates hundreds of hospitals, community-based health clinics, nursing homes and other healthcare facilities across the country. VA facilities typically have staff with expertise in trauma who may be able to assist in the larger community.

www.ncptsd.org

STATE GOVERNMENT

State Emergency Management Authority (SEMA)

The State Emergency Management Authority (EMA) is the agency designated by the governor to lead disaster emergency preparedness, response and recovery. In many States, this agency reports directly to the governor; in others, it resides in another office such as the National Guard or the State police. It typically develops and maintains the official State Emergency Management Plan, but relies on other State departments and agencies to carry out critical functions. When a disaster is severe enough to exceed the State's capacity to respond, the governor may seek a Presidential Declaration of Disaster, and the State EMA is usually the agency charged with coordinating activities with Federal agencies. Federal and State agencies can and frequently do begin working together before such a declaration is made. Such collaboration is often part of the assessment process to determine the level of damage done and needs created by a disaster. However, the activation of Federal disaster relief programs does not begin until after a Presidential declaration is issued. Programs such as the Federal Crisis Counseling Program can often reimburse expenses from the date of the incident, but will not do so until and unless a declaration has been issued.

State Mental Health Authority (SMHA)

Each State has a legally designated Mental Health Authority, which maintains the public mental health system. In some States, the Mental Health Authority is a freestanding department that reports directly to the governor; in others, it resides within another department, or is combined with the State Substance Abuse or Developmental Disabilities Authorities. Some State Mental Health Authorities work directly with local communities, while in others they work primarily through counties or regions.

In many (although not all) States, this agency focuses primarily on serving adults (and sometimes children) with serious and long-term mental illnesses, rather than attempting to meet the broader mental health needs of the entire community. State Mental Health Authorities usually have direct responsibility for funding and operating State psychiatric hospitals. They also fund and oversee community-based services; in some States, such services are provided directly by the State, while in others they are delivered primarily through grants and contracts with other providers.

The Mental Health Authority is typically responsible for conducting the disaster mental health activities outlined in the State Emergency Management Plan. When a disaster strikes, the Mental Health Authority is often charged with ensuring continuity of services in State facilities, contracting with agencies, and operating the Federally funded Crisis Counseling Program in areas where the President has declared a disaster.

The National Association of State Mental Health Program Directors (NASMHPD) represents the interests of State Mental Health Authorities and their directors at the national level. This organization is currently undertaking a major effort to improve disaster planning by State Mental Health Authorities. While the NASMHPD project focuses primarily on State-level planning, its findings are useful in informing mental health planning at every level.

State Substance Abuse Authority

The State Substance Abuse Authority is typically responsible for services to people with substance abuse problems involving drugs and/or alcohol. In a few States, this is a freestanding agency, but in most States it is located within another State department or agency. State emergency plans rarely address substance abuse issues directly. During or after disasters, this authority usually focuses on maintaining treatment services, and preventing or addressing abuse of substances caused by disaster-related stress.

State Public Health Authority

In dealing with typical disasters, the State Public Health Authority is primarily concerned with ensuring the adequacy of safe water and sewage, monitoring for infectious disease outbreaks, and ensuring that the population has appropriate immunizations. In this era of bioterrorism threats, State Public Health Authorities are under increased pressure to enhance monitoring and surveillance and conduct sophisticated epidemiological analysis. Through its new homeland security initiative, the Federal government has recently increased funding for these activities. However, State Public Health Authorities have historically lacked the resources necessary to perform their jobs, and as a result a major national game of “catch up” is underway to prepare for new terrorism threats involving nuclear, chemical and biological weapons.

State Education Authority

State Education Authorities fund and oversee the provision of public education throughout the State, although local school districts usually supervise local schools’ day-to-day operations. In recent years, several State Education Authorities have led the effort to develop Statewide crisis, emergency and disaster guidance and plans to address school violence, student or staff death or suicide, and disasters.

State Social Services Authority

Under normal conditions, the Social Services Authority provides a wide variety of social support programs. After disasters, the State social services system frequently administers the State’s disaster unemployment program to help those who have suffered disaster-related job loss. Most social services programs also provide support to citizens whose social, psychosocial and economic situations make them particularly vulnerable to disasters’ negative impacts.

State Attorney General's Office

The State's Attorney General's Office may play a central role in prosecuting those accused of initiating or enabling human-caused disasters. The way in which these functions are handled can have a significant impact on mitigating or adding to individuals' or communities' post-disaster stress. This office may also coordinate the work of volunteer lawyers who can provide legal assistance to disaster survivors.

Office of Crime Victims' Services

Although the name of the Office of Crime Victims' Services can vary from State to State, in all cases this agency advocates to protect the rights of people who have been the victims of crime. It often plays a central role in responding to terrorist acts. Since terrorism is a criminal act, survivors are eligible for a wide variety of services following such incidents, including mental health counseling and treatment.

LOCAL GOVERNMENT AGENCIES

Whereas State agencies tend to focus largely on policy, regulation, and standard setting, local public agencies tend to be more involved in direct operations or service provision.

Local Emergency Management Authority

As at the local level, the local Emergency Management Authority (EMA) may be housed within a variety of government agencies. Local EMAs are valued as providers of community risk assessments and can be relied upon to identify local emergency plan participants. They also track which agencies are involved, their roles, and the nature and extent of exercises that are conducted to update and enhance existing plans.

Local Mental Health Authority

The local Mental Health Authority may be maintained at the city, county, or multi-county level. Depending on the locality, it may administer or provide comprehensive community-based mental health services (particularly in rural areas), or it may focus solely on serving people who have serious and long-term mental illnesses. In either case, the Mental Health Authority is central to local disaster planning. Local Mental Health Authorities that serve a broad target population under normal conditions are in a better position to provide broad-based, comprehensive, preventive services in response to disaster. Those whose service scope is more limited, however, often find it difficult to adopt a new and broader disaster mental health role. Some local Mental Health Authorities prefer to focus on the disaster-related needs of consumers they're already serving while endorsing or supporting the activities of other agencies or groups that serve the broader population.

Planners should expect the abilities of local Mental Health Authorities to promote disaster mental health planning and response to vary widely.

Local Substance Abuse Authority

After a disaster, the local Substance Abuse Authority is most likely to focus on re-establishing substance abuse treatment services, providing expanded detoxification services, and preventing inappropriate drug and alcohol use to self-medicate in response to disaster-related stress. Where local Substance Abuse Authorities have established positive working relationships with health departments and Mental Health Authorities, they tend to work well with these agencies in responding to a crisis or disaster. However, in cases where these relationships have been strained, disasters sometimes intensify those difficulties.

Local Public Health Authority

Local Public Health Authorities tend to shoulder extraordinary responsibilities and authority during the post-disaster response phase. However, the nature and extent of the disaster will often determine how central and extensive their participation will be. Collaboration between local Public Health Authorities and Mental Health Authorities can improve psychosocial response and recovery after a disaster.

Local Education Authority

School boards usually assume the role of local Education Authorities, which have jurisdiction over public (but not private) schools in their areas. Most local school systems have crisis plans geared primarily to cover incidents that can occur within schools, such as interpersonal violence and suicide. These plans are usually less oriented to community-wide events. In disaster planning, it is crucial to learn about the scope and nature of existing school plans. It is also important to remember that many schools have personnel who, with proper training, can do a great deal to help address the psychosocial consequences of disasters and emergencies. This includes teachers, guidance counselors, school psychologists, school social workers, and school nurses.

Engaging schools in community-wide disaster preparedness can be complicated. Although schools are central to the life of a community, their activities are often governed by a combination of strict legal and policy requirements. Nonetheless, because of their close interaction with children and families (and the assistance they can potentially provide to others), schools can have a major positive impact on community healing after a disaster. Approaching educators and engaging schools in disaster planning requires knowledge, creativity, and sensitivity.

Local Social Services Authority

Local Social Service Authorities often work extensively with disaster survivors, especially in administering disaster unemployment programs.

First Responders

In typical disasters, first responders usually include police, fire and rescue personnel. In biological, chemical, or radiological events, healthcare personnel or others may assume this role. During the initial response to a disaster, first responders often have first and primary contact with the most severely affected victims, and they control access to impacted areas. As a result, they are often exposed to traumatizing experiences, and their psychological needs must be recognized.

SERVICE PROVIDERS

The following list describes some of the service providers who typically are, or should be, involved in some level of disaster mental health planning and response.

Hospitals

Hospital planning is extremely complex and encompasses many different scenarios, all of which have mental health consequences. These include:

- planning for hospital evacuation and relocation
- hostage situations
- quarantine involving highly infectious diseases
- mass influx of casualties
- surge of specialty care needs (such as burn treatment)

In the case of bioterrorism, one of healthcare providers' chief fears is that the system could become overwhelmed with people who believe they have been exposed, and who consequently need to be screened, triaged, treated and referred. Experience has shown that if people are told but do not believe that they were not exposed to a biological or chemical agent, they will continue to present for screening or testing until they feel confident they are safe.

Most hospitals have mental health personnel on staff, and hospitals are probably already incorporating them into their hospital preparedness plan. However, this staff will likely need to be augmented in case of a mass casualty incident. Also, an area should be designated for mental health triage, and alternate sites away from the hospital should be planned for further mental health assessment.

Community Mental Health Centers

Community mental health centers (CMHCs) provide community-based mental health (and in some cases, substance abuse) services. CMHCs were first established in the early 1960s under a federal program that sought to create centers that would provide a range of mental health services, including outpatient care, partial hospitalization, emergency services, consultation and education. Due to budget constraints, CMHCs in many states and localities have concentrated primarily or exclusively on serving individuals with the most serious and long-term mental illnesses. Most community mental health centers are private non-profit agencies, but some are public agencies run by the state, county, or local government.

Community mental health centers frequently play a central role in organizing, coordinating, and directing mental health and substance abuse services following a disaster. In many communities, they are an integral part of governmental and voluntary (for example, Red Cross) plans. In those communities that have CMHCs, these agencies should be a central part of the disaster response assessment and planning process.

Private Mental Health Facilities and Providers

Private mental health practitioners vary in their willingness, preparedness (are they trained in disaster mental health response?), and interest to participate in emergency planning, response and recovery.

Planners should survey private facilities and providers as part of their disaster response readiness assessment. They may be willing to be involved but may need training in disaster mental health response.

Community Health Centers

Many people who have low incomes receive their routine healthcare (and in some cases mental health care) at community and migrant health centers. When disaster strikes, these centers can expect to see large numbers of victims with a variety of health and mental health problems. Community health centers must be incorporated into any disaster mental health plan. In addition to treatment, they can also help provide psycho-educational interventions.

Primary Care Practitioners and Specialty Care Practitioners

In the U.S., primary care practitioners are the main healthcare providers for many people. They also frequently act as “gatekeepers” to accessing specialty care, including mental health services. As is true of community health centers, primary care providers can play important roles in providing mental health treatment and education in response to disaster.

Most specialty care providers (such as mental health specialists, pediatricians, cardiologists and gastroenterologists) treat conditions that can be exacerbated by the physical and emotional effects of disaster. In addition, many of these health problems can also create significant psychological stress under normal conditions. Reaching out to specialty care practitioners is one way of reaching out to and planning for the needs of people with pre-existing mental and physical disorders.

Assisted Living Facilities

In most States, assisted living facilities are required to have some type of disaster and emergency management plan. While age alone is not a risk factor for mental disorders associated with disaster experience, the presence of pre-existing health problems has long been recognized as a risk factor. Many residents in these facilities have serious health problems, and therefore may be at increased psychological risk. In addition, most people need some type of social support to recover emotionally from disasters. Because many people in assisted living facilities can be socially isolated or separated geographically from families or friends, it is crucial to address their social support needs under normal conditions, and particularly so after disasters.

Colleges and Universities

Colleges and universities are well-suited in many ways to participate in disaster preparedness and response planning. Academic departments of psychology, psychiatry, social work and counseling, among others, can provide valuable assistance in disaster preparedness and response.

Other academic departments can potentially contribute to mental health disaster planning and response efforts. For example, journalism and communications departments might be able to help shape risk communication and psychoeducational materials. Law schools might be able to work with planners to identify and address important legal issues such as the legal requirements surrounding consumer confidentiality or the use of volunteers. Education departments might be able to facilitate linkages between mental health response planners and local schools systems.

GROUPS AND ORGANIZATIONS

There are many non-governmental groups that can, and do, play a significant role in disaster mental health. Some, such as the National Mental Health Association, have both State and local affiliates who have established long-standing mental health roles in their communities. Others may not have pre-established long-standing mental health roles in their communities but can be very helpful when local resources are overwhelmed.

National Mental Health Association

The National Mental Health Association (NMHA) is the nation's oldest and largest advocacy organization devoted to addressing all aspects of mental health and mental illness. In partnership with more than 340 State and local Mental Health Association (MHA) affiliates nationwide, NMHA works to promote mental health, prevent mental disorders and achieve victory over mental illness through advocacy, education, research and service.

State and local MHAs typically bring together broad coalitions of mental health stakeholders – including consumers, family members, advocates and service providers – for collaboration and action. Many MHAs have experience in responding to disasters and crises, and can contribute valuable expertise and resources to crisis response planning efforts. Many have developed strong relationships with other agencies and organizations both in and outside of the mental health field. For additional information about the NMHA affiliate network, visit NMHA's Web Site at www.nmha.org, call the NMHA Resource Center's toll-free number at 800-969-NMHA, or send an e-mail message to affiliateinfo@nmha.org

American Red Cross – www.redcross.org “Click on Disaster Services”

The American Red Cross, or as it is more commonly known, “Red Cross” is one of the nation's oldest and best known disaster relief organizations. In addition to its national headquarters, the Red Cross provides support through a system of State, regional, and local chapters. Along with its traditional disaster response services, for the past decade, the Red Cross has operated a mental health program to nearly all major disasters and many smaller emergencies or crises.

The Red Cross also has statutory responsibility for providing support (including mental health care) to families of aviation disaster victims. In many cases, the Red Cross is among the first organizations to provide mental health services after a disaster. However, these interventions are typically provided on a very short-term basis, and are designed to augment (not replace) the range of mental health and psychoeducational services that disaster survivors need.

National Organization for Victim Assistance (NOVA) – www.ncvc.org

NOVA is a nationwide organization of victim and witness assistance programs and practitioners, criminal justice agencies and professionals, mental health professionals, researchers, former victims and survivors, and others who are committed to the recognition and implementation of victim rights and services. NOVA's mission is to promote rights and services for victims of crime and crisis, including disasters.

NOVA draws from its national network to dispatch crisis response teams (CRT) to respond to disasters and crises. A CRT typically consists of individuals from all over the country and includes mental health specialists, victim advocates, public safety professionals and members of the clergy, among others. CRTs' primary tasks include helping local decision-makers identify all the groups at risk of experiencing trauma; training local caregivers who are to reach out to those groups after the CRT has departed; and leading one or more crisis interventions (also known as "debriefings") to show how those private sessions can help victims start to cope with their distress.

National Voluntary Organizations Active in Disaster (NVOAD) – www.nvoad.org

NVOAD and its affiliated State VOADS, coordinate planning efforts by voluntary organizations that respond to disasters. Once disasters occur, NVOAD or an affiliated State VOAD encourages members and other voluntary agencies to convene onsite. NVOAD serves member organizations by providing tools, guidance and forums to enhance communication, cooperation, coordination, education and leadership development among national, State and regional coalitions of organizations that respond to disasters. Many of the agencies that are active in NVOAD have played long-standing roles in disaster response and have seasoned staffs.

Professional Associations and Societies

Professional associations and societies such as State psychiatric, psychological and social work associations can play major roles in disaster mental health training and response. They can help conduct quality control, expand service capacity and provide information about available services. They can provide expanded services within a local area without the licensing complications that can occur when using providers from outside of the state. In addition, many are affiliated with or supported by disaster response programs run by their national organizations, which can bring another layer of expertise to the planning table.

Faith-Based Organizations

The importance of the faith community's role in disaster response cannot be overstated. Many Americans turn to faith-based organizations for support when they are most in need of help. An effective link with the faith community can benefit everyone. For example, faith-based organizations can assist mental health responders by disseminating psychoeducational information, and providing consultation and referrals to disaster survivors. They can also help increase the effectiveness of mental health interventions by teaching providers about the belief systems and cultures of those they serve. Also, many clergy members have training in counseling, and some are licensed to provide mental health services.

Service Organizations

Most communities have service organizations (such as the Kiwanis and Rotary and Lions Clubs) that frequently seek speakers on topics that are relevant to their communities. This can provide a good venue for educating the community about and advocating for disaster mental health planning and response activities. In addition, these groups are often seeking ways to help their communities and can be very helpful when planning for disaster or in filling service gaps after a crisis.

Charitable Organizations

State and local charitable organizations (such as United Way, Catholic Charities, Salvation Army and others) provide leadership, services and funding for activities related to mental health. In addition, these organizations may provide or fund mental health service provision, education or advocacy efforts. In addition, these organizations frequently have leadership roles in community planning for a range of health and human service needs. Any assessment of disaster mental health readiness and resources should include a listing of such agencies, an analysis of their capacity and interest in this area, and strategies for developing (or strengthening) relationships and collaborative efforts with them.

Many thanks to the National Mental Health Association for allowing us to include (with some adaptations) part of their handbook regarding “Key Players”. This full handbook, called *Blueprint for Responding to Public Mental Health Needs in Times of Crisis* is available from NMHA by calling the NMHA Resource Center’s toll-free number at 800-969-NMHA, or send an e-mail message to affiliateinfo@nmha.org

This handbook includes:

- Creating a Disaster Mental Health Response Plan
- Community Outreach and Policy Strategy
- Supporting Diverse Populations
- Building a Multiphase Response

BT AWARDEES LINKING WITH MENTAL HEALTH/SUBSTANCE ABUSE

Before a community can develop a plan for mental health preparedness, the leaders of the planning process must be familiar with the key players listed above. As much as possible, planning leaders should seek their input and let them know how they can participate in the planning process.

For BT awardees, this means that you should have regular contact with the mental health planning committee or group, and several of their members should be a part of your collaborative planning committee, to include some one from mental health, substance abuse, pediatric mental health, and developmental disabilities. Likewise, BT awardees (public health, hospital and pre-hospital providers) should ask to participate on their mental health committees. However this linkage happens, it is important that it happens early in the planning process.

The following information is from the SAMHSA “All-Hazards Regional Training” January 21-23, 2004, Washington, D.C.

BENEFITS OF THE PLANNING PROCESS AND KEY ELEMENTS

For BT Awardees to understand the planning process from the Mental Health planner’s viewpoint

Benefits to Planning

- Response will be:
 - Faster
 - Involve the right players
 - More efficient
 - Appropriately targeted
 - Documented
- Reduce unwanted assistance
- Increase protection from political interference/ criticism
(Flynn, 2003 “Creating a Road Map for Disaster Preparedness” presentation at SAMHSA conference)

Benefits Identified by State Participants in Focus Group

(Conducted by NASMHPD) for the all-hazards planning guidance)

1. The process is as valuable as the product
2. The teamwork developed will be what you depend on in the disaster response efforts.
3. Planning facilitates a statewide needs assessment resulting in increased information available on line and improved SEMA support.
4. The planning process enhanced collaboration with other State and county agencies, and with Red Cross resulting in the development of a statewide crisis response teams to assist emergency personnel.
5. The process resulted in a full-time position for SMHA disaster response.

Five Basic Tasks in All-Hazards Planning (From the Mental Health Perspective)

1. Understand All-Hazards Planning and Incident Command System
 - Embrace the philosophy of all-hazards planning so that your SMHA will be prepared for any critical event with a similar emergency response and process that is adjusted based upon the event. An online ICS course can be found at www.fema.gov
2. Decide on Planning Process
 - Who will lead the organization? What is role of Commissioner, Emergency Coordinator, etc.? Who will be involved in planning at State level, between State and local, and at the local level?
3. Decide upon and develop plan content
 - Read the requirements of your SEMA Emergency Operations Plan (EOP). Scope of plan based on political, financial, staffing, time, and sustainability realities.
4. Assure plan integration/coordination

This is where MHAs should be reviewing your plans (and vice versa), and other emergency plans, to include adjoining jurisdictions.

5. Keep plan alive and viable through exercises/updates/maintenance

Someone needs to be responsible for the MH plan. For BT Awardees, find out who this is, and talk with them often.

Critical Elements

- Sustainability – the plan is not being developed to sit on a shelf
- Training
- Testing
- Exercising
- Updating – Uncovered problems, changes in systems, and sections “in development” should be reviewed and updated on at least an annual basis.
- Remember, you are in it for the long haul...It’s a PROGRAM, not just a PLAN.

Unifying Essential Characteristics

- Good preparation, and
- Diplomatic process sensitive to strengths, challenges, and other priorities.

The Context of Planning

- Secure support at the highest level possible
Support for planning from the governor’s office can help improve the chances of success
- Know the culture of State government (seeking change vs. maintaining, fiscal expansion or contraction)
- Know the major players
SMHA is typically part of a larger State response and recovery effort and it often functions under SEMA’s authority. It is important to know who is responsible and/or in charge of the larger operation.

It is imperative to develop relationships prior to an event than to attempt to forge important relationships in the midst of crisis!

Process Guidance

- Anticipate problems – anticipating problems that can be avoided or mitigated from the start allows everyone to have a more successful planning process and a more successful plan.
- Err on the side of over-inclusion rather than leaving some portion of the system out. If key players are left out, the value of their contribution could be lost and valuable time and human resources may be expended to mend fences and/or cope with resistance to the process or product.
- Have a leader, but share the work. Without someone to guide and oversee this process, it frequently becomes the victim of other emerging priorities. At the same time, workload and differential expertise and authorities demand that the work be shared.
- Keep reminding of all the benefits

- Appreciate and acknowledge others concerns/constraints/expertise
- Involve decision-makers
- Keep expectations and timeliness realistic

In the Beginning

- Conduct a thorough and honest assessment of the current plan, the resources available to establish and maintain the plan, and ongoing commitment.
- Few organizations will have the resources to accomplish everything they desire, but most will be able to delineate the basic elements of a plan.

Plan for Continuation

- Effective plans are: exercised, modified, and updated regularly.
- If a plan is not kept alive and vital, it will have very limited value
- Plan to maintain

TRAINING AVAILABLE FOR DISASTER MENTAL HEALTH LEADERS:

FEMA –

- ICS self study course available at www.fema.gov
- EMI (Emergency Management Institute) located in Emmitsburg, MD offers the Crisis Counseling Training, as well as a variety of other training programs. States and governmental jurisdictions can apply to send individual students or teams to participate in classes, exercises and simulations. All applications must contain a signature from the head of your sponsoring organization and be submitted through the appropriate State Emergency Management Agency for approval and forwarding of application to the Emergency Management Institute. For example, Jefferson county Colorado had a law enforcement delegation attend training in terrorism and hostage response the summer prior to the Columbine High School shootings.

OTHER TRAINING-

The American Red Cross has various disaster courses from mental health to mass care to donated goods management; the National Organization Victims Assistance and Department of Justice have their own mental health response model. National Mental Health Association is conducting regional disaster trainings.

THE PSYCHOSOCIAL ASPECTS OF DISASTERS

(From SAMHSA's All-Hazards Regional Training, January 21-23, 2004, Washington, D.C. – Slide Presentation by Dr. Bonnie Selzler, State Liaison, SAMHSA DTAC)

Definition of A Disaster:

A disaster is an occurrence such as a hurricane, tornado, flood, earthquake, explosion, hazardous materials incident, war, terrorism, transportation accident, mass shooting, fire, famine, or epidemic that causes human suffering or creates human need that the victim cannot alleviate without assistance.

(*Training Manual for Mental Health and Human Service Workers in Major Disasters, 2nd Edition*, U.S. Dept. of HHS, 2000.)

Effects of Trauma

- Varies by a person's age, developmental stage, prior condition, and degree of personal impact
- Varies by the disaster's severity, the amount of advance warning, the level of community preparedness
- May include physical, emotional, cognitive or behavioral reactions

Critical Disaster Stressors

- Threat to one's life
- Threat of harm to one's family
- Destruction of one's home or community
- Significant media attention
- Witnessing others' trauma
- Being trapped or unable to evacuate

Cognitive Reactions (Training Manual, U.S. DHHS, 2000)

- Trouble concentrating or remembering things
- Difficulty making decisions
- Preoccupation with the event
- Recurring dreams or nightmares
- Questioning of spiritual beliefs

Emotional Reactions (Training Manual, U.S. DHHS, 2000)

- Feeling depressed or sad
- Feeling irritable, angry, or resentful
- Experiencing anxiety or fear
- Feeling despair or hopelessness
- Feeling guilt or self-doubt
- Experiencing unpredictable mood swings

Behavioral Reactions (Training Manual, U.S. DHHS, 2000)

- Isolation from others
- Problems with sleep
- Increased conflicts with family
- Hyper-vigilance, startle reactions
- Avoiding reminders
- Crying easily
- Increase or decrease in appetite

Physical Reactions (Training Manual, U.S. DHHS, 2000)

- Exacerbation of pre-existing conditions
- Somatic complaints
- Appetite change
- Hypertension, cardiovascular conditions, heart pounding
- Gastrointestinal distress
- Fatigue or exhaustion

Key Concepts

- Remember that the target population is normal
- Avoid mental health labels
- Be innovative in offering help
- Fit the program into the community

Risk Factors of Disaster Survivors

- Family instability and conflict
- Lack of social support
- Presence of children in the home
- Age in middle years (40-60)

Resiliency

- The capacity of children, families, neighborhoods, communities to “bounce back”
- Power of people to recover, heal, grow and succeed in the midst of change
- Intrinsic quality in many people
- Being interconnected
- Can be learned – everyone has the capacity to become more resilient
- Equips people and communities with tools to empower themselves
- Will fade if no attention is paid to it

DISASTER COUNSELING:

Disaster counseling is not the same as mental health counseling. Many States believe they can count on their trained clinical mental health providers to deliver disaster counseling services after a disaster occurs. This is a mistake. Licensed mental health professionals may or may not have disaster counseling skills training.

Mental health providers can get training in disaster mental health counseling, but non-professionals can get this training also. This is important to remember given the limited mental health resources in most communities. The licensed mental health providers may be more likely to provide the long-term counseling and treatment for those who are not functioning well and need more intervention than the disaster counseling model allow.

Below is information that will provide you with a better understanding on the components of disaster counseling.

Disaster Counseling

From the Center for Mental Health Services website

DISASTER COUNSELING SKILLS

Disaster counseling involves both listening and guiding. Survivors typically benefit from both talking about their disaster experiences and being assisted with problem-solving and referral to resources. The following section provides "nuts-and-bolts" suggestions for workers.

ESTABLISHING RAPPORT

Survivors respond when workers offer caring eye contact, a calm presence, and are able to listen with their hearts. Rapport refers to the feelings of interest and understanding that develop when genuine concern is shown. Conveying respect and being nonjudgmental are necessary ingredients for building rapport.

ACTIVE LISTENING

Workers listen most effectively when they take in information through their ears, eyes, and "extrasensory radar" to better understand the survivor's situation and needs. Some tips for listening are:

- **Allow silence** - Silence gives the survivor time to reflect and become aware of feelings. Silence can prompt the survivor to elaborate. Simply "being with" the survivor and their experience is supportive.
- **Attend nonverbally** - Eye contact, head nodding, caring facial expressions, and occasional "uh-huhs" let the survivor know that the worker is in tune with them.

- **Paraphrase** - When the worker repeats portions of what the survivor has said, understanding, interest, and empathy are conveyed. Paraphrasing also checks for accuracy, clarifies misunderstandings, and lets the survivor know that he or she is being heard. Good lead-ins are: "So you are saying that . . ." or "I have heard you say that . . ."
- **Reflect feelings** - The worker may notice that the survivor's tone of voice or nonverbal gestures suggests anger, sadness, or fear. Possible responses are, "You sound angry, scared etc., does that fit for you?" This helps the survivor identify and articulate his or her emotions.
- **Allow expression of emotions** - Expressing intense emotions through tears or angry venting is an important part of healing; it often helps the survivor work through feelings so that he or she can better engage in constructive problem-solving. Workers should stay relaxed, breathe, and let the survivor know that it is OK to feel.

SOME DO'S AND DON'T'S

Do say:

- These are normal reactions to a disaster.
- It is understandable that you feel this way.
- You are not going crazy.
- It wasn't your fault, you did the best you could.
- Things may never be the same, but they will get better, and you will feel better.

Don't say:

- It could have been worse.
- You can always get another pet/car/house.
- It's best if you just stay busy.
- I know just how you feel.
- You need to get on with your life.

The human desire to try to fix the survivor's painful situation or make the survivor feel better often underlies the preceding "Don't say" list. However, as a result of receiving comments such as these, the survivor may feel discounted, not understood, or more alone. It is best when workers allow survivors their own experiences, feelings, and perspectives.

Activities Steps for HRSA BT Awardees as you begin this process:

At the State Level:

1. Get to know all of the “players” at the State level (listed above).
2. Get copies of all of the local mental health plans and see how they overlap with the hospital plans or where there are gaps or problems.
3. Work with the State Mental Health Authorities to see how to work together to integrate plans and responses.

At the Local Level:

1. Public health and hospital/pre-hospital providers should get to know all of the “players” at the local level.
2. Discuss with the “players” how to integrate disaster plans to make the best use of resources.
3. Develop interagency collaborative group with mental health and substance abuse providers, community agencies and groups, businesses, schools to continue to address disaster preparedness efforts. (This group may be broken down into smaller sub-committees, with representation from each group on the main collaborative group/committee.)

SECTION 2: DEVELOPING SHORT- AND LONG-TERM RESPONSE STRATEGIES

This material is drawn from the *Blueprint for Responding to Public Mental Health Needs in Times of Crisis, copyright, 2003, and is used by permission of the National Mental Health Association.*

(Note: This information is not clinical and is presented for educational purposes. It is not a substitute for informed medical advice or training. Do not use this information to diagnose or treat a mental health problem without consulting a qualified health or mental health care provider)

Disaster mental health planners must prepare for the mental health challenges of each phase of recovery, both immediately after the crisis and in the long term. This section reviews the various phases of mental health response and interventions that are sometimes employed. It discusses needs that require both immediate and sustained mental health supports in the community. This section also suggests steps that mental health stakeholders and others can take to facilitate psychological recovery during each phase of disaster response.

Common Principles of Disaster Response

Effective disaster response strategies can differ according to the nature of the disaster, the community affected, and other factors. Broadly speaking, however, some issues cut across all aspects of disaster response:

- **Needs assessments** must be conducted to help responders determine the overall impact of the disaster and which resources, agencies and personnel are needed to address problems. Because response needs will change over time, this step should be included in each phase of the disaster response. During the needs assessment phase, mental health stakeholders who are knowledgeable about the population, history and geography of the affected area can play valuable roles by sharing their observations of reactions and changes in group behavior and needs. To maximize the value of their input, mental health stakeholders should be involved in the preparedness; ideally, their roles should be defined before a disaster happens.
- **Coordination and cooperation between agencies and personnel** is crucial to manage the complex problems caused by a disaster. Otherwise, effective service programs can be seriously compromised when organizations don't coordinate or collaborate well. It is important to identify, not only which agencies should be involved in the response, but also who will be responsible for monitoring those relationships.
- **Outreach** is a critical part of delivering disaster-related mental health assistance because the survivors who are most in need of these services frequently lack access to them due to financial, geographic, or other reasons. In addition, because of the pervasive stigma and misunderstanding surrounding mental health services may be afraid to seek them. In addition, people who are not "system-savvy" or

are at risk for other reasons (due to language or cultural barriers, for example) could “fall through the cracks” with devastating consequences. Outreach is an area in which mental health consumers, educators, advocates and others who are not clinically trained can provide an invaluable service to disaster victims. Mental health stakeholders who know the population, understand the local culture(s), and have access to community members can play a significant helping role by helping assess needs, providing educational materials, providing reassurance and directing survivors and their families to appropriate mental health services.

- **Providing available and flexible mental health services** where they are needed is a vital part of the outreach. Responders must go where the survivors and rescue personnel are. Such locations typically include shelters, meal sites, hospitals, urgent care clinics, police stations, survivors’ homes, schools, churches and workplaces. At these sites, the response team should set up private areas to ensure confidentiality and to remove the survivor from immediate reminders of the disaster. Planners need to consider requirements for physical access to many of these areas. They also need to identify those who might serve in these locations.
- **Personnel who have received disaster mental health training** – and who represent the ethnic and cultural diversity of the community in which they’re working – are a crucial component of crisis response. Crisis response teams should include mental health providers who have worked with trauma survivors and can provide immediate assistance to people with urgent mental health needs. They must also be able to identify people who are at risk of developing longer-term mental health problems and may need follow-up. In addition, response personnel themselves need attention in these stressful conditions. Response team leaders must be able to tell when they or other team members are feeling stress and make it a priority to provide the team with the nutrition, sleep, and “buddy care” it needs throughout the disaster response process. Few people receive disaster mental health training in the normal course of academic study. While many skills are transferable, special training is frequently provided through professional organizations, the American Red Cross, and other sources. Community organizations, such as state and local Mental Health Associations, can contribute by providing or sponsoring such trainings.

Phases of Response to Disaster

During or after a disaster, event sequencing is often not clear or linear. The response and recovery phase may be very distinct in some types of events but less so in others, depending on the type of event and its duration. For example, a tornado is typically over, for a given location, in a matter of minutes. In contrast, a slow volcanic eruption can last for years. Events may recur as in the case of repeat flooding. Multiple types of events may occur simultaneously or in close proximity.

Unfortunately, there is no set formula” for the movement from response to recovery. However, experience has shown that there are four general phases that most communities experience during and after a disaster. These include:

- The Impact Phase
- The Cleanup/Rebuilding Phase
- The Restoration Phase
- The Reconstruction Phase

Impact Phase

The impact phase is also known as the *emergency* or *heroic* phase. This refers to the period immediately following the disaster; typically the first day or two. This is a time of strong emotions and high energy and is devoted to rescue, providing shelter, emergency responses and clean up. It can be a time of great confusion, shock, and horror for those who are directly involved or close to the disaster, but it is also a time of heroism and great cooperation among people.

Most of the requirements during this period are of a practical nature, with the goals being to help survivors get to a safe place, communicate with their loved ones, and gain information about what happened. According to the National Institute of Mental Health (2002), the following are key components of early psychological interventions for survivors of mass violence or disasters.

Within 0-48 hours:

Address Basic Needs

- Provide the assistance necessary for survival, safety, and security. Gently guide survivors away from the site of destruction, continued danger, or those who are severely injured. This may be necessary if survivors are in shock or confused.
- Provide food and shelter.
- Make survivors aware of and facilitate their access to services and/or support.
- Connect survivors to their families, loved ones, or communities. Also, connect them to information and resources they need.
- Assess the environment for ongoing threats.

Provide Psychological “First Aid”

- Protect survivors from further harm.
- Reduce physiological distress – help establish a “safety zone” for survivors that minimizes their exposure to traumatic stimuli, including distressing sights, sounds, and smells.
- Provide support for those who are most distressed.
- Keep families together and facilitate reunions with loved ones.
- Provide information and education.

- Foster communication.
- Use effective risk communication techniques.

Monitor the Impact on the Environment

- Observe and listen to those who are most affected.
- Monitor the environment for toxins and stressors.
- Monitor services that are being provided.
- Monitor media coverage and rumors.

Provide Technical Assistance, Consultation, and Training

- Improve the capacity of organizations and caregivers to provide what is needed to reestablish community structure, foster family recovery and resilience, and safeguard the community.
- Provide assistance, consultation, and training to relevant organizations, other caregivers and responders, and community leaders.

Within One Week:

Assess Needs

- Assess the current status of individuals, groups, and/or populations and institutions, other caregivers and responders, and community leaders.

Conduct Triage

- Conduct clinical assessments, using valid and reliable methods.
- Refer people to mental health specialists when indicated.
- Identify vulnerable, high-risk individuals and groups
- Provide for emergency hospitalization.
- Try to determine which survivors are experiencing intense and overwhelming feelings of panic or grief that require medical intervention. This may require the use of medication.

Conduct Outreach and Disseminate Information

- Offer information/education and “therapy by walking around”.
- Use established community structures.
- Distribute flyers.
- Host web sites.
- Conduct media interviews and programs and distribute media releases.

Foster Resilience and Recovery

- Foster but do not force social interactions
- Provide coping skills training.
- Provide risk assessment skills training.
- Provide education on stress responses, traumatic reminders, coping, normal versus abnormal functioning, risk factors, and services
- Offer group and family interventions
- Foster natural social supports
- Look after the bereaved
- Repair the organizational fabric.

In the immediate response phase, it is sometimes difficult for people to see the value of mental health assistance beyond providing emergency psychiatric care. Experience, however, has clearly demonstrated the value of a much wider role for the mental health community. The presence of mental health providers, consumers and other stakeholders in many activities can be very helpful. For example, immediate roles can include providing:

- Presence in temporary shelter and feeding sites
- Assistance with family reunification
- Assistance with body identification
- Monitoring worker stress and consulting with management
- Orientation/education of incoming response workers

In some cases, simply being present during an event can be comforting and very helpful in establishing credibility later on. Those in the faith community call this the “ministry of presence”.

Efficiency and effectiveness will be enhanced if these roles are determined before a disaster occurs. As disaster response has become more organized, opportunities for spontaneous response by providers are rapidly diminishing. In fact, the management of well-meaning (and other) volunteers has become a major management challenge in large, visible events. For this reason, those who wish to be involved in the types of activities described above should affiliate with a group or organization that has an identified role in response plans. Likewise, groups and organizations that wish to participate in disaster mental health response should be sure they have a designated role in their community’s response plan.

Cleanup/Rebuilding Phase

The cleanup/rebuilding phase is also referred to as the early *post-impact* or *honeymoon* phase. This usually lasts days to weeks, and is a time when agencies and communities show a high level of cooperation. Outside assistance often comes pouring in during this period, and celebrities, politicians and others may show up to express support. It is also a time of extensive media coverage, which has its own benefits and liabilities related to emotional recovery. During this phase, survivors begin to display a variety of physical and emotional symptoms, including denial, intrusive thoughts, aches, pains, problems sleeping, and non-specific somatic ailments.

At the end of this period, media coverage begins to wane, VIPs stop visiting the community, and the energy level of recovery workers starts to taper off, just as the more prolonged restoration phase begins. Individuals and communities often feel abandoned or forgotten during this phase and those feelings can impede the healing process. Mental health stakeholders can play an important role by helping survivors understand that these phases are normal and to be expected. Another crucial task is to educate decision-makers to ensure that they understand that there are still psychosocial needs to be addressed. Advocacy strategies can include contact with political leaders, media outreach, budget advocacy, and other tactics.

Mental health disaster planning during this phase should focus heavily on how to provide general information about stress reactions and healthy coping mechanisms to all members of the community, including rescue and recovery personnel and community leaders. For some people, short-term interventions (such as debriefing or relaxation training) can be helpful for addressing acute distress. However, it is unclear at this time how effective these strategies are in the prevention of longer-term mental health consequences of trauma. Providing social support, helping people recognize their strengths and abilities to cope with difficult situations, and facilitating the re-establishment of normal routines are major goals during this period. In addition, the identification of people who are in need of more intensive mental health services and active follow-up is critical.

Community Outreach

The importance of community outreach in disaster response cannot be overemphasized. For a number of reasons, most people are reluctant to seek help for psychological problems after surviving a disaster. Some survivors consider themselves better off than those who lost their lives or were more severely affected, and, as a result, feel they don't need or deserve help in coping with what they've experienced. Others refuse to believe that they may have a problem, even when their lives have been severely disrupted or functioning severely compromised. Some survivors assume their problems will dissipate on their own. Others worry about the expenses they could face if they receive mental health treatment, or don't know where to find the help they need.

Stigma is also a major barrier to seeking help. Unfortunately, many people still believe that seeking or accepting mental health assistance is a sign of weakness, and this stigma

can have very real consequences. For example, some first responders (such as fire and police personnel) may fear that if they seek mental health services, they will risk being determined “unfit for duty”. Government and military personnel may fear losing security clearances or jeopardizing career advancement. Helping people understand that emotional distress is common can reduce stigma and encourage people to seek help.

For these reasons, crisis response practitioners and planners must reach out to all members of the community- and they must do so in a variety of ways. Effective community outreach requires the following steps:

- **Identify qualified personnel who can provide culturally and linguistically appropriate services for each person, family or community.** Such personnel should have received training in crisis management and mental health assistance. They should also know the community’s members and include representatives from different racial and ethnic groups, and professional organizations (such as those representing fire fighters, law enforcement personnel, and educators).
- **Teach primary care physicians and emergency room personnel how to recognize warning signs of mental health problems, including *somatization*, or physical symptoms that are triggered by psychological stress.** Most people first seek help (for both physical and emotional problems) by consulting with their primary care physicians or visiting emergency rooms. Practitioners in these facilities should be prepared to conduct routine mental health screening after a disaster occurs. In addition, the widespread shortage of mental health providers makes it imperative that survivors have access to other healthcare providers who are qualified and willing to identify and respond to their mental health needs.
- **Develop an outreach plan for those who have ongoing health and human service needs.** When resources are reprioritized abruptly or services suddenly become limited or unavailable, the lives of those who depend on such services may be severely disrupted, and their needs may even be inadvertently forgotten. Such groups can include people with serious and long-term mental illnesses, families with children who require special services, and single parents who depend on day care and other services to keep their jobs. In addition, people with pre-existing mental illnesses who are experiencing normal disaster-related stress are often inappropriately diagnosed as experiencing an exacerbation of their pre-existing illness. This hampers their recovery from both the disorder and the disaster. Providers must be trained to understand the difference between normal reactions and symptoms of illness when assessing the stress reactions of people with mental illness.
- **Address needs for social support.** Social support is one of the most critical factors in promoting recovery following trauma exposure; this fact should be emphasized to survivors. In addition, mental health disaster workers should identify and reach out to survivors who may have become (or have always been) isolated from their families, friends, or neighbors. Also, survivors should be assisted in recognizing their strengths and their abilities to cope with difficult situations from their past, in order to help them gain a sense of mastery over their environment, and hope for the future.

Some of the bonds and connections that were strengthened during the honeymoon phase come undone as individuals and communities begin to experience inequalities in their access to recovery sources, such as insurance coverage and government assistance. This is where the consequences of disaster hit directly at the “fault lines” in families and communities, and can create or exacerbate tensions between groups and individuals. Organizations and individuals who know the culture and community can be very helpful in working with community members to reduce these tensions between groups and individuals.

- **Include efforts to prevent substance abuse and violence in mental health outreach planning.** Research findings on the incidence of these problems following disasters are mixed. However, in the aftermath of a disaster, increased use of drugs and alcohol is common, and higher rates of relapse among people with former substance use problems have been reported. Domestic violence may increase following exposure to a traumatic event. Mental health practitioners should conduct outreach to prevent or lessen the extent of these behaviors, and other health service providers should be trained to recognize and address substance abuse and domestic violence among those they see.
- **Relaxation Training.** Conducting relaxation training, or assisting survivors to form self-help groups, may also be helpful during this period. Relaxation training, in particular, can be valuable for rescue workers who are often unwilling or unable to take long breaks while engaging in their recovery mission.
- **Respite Care.** Respite services for caregivers are an important element of post-disaster mental health assistance. After a disaster, caregivers often face increased burdens due to loss of basic conveniences, increased physical and emotional demands on themselves or their loved ones, and loss of services, including possibly transportation or communication. To help caregivers cope, respite services should be provided within the community. Caregivers must have time to take care of themselves, catch up on their sleep, and engage their own active coping mechanisms.

Respite care should be available and actively promoted to caregivers, who may be disinclined to request such help for themselves.

As with all mental health services, consumer choice should be a central value driving any disaster mental health response. The types and timing of survivors’ reactions to disaster can differ widely from one person to another. If someone chooses not to accept a particular form of help and is not in imminent danger because of their reaction, then the survivor’s wishes should be respected. While research is still underway to identify the most effective types of post-disaster interventions, there clearly is no “one-size-fits-all” intervention. Therefore, the best approach is to provide a menu of interventions that people can choose from; it’s also important to respect the fact that people will seek help from a variety of sources. Many sources, such as primary care providers and the faith community,

are outside the traditional mental health field. The task for planners is to ensure that these helpers have the information and tools they need to respond appropriately to mental health needs.

It is also important not to over-pathologize survivors' symptoms and concerns. Most people who are exposed to a traumatic event will recover with sufficient time and support. For many survivors, the most effective mental health intervention is to provide information about normal stress reactions and healthy coping mechanisms. However, for some individuals and families, greater attention from the mental health community and additional resources will be required.

- **Addressing Severe Stress Reactions.** As noted above, one of the most critical functions of mental health disaster responders is to identify survivors whose reactions suggest the need for immediate medical or psychological intervention, as well as those who require follow-up assessment because they are not at risk of developing longer-term mental health or substance abuse problems. The latter is an especially difficult task, since it requires the responder to be sensitive to the survivors' needs and reactions, knowledgeable about risk factors and warning signs for mental illnesses, and able to elicit critical information to help make this determination. Taking steps to follow up with vulnerable individuals is critical to ensure that they obtain the assistance they need as time progresses, if their symptoms do not dissipate. To adequately perform this type of triage, expertise in mental health and trauma are required along with education and training for other members of the community. These include primary care physicians, emergency room personnel, teachers, parents, and spiritual advisors and leaders, and anyone else who may be in a position to identify and interact with survivors in need of help.

For some people, medication, psychotherapy, or other forms of mental health treatment may be needed. These modalities are discussed below in the "Restoration Phase" section.

- **Death Notifications.** The issuance of death notifications may begin immediately after the disaster, but is most likely to be part of the second or third phase of the disaster response, depending on the nature of the event. Some people who lost family members on September 11 were still waiting for verification of the death of their loved ones through DNA evidence many months after the attacks. Such notification should be conducted by personnel who are trained to be sensitive in delivering this kind of news and who can respond if the recipients of the news become overwhelmed physically or emotionally by their grief. During this process, mental health providers can play valuable roles in supporting staff in the coroner's office or morgue. Supportive activities could include working with families who must identify deceased relatives, or teaching stress management techniques to mortuary workers. In many situations, the American Red Cross has responsibility for death notification. In such cases, mental health providers must coordinate their efforts with the American Red Cross.

In some cases, mental health practitioners are also called upon to notify people outside the immediate family about a death. For example, the MHA of Central Florida was asked to respond to the sudden death of a child at a nearby recreation center. The center asked the MHA to send trained personnel to tell a group of children that one of their playmates had drowned in the center's pool and to provide the necessary counseling.

- **Promoting Coping Skills and Strategies.** Mental health responders can also provide information on effective coping skills. During this and the other phases following disaster, the types of coping strategies that are most likely to be effective differ from one person to the next, depending on their needs and belief systems. For example, some people can regain their sense of self-control and competence by focusing on what to do next and on solving short-term problems. Others may want to adopt an expanded, more future-oriented perspective to help put the event in a larger context, which can dilute the strength of its impact. This is also an area in which the faith community is heavily involved, since many people cope by putting the event and their experience into a spiritual context.

Another common approach is for the affected person to focus on the strengths he or she, or the surrounding community, had shown in the past during difficult situations. This memory of being able to rally against tough circumstances can help increase a survivor's optimism about being able to make it through the current situation. In general, efforts to increase survivors' confidence in their own resourcefulness and abilities (together with evidence that others are willing to provide support) promote resilience.

A variety of coping behaviors that can also facilitate recovery include:

- Resumption of familiar routines.
- Physical self-care, which can include exercise, healthy diet and sleep.
- Psychological self-care through personal reflection, stress reduction and talking to others.
- Emotional self-care, which can take the form of laughter, music, crying, accepting care and affection from others, and caring for others.
- Spiritual self-care through meditating, praying, attending religious or cultural services, reading and communing with nature.
- Playful behaviors such as artistic activities and interacting with affectionate animals.
- Participation in the disaster recovery effort as a volunteer. Examples include collecting food or other necessary work the survivor feels comfortable performing.

It is also important to help survivors avoid feeling guilt or regret over the consequences of a disaster, especially when it has resulted in loss of life. People who were directly involved in the incident may question why they survived when

others didn't, or whether they did all they could to save others. Rescue workers who were present during the disaster, or arrived shortly afterward, often feel such doubts intensely. For some survivors, participating in the post-disaster recovery effort can be a way to channel their guilt and grief, while increasing their sense of self-worth, self-esteem, and belonging in their community.

It is particularly common for children to believe that they are somehow responsible for the bad things that happen in a disaster. For this reason, it is necessary for parents, teachers, and other caregivers to explore the child's understanding of the event and not make assumptions.

The importance of mental health promotion—and the fact that good mental health is more than just the absence of mental illness—has always been central to NMHA's message and approach. In the wake of disasters, organizations such as state and local MHAs can make valuable contributions to community mental health by undertaking efforts that can increase survivors' resilience. In addition, they have a crucial role to play in making sure that such efforts (such as teaching coping skills) are included in any disaster mental health response.

Restoration Phase

The restoration phase is also called the *disappointment* or *disillusionment* phase. This usually begins after the first weeks or months following a disaster and lasts for at least a year and sometimes longer. It is a time when survivors begin to realize that they cannot return to their previous lifestyles, and their expectations of aid and restoration are not being met. This is often a time when financial problems begin to emerge, but community supports begin to weaken.

During this period, survivors are still grieving, yet are required to negotiate with insurance companies, lawyers, and other administrative officials in addition to experiencing losses, unemployment, and possibly relocation.

Fatigue, irritation, financial disappointments, insurance problems, political priorities, and real or perceived injustice characterize this period. Mental disorders such as PTSD, depression, and substance use disorders emerge, often concurrently.

To ensure the full recovery of the community and its diverse members, crisis planning must address the restoration phase. Unfortunately, this is the point at which many crisis plans falter. A continuing commitment to address mental health needs during this period is required of state and local stakeholders in order to obtain the funding and resources necessary to ensure treatment and services for all those are still affected by the disaster. Advocates have an especially important role at this stage to ensure that mental health issues are attended to in the long term.

The requirements for mental health disaster planning during this phase will vary, depending in part on the nature and scope of the disaster. A critical task is the identification of individuals in need of mental health and/or substance abuse treatment because of unresolved symptoms and functional impairment. Common disorders resulting from trauma such as depression, PTSD, and substance abuse can become chronic and debilitating conditions if left untreated.

Tremendous socioeconomic and emotional challenges characterize this phase of recovery. To help people meet these challenges, mental health planning should aim to bolster related community supports and services.

Providing Care to Individuals With Disaster-Related Mental Health Problems

There are several strategies that communities can employ to address disaster-related mental health problems. They include the following activities, which should be built into disaster response plans.

- **Educate and involve primary care providers.** Many or most trauma survivors with mental health needs will not seek help from a mental health practitioner. Many will not seek help at all for a variety of reasons, including having feelings of guilt for having survived when others did not or believing that seeking help is a sign of weakness. However, some survivors will visit their primary care physicians, often complaining of somatic symptoms, such as headaches, stomachaches, chronic pain, hypertension, irritability, or an inability to sleep, all of which may be secondary symptoms of PTSD.

Some survivors may fear job-related reprisals if they are diagnosed with a mental disorder; this is particularly true for those involved in professions such as firefighting, law enforcement, and politics. In addition, as noted above, there may be increases in family violence as well as substance abuse. During this phase, primary care physicians must be especially vigilant and proactive in screening for mental illness and making referrals to mental health practitioners when needed. At the same time, in working with individuals who have pre-existing mental illnesses, providers must be careful not to interpret normal stress reactions as symptoms of the person's mental illness.

- **Provide screening tools to key members of the community who are in a position to identify individuals who are in need of mental health assistance.** This includes medical personnel, teachers, religious leaders, community organizations such as state and local MHAs, and even (responsible and reliable) Internet sites. The screening instruments should be easy to use, although training on their usage may be required. Some may be designed for survivors to use themselves to determine whether they should seek help. These tools should be designed to detect PTSD, other anxiety disorders, depression, substance abuse, and violence.

At the same time, it is necessary to ensure that the screening tools used are scientifically sound and reliable. One example of an easily administered depression screening tool is available at the NMHA's www.depression-screening.org Web site. The National Institute of Mental Health's Web site, www.nimh.nih.gov also provides information on reliable screening tools for a variety of mental disorders. **These types of screening tests are not intended to provide diagnoses for mental illnesses.** However, they can sometimes help identify related symptoms and determine whether a further evaluation by a medical or mental health provider is necessary.

- **Conduct community outreach through media campaigns and public education.** As noted earlier, this outreach is critical to initiate and maintain, since many survivors of trauma will not access services for the reasons noted above. Others may develop symptoms some time after the disaster occurred and not attribute their problems to the traumatic exposure. Therefore, it is important to continue to alert the public to the mental health underpinnings of diminished capacity at home, school, or in the workplace, as well as the hallmark symptoms of anxiety, depression, and substance abuse disorders. These messages should convey the fact that treatment is necessary, effective, and should be delivered by trained medical or mental health practitioners.
- **Make sure that a variety of mental health treatments and services are available.** Research findings indicated that 10 percent to 30 percent of people who have been exposed to a severe trauma (either directly or indirectly) will develop PTSD or related disorders such as depression, other anxiety disorders and substance abuse. PTSD is only diagnosed when symptoms persist for more than one month. Depression can also involve the chronic recurrence of symptoms. As a result, people who are diagnosed with these conditions often do not undergo treatment until several weeks or months following the disaster.

Treatment modalities for mental disorders such as PTSD and depression can include medication, psychotherapy, and other treatments and services. The choice of treatments will depend upon the mental health practitioner's expertise and the survivor's preference.

Medications are sometimes used as a short-term aid to help reduce acute symptoms, such as insomnia, and are also used to help manage long-term PTSD, anxiety and depression. The Food and Drug Administration (FDA) has approved some psychotropic medications specifically to treat PTSD. Survivors who undergo this treatment must receive frequent follow-up care to ensure that the medications they're taking are effective, that they are taking them properly, and that the side effects are tolerable. Some survivors may respond well to a course and treatment that involves taking prescribed medications along with psychotherapy.

Psychotherapeutic approaches may also be employed. In some cases, psychotherapy is combined with medication. Common psychotherapeutic treatments for stress disorders include:

- *Cognitive behavioral therapy (CBT)*: CBT focuses on increasing the person's awareness of automatic triggers of stress and fear in their environment in order to help them change their interpretation and reaction to these circumstances. It involves multiple but limited numbers of sessions (usually 5-10). CBT has been successfully used to treat PTSD and depression in both children and adults, and appears to have long-lasting positive effects. It has not been widely tested following exposure to disasters, although it has been used following other types of trauma, such as physical or sexual abuse.
- *Exposure therapy and stress inoculation*: Exposure therapy involves repeated exposure to feared situations, both imaginary and real. Stress inoculation combines elements of CBT, exposure therapy, and relaxation training. These forms of therapy have also been shown to be effective in reducing symptoms of PTSD.
- *Interpersonal psychotherapy (IPT)*: IPT focuses on increasing a person's awareness and understanding of how trauma, grief, and conflict affect their interpersonal relationships. Guidance and education are provided to help clients learn to better address and resolve relational issues. The emphasis is on reporting damaged personal relationships resulting from trauma and enhancing healthy alliances. Research evidence supports the effectiveness of IPT for the treatment of depression and/or relational disorders.

Eye movement desensitization and reprocessing (EMDR) involves the use of repetitive gestures by the therapist to guide eye movements, while the person is asked to remember and describe the traumatic event. It involves re-conceptualizing the trauma from a more positive perspective in order to achieve a healthier outcome. This form of intervention became popular in the 1990s, but remains out of the mainstream of common interventions. While it enjoys many advocates, its use is a subject of controversy and the technique's developers have made a number of changes in its application over time. While positive benefits are often reported, more research is needed to determine EMDR's short- and long-term efficacy. At this point, the evidence base supporting the effectiveness of EMDR is not as strong as for interventions such as cognitive behavioral therapy.

While these are some of the more common forms of treatment, it is not an exhaustive list of all therapeutic approaches to the treatment of stress disorders. The decision to employ any treatment modality should be made by a trained practitioner in partnership with the consumer. In addition, mental health-related support services (such as respite care and outreach to people who are socially isolated) should be provided.

As part of disaster planning, it is important to identify which members of the community have the types and levels of expertise to address mental health problems related to trauma. This is necessary in order to prevent well-intentioned but unskilled people from

using approaches that actually could harm survivors. This is especially true after disasters that trigger an overwhelming response from the community or even across the country, involving large numbers of people who, though not necessarily qualified to do so, want to help.

Employing Symbols and Rituals

In recent years, there has been a renewed appreciation for the power of symbolism and rituals in the individual and collective healing and recovery process. Political, military, and religious leaders throughout history have understood the enormous power of symbols and rituals to bring groups together and help them express their common experience, and articulate thoughts that are too powerful to put into words. Large-scale disasters (and even personal crises) are by definition outside the scope of normal experience. It is therefore not surprising that individually and collectively, people have a difficult time capturing in words what they have endured, what they are currently experiencing, or their view of the future. When the usual “coping tools” fail, people often seek ways to symbolize their thoughts, feelings and hopes by engaging in rituals that physically manifest what they wish to express.

After disasters, survivors often use a range of symbols and rituals to aid their psychological recovery. For example, some express their loss by placing black crepe on police badges or by flying flags at half-staff. Some express their desire to comfort others through such gestures as leaving teddy bears at the fence line in Oklahoma City and the World Trade Center. Some symbols reflect the community’s hopes for the future, such as the “survivor tree” at the site of the Oklahoma City bombing or memorial gardens at schools where shootings have occurred. People also develop and participate in rituals that express their common experience, such as one-year anniversary remembrance ceremonies or wreath-laying ceremonies.

Individuals and communities that have experienced loss and trauma often find creative ways to convey their experience and their need to find some benefit or meaning from the trauma and loss. Mental health consumers, advocates, planners and providers can play powerful roles in individual and collective healing by understanding the power of symbols and ritual in the healing process, and by making efforts to ensure that there are opportunities for this type of expression. Mental health stakeholders can:

- Help community leaders understand the importance of symbols and rituals.
- Provide consultation to groups that are organizing symbolic events.
- Assist planners in “thinking through” what is being symbolized (for example, whether the event is honoring those who died, those who survived, those who helped, and/or others) to ensure that a healing intent does not create more pain.
- Ensure that symbols and rituals embrace cultural appropriateness and diversity to make them meaningful to the greatest number of community members.
- Seek membership on committees planning physical memorials.
- Ensure that mental health personnel are present at events where they might be helpful should participants need emotional support.

Providing Community Services and Support

During this phase, the mental health needs of the community continue to require service delivery, social support, and respite services. In addition, communities can encourage positive responses to the disaster, for example, by creating memorials or holding services to honor those whose deeds saved others. Trying to restore community morale is also an element of the mental health response. Among the issues to address are:

- **Financial impact.** Unemployment, disability, and loss of possessions and homes will mean that people must relocate and negotiate with lawyers, insurance companies, and government administrators. To the extent that disaster response teams can facilitate these processes, they can lessen the degree of stress on survivors who have already been traumatized by the disaster.
- **Needs of people who depend on community supports under normal conditions.** People who faced extra challenges before the disaster (for example, due to conditions such as poverty or mental or physical illness) can become marginalized or isolated if their support services are cut or re-routed into other disaster-related efforts. It is important to ensure continuity of community support and services to prevent this from occurring. This would require reinforcement of the systems most likely to be overwhelmed in a disaster.
- **Family strengthening.** Increased stress, domestic violence, and substance abuse contribute to a breakdown in family structure and function. Prevention efforts aimed at strengthening families or providing respite care can be helpful.
- **Addressing long-term health concerns of survivors.** For survivors of a biological or nuclear attack, questions about their long-term health or the risks of genetic abnormalities in their children may be central concerns. Specific planning for such disaster types is needed, since it will require input from experts about the actual risks, best treatments, and expected outcomes, as well as information for the medical community on how best to tackle these problems. Failure to provide accurate information during all phases of response will impair recovery. In a worst-case scenario, it can lead to panic. In most cases, it will erode confidence in government and community leadership; this in turn reduces compliance with directions and increases the chance that people will behave in ways that are not in their best interest or in the interest of the larger community.

It is not possible to plan for every contingency associated with a disaster, and unfortunately, there are new lessons being learned following disastrous events that occur throughout the world. However, the more support that communities can provide to disaster survivors during the first three phases of response, the more likely survivors are to recover and rebuild their lives. Hopefully, the general principles outlined above can serve as a guide for considering how mental health needs will change over time and what resources are necessary to promote the final phase: reconstruction.

Reconstruction Phase

Also known as the *re-stabilization phase*, this phase occurs over several years, and involves survivors' efforts to rebuild their lives, families and homes. The process is geared toward engineering the survivor's return to employment, retirement living or school, and the acceptance of a "new normal." Some survivors' emotional symptoms resolve completely. They may even experience personal growth and ultimately see some benefits in what they have endured. People who report such benefits usually describe them as sudden insights that occur months to years after their experience. Surprisingly, some people who have had very traumatizing experiences have also shown striking benefits. For example, some veterans who were prisoners of war during the United States' war with Vietnam reported that they benefited from their experience in terms of reprioritizing their life's goals, and better appreciating their families and country.

For others, the recovery process can be lengthy and difficult. Some survivors may never fully recover because their ability to function remains diminished, or they endure easily triggered recurrences of their trauma-related symptoms. These survivors need active and continuous attention from the mental health community.

It is important to remember that just as people have different emotional reactions to disastrous events, they can also need varying amounts of recovery time. Support providers should work to understand each survivor's individual needs and avoid making generalizations or judgments about "reasonable" reactions or rates of recovery.

CONCLUSION

Mental health has a major role in both individual and community recovery. Individuals and communities may recover at different rates and, as indicated earlier, the path to recovery is not linear. The need for mental health assistance may last for years.

An effective disaster mental health response requires both short- and long-term strategies. With prompt and skillful application of interventions such as those outlined in this section, the damage inflicted by disasters can be reduced. And, it is to be hoped that, with thoughtful and sustained attention to the needs of all affected, the ultimate outcome will be an increased appreciation of life, family, and friends, and a strengthening of the bonds of community.

REFERENCES AND RESOURCES

“Hope and Remembrance”, a video developed by Texas State MH/MR Office in 1996 and released by The Emergency Services and Disaster Relief Branch in the Center for Mental Health Services in 2003, focuses on the effects of a disaster’s anniversary on its victims/survivors and shows how mental health services can help people at such a time. For a copy of this video, contact the Emergency Services and Disaster Relief Branch at 301-443-4735.

Flynn, B. Thoughts and Reflections Following the Bombing of the Alfred P. Murrah Federal Building in Oklahoma City. *Journal of the American Psychiatric Nurses Association*, 1 (5), 166-170. Elsevier, NY, 1995

National Center for Post-Traumatic Stress Disorder (NCPTSD *Disaster Mental Health Services: A Guidebook for Clinicians and Administrators.*) U.S. Department of Veterans Affairs, Washington, DC 2000.

National Institute of Mental Health. *Mental Health and Mass Violence: Evidence-based Early Psychological Intervention for Victims/Survivors of Mass Violence.* U.S. Government Printing Office, Washington, DC 2002

Responding to Terrorism Victims: Oklahoma City and Beyond, OVC, DOJ, Publication #NCJ 183949, Washington, DC, October 2000.

RESILIENT COMMUNITIES GUIDEBOOK

**For Bioterrorism and Other Public Health
Emergencies: A Mental and Behavioral
Health Wellness Model and Guide**

PART TWO:

DISASTER MENTAL HEALTH KEY ISSUES AND RESOURCES

**HRSA, Special Programs Bureau,
Division of Health Care Emergency Preparedness
April 2004**

**Resilient Communities Guidebook
For Bioterrorism and Other Public Health Emergencies:
A Mental and Behavioral Health Wellness Model and Guide**

PART ONE: BACKGROUND AND GENERAL INFORMATION
(Contains Sections 1&2)

Section 1: Introductory Material to Disasters and Terrorism

Section 2: Developing Short- and Long-term Response Strategies

PART TWO: DISASTER MENTAL HEALTH KEY ISSUES AND RESOURCES

Section 3: Disaster Mental Health Key Issues and Resources

- A. Planning**
- B. Surge Capacity**
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PART THREE: SPECIAL POPULATIONS AND RESOURCES

Section 4: Special Populations and Resources

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- K. Unemployed/underemployed/low income
- L. Pet owners
- M. Medical and mental health disaster responders
- N. Higher income families

PART 4: RESILIENT COMMUNITIES MODEL AND TOOLS

Section 5: Resilient Communities Model

Section 6: Table of Resilient Communities (Lead Team and Subcommittees)

Section 7: Community Mental Health Assessment by Population/Issue

Section 8: Checklist for Resilient Communities

APPENDIX I: State Mental Health Commissioners

APPENDIX II: Disaster Mental Health Coordinators

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PART TWO
(Contains Section 3)

SECTION 3: DISASTER MENTAL HEALTH KEY ISSUES AND RESOURCES

A. PLANNING

Planning is perhaps the most crucial aspect to successfully meeting the disaster mental health needs of a community. The *Resilient Community* Team/Collaborative is the primary conduit for planning. This collaborative serves as the umbrella organization that prepares for, responds to, and provides follow-up for disaster survivors.

As outlined in Section 2, this process of working together in a collaborative way is time-consuming but well worth the effort. It not only builds resiliency for a disaster, but strengthens the social fabric for any crisis that comes along.

Re-read Section 2 for the full details.

B. SURGE CAPACITY

Mental health casualties, and in WMD, those who feel they have been exposed to an agent, will show up at the hospital expecting services. Hospitals must have a mechanism for medical and mental health triage so that those who need medical care can get so in a timely manner, and those who need crisis intervention services can do directed to services to assist them.

During the planning stage, the collaborative team should already have identified alternate sites of care, so that not everyone will go to the ED, whether for medical or mental health care. They would know, for example, that X Community Health Center is their provider of care.

C. COMMUNICATION/MEDIA

Most communities have diverse cultures that get their information in a variety of ways. First there are the traditional means such as radio, TV, and newspapers. However, many individuals rely on neighborhood channels of information such as the local faith-based organizations, community leaders, non-English print media, etc.

Communities must plan for how they will disseminate information. One part of the planning process involves getting feedback from the community members themselves. They are the best ones to assist in developing a media strategy.

Communities must also develop risk communication protocols so as not to overly alarm community members, but to provide factual, helpful information that allows the members to make decisions based on the best information available.

D. DISASTER MENTAL HEALTH INTERVENTIONS

Disaster mental health interventions include both crisis response and long-term care. Crisis response is done in the hours and days following the event, and is often carried out by a mix of providers. This mix can include licensed mental health providers, Red Cross Disaster Mental Health teams, CISM trained volunteers, and other trained responders such as from NOVA.

The following information is from a powerpoint presentation (Patricia Watson, National Center for PTSD) that was given at the SAMHSA All-Hazards Regional Training, January 21-23, 2004, Washington, D.C.:

We don't have good empirical evidence for any disaster intervention to include: risk communication, psychological first aid, crisis counseling, psycho-education, debriefing, EMDR, and psychotherapy.

There are methodological limitations of uncontrolled debriefing studies:

- Treatment groups may differ from non-treatment groups on other factors
- Secondary factors (bereavement, loss of property) confound results
- Outcome measures unstandardized
- No pretest
- Reliance on self-report measures and satisfaction measures

Debriefings do not consistently reduce the risks of later developing PTSD or related adjustment difficulties. The reasons why debriefings might produce negative outcomes include:

- Association between heightened arousal in acute phase and long-term psychopathology
- Dismantling dissociation and avoidance in immediate phase may be detrimental to some individuals
- Multiple and complex stressors with different timelines
- Potential for re-traumatization by hearing the stories of others
- Inappropriate for acutely bereaved persons, certain cultures

Expert Panel Comments on Debriefing:

- Timing: For most people some avoidant "down time" is helpful, and debriefing can interrupt this process.
- Systematic ventilation of feelings is the objectionable part of debriefing.
- 'Mandatory' or exclusive offering are also objectionable.
- No assessment phase.
- Does not change core processes (it's only presented once, and doesn't give enough time for education or motivating behavior change).

How Should Early Intervention After Disasters Work?

- Reduce high arousal
- Increase social support
- Enhance coping with event and reactions
 - Decrease fear of symptoms
 - Increase understanding of traumatic stress reactions and grief
- Prevent maladaptive coping
 - Avoidance, rumination, substance abuse, isolation
- Prevent “loss of resources”
- Later (3 weeks-years):
 - Reframe negative cognitions
 - Increase therapeutic exposure
 - Facilitate emotional processing

Treatment Delivery:

- Start with outreach, education, support, bolstering resources
- Mandatory education vs. mandatory counseling
- Screening/assessment and triage for those more severely impacted
- Give enhanced services to those who are having trouble functioning
- Referral to treatment for those who are more distressed, have more complex history, or are more impaired in functioning

General Recommendations from Expert Panel:

- Interventions should be tailored to address individual, community and cultural needs and characteristics.
- A sensible working principle in the immediate post-incident phase is to expect normal recovery.
- The presumption of clinically significant disorder in the early post-incident phase is inappropriate except for those with pre-existing conditions.
- Interventions should promote normal recovery, resilience, and personal growth.
- Good practice in early intervention takes into account the special needs of:
 - Those who are disabled and other high risk groups disadvantaged so as to be less able to cope with unfolding situations.

Key Components of Early Intervention:

- Preparation
- Provision for Basic Needs
- Psychological First Aid
- Needs Assessment
- Monitoring of the Rescue and Recovery Environment
- Outreach and Information Dissemination
- Technical Assistance, Consultation and Training
- Fostering Resilience/Recovery
- Triage
- Treatment

Preparation:

- Train
- Gain knowledge
- Collaborate
- Inform and Influence Policy
- Set structures for Rapid Assistance

Provision of Basic Needs:

- Provide food and shelter
- Orient survivors to disaster and recovery efforts
- Facilitate communication with family, friends, and community
- Reduce ongoing environmental threat

Psychological First Aid

- Reduce physiological arousal
- Mobilize support for those who are most distressed
- Facilitate reunion with loved ones and keep families together
- Provide education about available resources and coping strategies
- Using effective risk communication techniques

Needs Assessment

Assess:

- Whether survivors' needs are being adequately addressed
- The characteristics of the recovery environment
- What additional interventions and resources are required.

Monitoring the Rescue and Recovery Environment

- Observe and monitor survivors for potential behavioral and physical health sequelae.
- Monitor the environment for ongoing stressors or toxins, services that are being provided, and media coverage and rumors.

Outreach and Information Dissemination:

- Provide "therapy by walking around",
- Utilize established community structures to provide information and support.
- Disseminate information via distribution of fliers and referral to websites.
- Provide media with materials to help increase knowledge about trauma and recovery.

Technical Assistance, Consultation and Training:

- Provide knowledge, consultation, and training to organizations, leaders, responders, and caregivers
- Improve the recipient's capacity to re-establish community structure to foster family recovery/resilience, and safeguard the community.

Fostering Resilience/Recovery

- Provide resources to improve social interactions, coping skills, risk assessment, self-assessment and referral.
- Provide group and family interventions.
- Foster natural social support.
- Look after the bereaved.
- Repair community and organizational fabric.

Triage:

- Assess survivors
- Identify vulnerable, high-risk individuals and groups
- Provide referral and/or emergency hospitalization when indicated.

Treatment:

- Reduce symptoms and improve functioning via:
 - Education
 - Individual, family, and group psychotherapy
 - Pharmacotherapy
 - Spiritual/existential support
 - Short-term or long-term hospitalization

Cognitive Behavioral Techniques(CBT):

Appear to have the most promising results in preventing subsequent psychopathology:

- Exposure techniques may be contraindicated in early phases
- When exposure therapy is contraindicated, other CB techniques may be effective
- There are no RCTs that have assessed the effectiveness of EMDR within the first four weeks of traumatic exposure.

CBT as Early Intervention:

- 4 of 5 RCTs found clear superiority of CBT group vs. control group/supportive counseling group

Three Core Components of Enhanced Services Intervention

- Psychoeducation
- Anxiety Management/Coping Skills
- Cognitive restructuring

Basic Requirements for Mental Health Providers

- Capacity to connect with wide range of individuals
- Tolerance for symptomatic behavior and strong expression of affect
- Capacity for rapid assessment of survivors
- Provide care tailored to timing of intervention, context, culture
- Recognition and response to emotional numbing processes
- Working sense of self-capacities

- Provide clear, concrete information
- Shift from conventional clinical practice
- Capacity for self-care

Take Home Message for Planners:

- Multiple avenues of intervention for:
 - Who: Different exposure levels, different types of individuals, Different cultures, different age groups, etc.
 - When: Different times
 - Where: Different settings
 - What: Different outcomes
- Multidisciplinary, multi-agency
- Evidence-informed or consensus-informed as much as possible
- The more universal the intervention, the more choice people should have and the less the possibility for harm should be
- Emphasize Resilience and Community-Building

The following are resources available from SAMHSA Disaster Technical Assistance Center (DTAC), 1-800-308-3515, DTAC@esi-dc.com

SAMHSA's National Mental Health Information Center, Center for MH Services, *Dealing with the Effects of Trauma: A Self-Help Guide* and *Anniversary Reactions to a Traumatic Event: The Recovery Process Continues*

American Psychological Association, *Managing Traumatic Stress: Tips for Recovering from Disasters and Other Traumatic Events*

National Institute of Mental Health, *Post Traumatic Stress Disorder, A Real Illness and Reliving Trauma* and *Facts About Post-Traumatic Stress Disorder*

E. LONG TERM TREATMENT STRATEGIES/ MODELS

Long term mental health treatment involves having adequate numbers of licensed mental health providers to include social workers, psychologists, psychiatrists, and psychiatric nurses.

Mental health providers must be knowledgeable and trained in effective strategies and models for PTSD, grief counseling, etc. For example, some cognitive models have been found to be effective in dealing with trauma related symptoms.

F. SUBSTANCE ABUSE

The following information is taken from a powerpoint presentation from the SAMHSA All-Hazards Regional Training, January 21-23, 2004 in Washington, D.C.:

Background:

Some important facts regarding substance abuse (SA) that may be relevant for disaster planning:

- After exposure to trauma, substance use can increase significantly.
- Alcohol consumption often increases following a disaster.
After Hurricane Hugo, beer consumption rose 25%.
Does not equate with abuse but should be monitored.
Increased substance use may increase for those with prior history of mental and/or substance abuse disorders.
- New York City: Liquor sales increased 12%, with 25% of Lower Manhattan residents reporting having had an extra drink per day.
- Washington, D.C. and New York reported 10% and 19% increases, respectively, in prescriptions for anti-anxiety medications six months following the WTC attacks. Sales of alcohol and cigarettes also increased.

Substance Abuse and Disasters:

- Increased substance use and abuse may be symptomatic of Acute Stress Disorder, Anxiety, and Post-Traumatic Stress Disorder after a disaster.
- PTSD Vulnerability: Are some people more vulnerable to the development of PTSD? Women more likely than men. Lifetime prevalence of PTSD in the U.S.: Men, 5-6%, Women, 10-14%; Minorities, younger age at exposure more likely.

Oklahoma City Bombing (April 19, 1995)

- 34% of survivors had PTSD 4-8 months later
- 63% of those with PTSD also had a co-morbid condition
32% drank alcohol to cope
- Of those with a non-PTSD diagnosis
40% drank alcohol to cope
27% took medications

(North, CS et al, *JAMA*, 282(8): 755-762 (1999))

PTSD and Substance Abuse Screening and Awareness

- Persons with a prior history of PTSD are more vulnerable to developing PTSD following a second trauma.
- Persons exposed to multiple critical incidents/trauma/disaster are at higher risk for PTSD and SA (first responders, children, women,..)
- Individuals with PTSD may self-medicate with drugs (and/or alcohol) and be misdiagnosed with SA disorder and not screened for PTSD.

PTSD and Substance Abuse Screening and Awareness

- Persons with a Substance Abuse disorder may not be screened or treated for PTSD (co-occurring) and thus are at greater risk for SA relapse.
Persons with a history of PTSD may develop SA problems after a disaster.
Persons with a history of SA are at higher risk for relapse after experiencing a new traumatic event.
Education and training about screening for SA and PTSD are crucial.

Planning and Training for SA and MH Staff in Preparation for a Disaster

- Comprehensive SA prevention and treatment plans and strategies are needed to adequately mitigate SA and mental health problems following a disaster.
- Increase collaboration between substance abuse prevention/treatment, mental health, and public health systems and emergency management.

Planning Strategies Should Include:

- Identification of the cultures and populations at higher risk for PTSD and SA (e.g., veterans, communities, workplaces, and schools with prior disaster exposure, Native Americans, homeless people, first responders, etc.)
- Know your State – use of census and other demographic or special MH/SA reports as well as outreach to local leaders to identify vulnerable populations who may be at higher risk.

SA Prevention and Treatment Issues:

- Prevention/mitigation
- Treatment
- Returning individuals, families, communities, workplaces, to the “new Normal”
- Prevent unhealthy behavior and promote healthy coping to reduce psychological impact
- <http://modelprograms.samhsa.gov>
- Prolonged Exposure Therapy for Posttraumatic Stress Disorders
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Planned for Focused Training:

- Training should be provided to crisis counselors, mental health and substance abuse professionals, first responders, faith-based staff, employee assistance professionals, and others in:
 - Healthy vs. unhealthy coping behaviors after a disaster.
 - Awareness of disaster survivors’ potential for self-medicating and how to screen/address this concern in the field.
 - Appropriate resources and referrals for SA and PTSD concerns in disaster survivors.
 - Relapse prevention strategies.

Planning and Coordination:

- SA experts can help provide planning and pre-event training.
- SA treatment system/providers can be an important resource for screening, crisis intervention, and clinical support following a traumatic event.
- SA provider system may be a source of education and outreach after a disaster (e.g. schools, special populations, elderly) and a source for pre-event expertise.

SA Prevention and Treatment Issues (cont.)

- Use of Public Service Announcements (PSAs)
- Public health campaigns may be utilized to:
 - raise awareness
 - address symptoms of fear, panic, stress
 - identify dysfunctional coping
 - provide information about available resources
- In the 9/11 New York disaster response, the Office of Mental Health and OASAS collaborated on the development of a brochure with information about normal disaster distress responses and the risk of an increase in SA. These brochures were utilized in public-education sessions and distributed to the general public.
- Addressing the self-care issues that may arise for staff in general or those with SA histories
- Continuing to address the ongoing needs of the SA population in a disaster response when an increase in SA itself taxes the delivery of services
- Opening lines of communication with the recovery communities
- Prevention and treatment systems should be encouraged to prepare methods for:
 - Identifying disaster victims with previous SA histories who may be at higher risk of relapse
 - Identifying individuals who may be at risk for relapse due to a pre-existing psychiatric disorder or previous exposure to a traumatic event.

Planning Strategies Should Include:

- The use of media in the delivery of prevention, self-screening, and referral information. (SA Prevention providers often have experience and contacts.)
- Inclusion of prevention and treatment system and SA staff in the planning process to identify relevant, available resources to help address pre- and post-disaster needs.
- Linkages to State/community coalitions and recovery community (AA, NA, NCADD, NMHA, NAMI).

G. SCHOOL PREPAREDNESS

The following information comes from a web broadcast April 23, 2002, "The 3Rs to Dealing with Trauma in Schools: Readiness, Response, & Recovery." Sponsored by the U.S. Department of Education, Harvard School of Public Health, Prevention Institute, Inc., and Education Development Center, Inc.

Lessons Learned and Recommendations

To gain a better understanding of actions taken in response to September 11, the U.S. Department of Education has met with educators, students, teachers, administrators, law enforcement officials, medical experts and mental health professionals from around the country. These meetings were very productive, and the following items were determined to be critical elements to ensuring successful crisis management.

- We strongly encourage schools to have a plan for dealing with crisis, including crises such as school shootings, suicides, and major accidents, as well as large-scale disasters, such as the events of September 11, that have significant impact on schools throughout the country. We recommend that every school review its school safety plan to ensure that it is comprehensive and addresses a wide range of crisis situations. Schools that do not have a school safety plan should implement a plan immediately.
- Effective school safety plans are developed with input from, and support of, a variety of public and private agencies, including agencies representing law enforcement, fire departments, emergency services, victim services, and agencies responsible for homeland security. To be effective, school safety plans must communicate goals and assignments clearly and be updated regularly to remain relevant over time. Whether schools are reviewing existing plans or developing new ones, they should seek to include agencies with relevant expertise that may not have routinely partnered with schools.
- Developing a comprehensive school safety plan is only part of the task. Schools should conduct practice drills on a regular basis, and the results of practice activities should be reviewed to determine if revisions are needed. Practices can be incorporated within regularly scheduled safety activities, such as fire drills. Schools are encouraged to maintain contact with agencies that respond to crises, such as local law enforcement and fire departments, emergency preparedness agencies, and the National Guard, to ensure schools are included in any community-wide emergency preparedness drills.
- During a crisis, there is not guarantee that normal chains of communication, command, and control will work as intended. Communications between schools and central headquarters can be disrupted, delayed, or otherwise impeded during a crisis. School-level administrators cannot be certain that information, guidance, or orders will be available, and they must have the skills and confidence to respond to any crisis situation they might face. School administrators are

encouraged to consider several options for overcoming communication difficulties. First, they may want to delegate decision-making authority to building-level principals during times of crisis. School district officials should work closely with law enforcement officials and other emergency service agencies in advance of a crisis situation to ensure that clear lines of authority are established and well known. Finally, we encourage officials to work with experts in the telecommunications field to understand what communication links are likely to be affected in certain circumstances, and explore back-up systems or plans, including “low-tech” or nontraditional communication strategies.

- Accurate and timely information on a crisis needs to be provided to students, family members, and faculty when appropriate. Absent such information, rumors and false information are likely to spread, which can cause additional problems for school and law enforcement officials. Therefore, school districts should develop a detailed procedure for providing accurate and timely information to students, parents, and faculty.
- School policies that address typical problems may not provide adequate guidance regarding some situations faced by schools in recent years. Policies need to be reviewed to make sure they address a wide range of situations. We encourage school districts to review policies related to the possession of cell phones, terror hoaxes, and assessment of threats against schools, students, and faculty. We believe all threats made against students, faculty, and school property must be taken seriously and handled appropriately. We also encourage schools to work with parents, faculty and students to develop strategies for publicizing the serious consequences associated with making threats.
- School safety plans must address issues beyond safety, and consider the health and mental health needs of students, faculty, and parents that result from a crisis. Crises such as the ones experienced at Columbine and on September 11 affect students, faculty, and parents, to varying degrees, in every school district. When addressing health and mental health issues, school safety plans should recognize that some students, faculty, and parents might need these health-related services for long periods of time. We recommend that every school safety plan include a section that deals with recovery issues, including the health and mental health needs of students, faculty, and parents.
- Almost every community has access to the health and mental health services that can address the needs of those affected by crisis, but many school districts have not developed linkages with the organizations that can provide these services, and as a result, these services are not immediately available in time of crisis. We encourage school districts to initiate conversations with local health and mental health providers and develop “memoranda of understanding” to delineate roles and responsibilities in times of crisis.

- Schools experiencing major crises invariably receive an outpouring of support from potential volunteers who want to help. However, few districts have a plan in place to screen volunteers to make sure they are qualified and suitable to provide services in schools. We recommend that school safety plans include a process for screening persons who volunteer to assist during a crisis. Schools may want to consider having a cadre of experts and other service providers prescreened, so they can participate in emergency response activities without any delay.
- Only a few school districts have staff members who are adequately trained to deal with the results of a crisis such as a school shooting or the events of September 11. We encourage every district to designate and train a person, or group, to act as lead official(s) for response to crisis situations.
- Students are sometimes further traumatized by actions taken, often with the best intentions, by teachers, faculty, and parents. Constantly retelling or reshowing portrayals of violent events can have a traumatic effect on students. School districts are encouraged to work with mental health service providers, teachers, and parent groups to establish guidelines for activities that respect the developmental capacity of students.

Additions to Consider for School Safety Plans in Response to September 11

Schools need to develop comprehensive school safety plans that address the variety of crises they might face. While many schools and school districts have revised school plans to address shootings such as the tragedy at Columbine High School, the terrorist attacks in New York City and Virginia raise concerns that may not be addressed in current plans. The information below identifies specific concerns and suggests possible approaches to addressing them.

- *Evacuation:* A major crisis may require several schools to be evacuated simultaneously. Because school plans frequently call for students to be evacuated to other schools in the district, alternate evacuation sites and routes should be identified. This will necessitate coordination of safety plans for individual schools with district-wide plans. Special plans are also necessary to address the threat or suspicion of bio-terrorism. In these situations, evacuation procedures must ensure that cross-contamination does not occur.
- *Attendance:* In a major crisis, schools may need to quickly account for students. A plan for collecting and maintaining accurate attendance figures throughout the school day is necessary to provide data for this process. Schools should remember that attendance records should be stored in locations that are readily accessible to teachers, administrators, emergency service workers, and law enforcement officials.
- *Information for Parents:* Parents expect schools to provide quick and accurate information regarding the location and status of their children. Schools should

establish procedures for making such notifications and should regularly share those procedures with parents. A major crisis impacting an entire community may also require evacuation of parents or other caregivers from their homes or places of employment. As a result, school safety plans need to address alternatives for communicating with parents. This scenario also requires schools to examine procedures for releasing students to parents or other caregivers. If parents or other designated individuals cannot reach their students, or if students cannot be transported to their homes, schools should have a plan to respond appropriately.

- *Transportation:* Alternate strategies for transporting students during evacuations and/or to their homes must be considered. During a large-scale crisis, usual methods for transporting students may not be available. Further, schools located in some sites such as military bases, may be closed to the public, thus alternatives for transporting those students would be necessary.
- *Lead Official:* Every school site should have one person designated “lead official,” who is well-trained, well-acquainted with all aspects of the school safety plan, and has the authority to take charge during a crisis. In addition to the lead official, schools should have a deputy or assistant lead official in case the lead official is not available in a time of crisis. Lead officials should meet regularly with law enforcement and other emergency responders to clearly define the roles and responsibilities for everyone involved.

Highlighted Programs

1. The Center for School Mental Health Assistance:

Mission- The Center for School Mental Health Assistance (CSMHA) provides leadership and technical assistance to advance effective interdisciplinary school-based mental health programs. We strive to support schools and communities in the development of programs that are accessible, family-centered, culturally sensitive, and responsive to local needs. The center offers a forum for training, the exchange of ideas, and the promotion of coordinated systems of care that provide a full continuum of services to enhance mental health, development, and learning in youth.

Framework- The CSMHA uses the term “expanded school mental health” (ESMH) to describe programs that deliver a range of services (prevention, assessment, treatment, case management) to youth in both general and special education, with strong collaboration between schools and community mental health agencies and programs. “Expanded” conveys that we are building on programs and services that exist in almost all schools; for example, reflecting the work of school psychologists, social workers, counselors, and in some cases other staff, such as school nurses, and teachers with particular expertise in addressing behavioral issues in students. *ESMH programs*

augment the work of these staff, and emphasize an effort by the school to fill in gaps and improve services in a collaborative and interdisciplinary team effort. Providing a range of services captures the notion of building comprehensive care for youth in the most universal natural setting, related to the strong evidence and growing awareness that most youth who would benefit from mental health care do not receive it. Our inclusion of youth in general and special education underscores the needs of all youth, and recognizes the reality that in many schools and school districts in the country more intensive mental health care is limited to youth in, or being referred into special education. Our emphasis on programs that involve significant collaboration between schools and community agencies and programs (e.g., mental health centers, health departments) is based on recognition that schools cannot do all of this work, and in many cases are being overburdened with demands that should be addressed in other community systems.

Goals

- 1) Conduct national training and education
- 2) Provide technical assistance and consultation
- 3) Analyze and promote discussion on critical issues
- 4) Gather, develop, and disseminate resource materials
- 5) Facilitate networking among those involved/interested in mental health in schools

Contact Information: 680 West Lexington Street, 10th Floor, Baltimore, MD 21201-1570
Phone: (410) 706-0980; 1-888-706-0980; Fax: (410) 706-0984, Email:
csmha@psych.umaryland.edu; Web: <http://csmha.umaryland.edu>

2. Los Angeles Unified School District:

The Los Angeles Unified School District (LAUSD) Mental Health Services, also known as School Mental Health, was established in 1933. Presently, Mental Health Services, District Crisis Intervention Teams and Suicide Intervention Programs serve all the students of the Los Angeles Unified School District (LAUSD), the second largest school district in the United States with an enrollment of 722,000 K-12 students in over 900 schools and centers. A staff of 160 psychiatric (clinical) social workers, clinical psychologists, child psychiatrists, and community workers; 250 District crisis team members; and Early Behavior Intervention Counselors at 175 elementary and middle schools provide a range of professional mental health services for students who evidence social emotional, behavioral and trauma related problems inhibiting their ability to learn.

LAUSD Mental Health provides the following services:

- Early Intervention and Prevention Services
- Special Education Assessments/Case Management
- Individual, Group, and Family Therapy
- Parent Education
- Crisis Intervention/Threat Assessment and Management

- Suicide Prevention
- Mental Health Consultation and Education
- Earthquake/Disaster Recovery Services and Training
- School Based Mental Health Program Development
- School Social Work Services

3. National Center for Child Traumatic Stress

The Center for Traumatic Stress at UCLA is part of a national network of 17 centers. The centers were formed to address the needs of children and adolescents who are exposed to a variety of traumatic events, including physical and sexual abuse or assault; natural and man-made disasters; injuries from accidents or animal attacks; chronic, severe or painful medical conditions, or invasive medical procedures; domestic, school or neighborhood violence; traumatic loss of family or friends; kidnapping; and war, terrorism and political oppression. UCLA and Duke University serve as co-directors of a joint coordinating center, which provides administrative resources, data management, and research and clinical expertise to members of the initiative and monitors and evaluates the activities of other center members. Members of the national network include intervention development centers and community treatment and service centers; all members are charged with improving access to services and raising the standard of care for traumatized children and their families throughout the United States. The network utilizes a developmental, family, and cultural perspective, to advance treatment and service innovations and build a bridge between science and practice in community settings. The National Child Traumatic Stress Network is supported through funding from the Donald J. Cohen National Child Traumatic Stress Initiative, administered by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration.

- Network members charged with identifying, supporting, improving or developing effective treatment and service approaches include Boston Medical Center; The Early Trauma Treatment Network, UC-San Francisco; Northshore University Hospital, Long Island, N.Y.; Yale University, New Haven, Conn.; and the Allegheny-Singer Research Institute, Pittsburgh.
- Network members charged with establishing community practice centers for implementing and evaluating services include Miller Children's Hospital Abuse and Violence Intervention Center, Long Beach, Calif.; The Center for Multicultural Human Services, Falls Church, Va.; Children's Institute International, Los Angeles; Arbour Health Systems, Boston; The Aurora Mental Health Center, Aurora, Colo.; University of Missouri-Kansas City; The Mental Health Corporation of Denver; Mount Sinai Adolescent Health Center, New York; the New Mexico Alliance for Children with Traumatic Stress, Santa Fe, N.M.; the Northwest Ohio Child Trauma Community Practice Center, Toledo, Ohio; Intermountain Health Care, Salt Lake City; and Safe Horizon-Saint Vincent's Child Trauma Care Center, New York.

Contact: Dr. Alan Steinberg, Associate Director or Dr. Robert Pynoos, Director, National Center for Child Traumatic Stress, University of California at Los Angeles, 11150 Olympic Blvd, Suite 770, Los Angeles, CA 90064. Phone: (310) 235-2633, Fax: (310) 235-2612.

4. The Partnership for Recovery in the New York City Schools - The emotional and psychological impact of the September 11th events on the 1.1 million public school students in New York City is not yet known. To address the mental health needs in the wake of this tragedy, the New York City Board of Education and The Children's Mental Health Alliance (CMHA), have formed The Partnership for Recovery in the New York City Schools (Partnership). This Partnership now includes hospitals, community-based providers, local experts on trauma, screening and public health issues, educators, funders, including the New York Times 9/11 Neediest Fund, and national experts from the CDC, the NYU Child Study Center, The Jewish Board of Family & Children's Services, St. Vincent's Hospital and the National Center for Children Exposed to Violence.

The goals of the Partnership are to:

- identify the needs of different populations of children throughout the city using the scientifically valid screening instrument which has been developed by the Partnership. This screening instrument will allow the Partnership and the Board of Education to better understand how children and teachers have been affected, and guide them in making thoughtful decisions about how to meet those needs and how to allocate resources;
- develop the capacity and infrastructure of the New York City schools to meet the short and long-term emotional needs of its children and to respond to a crisis in a coordinated and effective manner;
- create critical partnerships encompassing schools and mental health providers, law enforcement, and other community based services and organizations and develop a map of those resources and partnerships for all school districts throughout the city;
- coordinate an effort to guarantee that the children who are affected by a catastrophe have access to appropriate clinical interventions. This will include a review of best practices and models for working with children and staff following a disaster;
- coordinate and integrate the funding for this effort.

While the immediate aim of this program is recovery in New York City, the needs that it meets are both long-term and universal. When implemented, this program will boost the capacity of schools and communities to respond to the mental health needs of children that arise both in times of crisis and in daily life. Communities and schools in New York, the United States, and the world beyond must be empowered to respond, with a coordinated effort, to the mental health needs of children in order to provide for healthy development and the formation of healthy-functioning adults. This has always been the mission of the Children's Mental Health Alliance and now it is bringing the benefit of years of experience to the recovery efforts in New York City.

Contact Information: The Partnership for Recovery in the New York City Public Schools, NYC Board of Education, Children Mental Health Alliance, 52 E. 72nd Street, New York, NY 10021. Phone- 212- 879-5244, Fax-212- 249-4186, E-mail, info@cmhalliance.org, web-site-www.cmhalliance.org

THE PARTNERSHIP FOR RECOVERY IN THE NEW YORK CITY SCHOOLS

Co-chairs: Judith A. Rizzo, Ed.D. Pamela Cantor, M.D.
Deputy Chancellor *President*
NYC Board of Education Children's Mental Health Alliance

Partners:

New York City Board of Education
Children's Mental Health Alliance
The After School Corporation
Applied Research and Consulting, LLC
Center for Social and Emotional Education
Columbia University School of Public Health
Educators for Social Responsibility
The Jewish Board of Family and Children's Services
Mount Sinai Medical Center
National Center for Child Traumatic Stress
National Center for Children Exposed to Violence
National Center for Children in Poverty
New York City Department of Mental Health
New York City Office of Emergency Management
New York State Office of Mental Health
New York State Psychiatric Institute
New York University Child Study Center
New York University School Recovery Program
Safehorizon
Saint Vincent's Hospital and Medical Center
Yale University Child Study Center

5. Polk County Mental Health Collaborative

The current Mental Health Collaborative has its roots in a school-based youth services program, SUCCESS. SUCCESS began by offering the services of four full-time staff in the fall of 1990 through a state grant for School-Based Youth Services Programs. The SUCCESS model features partnerships between mental health therapists and case managers. All case managers serve students and their families in a holistic manner by assessing need, developing case plans based on families strengths and desired goals, and advocating for them to connect with available community resources. The elementary level has the most comprehensive level of service, with full-time guidance counselors in each building, a full-time therapist, and a site-based case manager. The SUCCESS program has been extensively evaluated and nationally recognized. This program formed the basis for the County's Safe Schools, Healthy Students Application. With the Safe Schools, Healthy Students award, the County was able to expand its mental health services and its collaborative partners.

Originally consisting of the Des Moines Public Schools, United Way of Central Iowa, and Des Moines Child and Adolescent Guidance Center, the collaboration has expanded

to include the Greater Des Moines Foundation and a local pastoral counseling center. The grant award enabled the program to expand in several significant ways:

- Four bi-lingual case managers are now on staff.
- One elementary level and fifteen secondary level case managers were hired, resulting in the presence of a case manager in every middle and high school in Des Moines.
- Full-time therapists were added in Des Moines Public Schools as well as two therapists in a rural school district and one therapist at an urban school district
- A coordinator was hired by Des Moines Child and Adolescent Guidance Center to train all County school guidance counselors and school nurses in key mental health issues identified by staff. Coordinator responsibilities also include working with counselors in each district to facilitate/streamline the referral process for mental health services.
- Funds have been made available for psychiatric services, other than hospitalization, for children who are under-or uninsured.
- Training is now provided for guidance staff and SUCCESS case managers to implement research-based curriculum such as Project Alert and Second Step Violence
- Parent education is offered by Iowa State University Polk County Extension Services
- Family Development Specialist Training is offered at no cost to any human service provider in Polk County.

Contact Information: Cyndy Erickson, Safe Schools/Healthy Students Coordinator, Des Moines Independent Community School District, 1800 Grand Avenue, Room 450, Des Moines, IA 50309-3382, Ph-515-242-7893, Fax-515-242-7396, E-mail, Cyndy.Erickson@dmps.k12.ia.us

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Peace by Piece: A Violence Prevention Guide for Communities

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Peace by Piece is based on the experiences of a myriad of exemplary programs from across the country. The initiatives discussed have all demonstrated effectiveness. Program descriptions, practitioner insights, research into their theoretical basis, and evaluation options for many of the activities have been collected and categorized into several key components. Media campaigns, parenting education, after-school programs, and gang violence prevention initiatives are just a few examples of the components presented in the guide.

Advanced Leadership Training in Violence Prevention Resource Manual,

Vol I Cost: \$18.00 Quantity requested: _____ Total: \$ _____

- 200 pages, 7 chapters: contains recent journal articles, book chapters, and other publications relating to the topic of violence prevention. Chapters include: A Comprehensive Approach to Violence Prevention; Community Leadership; Youth Development; Coalitions; Risk and Resiliency; School Centered Prevention; and Changing School Climate.

Advanced Leadership Training in Violence Prevention Resource Manual,

Vol II Cost: \$18.00 Quantity requested: _____ Total: \$ _____

- 200 pages, 8 chapters contains recent journal articles, book chapters, and other publications relating to the topic of violence prevention. Chapters include: Violence and the Media; Multi-cultural Issues and Hate and Bias Crime; Dating Violence Prevention; Alcohol, Other Drugs and Violence; Youth Suicide Prevention; Gang Violence Prevention; Guns; and Evaluation

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The following information comes from a PHTN Satellite Broadcast & Webcast that originally aired May 16, 2002: “CDC & U.S. Department of Education Collaborate to Help Schools Prepare for Possible Terrorism.” <http://www.phppo.cdc.gov/PHTN/schools/QandA.htm>

Frequently Asked Questions:

As an educator, what are the most important things for me to do in the short term to be prepared to respond to a potential terrorist event impacting my school?

Look at your school’s current safety plan. Review the plan and make sure it’s up to date. Review the evacuation and transportation plans. Look at the plans for returning children to their families, or moving students to a safe location should they need to leave school property.

You can also review family contact procedures, to make sure that your contact information lists are up to date, and policies and procedures for contacting parents and other caregivers are in place. You can also get to know your local and state emergency management colleagues, such as fire department staff, emergency medical services (EMS), and, of course, your local and State public health officials.

How often should schools conduct drills to test their plans?

Ideally, they should conduct drills quarterly. At a minimum, drills should be conducted each semester, both to remind the school community of the appropriate procedures and to teach new students and staff. Drills can help schools test their plan and identify strengths and weaknesses.

Are there items we should stockpile in the event that we have to shelter students at school?

For schools near chemical facilities, like a chemical storage or production plant, or those near nuclear facilities, school and community response plans may include “sheltering in place,” or keeping students and staff inside the school building in an emergency. In an emergency that required sheltering in place, your local emergency management agency would instruct you about what to do, which may include sealing cracks in doors and windows. Other than that, we don’t recommend stockpiling drugs or gas masks. A resource for information on recommended emergency supplies for schools is located on the American Red Cross Web site at

<http://www.redcross.org/disaster/masters/supplies.html>

Having a safety plan in place, if and when we identify a biological, chemical, or radiological situation, which local agencies should we contact?

Please refer to CDC’s web page “Who to Contact in an Emergency”

(<http://www.bt.cdc.gov/EmContact/index.asp>). CDC’s Public Response line can be reached by calling 1-888-246-2675 (English) or 1-888-246-2857 (Spanish) or 1-866-874-2646 (TTY). Calling 911 or your emergency call number should start the response procedures in most communities regardless of the cause of the event.

How can districts identify local emergency management or health agencies?

Local school administrators can contact their public health agencies to begin a dialogue and to learn what their local public health agency is already doing to address terrorism preparedness. Both State and local public health agencies have been involved, at some level, in community preparedness planning. Remember, local school districts are often different from local or regional public health districts; you might need to contact more than one public health agency. To link to State and local health departments, go to <http://www.cdc.gov/other.htm#states>

The Federal Emergency Management Agency (FEMA) can help you learn about local emergency management agencies: www.fema.gov

What can local health departments do to help schools?

Local health departments can identify schools in their areas, establish a point of contact at each school, and share information through the internet, by fax, or at school-based presentations. The CDC Health Alert Network (HAN) is a nationwide program to establish the communications, information, distance-learning, and organizational infrastructure for a new level of defense against health threats, including the possibility of bioterrorism. The HAN will link local health departments to one another and to other organizations critical for preparedness and response: community first-responders, hospital and private laboratories, State health departments, CDC, and other Federal agencies. Because schools cannot directly access the HAN, it is important for local health departments to share critical information. To link to State and local health departments go to: <http://www.cdc/other.htm#states>

What can schools do to involve parents in the implementation of terrorism action plans?

Parents, or other caregivers, should be part of the planning team. Family members can bring information to the table through parent-teacher organizations. They can also help by discussing plans and exercises with children and preparing children to participate in exercises and training programs.

What role should law enforcement have in developing comprehensive school safety plans?

Law enforcement and school-based security must have a relationship in place that has, at its core, the safety and welfare of students. In conjunction with other key players (e.g., education, emergency management, public health), law enforcement should be involved in every aspect of crisis plan development and implementation. They need to be at the table as the plan is developed; active participation in drills and practices; and part of the team that regularly reviews and makes changes to the plan.

How can the media (such as newspapers, radio, and television stations) help supply accurate and helpful information to the public?

During an emergency, the public needs to understand both what government agencies and officials are doing and what they need to do. School and community officials can have workshops with the media before an event occurs. Accuracy is the main concern. During an event, communities can establish a joint communications center, where people

from various agencies can coordinate and share information with the public through a single spokesperson. Holding daily media briefings at a consistent time, coordinated across all agencies, can also be helpful.

What plans do you have for working with post-secondary institutions?

Just like K-12 schools, colleges and universities should have plans for responding to all types of emergencies, whether they are natural disasters, violent actions, or terrorist events. A comprehensive safety plan that involves public and private agencies is crucial. Many of the same components of a school-based emergency plan would apply to a college plan. The college should also consider how its plan is a part of the larger community response plan. The National Association of College and University Business Officers' emergency preparedness Web site: www.nacubo.org/business_operations/emergency_preparedness/ offers links to resources, including sample college and university safety plans.

The Crisis Procedure Checklist that follows is from "Early Warning, Timely Response: A Guide to Safe Schools," U.S. Department of Education, Special Education and Rehabilitative Services. The full copy of this public domain publication is available at the Department's Home Page: <http://www.ed.gov/offices/OSERS/OSEP/earlyvwrn.html>

CRISIS PROCEDURE CHECKLIST

A crisis plan must address many complex contingencies. There should be a step-by-step procedure to use when a crisis occurs. An example follows:

- ___ Assess life/safety issues immediately.
- ___ Provide immediate emergency medical care.
- ___ Call 911 and notify police/rescue first. Call the superintendent second.
- ___ Convene the crisis team to assess the situation and implement the crisis response procedures.
- ___ Evaluate available and needed resources.
- ___ Alert school staff to the situation.
- ___ Activate the crisis communication procedure and system of verification.
- ___ Secure all areas.
- ___ Implement evacuation and other procedures to protect students and staff from harm.
 Avoid dismissing students to unknown care.
- ___ Adjust the bell schedule to ensure safety during the crisis.
- ___ Alert persons in charge of various information systems to prevent confusion and misinformation. Notify parents.
- ___ Contact appropriate community agencies and the school district's public information office, if appropriate.
- ___ Implement post-crisis procedures.

Additional School Resources:

- **US Department of Education, Safe and Drug Free Schools Program**
 - <http://www.ed.gov/offices/OSERS/OSEP/Products/earlywrn.html>- to order the Early Warning, Timely Response guide
 - http://www.ed.gov/offices/OSERS/OSEP/Products/ActionGuide/Action_Guide.pdf- to order to Action Guide, the companion to the Early Warning Guide.
 - www.ed.gov/offices/OESE/SDFS/index.html - Safe and Drug-Free Schools Program Web-site
 - www.thechallenge.org- to view the Challenge newsletter
 - To order any Department of Education publication, call toll-free 1-877-433-7827 or visit their website at www.ed.gov/pubs/edpubs.html.
- **Harvard School of Public Health, Violence Prevention Programs**
 - www.hsph.harvard.edu/php
 - **Prevention Institute. Inc.**
www.preventioninstitute.org
 - **Education Development Center, Inc.**
www.edc.org

School Safety-Related Sites:

- Center for Effective Collaboration and Practice: <http://cecp.air.org/>
- Hamilton Fish Institute for School and Community Violence: <http://hamfish.org/>
- Jane's Information Group: <http://janes.com/company/catalog/>
- National Association of School Psychologists:
<http://www.nasponline.org/index2.html>
- National Mental Health Association: <http://www.nmha.org/>
- Southwest Regional Education Laboratory: <http://www.nwrel.org/>
- National Resource Center for Safe Schools: <http://www.safetyzone.org/>
- School Safety and Violence Prevention: <http://cecp.air.org/guide/>

Children's National Medical Center, International Center to Heal Our Children (ICHOC)
www.dccchildrens.com/ichoc

The vision of the International Center to Heal Our Children is to:

- Educate and empower first responders, healthcare professionals, teachers, child care providers and parent groups across the nation with the tools needed to identify and help children heal and cope with the emotional consequences of trauma.
- Offer culturally competent and family-centered guidance, resources, and technical support to professionals and parents as they work together toward building healthy minds and futures for our children.

Contact ICHOC to learn more about:

- Training and educational programs and resources
- Crisis response and outreach
- Consultation
- Collaborative activities

- Research opportunities
- Web chats and community forums
- THEY ALSO HAVE ON THEIR WEBSITE A DOWNLOADABLE HANDBOOK: Handbook of Frequently Asked Questions Following Traumatic Events: Violence, Disasters, and Terrorism” (A Spanish translation is currently being developed.)

National Association of School Nurses www.nasn.org

Disaster Preparedness for School Nurses – a training curriculum for school nurses

FEMA has a website that outlines four *Compendiums*. “ *A Compendium of Exemplary Practices in Emergency Management*” They are published on the Internet at www.fema.gov/library/lib07.htm

One of the best practices (in Volume IV) is from California:

Los Angeles Unified School District Earthquake and Safe Schools Training. This training can be modified for other disasters. The training prepares all adult employees to protect and shelter students in the event of a major disaster. Contact is: Dan Austin, Chief of Staff/Assistant Superintendent, Los Angeles Unified School District, 450 North Grand Avenue, Los Angeles, CA 90012. Tel: 213-625-6251, fax: 213-485-0321. e-mail is: mwong01@lausd.k12.ca.us

FEMA has a website that outlines four *Compendiums*. “ *A Compendium of Exemplary Practices in Emergency Management*” They are published on the Internet at www.fema.gov/library/lib07.htm

Another FEMA *Compendium (Volume IV)* best practice is:

School-Based Disaster Mental Health Services for Children in the Laguna Beach Firestorm. Program type: crisis counseling.

The Laguna Beach United School District asked Children and Youth Mental Health Services of Orange County to develop continuing mental health services to help children and adolescents cope with post-traumatic stress in the aftermath of the firestorm there. Using a collaborative school-based model, a partnership that included schools, the Orange County Health Agency, and private corporations, provided services to parents and children at each school that included crisis assessment; individual, family, parent, group, and school counseling services; bilingual services; and specialized outreach to minority populations. Contact is: Merritt D. Schreiber, Ph.D., Clinical Psychologist, Children and Youth Mental Health Services, Orange County Health Care Agency, Costa Mesa, CA 92626. Tel: 949-499-5346; fax 714-850-8492. E-mail is chipzhz@aol.com

FEMA has a website that outlines four *Compendiums*. “ *A Compendium of Exemplary Practices in Emergency Management*” They are published on the Internet at www.fema.gov/library/lib07.htm

Another FEMA *Compendium (Volume IV)* best practice is:

Kentucky Community Crisis Response Board (KCCRB) Crisis Intervention Program Under 1998 school safety legislation, the Kentucky Dept. of Education and the Kentucky School Board Association authorized the KCCRB to train school district personnel in crisis preparedness management and crisis recovery.

Contact is: Renelle Grubbs, Executive Director, Kentucky Community Crisis Response Board, 612-B Shelby Street, Frankfort, KY 40601-3466. Tel: 502-564-0131, fax: 502-564-0133. E-mail: kyccrb@bngc.dma.state.ky.us

FEMA has a website that outlines four *Compendiums*. “ *A Compendium of Exemplary Practices in Emergency Management*” They are published on the Internet at www.fema.gov/library/lib07.htm

Another FEMA *Compendium (Volume IV)* best practice is:

School Safety Project (Georgia)

The School Safety Project includes nine programs that cover various aspects of emergency management as it affects schools. Each program includes a lesson plan, a program outline, handouts, slides, overheads, and instructor notes. Descriptions of each unit are available from the Georgia Emergency Management Agency (GEMA). GEMA has also prepared *Emergency/Disaster Preparedness – A Planning Guide*, a comprehensive 50-page guide to assist local school systems and individual schools (both public and private), in reaching preparedness objectives through the development of a comprehensive emergency/disaster plan. Contact is : Karen Franklin, State School Safety Coordinator, Georgia Emergency Management Agency, PO Box 18055, Atlanta, GE 30316-0055. Tel: 404-635-7244; fax: 404-635-7205. E-mail:

kfranklin@gema.state.ga.us

FEMA has a website that outlines four *Compendiums*. “ *A Compendium of Exemplary Practices in Emergency Management*” They are published on the Internet at www.fema.gov/library/lib07.htm

Another FEMA *Compendium (Volume I)* best practice is:

Family Protection Plan/School Disaster Preparedness (Michigan)

The Family Protection Plan/School Disaster Preparedness program disseminates family protection and disaster preparedness information through public and private school systems in Dearborn, Michigan. The Emergency Management Coordinator developed family protection presentations and introduced the programs to all schools in the city of Dearborn. Contact is: Peter Locke, Emergency Management Coordinator, Dearborn City Civil Preparedness, 3750 Greenfield Road, Dearborn, MI 48120. Tel: 313-943-2016.

Fax: 313-943-3027.

National Center for Children Exposed to Violence - www.nccev.org
1-877-49-NCCEV
Teacher's Guide for Talking with their Children About War

National Association of School Psychologists (NASP)
Coping with Crisis – Helping Children with Special Needs – Tips for School Personnel and Parents www.nasponline.org/NEAT/specpop_general.html

National Child Traumatic Stress Network - www.nctsn.net
A Checklist for Schools (PDF version and Word version) – prepared in coordination with the U.S. Dept. of Education, helps administrators and principals assess and address the mental health issues that go along with ensuring the safety and well-being of students and school personnel before, during, and after an emergency.

U.S. Dept. of Education, Emergency Planning – Office of Safe and Drug-Free Schools
<http://www.ed.gov/admins/lead/safety/emergencyplan/index.html>
As schools and communities across the U.S. prepare and develop plans for responding to potential emergency situations, U.S. Secretary of Education Rod Paige has unveiled this new web resource to help. It is designed to be a one-stop shop that provides school leaders with information they need to plan for any emergency, including natural disasters, violent incidents and terrorist acts. The site will be regularly updated.

Crisis Planning Resources include:

- Emergency Planning for America's Schools
- School Emergency Response and Crisis Management Plan, Discretionary Grant Program
- National Clearinghouse for Educational Facilities – Disaster Preparedness for Schools
- Examples of Promising Practices in School Emergency Response: Fairfax County, VA; Montgomery County, MD, North Carolina's Critical Incident Response Kit Project

North Carolina's Critical Incident Response Kit Project -

www.ncdjjdp.org/cpsv/cirk/cirk.htm

Includes:

- Critical Incident Response Kit Recognition Program
- CIRK Recognized Schools
- Frequently Asked Questions
- Critical Incident Response Booklet (page 13 reference MOU)
- Information About Locking Mechanisms

Kentucky Center for School Safety www.kysafeschools.org/clear/issues/moa.html

Creating working Memorandums of Agreement

Offers a template for a useable Memorandum of Agreement (MOA) to use when forging community or interagency alliances.

SAMHSA Center for Mental Health Services –
www.mentalhealth.org/cmhs/TraumaticEvents/tips/sap
Tips for talking about traumatic events – tips for teachers

American Red Cross - www.redcross.org.services.disaster/eduinfo

1. Masters of Disaster - an innovative curriculum for children in grades K-8 that helps teachers meet academic requirements by providing lessons on science, math, social studies, language arts, and fine arts through studying the hazards of earthquakes, floods, etc. Also lists disaster supplies for school classrooms and the whole school.
2. Be Ready 1-2-3 – materials that help young children, ages 4-7, learn through activities and demonstrations. Instructors manuals also with lesson plans. The Be Ready Book - A Workbook for Children is available in English or Spanish PDF files.

CPR/BLS - Washington state EMSC developed a training program for training high school students in CPR. It has developed a resource manual for high school administrators, parents, teachers to use in developing CPR student training programs. A downloadable copy of the manual is available at www.washingtonemsc.org Once there, click on “CPR Student Training”.

CERT Training (Community Emergency Response Team) to high school students –
www.training.fema.gov/EMIWeb/cert/wintercer.asp

Description of Seminole County C.E.R.T. Training at Winter Springs High School. Students in Winter Spring High School’s Environmental Class completed CERT training and received high school credit for learning how to help themselves and fellow students in their own environment. Among other skills, the post-disaster psychology portion of the training was somewhat altered to teach the students what is normal, expected, and abnormal. They also learned how to avoid undue stress, assist with peers, and recognize symptoms of disaster-related psychological actions.

www.edfacilities.org/rl/disaster.cfm

National Clearinghouse for Educational Facilities
Disaster Preparedness for Schools

NCEF’s resource list of links, books, and journal articles on retrofitting schools to withstand natural disasters and terrorism, developing emergency preparedness plans, and using school buildings to shelter community members during emergencies.

www.odedodea Once there, click on “Crisis Management”

DoDEA Crisis Management Website. Managed by the Defense Education Activity (DoDEA), this website offers a menu of information, strategies, and resources that can aid school personnel and families in the event of traumatic events such as assaults, natural disasters, and war. Since these crises have the potential to affect the entire school community, links with local resources as well as many professional agencies with expertise in helping children and adults deal with crisis can be found on this site.

H. STRESS PREVENTION AND MANAGEMENT

The information that follows is from the *Training Manual for Mental Health and Human Service Workers in Major Disasters, 2nd Edition*. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, DHHS Pub. # ADM 90-538.

Copies are available at no charge from the Center for Mental Health Services:

National Mental Health Services Knowledge Exchange Network
P.O. Box 42490
Washington, D.C. 20015

Toll free information line 1-800-789-2647
CMHS Electronic Bulletin Board 1-800-790-2647
TTY: 301-443-9006
Fax: 301-984-8796
Web site: www.mentalhealth.org

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

1. Effective management structure and leadership
2. Clear purposes and goals
3. Functionally defined roles
4. Team support
5. Plan for stress management

Psychologically healthy and well-balanced individuals are best equipped to implement and maintain an effective disaster mental health recovery program. Programs can build in supports and interventions to ensure that the majority of their staff will be functioning in the “healthy and balanced” range. As community needs change over time, so will workers’ stress management intervention needs. Listed below are four skill building areas to address when designing the staff stress management component of a program:

1. Management of workload (ex. Existing workload delegated so workers not attempting disaster response and usual job)
2. Balanced lifestyle (ex. Exercise, nutritional eating, adequate sleep and rest)
3. Strategies for Stress Reduction (ex. Time off, cognitive strategies)
4. Self-Awareness (ex. Over identification with survivors’ grief and trauma may result in avoiding discussing painful material)

I. TRAINING AND EDUCATION

The information that follows is from the *Training Manual for Mental Health and Human Service Workers in Major Disasters, 2nd Edition*. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, DHHS Pub. # ADM 90-538.

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Participation in disaster mental health training prepares program staff for the unique organizational, procedural, emotional, and environmental aspects of disaster work. While new staff undoubtedly have relevant skills from their prior professional activities, disaster mental health work presents most with significantly different challenges. The overwhelming response of mental health professionals after disaster mental health training is: "I didn't know how useful this would be!"

Effective training combines lecture presentations, films, skills practice, self-awareness exploration, group discussion, and experiential learning. Participants are exposed to case scenarios and videotapes that simulate disaster situations, so they are able to explore their own reactions and achieve some stress-inoculation prior to assignment

Initial Start-Up Training:

(Note: Using our *Resilient Community* framework, this training should be done prior to an event occurring as a method of preparedness, however, if necessary, training can be done after the event.)

In the immediate aftermath of the disaster, administrators must rapidly identify and deploy staff. If a disaster-trained group of available mental health professionals does not already exist, then training becomes a priority. Even those with prior disaster mental health training need to be oriented to the current disaster and response operation. An initial four to eight hour start-up training should be offered quickly and repeated as new staff come on board.

The pamphlet *Field Manual for Mental Health and Human Service Workers in Major Disasters* (CMHS, Rev. ed. in press) that can be ordered along with this manual from the address listed above, also provides a practical overview and "how to" information. It is a valuable pocket guide for ready-reference in the field.

Comprehensive Disaster Mental Health Training

Comprehensive training typically occurs after the majority of staff have been hired and toward the end of the immediate disaster response phase. This may be 3-6 weeks after the disaster. Depending on program implementation and the timing of hiring staff, it may be most appropriate to provide comprehensive training twice – once at 3-6 weeks and again after 3-4 months. Training should be mandatory for all staff and volunteers who will be involved in the disaster mental health interventions, including supervisors and administrators.

This comprehensive training serves a number of functions. In addition to providing information about people's reactions to disaster and the range of disaster mental health interventions, training goals are to:

- Develop group cohesion and a program identity.
- Orient staff to organizations involved with disaster response and recovery.
- Establish norms and procedures for staff stress management.
- Communicate the goals, mission, and philosophy behind the Crisis Counseling Program.
- Present the plan and rationale for on-going supervision, case consultation, and in-service training.
- Communicate program policies and procedures with regard to organizational structure, financial management, and program activity data collection.

While the initial training is a “start-up” training, the comprehensive training can be viewed as a program “kick-off.” This can be a time that old and new program staff convene to form a collaborative and cohesive work team. Procedures for program monitoring, staff stress management, and the long-term program structure have been established and can be further implemented through the training.

Paraprofessional outreach workers will need training beyond the comprehensive disaster mental health training. They bring a range of life and work experiences that enriches the program. However, it is important that they participate in specific training on counseling skills, intervention guidelines, and when and how to make referrals (this information is found in this training manual referenced here.) Providing this training is helpful prior to the comprehensive disaster mental health training, so paraprofessional staff have a broader framework for integrating the information. Training should be ongoing so that skills can be developed and honed over time. Close and supportive supervision is helpful during the early phase of the program. While it is important that paraprofessional staff participate in skill-building training, inadvertently encouraging a division between program staff would be destructive. Program administrators must address the need for additional paraprofessional training without compromising group cohesion and team support.

Setting Up The Training

The training should be held in a comfortable setting with audio-visual equipment suitable for the room and size of the group. Although less than thirty participants is an ideal size for training, logistics may dictate that the group be larger. Under these circumstances, having additional small group facilitators and trainers to review and give feedback on role-plays enhances the depth of the training.

Selecting the Trainer

In the immediate response to the disaster, the importance of rapidly training and deploying disaster mental health staff may require the program to involve a local mental health professional with no disaster experience as a trainer. While having prior disaster experience is preferable, it may not be practical. Alternate relevant background experience might include: crisis intervention in a mental health center, critical incident stress management with emergency service workers, experience in community-based settings, breadth in professional and clinical work, and effectiveness as an educator. This Manual, *Training Manual for Mental Health and Human Service Workers in Major Disasters*, and *Disaster Response and Recovery: A Handbook for Mental Health Professionals* (CMHS, 1994) will enable the trainer to become oriented quickly.

The comprehensive training must be taught by a mental health professional with disaster experience and, ideally, experience in a nine-month crisis counseling grant. Not only should the trainer have the requisite knowledge to present the material, but he or she should also be an engaging presenter and highly skilled with group processing of emotions. The trainer must be able to model skills, as well as teach them. Trainers coming from outside the geographic area of the disaster will need to become familiar with the local disaster – its impact, population groups affected, damage assessment information, dynamics of the disaster having psychological implications, and relief efforts to date.

The comprehensive training may require 2.5-4 days. The program design has 11 major content areas (times are suggested times required):

1. Introduction – 1 hour
2. Disaster Information – 1.5 hours
3. Organizational Disaster Response Network – 1.5 hours
4. Phases of Reactions to Disaster - .5 hours
5. Adult Reactions to Disaster – 2 hours
6. Disaster Mental Health Interventions – 4 hours
7. Children in Disaster – 2.5. hours
8. Special Populations in Disaster – 2 hours
9. Planning Workgroups – 1.5 hours
10. Stress Prevention and Management – 2 hours
11. Program Implementation – 1.5 hours

J. GENERAL BIOTERRORISM, TERRORISM, AND MENTAL HEALTH ISSUES

Resources:

The following resources are from SAMHSA's Disaster Technical Assistance Center (DTAC), 1-800-308-3515, DTAC@esi-dc.com:

- American Psychiatric Association, *Coping with Bioterrorism Anxiety: Advice from the American Psychiatric Association*
- American Red Cross:
 - *Terrorism, Preparing for the Unexpected*
 - *American Red Cross Homeland Security Advisory System Recommendations*
 - *Anthrax Questions and Answers*
 - *How Do I Deal with My Feelings?*
 - *Why Do I Feel Like This?*
 - *Facing Fear: Helping Young People Deal with Terrorism and Tragic Events*
- FEMA:
 - *Managing the Emergency Consequences of Terrorist Incidents – Interim Guidelines*
 - *Tool Kit for Managing the Emergency Consequences of Terrorist Incidents*
 - *CONPLAN – Federal Interagency Domestic Terrorism Concept of Operations Plan*
- Project Phoenix, New Jersey Crisis Counseling Program, *Guide for Mental Health Counselors after Regional Vaccination Clinics*
- Project Phoenix, New Jersey Crisis Counseling Program, *Coping with the Emotional Aspects of the Smallpox Vaccination*
- David Wee, Disaster Mental Health Coordinator, Mobile Crisis Team, City of Berkeley Mental Health, *Mental Health Impacts*
- California Department of Mental Health, *Helping Your Employees Cope with the 9/11 Anniversary*

RESILIENT COMMUNITIES GUIDEBOOK

**For Bioterrorism and Other Public Health
Emergencies: A Mental and Behavioral
Health Wellness Model and Guide**

PART THREE: SPECIAL POPULATIONS AND RESOURCES

**HRSA, Special Programs Bureau,
Division of Health Care Emergency Preparedness
April 2004**

PART THREE
(Contains Section 4)

Resilient Communities Guidebook
For Bioterrorism and Other Public Health Emergencies:
A Mental and Behavioral Health Wellness Model and Guide

PART ONE: BACKGROUND AND GENERAL INFORMATION

Section 1: Introductory Material to Disasters and Terrorism

Section 2: Developing Short- and Long-term Response Strategies

PART TWO: DISASTER MENTAL HEALTH KEY ISSUES AND RESOURCES

Section 3: Disaster Mental Health Key Issues and Resources

- A. Planning
- B. Surge Capacity
- C. Communications/Media
- D. Disaster Mental Health Interventions
- E. Long Term Treatment Strategies/Models
- F. Substance Abuse
- G. School Preparedness
- H. Stress Prevention and Management
- I. Training and Education
- J. General Bioterrorism, Terrorism and Mental Health Issues

PART THREE: SPECIAL POPULATIONS AND RESOURCES

Section 4: Special Populations and Resources

- A. First Responders**
- B. Severely/Chronically Mentally Ill**
- C. Substance Abuse/Dual Diagnosis**
- D. Children (include foster care issues, residential treatment fac.)**
- E. Non-English Speaking/ Culturally Diverse**
- F. Physically Disabled/Hearing Impaired/Visually Impaired**
- G. Trauma Survivors/Refugees**
- H. Elderly**
- I. Incarcerated**
- J. Homeless**
- K. Unemployed/underemployed/low income**
- L. Pet owners**
- M. Medical and mental health disaster responders**
- N. Higher income families**

PART 4: RESILIENT COMMUNITIES MODEL AND TOOLS

Section 5: Resilient Communities Model

Section 6: Table of Resilient Communities (Lead Team and Subcommittees)

Section 7: Community Mental Health Assessment by Population/Issue

Section 8: Checklist for Resilient Communities

APPENDIX I: State Mental Health Commissioners

APPENDIX II: Disaster Mental Health Coordinators

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SECTION 4: SPECIAL POPULATIONS AND RESOURCES

A. FIRST RESPONDERS

First responders are most often personnel from emergency medical services, fire and rescue, and police. Additionally, with bioterrorist weapons, first responders are often medical or healthcare personnel. First responders generally have hardiness and a culture that offers some protective factors to them as a group. They tend to minimize stress and psychological reactions or symptoms. This is positive during the actual response and allows them to get their job done, but at great cost. Because they do not tend to seek out help, they may use alcohol or drugs as a coping strategy, may have increased interpersonal conflict, and may be at higher risk for suicide.

One method of addressing this issue has been through Critical Incident Stress Management (CISM) debriefings and defusings. CISM is generally used within 48 hours of an event and includes discussion of the facts, thoughts, minimal processing, discussion of symptoms that may occur, and resources that can be accessed. For CISM information, go to: www.icisf.org

Additional Resources:

FEMA has a website that outlines four *Compendiums*. “*A Compendium of Exemplary Practices in Emergency Management*” They are published on the Internet at www.fema.gov/library/lib07.htm

Another FEMA *Compendium (Volume III)* best practice is:

The Santa Barbara City Fire Department Dependent Care Program (California)

The Santa Barbara City Fire Department Care Program was developed to address the issue of dependent safety for on-duty personnel in the event of a regional natural disaster. During a natural disaster, if firefighters know their families’ safety has been addressed and they are out of danger, they can focus full attention to their jobs. It was decided that the program had to involve more than merely notifying on-duty personnel about the status of their families. The plan had to teach these families to be self-sufficient during the firefighter’s absence. The program consists of three parts: 1) Pre-event preparation; 2) “Mutual aid” by department members who are neighbors; 3) Telephone verification of the family’s safety. Contact is: Chris Albertson, Battalion Chief/Training, Santa Barbara City Fire Department, 121 W. Carillo Street, Santa Barbara, CA 93101. Tel: 805-965-5254. Fax: 805-564-5730.

B. PEOPLE WITH SERIOUS AND PERSISTENT MENTAL ILLNESS

(from SAMHSA's *Training Manual for Mental Health and Human Service Workers in Major Disasters*)

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

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

Many people with mental illnesses are vulnerable to sudden changes in their environment and routines. Orienting to new organizations and systems for disaster relief assistance can be difficult. Program planners need to be aware of how disaster services are being perceived and build bridges to facilitate access and referrals where necessary. Disaster mental health services designed for the general population are equally beneficial for those with mental illness; disaster stress affects all groups. In addition, when case managers and community mental health counselors have a solid understanding of disaster mental health issues, they are able to better provide services to this population following a disaster.

Resources:

Responding to the Needs of People with Serious and Persistent Mental Illness in Times of Major Disaster. Center for Mental Health Services. Washington, D.C.: U.S. Department of Health and Human Services; Publication No. (ADM) 86-1070. (Revised edition in press.) or Publication No. (SMA) 96-3077, 1996.

C. SUBSTANCE ABUSE/ DUAL DIAGNOSIS

When discussing mental health, substance abuse issues are often overlooked, even though many individuals after disasters or trauma “self-medicate” with alcohol or drugs. Additionally, those who have been in recovery are at increased risk for relapse after a disaster or terrorist event, and those who have been using may increase their usage. Another concern after an attack is how to manage methadone treatment when certain clinics are closed.

Additionally, dual diagnosis (substance abuse disorder and another mental health disorder such as depression, or generalized anxiety) is a problem that is not always addressed in an integrated manner.

After a disaster or terrorist event, it is important to identify victims with previous substance abuse issues and provide outreach to them. It is also important to maintain services for those in treatment or in recovery so that they do not relapse.

Resources:

Resources available from SAMHSA's Disaster Technical Assistance Center (DTAC), 1-800-308-3515, DTAC@esi-dc.com:

National Institute on Drug Abuse, *Depression, PTSD, Substance Abuse Increase in Wake of September 11 Attacks*

D. CHILDREN

(The following information is from SAMHSA's *Training Manual for Mental Health and Human Service Workers in Major Disasters* and from SAMHSA's National Mental Health Information Center Facts Sheet: *Reactions of Children to a Disaster* - <http://www.mentalhealth.samhsa.gov>)

Each stage of life is accompanied by special changes in coping with the aftermath of a disaster and age-related vulnerabilities to disaster stress. For children, their age and development determine their capacity cognitively to understand what is occurring around them and to regulate their emotional reactions. Children are more vulnerable to difficulty when they have experienced other life stresses in the year preceding the disaster, such as a divorce or move.

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

Preschool (ages 1-5)

Typical responses include:

- Thumb sucking
- Bed Wetting
- Fear of the darkness or of animals
- Clinging to parents
- Night Terrors
- Loss of bladder or bowel control, constipation
- Speech difficulties (e.g., stammering)
- Loss or increase of appetite

Children in this age group are particularly vulnerable to disruption of their previously secure world. Because they generally lack the verbal and conceptual skills necessary to cope effectively with sudden stress by themselves, they look to family members for comfort. They are often strongly affected by reactions of parents and other family members. Abandonment is a major fear in this age group, and children who have lost family members and even pets or toys will need special reassurance.

Some things that may be helpful include:

- Encourage expression through play reenactment
- Provide verbal reassurance and physical comforting
- Give frequent attention
- Encourage expression regarding loss of pets or toys
- Plan calming, comforting pre-bed-time activities
- Allow short term changes in sleep arrangements such as allowing children to sleep with a light on or with the door open, or on a mattress in the parents' or another child's room, or remaining with the child while the child falls asleep.

Early Childhood (Ages 5-11):

Typical responses include:

- Irritability
- Whining
- Clinging
- Aggressive behavior at home or school
- Overt competition with younger siblings for parents' attention
- Night terrors, nightmares, fear of darkness
- School avoidance
- Withdrawal from peers
- Loss of interest and poor concentration in school
- Being "super good" to avoid burdening parents
- Somatic complaints

Regressive behavior is most typical of this group. Loss of pets or prize objects is particularly difficult for them to handle.

Some things that may be helpful are:

- Patience and tolerance.
- Play sessions with adults and peers.
- Discussions with adults and peers.
- Relaxation of expectations at school or at home (with a clear understanding that his is temporary and the normal routine will be resumed after a suitable period).
- Opportunities for structures but not demanding chores and responsibilities at home.
- Rehearsal of safety measures to be taken in future disasters.

Pre-Adolescent (Ages 11-14)

Typical responses include:

- Sleep disturbance
- Appetite disturbance
- Rebellion in the home
- Refusal to do chores
- School problems (e.g., fighting, withdrawal, loss of interest, attention seeking behavior)
- Physical problems (e.g., headaches, vague aches and pains, skin eruptions, bowel problems, psychosomatic complaints)
- Loss of interest in peer social activities

Peer reactions are especially significant in this age group. The child needs to feel that his/her fears are both appropriate and shared by others. Responses should be aimed at lessening tensions and anxieties and possible guilt feelings.

Some things that may be helpful are:

- Group activities geared toward the resumption of routines.
- Involvement with same age group activity.
- Group discussions geared toward reliving the disaster and rehearsing appropriate behavior for future disasters.
- Structured but undemanding responsibilities.
- Temporary relaxed expectations of performance at school or at home.
- Additional individual attention and consideration.

Adolescent (Ages 14-18)

Typical responses include:

- Psychosomatic symptoms (e.g. rashes, bowel problems, asthma)
- Headaches and tension
- Appetite and sleep disturbance
- Hypochondriasis
- Amenorrhea or dysmenorrhea
- Agitation or decrease in energy level
- Apathy
- Irresponsible and/or delinquent behavior
- Decline in emancipatory struggles over parental control
- Poor concentration

Most of the activities and interest of the adolescent are focused in his/her own age group peers. They tend to be especially distressed by the disruption of their peer group activities and the lack of access to full adult responsibilities in community efforts.

Some things that may be helpful are:

- Encourage participation in the community rehabilitation or reclamation work.
- Encourage resumption of social activities, athletics, clubs, etc.
- Encourage discussion of disaster experiences with peers, extended family members, significant others.
- Temporarily reduce expectations for level of school and general performance.
- Encourage, but do not insist upon, discussion of disaster fears within the family setting.

(The source of this information on SAMHSA's Fact Sheet is Marin County Community Mental Health Services and Santa Cruz County Mental Health Services, California)

Resources

Resources available from SAMHSA's Disaster Technical Assistance Center (DTAC), 1-800-308-3515, DTAC@esi-dc.com:

SAMHSA's National Mental Health Information Center, Center for MH Services:

- *Age-specific Interventions at Home for Children in Trauma: From Preschool to Adolescence*
- *Como ayudar a los niños a verse las con el miedo y la ansiedad*
- *Helping Children Cope with Fear and Anxiety*
- *How Families Can Help Children Cope with Fear and Anxiety*
- *Reaction of Children to a Disaster*
- *Family Readiness Kit: Preparing to Handle Disasters*
- *Helping Children and Adolescents Cope with Violence and Disasters*

State Program Materials:

- California FEMA Crisis Counseling Program, *Coping Strategies for Adolescents After a Disaster*
- California FEMA Crisis Counseling Program, *Helping Children After A Disaster*
- Florida FEMA Crisis Counseling Program, *Checklist for Parents: Did the Disaster Affect Your Child?*
- Guam FEMA Crisis Counseling Program, *Teaching Aids for Emotional Recovery After a Disaster*
- Missouri FEMA Crisis Counseling Program, *Children's Responses to Trauma: Preschool Through Second Grade*
- Pennsylvania FEMA Crisis Counseling Program, *...And the Next Day, the Kids Came to School: Lesson Plans for Teachers*
- Texas FEMA Crisis Counseling Program, *My Disaster Book*

Additional Resources:

National Child Traumatic Stress Network - www.nctsnet.org

A checklist and wallet cards to help families be prepared in the event of a disaster. A Family Preparedness Plan (PDF and Word versions) helps make sure that families are “on the same page” when it comes to planning whom to call. The Family Preparedness Wallet Card (PDF) includes important telephone numbers and website for emergency information.

SAMHSA Center for Mental Health Services –

www.mentalhealth.org/cmhs/TraumaticEvents/tips/sap

Tips for talking about traumatic events – tips for parents and emergency and disaster response workers.

Federal Emergency Management Agency (FEMA)

http://www.fema.gov/tab_education.shtm

FEMA Education and Training website containing several links to educational materials that can be used by parents and teachers for helping children prepare for a disaster or crisis situation.

FEMA for Kids <http://www.fema.gov/kids/>

FEMA website specifically designed for children. This is an excellent site for helping children learn about and cope with disasters and crisis.

Your Family Disaster Plan <http://www.fema.gov/pdf/library/yfdp.pdf>

A guide produced by FEMA and the American Red Cross to help families prepared for a disaster.

American Academy of Child and Adolescent Psychiatry www.aacap.org

Includes “Facts for Families”, a fact sheet on post-traumatic stress disorder

Child Welfare League of America www.cwla.org

Offers tips for “Talking with Children about Disasters and Violence.

Federal Emergency Management Agency has added:

- web information specifically to help parents talk to children about terrorism. See www.fema.gov/kids
- a summary of phone numbers (with disaster relief, donation, government resources, etc.) at www.fema.gov/nwz01/nwz_101.htm

FEMA has a website that outlines four *Compendiums*. “*A Compendium of Exemplary Practices in Emergency Management*” They are published on the Internet at

www.fema.gov/library/lib07.htm

Another FEMA *Compendium (Volume I)* best practice is:

“The First 72 Hours” - Plans for Survival (Ohio)

The local Emergency Management Office, in conjunction with the Board of Mahoning County Commissioners, identified the first 72 hours of an emergency as the most critical

time for obtaining information on matters such as sources of shelter and medical attention. Critical items needed for emergencies include items such as a flashlight, first aid kit, blankets, emergency food, and lists of relatives or friends. To reach the family and the community, the local Emergency Management Director and the Lake-To-River Girl Scouts Council Chief Executive agreed to identify “Emergency Preparedness, the First 72 Hours” as a merit badge and patch for the local scout council. Contact is: Walter Michael Duzzny, Director, Mahoning County Emergency Management, 120 Market Street, Youngstown, OH 44503. Tel: 216-740-2200. Fax: 216-740-2006.

Facing Fear Together - www.facingfearttogether.org

America’s Health Together, a non-profit health education and advocacy organization, has created a ground-breaking partnership of the nation’s leading medical, public health, nurse practitioner and mental health groups to bring emotional preparedness to the forefront and to help strengthen the healthcare system’s capacity to meet the heightened needs of Americans. This coalition, known as *Facing Fear Together*, was fully funded by The Robert Wood Johnson Foundation. This national initiative seeks to enhance primary care providers’ awareness of mental health issues and strengthen their capacity to care for their patients’ emotional and psychological needs.

Children’s National Medical Center, International Center to Heal Our Children (ICHOC)
www.dcchildrens.com/ichoc

The vision of the International Center to Heal Our Children is to:

- Educate and empower first responders, healthcare professionals, teachers, child care providers and parent groups across the nation with the tools needed to identify and help children heal and cope with the emotional consequences of trauma.
- Offer culturally competent and family-centered guidance, resources, and technical support to professionals and parents as they work together toward building healthy minds and futures for our children.

Contact ICHOC to learn more about:

- Training and educational programs and resources
- Crisis response and outreach
- Consultation
- Collaborative activities
- Research opportunities
- Web chats and community forums
- **THEY ALSO HAVE ON THEIR WEBSITE A DOWNLOADABLE HANDBOOK: Handbook of Frequently Asked Questions Following Traumatic Events: Violence, Disasters, and Terrorism” (A Spanish translation is currently being developed.)**

Pediatric Basics: Age and Growth Characteristics/Psychological Aspects – Version 1 (CD-ROM) – Available from the EMSC Clearinghouse

www.ems-c.org

This CD-ROM is designed to help prehospital care providers improve their techniques in interacting with young patients. Discussions center on children's emotional and behavioral development, as well as what to expect during a pediatric emergency. Product number is 000575, publication date: 1997, producer: Critical Illness and Trauma Foundation, MT.

Effective Communication and Cultural Competence in Emergency Care of the Adolescent Training Curriculum (manual, slides) – available from the EMSC Clearinghouse www.ems-c.org

This comprehensive training curriculum is designed to improve and/or enhance the cognitive skills and interpersonal capabilities of emergency medical services providers in communicating with and understanding adolescents. It enables these providers to identify the common behavioral and psychosocial emergencies of adolescence; understand the legal issues pertinent to the care of adolescents in emergency settings; explore cross-cultural knowledge, beliefs, attitudes, and practices and integrate this knowledge into the delivery of culturally competent care to specific ethnic group members; and understand the physical, cognitive, and maturational patterns of adolescent development. Product number is 000851, publication date: 2000, 224 pages and slides Multi-media, producer: Children's National Medical Center, D.C.

American Psychological Association - <http://helping.apa.org/daily/>
Coping with terrorism information.

National Center for Post Traumatic Disorder www.ncptsd.org/disaster.html
Information for both the public and professionals on children and terrorism.

American Academy of Pediatrics

“How Pediatricians Can Respond to the Psychosocial Implications of Disasters (RE9813) <http://www.aap.org/policy/re9813.html>

Journal of Emergency Nursing June 2003 29:3

“Increased Volume/Length of Stay for Pediatric Mental Health Patients: One ED's Response” by Joan Meunier-Sham, MS, RN, Needham, Mass

For reprints, write: Joan Meunier-Sham, MS, RN, 388 Manning St, Needham, MA 02492, e-mail: joan.sham@bmc.org

National Child Traumatic Stress Network www.nctsnet.org/nccts/nav
The National Resource Center for Child Traumatic Stress

Includes:

- Understanding Child Traumatic Stress - This section provides general information about child traumatic stress, including a description of the range of types of trauma, information about best practices, and facts and figures.
- Resources on Terrorism and Disaster - How terrorism and disaster impact children and families and what can be done to help children cope.
- For Parents and Caregivers - Information tailored for parents and caregivers, including quick links to other sections of this site as well as additional resources.
- For School Personnel - Information tailored for school personnel, including quick links to other sections of this site as well as additional resources.
- For Professionals – Information tailored for professionals, including quick links to other sections of this site as well as additional resources.
- For the Media - Information tailored for the media, including quick links to other sections of this site as well as additional resources.
- Tools and Materials – This section contains tools for mental health professionals and others concerned about child traumatic stress, including presentation materials and educational resources for a variety of audiences.
- Research library - Through this section of the site, users can access the PILOTS database of scientific literature on traumatic stress as well as other materials, including full-text reports, related reading lists, and an archive of NCTSN newsletters.

American Psychiatric Association www.psych.org

Includes press releases and fact sheets on the psychiatric dimensions of disaster

American Psychological Association www.apa.org

Addresses concerns about when to seek professional help, how to help one's family and self, and how to specifically help children.

National Alliance for the Mentally Ill www.nami.org

Offers links to local chapters as well as background such as “Helping Children Cope After a Terrorist Attack”

National Association of School Psychologists www.nasponline.org

Offers extensive materials (many in languages other than English). Among topics addressed are preventing suicide, promoting tolerance, recognizing severe trauma reaction, and helping children with special needs cope.

National Association of Social Workers (NASW) www.naswdc.org

Includes a variety of resources and links, including an article on “Children's Responses to Terrorism”

National Institute on Mental Health www.nimh.nih.gov/anxiety/ptsdmenu.cfm
Includes references to fact sheets related to post-traumatic stress disorder, helping children cope with violence and disasters, and other resources

National Mental Health Association www.nmha.org
Offers facts on “Helping Children Handle Disaster-Related Anxiety” and “Post-Traumatic Stress Disorder”

Substance Abuse and Mental Health Services Administration
www.mentalhealth.org/cmhs/EmergencyServices/terrorism.htm
Includes links to multiple resources, including Spanish-language materials and ideas on “How to Help Children After Disaster”

National Center for Post Traumatic Stress Disorder www.ncptsd.org/disaster.html
Information for both the public and professionals on children and terrorism.
Also includes “*Disaster Mental Health Services: A Guidebook for Clinicians and Administrators*”. www.ncptsd.org/publications/disaster/index.htm

Child Welfare League of America www.cwla.org
Offers tips for “Talking with Children about Disasters and Violence.”
Federal Emergency Management Agency has added:

- web information specifically to help parents talk to children about terrorism. See www.fema.gov/kids
- a summary of phone numbers (with disaster relief, donation, government resources, etc.) at www.fema.gov/nwz01/nwz_101.htm

Federal Emergency Management Agency (FEMA)
http://www.fema.gov/tab_education.shtm
FEMA Education and Training website containing several links to educational materials that can be used by parents and teachers for helping children prepare for a disaster or crisis situation.

www.cphd.ucla.edu UCLA Center for Public Health and Disasters
Developed a comprehensive Head Start Disaster Preparedness Workbook for use by Head Start staff.

E. NON-ENGLISH SPEAKING/ CULTURALLY DIVERSE

(taken from SAMHSA's "Training Manual for Mental Health and Human Service Workers in Major Disasters")

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

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

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

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

Resources:

[Resources available from SAMHSA's Disaster Technical Assistance Center \(DTAC\), 1-800-308-3515, \[DTAC@esi-dc.com\]\(mailto:DTAC@esi-dc.com\)](#)

SAMHSA, Center for Mental Health Services:

- *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations*
- *The Role of Culture in Helping Children Recover from a Disaster*
- *Cultural Competence in Serving Children and Adolescents With Mental Health Problems*

- *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups*

National Technical Assistance Center for State Mental Health Planning:

- *Cultural Diversity Series: Meeting the Mental Health Needs of Asian and Pacific Islander Americans*
- *Cultural Diversity Series: Creating Culturally Competent Mental Health Systems for Latinos: Perspectives from an Expert Panel*
- *Examples from the Field: Programmatic Efforts To Improve Cultural Competence in Mental Health Services*
- *Cultural Diversity Series: Meeting the Mental Health Needs of Gay, Lesbian, Bisexual and Transgender Persons*
- *Cultural Diversity Series: Meeting the Mental Health Needs of African Americans*

State Program Materials:

- Texas Department of Mental Health and Mental Retardation, *Disaster Assistance Training Program: Cultural Competency Powerpoint Training Materials*

D.C. BT Work Plan - DMH has created public information materials (fact sheets, guides, multiple languages). Brochures about emergency-related mental health issues include: *When Terror Strikes: Tips for Handling the Crisis; When Terror Strikes: Rebuilding Our Lives and Taking Control of Emergency Situations*. These information materials are available in 6 languages: English, Spanish, Chinese, Korean, Amharic, and Vietnamese. In addition to hard copy, an electronic version is available on the DMH website.

F. PHYSICALLY DISABLED/ HEARING IMPAIRED/ VISUALLY IMPAIRED

Planners must pay attention to the needs of those with physical disabilities, and those who are hearing or visually impaired. Transportation plans need to be in place, and there needs to be a mechanism to locate those with impairments or who need special assistance. Having written and audio-visual material with closed captioning, Braille, or large lettering is important and these must be provided to these individuals. Planners must work closely with agencies and community organizations involved with these individuals who may need special accommodations.

Resources:

From SAMHSA's Disaster Technical Assistance Center, 1-800-308-3515, DTAC@esi-dc.com: National Technical Assistance Center for State Mental Health Services Planning, *Cultural Diversity Series: Meeting the Mental Health Needs of Persons Who Are Deaf*

FEMA has a website that outlines four *Compendiums*. "A Compendium of Exemplary Practices in Emergency Management" They are published on the Internet at www.fema.gov/library/lib07.htm

From Volume II:

Special Needs Awareness Program (SNAP)

After flooding occurred in areas of southeast Texas in October 1994, students in the Community Problem Solving class of Austin Middle School, Beaumont, Texas, responded to stories they had heard about people having difficulty during emergency evacuations. The students originated the idea for SNAP and established a pilot program in their community. The goal of SNAP is to identify those persons, such as the elderly, mentally and physically challenged, or homebound, who would have difficulty in an emergency evacuation. These residents are given special SNAP signs for display only during an emergency. SNAP also notifies police, fire, and emergency management personnel that they should look for the SNAP signs to determine where assistance is needed in an evacuation. Contact is: Sgt. Robert J. Smith, Project Director, St. Luke's UMC, 4265 E. Lucas Drive, Beaumont, TX 77708. Tel: 409-880-3818, Fax: 409-880-3873.

Iowa BT Work Plan - IDPH through the public health and healthcare planning regions will be sharing the "Smart Practices Spotlight" developed by Linn County Emergency Management as a model for the development of operating procedures that cover evacuation with individuals with special needs. The model includes the development of a registry system at the county level to identify individuals with special needs. This information is entered into a database and may be cross-walked with the county's Geographic Information System. This will allow emergency personnel to quickly determine the location of specific needs of individuals during a disaster.

Disaster Preparedness Resources for People with Disabilities

<http://www.jik.com/disaster.html>

Web site with specific information for preparing for a disaster for people with disabilities.

READY.GOV www.ready.gov

Making a plan – special needs items list.

G. TRAUMA SURVIVORS/ REFUGEES

Many people have come to this country to flee the civil wars and terror of their own countries. They may be at increased risk to develop post traumatic stress disorder (PTSD) because of the terror to which they were previously exposed. Refugees may also be reluctant to seek out or take assistance from their government because of past abuse at the hands of government or because of fear of deportation. Finding indigenous outreach workers to link the refugees with services is crucial.

Past trauma survivors are also at increased risk for PTSD. Often we think of Vietnam Vets or other war survivors when we think of trauma. Another group often overlooked is those who grow up and live in violent neighborhoods, those who are victims of child abuse or spouse abuse, and those who have been victims of violent crimes or previous disaster victims. Increased efforts and outreach should be focused on these populations.

H. ELDERLY

The elderly have had to deal with and learn to cope with many losses, crises, stresses in their life over the course of time. This has made some older Americans more resilient; however others may be worn down by the ordeals of their life.

Many older Americans have physical and cognitive limitations, may suffer from chronic medical illnesses, and rely on environmental cues to remain independent. Many also have limited income and may not be able to afford to make the repairs or replace needed resources. They also suffer great emotional distress at the loss of irreplaceable items such as photos and letters. They may also be reluctant to admit they are having any physical or emotional distress for fear of losing their independence.

Intervention options include among other things: case management and referral to link them with financial, medical, mental health and social services assistance; help with finding housing if needed, and allowing expression of their emotions related to their losses.

Resources:

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

Florida BT Work Plan - EMS: The Florida Dept. of Health certifies EMTs and Paramedics. It has extensive programs for both the elderly and children. (The EMS-C won a national award a few years ago.)

New Jersey BT Work Plan - *The Geriatric Education for Emergency Medical Services Program (GEMS)* : GEMS is the first and only national continuing education curriculum

that focuses on geriatric patient care for the pre-hospital professional, including first responders, EMTs, paramedics, and other emergency care providers. A secondary audience is the health care professional responsible for emergency care of older people in the hospital or primary care facility.

Ready.gov www.ready.gov/special_needs_items.html
Making a kit of special needs items for infants, the elderly and persons with disabilities.

New York City's Guide to Emergency Preparedness for Seniors and Peoples with Disabilities.
City of New York, Office of Emergency Management; Mayor's Office for People with Disabilities; and Dept. for the Aging
www.nyc.gov.oem

National Organization on Disability's Emergency Preparedness Initiative
www.nod.org/emergency
This website provides information about specialized emergency equipment and articles about planning and preparedness for people with disabilities. The site also features a bulletin board where users can post questions and discuss challenges, solutions, and best practices.

Pennsylvania Department of Health www.dsf.health.state.pa.us/health/cwp/view
Special Populations Emergency Preparedness Planning
Topics include:

- Tips for People With Disabilities
- Tips for People Who Are Hearing Impaired
- Tips for the Elderly
- Tips for People With Special Medical Needs
- Tips for School Officials
- Tips on What to do for Your Pet After a Disaster
- Tips for Schools and Daycare Centers
- Tips for People Who Use Life Support Systems
- And much more

FEMA has a website that outlines four *Compendiums*. "A *Compendium of Exemplary Practices in Emergency Management*" They are published on the Internet at www.fema.gov/library/lib07.htm

From Volume III:

Caring Agencies Respond (CAR)

CAR is an inservice training program that was developed by the Palm Beach County Division of Emergency Management in an effort to reach county residents who may be homebound, on life-support systems, or receiving home healthcare services from licensed home healthcare. In 1996 CAR began educating healthcare agencies in the preparation of disaster plans to include the education of nurses in preparation of their personal family disaster plans and other clients in home preparedness and temporary self-care until a nurse's arrival at a disaster. Inservice includes a video, self-preparedness test,

discussions about networking agency and county programs, evacuation issues, special care issues, SLOSH maps, and shelters and concludes with a question-and-answer session. The program can be adapted to any organization that serves homebound. Contact is: Lucy S. Keely, CEM, Emergency Management Specialist, Palm Beach County Division of Emergency Management, 3723 Belvedere Road, West Palm Beach, FL 33406. Tel: 561-233-3500. Fax: 561-689-6680.

I. INCARCERATED

Individuals who are incarcerated often have limited social support which means they may be at higher risk for trauma. They also can lack a sense of control due to their confinement, and may act out or suffer increased anxiety or depression. They may also be anxious to know how their family members are who may have been exposed to the terrorist event or disaster, or their family members may wonder if they are okay.

J. HOMELESS

The homeless are already a vulnerable population who often rely on food kitchens and other social support services that may be disrupted after an event or disaster. Many may be battling drug or alcohol addiction, or mental illness and may rely on community health centers for their health care; these centers may be inundated after an event.

Because the homeless are transient, it may be hard to get information to them, or to provide follow-up services.

K. UNEMPLOYED/ UNDEREMPLOYED/ LOW INCOME

(from SAMHSA's Training Manual for Mental Health and Human Service Workers in Major Disasters)

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

Faced with these multiple challenges and assistance that falls short of solving the problems before them, low-income disaster survivors can feel overwhelmed. For those with limited reading and writing abilities, obtaining accurate information and completing

forms is difficult. Disaster mental health workers are most effective when they provide concrete problem-solving assistance that facilitates addressing priority needs. Workers must be knowledgeable about the full range of community resources available to people of limited economic means and actively engage this resource network with those in need.

L. PET OWNERS

During evacuation, many pet owners will not leave their homes because they won't leave their pets. For many, pets are part of their family just like "children." Rather than argue or have loss of life because of refusing to abandon pets, planners must address this issue. American Red Cross shelters do not allow pets. Many veterinarians are members of VOAD and they can serve as a resource for pet owners.

Resources:

FEMA has a website that outlines four *Compendiums*. "A Compendium of Exemplary Practices in Emergency Management" They are published on the Internet at www.fema.gov/library/lib07.htm

From Volume II: (Indiana)

Veterinary Services and Animal Care Annex

In disasters, animal owners may hinder effective emergency management by remaining with their animals during an evacuation or by attempting reentry in dangerous areas. In addition, the environment may be affected by disrupted livestock production systems. The Veterinary Services and Animal Care Annex to the State Emergency Operations Plan was implemented through a collaborative effort among the Indiana State Emergency Management Agency, State Board of Animal Health, Indiana Veterinary Technicians Association, and several accredited zoos. Unique to this annex are a series of Memoranda of Understanding among the Emergency Management Agency, State Veterinarian, and professional animal care-providing groups, because they integrate existing emergency management services with qualified groups that know how to deal with animals in disasters. Contact is Melvin Carraway, Director, Indiana State Emergency Management Agency, 302 West Washington Street, Room E208 IGCS, Indianapolis, IN 46204. Tel: 317-232-3986. Fax: 317-232-3895.

M. DISASTER MENTAL HEALTH WORKERS

(from SAMHSA CMHS' *Training Manual for Mental Health and Human Service Workers in Major Disasters*)

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

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

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

Organizational Context of Stress Prevention and Management:

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

Individual Context of Stress Prevention and Management:

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

Additional Resources:

Center for Mental Health Services. *Field Manual for Mental Health and Human Service Workers in Major Disasters*. Washington, D.C.: U.S. Department of Health and Human Services; Publication No. (ADM) 90-537. (Revised edition in press.)

Center for Mental Health Services. Support and stress management for disaster mental health staff. In: *Disaster Response and Recovery; A Handbook for Mental Health Professionals*. Washington, D.C.: U.S. Department of Health and Human Services; Publication No. (SMA) 94-3010, 1994.

The following are available from SAMHSA's Disaster Technical Assistance Center (DTAC) by calling 1-800-308-3515 or by emailing: DTAC@esi-dc.com

SAMHSA and Other Publications:

- *Self-Care Tips for Emergency and Disaster Response Workers*
- *Self-Care Tips for Dealing with Stress*

State Program Materials:

- South Dakota FEMA Crisis Counseling Program *Signs of Burnout*
- FEMA Crisis Counseling Program *Taking Care of the Caregiver*
- New Mexico FEMA Crisis Counseling Program *Watch Out for Compassion Fatigue*

N. HIGHER INCOME FAMILIES

(from SAMHSA's *Training Manual for Mental Health and Human Service Workers in Major Disasters*)

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

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

O. EMPLOYERS/EMPLOYEES

(This material is drawn from the *Blueprint for Responding to Public Mental Health Needs in Times of Crisis*, copyright 2003, and is used by permission of the National Mental Health Association.)

What Employers Can Do

To help employees work through the emotional toll of a disaster and reduce the impact on an organization's productivity, NMHA recommends that employers take the following steps:

- **Speak to the entire organization as soon as possible.** Leadership should meet with staff at all levels to express shared grief, as well as to promote available counseling services, and other resources.

- **Educate your supervisors and managers.** Inform all supervisors and human resources professionals about the signs of emotional distress, all policy changes and actions that are being taken in response to the crisis, and available treatment resources so that they can inform their staff. Direct them to encourage staff to seek treatment when necessary. Most importantly, remind them that they should seek support as needed, in addition to facilitating such assistance for the people they supervise.
- **Provide educational resources.** Your employee assistance program (EAP) and/or mental health administrator may have educational materials and information on covered treatment resources. NMHA has resources available on coping with loss, helping children cope, post-traumatic stress disorder and other topics through its Web site at www.nmha.org and toll-free number, 800-969-NMHA (6642).
- **Facilitate communication among employees.** Support among colleagues can help employees work through difficulties. Consider allowing people to take breaks from work periodically to talk. Provide a comfortable environment for them to gather.
- **Consider bringing a professional counselor/facilitator on-site.** One or more mental health practitioners could be brought to the workplace to conduct group meetings and provide individual counseling. Such an approach can help you identify and get help to those who need it, which will alleviate their immediate pain and reduce their need for services down the road.
- **Revamp your leave policy temporarily.** Allow people to take additional time off to donate blood, conduct community activities and take care of personal needs. Employees will benefit significantly if they feel they are able to take positive action and make a difference.
- **Reconsider your current travel needs.** Employees, clients and other individuals may be hesitant to make business trips for some time. Consider postponing or canceling upcoming conferences and other meetings that require travel. Your EAP may assist staff in dealing with flight anxiety. You may also need to revamp your travel policy as flight security regulations change.
- **Organize community action.** Hold a blood drive at your worksite, collect clothes and food for the victims and their families, or start a voluntary collection fund for relief efforts. Show employees that your organization is committed to helping those in the workplace, as well as the community at large.
- **Plan for future emergencies.** Create or review your organization's emergency plan to address any difficulties that arose in connection with the recent disaster. Be sure to involve all segments of your staff in the planning process.

RESILIENT COMMUNITIES GUIDEBOOK

**For Bioterrorism and Other Public Health
Emergencies: A Mental and Behavioral
Health Wellness Model and Guide**

PART FOUR:

RESILIENT COMMUNITIES

MODEL AND TOOLS

**HRSA, Special Programs Bureau,
Division of Health Care Emergency Preparedness
April 2004**

**Resilient Communities Guidebook
For Bioterrorism and Other Public Health Emergencies:
A Mental and Behavioral Health Wellness Model and Guide**

PART ONE: BACKGROUND AND GENERAL INFORMATION

Section 1: Introductory Material to Disasters and Terrorism

Section 2: Developing Short- and Long-term Response Strategies

PART TWO: DISASTER MENTAL HEALTH KEY ISSUES AND RESOURCES

Section 3: Disaster Mental Health Key Issues and Resources

- A. Planning
- B. Surge Capacity
- C. Communications/Media
- D. Disaster Mental Health Interventions
- E. Long Term Treatment Strategies/Models
- F. Substance Abuse
- G. School Preparedness
- H. Stress Prevention and Management
- I. Training and Education
- J. General Bioterrorism, Terrorism and Mental Health Issues

PART THREE: SPECIAL POPULATIONS AND RESOURCES

Section 4: Special Populations and Resources

- A. First Responders
- B. Severely/Chronically Mentally Ill
- C. Substance Abuse/Dual Diagnosis
- D. Children (include foster care issues, residential treatment fac.)
- E. Non-English Speaking/ Culturally Diverse
- F. Physically Disabled/Hearing Impaired/Visually Impaired
- G. Trauma Survivors/Refugees
- H. Elderly
- I. Incarcerated
- J. Homeless
- K. Unemployed/underemployed/low income
- L. Pet owners
- M. Medical and mental health disaster responders
- N. Higher income families

PART 4: RESILIENT COMMUNITIES MODEL AND TOOLS

Section 5: Resilient Communities Model - page 108

**Section 6: Table of Resilient Communities (Lead Team and Subcommittees)
page 119**

**Section 7: Community Mental Health Assessment by Population/Issue
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APPENDIX I: State Mental Health Commissioners – page 157

APPENDIX II: Disaster Mental Health Coordinators - page 161

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PART FOUR: RESILIENT COMMUNITIES MODEL AND TOOLS

(includes Sections 5, 6, and 7)

SECTION 5: RESILIENT COMMUNITIES: A GUIDE FOR MENTAL HEALTH PREPAREDNESS

Some information for this section was adapted from *Together We Can: A Guide for Crafting a Profamily System of Education and Human Services*. Developed jointly by the U.S. Department of Education and the U.S. Department of Health and Human Services, April 1993.

In many communities, community mental health centers, social service agencies, and community health clinics are free-standing, non-integrated entities with narrowly focused missions and goals. Much of this is due to the way services are funded. Additionally, it has not been the norm that the above referenced agencies/centers interacted in any meaningful or organized way, nor did they interact or collaborate with hospitals, schools, businesses, cultural organizations, law enforcement and local government. None know what each other is doing, and what strengths or weaknesses they bring to the community. The time for integration and collaboration is upon us. If we are to continue as one of the greatest Nations in the world, then we must begin building resilient communities.

The Terrorist Goal

September 11th brought home to Americans that the psychological aspects of terrorism are the main goals of terrorism. If terrorists are able to destroy the social fabric of our communities and destroy our faith in each other to work together, then they will have succeeded in their mission. Social support and strong resilient communities must be central to the planning process for preparedness for bioterrorism and other public health emergencies.

Much attention has been focused on security and physical infrastructure. This is important to our physical safety and protecting against loss of life. However, just as important is psychological preparedness and building resiliency. Wars have been won or lost based on the will of the people. Terrorists seek to destroy our government and way of life by destroying the will of the people to work together, by making Americans feel disempowered and immobile. Americans need to know that their community preparedness planners keep psychological well-being at the forefront of planning activities.

An important reminder of just how important mental health issues are: the sarin gas attack in Tokyo had a ratio of 4:1, mental health casualties to physical health casualties. This doesn't even account for those who had psychological problems but didn't seek help.

Resilient Communities: A Collaborative, Systemic, Empowering Approach To Planning

Definition of *Resilient Communities*:

Resilient Communities are communities that have made a commitment to collaborate and to integrate services and activities to improve the psychological well-being and preparedness for bioterrorism, public health emergencies, or any other crises that affect the community through empowering policies that share power, and through community outreach and education.

Collaboration and integration of services for community resiliency is a systemic approach to planning and represents a paradigm shift for many organizations. It may mean giving up some control and investing time and resources in building the capacity of the community to recover from a crisis through a thorough needs assessment and prioritization of needs. It means the community may not see tangible results (ex. A new building or service) right away, but that the planners understand that the foundation must be laid based on accurate information.

In a *Resilient Community*, disaster response cannot focus only on the event itself and the immediate aftermath. For psychological well-being, the approach must emphasize preparedness and the long term consequences. For the most part, historically, crisis intervention has been available immediately after an event. But the responders go home, and there is often no plan for long term needs. Resilient communities have developed the social fabric through their upfront preparedness efforts, so that they are already prepared to address the long term issues after an event.

Resilient Communities are not only ready for bioterrorism or other public health emergencies, but have the social support infrastructure to build health overall in the community. For example, it is important to link every individual in the community to a medical “home” so that the hospitals aren’t inundated with those after an event who are experiencing multiple unexplained physical symptoms, but may be experiencing stress that is bringing on these symptoms. By having this medical “home” for preparedness, you are also providing the individual with better health linkage overall.

Resilient Communities recognize the protective factors that help an individual develop resilience. These include emotional connection to a supportive, caring adult, good coping strategies, good problem-solving skills, a feeling of worth and competency, an optimistic outlook, good social skills, and emotional control. A *Resilient Community* helps the individual develop these skills through education and treatment, and provides social support through outreach and linkages.

To build *Resilient Communities*, the main emphasis must be on the preparedness – long before an event happens. Also, the mindset must be one of responsiveness to ANY event, even a small one, so that the resources are mobilized as often as possible. The emphasis

on preparedness creates a feeling of confidence among the community members because they feel they have some control because they know where to turn and what to do.

The idea of *Resilient Communities* is to develop a strengths-based, collaborative model that moves mental health from a stigma-based service to a universal proactive response. All communities have strengths as well as stress. Getting help from a neighbor may be less threatening than initially going to a mental health professional. If the neighbor has some basic crisis intervention and active listening skills, the effect can be profound. It may be all that is needed: a caring ear. It may also be that the neighbor is trained to recognize when a person needs professional guidance and by developing that rapport by listening, may be able to encourage the person to seek out further help. The emphasis of *Resilient Communities* is on supportive linkages, and away from emergency psychiatric intervention at a hospital or clinic.

All communities are different so it is not possible to state “have X number of mental health clinics every X miles, train X number of people in crisis intervention, etc.” Communities need to come together with broad representation and do the hard upfront work on preparedness, which includes dealing with diverse viewpoints, giving up some control, moving away from a medical model to a strengths-based, systemic approach, and making the difficult decisions of how best to utilize limited financial and mental health resources.

Cooperation and collaboration are not the same things. Cooperation is more information sharing and some working together but without substantially changing the way business is done. Collaboration, on the other hand, is one in which members have a shared vision and goals, and perhaps make modifications to existing program structures to create the vision.

A *Resilient Community* has a strategy for integration and collaboration that will meet the mental health needs of the community in a supportive, non-stigmatizing way. If a community is based on the strengths and health of its neighborhoods, families and individual members, then services need to be built around those strengths. Too often medical professionals and hospitals are focused on problems or pathology and project that into services. Because of this, mental health services and supports are often underutilized. Also, there is a lack of communication and a lack of knowledge between service providers as to what each group has to offer.

Resilient Communities embrace caring as their vision and build rings of supportive services around individuals, families, and their neighborhoods. *Resilient Communities* depend on strong communication linkages that are often redundant to ensure needs are met. *Resilient Communities* have a vision that is bigger than the individual organization, and can put aside turf issues for the well-being of the community. The focus is always on the big picture, the goal of mental health readiness from a strengths-based, collaborative approach.

This is perhaps the biggest hurdle for a community to overcome – the paradigm shift to a systemic, collaborative approach. Funding constraints, professional affiliations, biases to a certain approach – these issues need to be addressed. Open-mindedness, flexibility, active listening and conflict resolution skills are all necessary for those who come to the table to build a *Resilient Community*.

Effective integration initiatives have several things in common: First, they are based in the community and have State and political support. Second, they use specific prototypes through which services are delivered. These prototypes are determined by the community to meet its unique needs. Third, initiatives have baseline data which shows the current “mental well-being” of the community. Fourth, initiatives are financially sound. Attempts are made to utilize existing resources in a more efficient way, and to seek additional financial resources when necessary. Fifth, training moves from primarily profession-specific to more cross-training with other disciplines. Health professionals understand what helping organizations provide, mental health professionals understand the medical aspects of disasters and terrorist events, etc. Sixth, initiatives involve all citizens in the decision-making process about how to develop a *Resilient Community*. Finally, there is sufficient technical expertise to monitor performance and to regularly re-evaluate progress and lessons learned.

Throughout this process, it is important to stay focused on the big picture, the vision. If disagreements over details are slowing the process, it is important to go back to the vision and work backwards from there.

BUILDING RESILIENT COMMUNITIES: THE PROCESS

There is no single “right way” for a community to change. Each community needs to look at its strengths, challenges, resources, and commitment and build from there. How quickly or slowly communities go through this process will differ. Some may seem to go backward at times, but this is actually a good sign because it is laying a more sound foundation. Trying to speed through the process will probably result in failure.

DECIDING TO ACT

During this stage, a small group meets to explore how to develop a *Resilient Community*. It doesn't matter who starts the collaborative. It could be the local health department, the mental health department, a hospital, a non-profit, or concerned citizens. Strategies that are mandated by the State are often referred to as “top-down”. Those that are grassroots initiatives are often referred to as “bottom-up”. The most successful blend the bottom-up community knowledge and sense of urgency with the support that comes from the top. Whoever initiates action at the local level should be a person who is seen to be impartial and knowledgeable. For example, a local hospital could initially pull together a leader from the local mental health community, a business leader and an academician.

PUTTING TOGETHER A REPRESENTATIVE COLLABORATIVE TEAM

This small group identifies other community members who have a stake in mental health preparedness, to include diverse representation that parallels the community demographics. Organizers look for those who have a power base in the community. Organizers also look for those who have a strong commitment to the vision regardless of their professional or organizational affiliation. They also look for those of different ethnic, racial, cultural and religious perspectives. The group should include mental health agencies, substance abuse agencies, disability advocates, public health, medical clinics, legal experts, consumers, public sector organizations (to include financial assistance services), faith-based organizations, non-profit organizations, schools, cultural community organization leaders, law enforcement, businesses and business organizations, elected officials, IT professionals and the media. This list is not all inclusive. There may be other participants based on your community demographics.

Once identified, they come together with a commitment to collaborate and agree to the vision as the unifying theme. They establish shared leadership, ground rules, and look for ways to finance their efforts.

COMMITTING TO COLLABORATION

The group agrees on a vision for a *Resilient Community*, establishing a structure for shared leadership, setting ground rules, and identifying and securing financial resources for the planning effort.

A major task for the group is to realistically assess whether collaboration will work. Collaboration takes much more effort than cooperation. Each member must clearly understand what is being asked of them; that they will be asked to put aside their individual or agency agenda and work toward the vision. It involves a long term commitment and can be time consuming, but can have profound results to the health of the community. A collaboration will probably work if the members realize they cannot tackle this problem on their own, and that only by pooling resources (both financial and manpower) will they have a community prepared for the mental health needs after a disaster or terrorist event. If a community is not at this point yet, it may be best to aim for a cooperative strategy initially to set the stage for future collaborative efforts. It is not wise to push collaboration if there is a lot of resistance. To decide whether collaboration will work, here are some questions to ask:

1. Will the benefits of collaboration outweigh the costs?
2. Is there a history of communication and cooperation and a foundation of trust among the various community groups and organizations the collaborative will involve?
3. Is each of the potential partner institutions stable enough to withstand the change that integrating services would introduce?
4. Do all of the key players have enough financial staff leeway to commit some of their resources to collaborative activities, or are they overextended in their day-to-day operations?

5. Are partners willing to explore ways for key players such as grassroots organizations operating on shoestring budgets to participate?

Groups that agree to move forward may want to develop a theme beyond that of *Resilient Communities*. They may want to think of a message that conveys their thoughts on mental health preparedness. An example might be “Caring communities reach out”, or “We all have a role to play for community health”. The best phrases come from the community themselves.

In a collaborative, the best outcomes are in those with shared leadership. Each member brings to the table unique strengths and knowledge, and none is more important than another. This is a new mindset for many. The new operating principle is that the dynamics of the group is more important than the sum of its parts. Shared governance means shared responsibility so that each member is fully invested in the success of the endeavor.

Setting ground rules is another key component in successful collaborations. These rules should cover how partners will maintain communication with each other, how to keep the readiness momentum of the collaborative effort on a day to day basis, how to resolve personal and organizational conflicts, and how to run meetings. Will partners make decisions by consensus or majority rule? How can partners ensure decision-making occurs in the meetings and not behind the scenes?

As the group grows larger, it may entail the development of subcommittees or ad hoc committees to divide tasks efficiently. Some examples of ad hoc or subcommittees might be: media/communications, funding, focus groups, information management, and cultural issues.

Another important aspect is to secure financial resources for the collaborative’s planning efforts. Members often underestimate what planning will cost, and may push for premature action before the group is ready to work as a team. Some avenues to consider are HRSA and CDC funds from awards already given to the States, SAMHSA grants, foundations, civic organizations, and businesses.

Begin to develop cohesiveness and collaboration by tackling a task early on that results in a tangible product and gives a sense of ownership to the community members. An example might be developing a directory of current mental health agencies, substance abuse prevention and treatment programs, social services organizations, neighborhood groups, community centers, etc. It could be called the *Resilient Community Directory*, or be given some other name.

Also, involve media to educate the public and ask for their input in the process. Town meetings, focus groups etc. are a way to empower the public and enhance the preparedness efforts.

COMMUNITIES STRUGGLING WITH COLLABORATION

For communities that are struggling with the collaborative process, it is worth the time to get to know the “culture” of the community collaborative team members to include beliefs, goals and professional biases. Partners need to know what each member brings to the group. The group must understand the policies, rules, financing, values and goals of organizations represented in the collaborative effort and how working collaboratively might affect them both positively and negatively. It can be good to make site visits to each other’s organizations, use trainers to run workshops on team dynamics, conflict resolution, and cultural sensitivity.

Awareness workshops can be helpful in many ways. They can help partners understand personality issues, beliefs and behaviors that impact the group. Understanding differences can actually build trust if differences are discussed in a safe environment. The choice of facilitator for these workshops should be carefully considered. It should be a neutral person acceptable to all.

COMMUNITY NEEDS ASSESSMENT

The collaborative should conduct a community needs assessment to gather information on mental health well-being in the community, barriers to mental health service, gaps in mental health services, and other special needs related to mental health and well-being. Some of these other special needs often not thought of as mental well-being related, include economic stability, housing stability, and exposure to crime and violence. The dimensions of the needs assessment will be fully outlined in Section 7: Needs Assessment for *Resilient Communities*. The needs assessment is vital to identify indicators for the mental health of a community in order to establish a baseline rate and identify services, gaps, special population concerns, and priority areas.

The community or “neighborhood” analysis should profile the history, racial and ethnic composition, cultural and language diversity, and primary mental health risk factors to individuals, families, and children. The analysis should also catalog the assets of the “neighborhood”. For example, the collaborative would want to know of the mental health resources offered by hospitals, clinics, and schools; the support offered by churches, synagogues, mosques, community centers, family support centers, day care centers, recreation centers, boys and girls clubs, businesses, academic institutions, social service agencies, etc.; and the emergency resources such as proximity of emergency rescue, fire departments, and crisis intervention services.

Collaboratives should also conduct focus groups, surveys, and site visits. It is important for collaborative members to hear first-hand the experiences of community members with mental health concerns. Community members can speak about their experiences with service providers, barriers to service, what they need, and what they would change. They could also explain how they think crisis and long term mental health support would best be accepted by those who fear stigma by use of services.

DEVELOPING A VISION AND GOVERNANCE STRUCTURE FOR SUSTAINED COMMITMENT

Collaborative partners need to develop a governance structure to sustain the commitment. Each partner needs to understand their roles and responsibilities, hierarchy for communication and leadership. The collaborative should develop Memorandums of Understanding between agencies, providers, hospitals, etc.

Members and agencies should be clear on what their responsibilities are, with formalized agreements as necessary. The plan that is developed is a delineation of responsibilities. This plan will provide a description for key partners and community members. Collaborative members must formalize agreements among themselves, to include redeployment of personnel and governance as necessary. These agreements are written pacts and are a visible demonstration of agency commitment. However, that doesn't mean there can't be flexibility.

As part of this process, collaborative partners need to define a shared vision and goal. Clear language is important. "Resilient Communities" or "mental health wellness" may mean different things to different collaborative members. Members need to develop a clear statement of goals and a clear vision. Members must agree on what is wrong and what is right with the current system and what a "resilient community" would look like. When writing a vision statement it should be broad enough to help each member understand why they are part of this effort, yet specific enough that the meaning is not lost when it comes time for action.

The mission statement specifies how the collaborative intends to reach the goal of becoming a *Resilient Community*. The mission statement should also suggest how the collaborative plans to augment already existing services. It is helpful if the governing boards of the members' organizations formally endorse the mission statement to give the collaborative greater support.

DEFINING TARGET OUTCOMES

After analyzing the needs assessment and hearing from community members, it is time to choose from those indicators the ones the collaborative wants to address. Some examples might be:

- Increase the visibility of community organizations through media outreach and education to include a website, multi-language pamphlets, public service;
- Increase the preparedness knowledge of the community through fact sheets, family preparedness kits, community training and education activities. Information/handouts will be available in medical and mental health organizations, civic group, daycares, schools, etc.;
- Increase attendance at school and workplace "crisis response" education;
- Increase the number of trained peer responders who have disaster mental health training through the Red Cross and through CISM training;

- Identify and educate the public on alternative sites for medical, substance abuse and mental health intervention after an event; and
- Register every community member to a medical “home”.

Collaborative members should also identify the desired behavioral outcomes they expect to see at all levels. This includes personal and organizational behavioral change, a systemic shift to a strengths-based approach, flexibility and responsiveness to a range of situations, and efficient responsiveness to community members

INTERAGENCY SERVICE DELIVERY

The next step is to define how service delivery will be accomplished in the *Resilient Community*. It is important to include primary, secondary and tertiary prevention activities in the prototype. Primary prevention includes neighborhood events at neighborhood community centers, helplines, information and referral activities, websites with educational information, brochures and pamphlets, and wellness activities. They are broad-based services that are useful for most everyone in the community. There is generally no or little stigma involved with these activities.

Secondary prevention activities are for populations that may be at higher risk due to poverty, illness, street violence, drug activity, etc. Activities for this population might include targeting schools with high absenteeism with interventions, community outreach to the neighborhood, and case management of vulnerable populations.

Tertiary prevention activities are for populations that are already in ongoing crisis. Activities in this area might include intensive case management, hospitalization, family preservation, home visits, medication management, linkage to mental health services, and disability determinations.

The collaborative members need to decide what services and service delivery designs are most likely to lead to a *Resilient Community* – a community that is resilient enough to withstand the mental health fallout of a terrorist event or disaster. Hopefully, the design will include the three levels of prevention above, will be strengths-based, will be well-integrated, flexible, sensitive to race, culture, gender, age, and to individuals with disabilities, and outcomes oriented. Below is a checklist of questions to help make service delivery choices for a *Resilient Community*:

- What steps can collaborative members take to ensure that all community members receive the degree of services they need after an event, while reserving the most costly services for those most in need?
- How can the collaborative educate the community on roles they can play before, during, and after a disaster or terrorist event?
- What mechanisms will the collaborative use to make referrals and ensure follow-up?
- How will the collaborative identify and complement community strengths?

- How can the collaborative overcome community members' distrust of service providers?
- What actions can the collaborative take to ensure that service delivery is not only equal and nondiscriminatory, but also responsive to the needs of all groups?
- Where and when will the prototype provide services?
- How can the collaborative "normalize" mental health intervention following a crisis?
- What can the collaborative do to reduce accessibility barriers such as limited transportation, lack of child care, and lack of handicapped access?
- How will the collaborative provide services that work with families?

The collaborative also needs to set up a management information system (MIS). An effective MIS should allow retrieval of aggregate data for tracking services used, care available, increases or decreases in capabilities, volunteer management, providers with specified training, new initiatives, etc. The MIS will have different levels of access with one level allowing community members to add input. This will give the community a picture of their "health" and will maintain higher levels of preparedness.

Ongoing training, communication, and feedback are important to keep all members of the collaborative effort focused on the vision of *Resilient Communities*. Agencies that are a part of the collaborative must clearly indicate how much time they are willing to allow their staff to devote to collaborative planning, training, and activities. Redundant means of communication are also key for collaborative members just as communication will be later on for the community when the plan is put into action.

IMPLEMENTING AN INCLUSIVE OUTREACH STRATEGY

It is important that the collaborative members consider how to reach out to families and individuals and work to keep them from becoming isolated. Different communities get information in different ways. Redundancy of communication, through media, newsletters, faith-based organizations, neighborhood centers, schools, and cultural organizations is vital. It is also important to have person-to-person contact when talking about mental health supports and services. It is less stigmatizing if stress and crisis are normalized as a part of life, and that reaching out for help early is a sign of strength and not weakness.

Collaborative outreach must also be sensitive to special needs groups that include those with disabilities, those who speak a different language, and those of a different cultural background. It is important to identify the natural supports that many turn to in a crisis and then help those natural supports develop the skills to maintain connection for mental health.

EVALUATING PROGRESS

A final step is to evaluate progress. By responding to smaller scale crises such as fires, power outages, flooding, etc. the *Resilient Community* system has a chance to respond and evaluate system delivery. Another way to evaluate system delivery is through mock exercises conducted on a quarterly basis. When response becomes secondhand, that is when it will be ready during a major event. It also fosters community resiliency just by the knowledge that resources are available on an ongoing basis.

The outcomes should be measurable, otherwise there will not be ongoing support for this type of effort. It is imperative that adequate data collection systems be available and that data is collected over a sufficient period of time. Measures should also identify an increase in strengths such as seeking mental health services before it reaches crisis proportions. . Since crises do not occur everyday, it is also wise to show how this readiness benefits the health of the community on a daily basis.

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**SECTION 6: TABLE OF RESILIENT COMMUNITIES TEAM/
COLLABORATIVE
(LEAD TEAM AND SUBCOMMITTEES)**

AREA/GROUP REPRESENTING	CONTACT: NAME/TITLE	E-MAIL/PHONE ADDRESS	SUBCOMMITTEES TEAM TO WHICH TASKED	RESPONSIBILITIES/TASKS
LOCAL MHA				
MH TREATMENT PROVIDER REPRESENTATIVE				
SUBSTANCE ABUSE TX PROVIDER REPRESENTATIVE				
PREVENTION/OUTREACH REPRESENTATIVE				
LOCAL EMERGENCY MANAGEMENT AGENCY REPRESENTATIVE				
MEDIA REPRESENTATIVE				
LAW ENFORCEMENT REPRESENTATIVE				
LOCAL GOVT. REPRESENTATIVE				

**SECTION 6: TABLE OF RESILIENT COMMUNITIES TEAM
(LEAD TEAM AND SUBCOMMITTEES)**

AREA/GROUP REPRESENTING	CONTACT/ LEAD TEAM MEMBER	E-MAIL/PHONE ADDRESS	SUBCOMMITTEES TO WHICH TASKED	RESPONSIBILITES TASKS
FIRE DEPT				
EMS				
SCHOOLS/ADMIN				
SCHOOLS/NURSES				
DAYCARE CENTERS				
NURSING HOME REPRESENTATIVE				
DOMESTIC VIOLENCE/SHELTER REPRESENTATIVE				
CHAMBER OF COMMERCE REP.				
CORRECTIONAL FACILITIES REPRESENTATIVE				

**SECTION 6: TABLE OF RESILIENT COMMUNITIES TEAM
(LEAD TEAM AND SUBCOMMITTEES)**

AREA/GROUP REPRESENTING	CONTACT/ LEAD TEAM MEMBER	E-MAIL/PHONE ADDRESS	SUBCOMMITTEES TO WHICH TASKED	RESPONSIBILITES TASKS
EAP REPRESENTATIVE				
RESIDENTIAL TREATMENT FACILITES REPRESENTATIVE				
CITY/COUNTY PLANNING REPRESENTATIVE				
ENGINEERING REPRESENTATIVE				
COLLEGE REPRESENTATIVE				
PTA REPRESENTATIVE				
CULTURAL COMMUNITY REP: _____				
CULTURAL COMMUNITY REP: _____				
CULTURAL COMMUNITYREP: _____				

**SECTION 6: TABLE OF RESILIENT COMMUNITIES TEAM
(LEAD TEAM AND SUBCOMMITTEES)**

AREA/GROUP REPRESENTING	CONTACT/ LEAD TEAM MEMBER	E-MAIL/PHONE ADDRESS	SUBCOMMITTEES TO WHICH TASKED	RESPONSIBILITES TASKS
CIVIC ORGANIZATION REP: _____				
CIVIC ORGANIATION REP: _____				
COMMUNITY GROUP REP: _____				
COMMUNITY GROUP REP: _____				
COMMUNITY GROUP REP: _____				
FAITH-BASED REP: _____				
FAITH-BASED REP: _____				
SALVATION ARMY REPRESENTATIVE				

**SECTION 6: TABLE OF RESILIENT COMMUNITIES TEAM
(LEAD TEAM AND SUBCOMMITTEES)**

AREA/GROUP REPRESENTING	CONTACT/ LEAD TEAM MEMBER	E-MAIL/PHONE ADDRESS	SUBCOMMITTEES TO WHICH TASKED	RESPONSIBILITES TASKS
HOSPITAL TRAUMA PROVIDER				
PEDIATRICIAN				
HEALTH DEPT.				
HOTLINE/CRISIS OUTREACH				
DISABILITIES REPRESENTATIVE				
AGING OFFICE				
RED CROSS				
CHILD PROTECTIVE SERVICES				
SOCIAL SERVICES/ JOBS/FINANCIAL ASSISTANCE				

**SECTION 7:
COMMUNITY MENTAL HEALTH ASSESSMENT BY
POPULATION/ISSUE**

To build a *Resilient Community*, the collaborative partners must understand what services are needed before, during and after an event, assess what mental health services are available, when they would be available, what gaps are evident, and who the contacts are for a variety of services, programs and issues. This should be done by population and by issues. This process will be crucial to doing the final “Outcomes Checklist for *Resilient Communities*” which will identify your community’s progress toward achieving maximum resiliency.

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FIRST RESPONDERS

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
EX. Stress Management Education	Pre-event Post	1. Yearly stress mgmt education 2. CISM debriefings	Volunteer providers do not always get the yearly stress management training	John Brown EMS Training Dir. (632-555-4321)
Stress Management Education				
Debriefing/CISM Services				
Trained CISM or Red Cross MH disaster counseling providers				
Services to care for first responders' families				
Plan for regular breaks/shift limits for first responders				
Plan for transportation of MH first responders				
Treatment for first responders (Acute)				
Treatment for first responders (Long term)				
Plan for credentialing of MH first responders across state lines				
First-aid volunteers in workplace				

**SEVERELY/CHRONICALLY MENTALLY ILL/
MR/DEVELOPMENTALLY DISABLED**

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
System to get clients their medication in case of clinic closings(privacy issues and updating)				
Locations of psychotropic medicine during an emergency				
Outpatient treatment services				
Residential treatment services				
In-patient treatment services				
Day Treatment Programs for MR/DD				
Transportation to Programs				
Crisis intervention/immediate triage				
Educational materials and outreach				
Plan for continuity of care for those already in tx when resources diverted				
Outreach services				
Case management				

SUBSTANCE ABUSE/DUAL DIAGNOSIS

SERVICE NEED	TIME FRAME AVAILABLE pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICES	POINT OF CONTACT
EX. Outreach	Pre-event impact and post event	ex. 5 mobile teams	1. Need 2 Spanish speaking teams 2. Need 2 teams to work 3-11 pm shift	Jane Smith, Crisis Outreach Center 301-555-1234
Substance Abuse Outpt. Treatment-Adults				
Substance Abuse Outpt. Treatment – Children				
Substance Abuse Education – Adults				
Substance Abuse Education – Children				
Substance Abuse Outreach – Adults				
Substance Abuse Outreach – Children				
Substance Abuse Helpline/Information Line				
Dual-Diagnosis Treatment				
Inpatient treatment facilities				
Partial hospitalization programs				
School-based services				
Methadone programs/medication continuity				
Crisis intervention/triage				
Crisis hotline				
Support groups				

CHILDREN

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Family preparedness resources/education				
Training for school professionals, and support staff on disaster mgmt./ crisis intervention				
Shelter in Place Rules/Training				
Training on disaster issues for daycare and early intervention staff				
Plan for linking children with their parents				
Medically fragile children's medication and transportation issues				
Child survivors of previous trauma				
Plan for keeping injured children and parents together				
Education (age appropriate) for children on disasters				
Education for parents on how to help their children cope				
Treatment for children (developmentally appropriate)				
Plan and tracking of foster children/ children in care				
Plan and tracking for children in school				

CHILDREN (CONTINUED)

Plan and tracking for children in daycare				
Media instruction on how children can reunite with their children/traffic management				
Training on screening and triage of children				
Crisis intervention for children				
Care for children without their parents/social services care plan				
Crisis hotline for children/adolescents				
Information line for parents				
Alternate educational plans in case of quarantine				
Recreational plans during disaster response				
Support groups				

NON-ENGLISH SPEAKING/CULTURALLY DIVERSE

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Education/information materials in multiple languages				
Understanding of cultural issues and differences/ natural helpers				
Knowledge and linkage of cultural leaders/gatekeepers who community members seek out for news (part of collaborative)				
Alternative/non-government helpers				
Services and treatment for trauma survivors/refugees				
Redundant communication avenues				
Treatment providers from same culture who speak same language				
Outreach services				
Training for staff on cultural competency as it relates to trauma and disaster response				
Faith-based interventions and support				
Interpreter services and sites where interpreters are located				

**PHYSICALLY DISABLED/HEARING IMPAIRED/
VISUALLY IMPAIRED**

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Communication mediums (signers, readers, braille information sheets, etc.) to address the population's special needs				
Evacuation strategies and sheltering				
Treatment providers who can sign				
Crisis intervention and follow-up				
Continuity of medical care				
Case management				
Outreach				
Database of volunteer signers and readers				

TRAUMA SURVIVORS/REFUGEES

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Treatment providers who are trained in PTSD effective intervention				
Educational materials				
Identification of populations who may be trauma survivors				
Outreach/ education on coping strategies				
Linkages to services (social, medical, religious, outreach, case management))				
24 hour crisis services				
Medication continuity				
Interpreter services				

ELDERLY

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Transportation				
Case management				
Crisis intervention				
MH treatment				
Medication continuity				
Sheltering				
Social services				
Continuity of support services (ex. PT, OT)				
Faith-based services continuity				
Acute care issues				
Chronic care issues monitoring				
Screening and triage				
Nursing home staff training				
Plan for family reuniting				

INCARCERATED

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Evacuation				
Family contacts				
Crisis intervention				
MH treatment				
Medication management				
Substance abuse services continuity				
Training for Correctional Staff on MH Disaster Issues				
Crisis intervention				
Triage and screening				

HOMELESS

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Tracking of homeless living areas				
Crisis intervention				
Case management				
Food/shelter/clothing				
MH treatment				
Medication management				
Triage and assessment				
Social services linkage				
Linkage to medical care				

**UNEMPLOYED/UNDEREMPLOYED/
LOW INCOME**

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Crisis intervention				
Social service/MH linkage – one-stop shopping				
Job assistance				
Medical services linkage/ medical “home”				
MH treatment (Acute)				
Daycare assistance				
Outreach				
Affordable housing				
MH treatment (Long-term)				
Faith-based services linkage				
Legal assistance				

PET OWNERS/ FARMERS

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Evacuation protocols				
Education on protocols and sites for pet evacuation				
Sheltering/food for pets and their owners				
Treatment for pets				
Medication for pets				
Plan for identification and disposal for pets/animals				
Plan for abandoned animals				
Volunteer vets				

DISASTER MH PROVIDERS AND MEDICAL PROVIDERS

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Stress Management education				
Disater MH counseling training				
Credentialing system for providers and volunteers				
MH treatment				
Training on MH triage and assessment				
Debriefing and defusing				

HIGHER INCOME FAMILIES

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Education on social services access				
Disaster management education				
Family disaster plan				

**SURGE CAPACITY/
MULTIPLE UNEXPLAINED PHYSICAL SYMPTOMS (MUPS)**

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Alternative sites of care				
Triage and assessment				
Training for healthcare providers to recognize mental health distress				
Training healthcare providers on referral sources				

**GOVERNANCE STRUCTURE/INTERAGENCY LINKAGES/
LINKAGES BETWEEN FEDERAL, STATE AND LOCAL AGENCIES
STANDARD OPERATING PROCEDURES**

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Ex. Interagency council (collaborative)	Ex. Pre Impact Post	Ex. Forum for service delivery	Ex. Changing membership on collaborative making continuity difficult	
Interagency council (collaborative)				
Governance mechanism for collaborative/ Interagency council				
Memorandums of Understanding between collaborative Members				
Standard Operating Procedures for preparedness, response and recovery				
Communication mechanism				
Linkage with Federal and State Agencies				

COMMUNICATION/MEDIA/RISK COMMUNICATION

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Standard operating procedures for communication				
Audio-Visual means of communication				
Printed means of communication				
Management Information System				
Community education and outreach				
Risk communication protocols				
Identification of public speakers whom the community trusts				

MH TRIAGE AND ASSESSMENT

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post Event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
MH triage services				
Mental health assessment				
Valid mental health triage tool				
Valid mental health assessment tool				
Alternate sites/additional sites for triage and/or assessment				

LONG TERM MH TREATMENT

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post Event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Adequate number of licensed MH professionals				
Memorandums of agreements with other agencies for long-term mental health care				
Funding mechanism for long-term mental health care				
Adequate inpatient treatment beds				

**EVACUATION/LOCATION OF SERVICES/
ALTERNATE SITES OF CARE/TRANSPORTATION/
ACCESS TO SITES/CREDENTIALING**

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post Event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Evacuation plan				
Drill using evacuation plan				
Plan and agreements for sites for delivery of services to include alternate sites				
Education and information to public on evacuation, alternate sites of care				
Plan and agreement for transportation services				
Credentialing system for MH volunteers				
Roster of MH volunteers				
Adequate interpreter services and their location				

PHARMACOLOGICAL ISSUES

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post Event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Adequate psychotropic drug availability				
Plan with pharmaceutical company or other venue for delivery of psychotropic medication				
Plan for funding of psychotropic medication				
Plan for medication management				

DRILLS/EXERCISES/SUSTAINABILITY

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post Event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Drills for MH integrated with larger disaster drill				
Table top drills with members of the collaborative				

**SERVICES TO THOSE WHO HAVE LOST A LOVED ONE DURING AN
EVENT**

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post Event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Grief counseling				
Mortuary services				
Victims Services				
Financial Assistance				
Insurance assistance				
Legal assistance				
Job assistance				
Housing assistance				
Counseling services for adults				
Counseling services for children				
Bereavement support groups				
Case management and follow-up				

**MANAGEMENT INFORMATION SYSTEMS/
DATABASES/DATA COLLECTION TOOLS**

SERVICE NEED	TIME FRAME AVAILABLE Pre/impact/post Event	SERVICE AVAILABLE	GAPS IN SERVICE	POINTS OF CONTACT
Management Information Systems				
Mechanism for data storage for privacy information				
Data collection tools				
Access to MIS				
Updating of MIS				

SECTION 8: RESILIENT COMMUNITIES CHECK LIST

Community:

Date:

Reviewers:

Initial Review **Annual Review** **Date of last review:**

Y	N	P¹	PERFORMANCE TARGETS	COMMENTS
			PLANNING	
			1. Meeting with other community members to begin to develop a team for <i>Resilient Communities</i> .	
			2. List of all members to invite to the collaborative planning process to develop a <i>Resilient Community</i> .	
			3. Have met as a collaborative team to begin the planning process.	
			4. Team is representative of the community (See Section 6).	
			5. Development of MH command structure and governance.	
			6. Description of plan for linkage of MH command structure to community command structure.	
			7. Description of MH command structure and assignment of roles.	
			8. Description of cooperative planning among other health/mental health organizations in the geographic area (including CSA) to facilitate the timely sharing of information, including sharing command structure, names, roles, telephone.	

¹ Y=In Compliance; N=Not In Compliance; P=Partial Compliance with Standard

			numbers, resources and assets that could be shared or pooled.	
			9. Identification of procedures to be used in response and recovery phases, including a description of how, when and by whom the phases are to be activated.	
			10. Notification of emergencies to external authorities: (a) MHA; (b) DHMH; (c) CSA; (d) County officials; (e) local jail/detention center; etc.	
			11. Notification of personnel when emergency response measures are initiated.	
			12. Identification and assignment of personnel to cover all necessary staff positions under emergency conditions.	
			13. Needs assessment completed.	
			14. Development of standard operating procedures.	
			15. Identification of targeted outcomes.	
Y	N	P	PERFORMANCE TARGETS	COMMENTS
			SERVICE DELIVERY ISSUES	
			16. Description of primary, secondary, and tertiary prevention activities and staff/agency responsible.	
			17. Management information system in place.	
			18. Mechanism for ongoing feedback to staff, community members, etc. regarding community wellness.	
			19. Protocols for service delivery.	
			20. Implementation of inclusive outreach and education.	
			21. Description of evaluation plan and quality improvement.	
			22. Alternate care site identified, e.g., “hot, warm and cold sites” (e.g., another MHA or DHMH facility, community facility, etc.)	
			23. Transportation of community members, staff, equipment, etc. to alternate care site identified.	
			24. Alternate site for medication management for MH and substance abuse patients.	
			25. Patient tracking mechanism for follow-up care.	
			26. Re-establishment of usual operations following an emergency.	

Y	N	P	PERFORMANCE TARGETS	COMMENTS
			27. Backup internal and external communication systems in the event of failure during emergency.	
			28. Alternate roles and responsibilities for personnel during emergencies, including whom they report to within the command structure.	
			29. An orientation and education program for all personnel who participate in implementing the emergency management MH plan (roles, responsibilities, how to recognize types of emergencies, information and skills required to perform assigned duties during emergencies, backup communication system, how supplies and equipment are obtained, etc.)	
			30. Plan for continuity of care for MH and Substance Abuse patients already receiving care.	
			31. Plan for augmenting MH responders to meet the MH need.	
			32. Risk communication protocols and identification of trusted community public speakers.	
			33. Reporting forms developed, i.e., program activities, expenditures, obligations, human resource utilization, volunteer services, arrangement for support needs, communication form, etc.	
			34. Plans for shelters/mass care.	
			35. Linkage with American Red Cross.	
			36. Description of drills/exercises.	

Y	N	P	PERFORMANCE TARGETS	COMMENTS
			SERVICE DELIVERY ISSUES	
			37. Plan for MH triage services and assessment.	
			38. Identification of mental health triage and assessment tools.	
			39. Credentialing plan for MH disaster providers.	
			40. Monitoring and updating of credentialed MH	

			disaster providers/ roster of volunteers.	
			41. Adequate MH and substance abuse inpatient treatment beds.	
			42. Funding mechanism for long-term mental health care.	
			43. Protocols for volunteer management.	
			44. Evacuation plans and drills.	
			45. Education and information to public on evacuation, and alternate sites of care.	
			46. Adequate psychotropic drug availability.	
			47. Drills for MH integrated with larger disaster drills.	
			48. Social services assistance plan and set-up (to include housing assistance, job assistance, financial assistance, legal assistance)	
			49. Range of MH treatment services available: crisis intervention, grief counseling, bereavement support groups, individual, family and group therapy.	
			50. Range of educational and support services: CISM, Victims Services, stress management, support groups.	
			51. Prevention and outreach MH and substance abuse services available.	
			52. Protocols for responders: ex. Rest breaks, length of shifts, stress management education, etc.	
			52. MH and substance abuse treatment, prevention, and outreach for children and adolescents.	
			53. Protocols for when to refer for counseling.	
			54. Continuity and provision of case management services and treatment for vulnerable populations	
			55. Crisis hotline	
			56. Community activities/education/information help-line for parents/families/community.	
			57. Plan and tracking for children in daycare, schools, etc.	
			58. Cultural competency for MH issues – education and information.	
			59. Multi-language educational materials (to include sign, Braille)	
			60. Interpreters at sites of care and education to communities where native speakers will be located during a disaster/terrorist event.	
			61. Services and treatment for trauma survivors/refugees	

OVERALL COMMENTS:

AREAS THAT NEED IMPROVEMENT:

DRAFT

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