Disaster Mental Health Handbook

Disaster Services

October 2012

American Red Cross

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Introduction

Welcome

Welcome to the Disaster Mental Health Handbook. This document provides the information you need to have a successful and rewarding experience as a Red Cross Disaster Mental Health (DMH) worker.

Purpose of the handbook

This Handbook presents the approved DMH interventions used to provide support both at your Red Cross chapter and on a disaster relief operation (DRO) that spans multiple affected chapters. You will use DMH interventions to support individuals, families, neighborhoods, communities and Red Cross workers across the continuum of disaster preparedness, response and recovery.

Audience

The audience for the handbook includes all DMH workers providing services, including service delivery staff, supervisors and leadership.

Terminology

In this handbook, the terms client and survivor refer only to community members affected by disaster. Other Red Cross workers are referred to as disaster responders, staff or workers. DRO headquarters refers to the Red Cross response headquarters, whether at a chapter office or at a separate facility set up for a larger DRO.

In this handbook

The Disaster Mental Health Handbook is organized into six chapters and four appendices:

How to use this handbook

This handbook is your primary source for providing DMH services during Red Cross disaster operations. It is the foundation for Red Cross DMH training. The following table includes tips for how you can make the best use of the handbook:

Feature	Description
Online use	Read and review this handbook online to ensure you have the latest information, to conserve resources and to allow full access to hyperlinked resources. You will find an electronic version of the handbook with other Disaster Services guidance on the Red Cross intranet.
Links	Hyperlinks in this handbook will take you to the tools and resources appendix. From there, you can link to the online resources you will need to complete DMH tasks. Please contact the DMH staff at national headquarters to report problems with links in this handbook.
DMH management responsibilities	This handbook provides general guidance for all DMH workers and specific guidance for individuals supervising DMH workers and providing leadership to DMH on a disaster response.
Requirements	You will find sections in the handbook with the label *Requirement*. Requirements identify a procedure or result that is: • Required by a Red Cross policy; • Based on our principles; • Vital to keeping our commitments to our five constituents: clients, donors, partners, Red Cross workers and the public. Please note all the requirements in the handbook and follow the directions carefully. If you have a question or cannot carry out a requirement, you should ask for help from your supervisor or other Disaster Mental Health leadership.

Chapter 1: Scope of Disaster Mental Health Services

Chapter Overview

Introduction

In this chapter, the unique nature of disaster mental health services will be described. You will also find information about the mission and values that guide our work and a discussion of ethics, worker competencies and other guidance that form the foundation of the DMH activity.

In this chapter

This chapter contains the following topics:

DMH Mission, Values, Ethics and Assumptions

Mission of DMH

The mission of DMH is to respond to the psychosocial needs of people affected by disaster, including Red Cross disaster workers, across the continuum of disaster preparedness, response and recovery.

Values guiding DMH services

DMH values are consistent with those espoused by the professions of the DMH-eligible disciplines and the Fundamental Principles of the International Red Cross and Red Crescent Movement. In general, the professional values include but are not limited to:

- Dignity and worth of the person;
- Importance of human relationships;
- Integrity;
- Competence;
- Privacy and confidentiality.

As a DMH worker, you must understand and accept the fundamental principles, including those of impartiality and neutrality, when delivering Red Cross DMH services, since these are not generally found in professional codes of ethics.

Ethics guiding DMH services

All DMH workers are licensed or certified professionals bound by professional codes of ethics that establish standards of practice for the profession. Typically, practice standards establish the following requirements:

- Practice in a manner that is in the best interest of the public.
- Provide only those services deemed necessary.
- Practice only within the competency areas of the practitioner's education and/or experience, maintaining the limitations established by licensure or certification.
- Maintain a confidential client-practitioner relationship.
- Disclose client information to others only with written consent of the client on a strict business-need-to-know basis.
- Refrain from engaging in dual relationships with clients.

Assumptions of DMH services

DMH services are based on the assumption that many people are resilient. However, a significant minority are at risk of developing a new or aggravated clinical disorder. DMH services should alleviate immediate emotional distress and mitigate long-term consequences. Most individuals and families function adequately during and after a disaster, but their effectiveness in daily activities may be diminished.

DMH services should augment the community's mental health resources, not replace them. Your clients will be individuals, families, neighborhoods, community groups and other Red Cross disaster responders who are experiencing stress related to the impact of the disaster.

During a disaster response, DMH interventions are short-term and can range from as little as 10 minutes of support to a much longer period. You will likely engage with a client once or twice, but generally no more than three times. The most effective contact will often involve problem solving and task-centered activities to address basic needs and the reduction of stress. The sections on enhanced psychological first aid and crisis intervention in Appendix A discuss these ideas in more depth.

DMH Eligibility and Competencies

Introduction

To work as a Red Cross DMH responder, you must meet both professional eligibility requirements and competencies for the position that you are assigned to. This section describes those eligibility requirements and competencies.

Requirement: Eligibility: who can be a DMH worker?

Each Red Cross DMH worker must hold an active, unencumbered license or certification to practice independently without onsite supervision in the state in which he or she lives. The licensing of mental health professionals is determined by individual states or U.S. territories whose regulations must be followed by the Red Cross. There is no distinction made among types of mental health educational degrees. You could be a clinical social worker; licensed professional counselor; marriage, child or family counselor; psychiatric nurse; psychiatrist; clinical or counseling psychologist; or school counselor or school psychologist.

NOTE: A state certification is allowable as noted in criteria *b* shown below.

In addition to the requirements above, the individual must:

a. Have an independent license (license to practice without supervision) and master's degree as a clinical social worker, psychologist, professional counselor, marriage and family therapist, psychiatric nurse, or psychiatrist , or
b. Have a state license or state certification and master's degree as a school psychologist or school counselor issued by a state board of education. (This is an expansion to the DMH eligibility requirements cited in 2008.), or
c. Have a state license and a bachelor's degree (BSN) as a registered nurse and American Nurses Credentialing Center (ANCC) certification for psychiatric and mental health nursing to include RN-BC or PMHNP-BC or PMHCNS-BC.

Exception: An individual enrolled in the DMH program prior to June, 2010 who does not meet these new educational requirements and clarified eligibility criteria (independent licensure or nurse certification) can continue to work in the DMH activity given good standing with his/her chapter and a positive performance history while working on local and/or national relief.

DMH competencies

You will find the competencies for each DMH position in the position requirements posted on the Red Cross intranet.

This information will support your advance in responsibility and leadership within the Red Cross organizational structure. These competencies include training and experience in:

- Leadership and team building;
- Cost analysis and service delivery planning;
- Relationships;
- Complex problem solving;
- Technical and systems knowledge.

DMH professionals are expected to work within their areas of competence when serving the American Red Cross.

Informed Consent in DMH Settings

Introduction

Informed consent requirements in the DMH setting are different from requirements in traditional mental health settings. Follow these guidelines regarding informed consent in your DMH work.

Informed consent

In non-disaster settings, mental health professionals are required to obtain informed consent before working with clients. However, in a disaster setting, Red Cross DMH workers are not expected to present a formal written informed consent policy before providing short-term support. Additionally, where an informed consent policy might convey the beginning of a traditional therapist/client relationship, your DMH support is brief and does not allow for formal mental health assessment or treatment.

Nonetheless, it is important to inform the client that you are a disaster mental health worker when you begin a clinical intervention (described in detail in Appendix A). You can identify yourself generically as a disaster mental health worker or disaster counselor, or you can reference your professional discipline as a licensed psychologist, school counselor, etc. However, you should not identify yourself by using your professional title (e.g., “doctor”). Each community and disaster circumstance is different, and you should identify yourself in a way that is clear for each client and conveys that you will only be providing short-term support. For example, in some communities, it might be more effective to identify yourself as a “licensed social worker with the Red Cross team” than as a “disaster mental health worker.”

As you identify yourself to your team members, remember to do so with a collaborative tone, keeping in mind that the approved DMH interventions are the same regardless of the professional discipline and licensure.

Overview of Red Cross DMH Services

Introduction

All disaster relief operations begin and end at the local level. Depending on the size and scope of the disaster, staff from regional, state or national levels may participate in the relief operation. If the disaster exceeds the ability of the affected chapter, human resources and material support will be mobilized from beyond the chapter's jurisdiction. DMH services are offered on all disaster relief operations as well as during the preparedness and recovery phases.

What does DMH do?

DMH workers respond to the emotional needs of people affected by disaster. This includes members of the affected community as well as other Red Cross workers experiencing the stress of disaster response.

Using professional knowledge and skills, DMH workers provide approved disaster mental health interventions that focus on basic care, support and comfort of individuals experiencing disaster-related stress.

Professionals acting within the scope of their licenses provide DMH services; these interventions should supplement, not supplant existing community mental health services. Services address disaster-aggravated or disaster-caused mental health needs and are offered during all phases of disaster, including preparedness, response and recovery.

DMH work is divided into mission-critical and mission-noncritical tasks. The first mission-critical task is to promote worker care (for self and others). Maintaining the priority of the mission-critical tasks is essential for the success of the relief operation. (See Chapter 3: Disaster Response for a complete discussion of the DMH mission-critical task list).

Services to individuals, families, neighborhoods and communities

Disasters vary in size and scope and may affect single or multiple family dwellings, neighborhoods, communities, states, regions or the nation as a whole. Red Cross DMH workers also help communities mitigate the effects of disasters by providing family, neighborhood and community preparedness and resilience training.

DMH services include:

- Identifying mental health needs through individual psychological triage and mental health surveillance;
- Promoting of resilience and coping, including enhanced psychological first aid (EPFA), individual psychoeducation, community level support and community resilience training;
- Providing targeted disaster mental health interventions, including secondary assessment and referrals, crisis intervention, casualty support and advocacy.

You will find complete descriptions of these services in Appendix A.

DMH services to other Red Cross workers

Disaster responders encounter considerable stress as they provide services to individuals affected by a disaster, and you may provide services to disaster responders before, during and/or after the relief operation. DMH workers use force health protection strategies to help other Red Cross responders manage stress

through education, individual or group contacts, surveillance of stressors within the environment and consultation with disaster relief leadership.

Keep in mind that while stress reactions may occur among disaster responders, compassion satisfaction is another common outcome of participation in disaster work. The personal satisfaction of helping people affected by a disaster can moderate the level of stress experienced by our disaster responders. In fact, disaster responders report that their disaster assignments sometimes result in positive life-changing experiences.

Unique Aspects of DMH work

Introduction

Providing mental health services during a disaster is challenging for many reasons. There are important differences between your day-to-day work as a mental health professional and the delivery of mental health services during a disaster. This section highlights some of these differences.

Differences between DMH setting and traditional mental health setting

Aspect	Typical mental health setting	DMH setting
Worksite	A designated space is available with a desk, computer and appointment scheduling.	Takes place in service delivery locations such as shelters, feeding sites and emergency aid stations, where desks, computers and administrative resources are unavailable.
Teamwork	Mental health professionals frequently work alone.	DMH workers may deliver services as part of an outreach team or integrated care team (ICT) with other Red Cross workers from Health Services, Client Casework and Disaster Spiritual Care. They may work in kitchens or with mass care responders in shelters or bulk distribution sites.
Initiation	Often the client voluntarily comes to the mental health professional for services.	The DMH worker usually initiates contacts with clients.
Relationship	The relationship between client and mental health professional has formal parameters.	Relationships between DMH workers and clients are professional, although formal parameters may not be apparent.
Duration	Most mental health services are time-limited but there is the ability to extend services until goals are met.	Interventions are short term; many services are delivered in one face-to-face contact with generally no more than three contacts. Longer-term services are provided through referral to existing community resources.
Methodology	Counseling and psychotherapy are often client-centered, where the mental health practitioner engages in reflection with the client.	DMH workers are more directive with clients in the disaster situation in an effort to provide approved interventions that lead to disaster recovery.
Nature of interventions	Interventions typically focus on emotional states.	DMH work is task-centered and focuses first on meeting clients' urgent needs rather than a primary focus on emotional states.

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Differences between DMH setting and traditional mental health setting (Continued)

Scheduling	Sessions with clients are typically prearranged.	Interventions are more likely to be spontaneous and involve outreach efforts in neighborhoods and communities.
Accessibility	Clients are typically easy to locate, since the mental health professional has information about the client's address, phone number, etc.	Clients and family members can be difficult to track as housing situations change in the aftermath of a disaster; clients leave shelters for other housing arrangements without providing forwarding or locating information.
Responsibility	Mental health professionals usually have primary clinical responsibility for the welfare of their clients.	Red Cross workers supplement and provide secondary assistance to disaster-affected clients.

Chapter 2: Chapter Services

Chapter Overview

Introduction

All Red Cross activities including DMH start with local chapters that serve the community. There are many opportunities to further your involvement in DMH and other activities in your local chapter. This section provides information about DMH services in chapters.

In this chapter

This chapter contains the following topics:

Activities in Chapters

Introduction

This section describes the many ways in which you can provide DMH services at your chapter. In general, the range of response interventions used by DMH workers is the same on a large relief operation as in a chapter. However, as you will learn, chapter involvement also offers unique opportunities for participation.

Disaster action response teams

A chapter's disaster action team (DAT) is charged with the initial response for most, if not all, disaster events. Each DAT is responsible for providing emergency food, clothing and shelter to victims of disaster. DATs also support emergency workers, usually through canteening services, during emergency situations. Additional disaster services may be available depending on verified, disaster-caused needs. All disaster assistance provided by the Red Cross is free.

DMH members can best participate as full members of the DAT, providing emergency assistance (e.g., mass care or client casework) in addition to mental health support. If your chapter does not currently include DMH members on the DAT, you may work with emergency services leadership to increase DMH involvement.

DMH workers may provide these mental health services on a DAT:

- Assessing and meeting the mental health needs of people affected by disaster and other Red Cross workers according to the DMH intervention standards;
- Making appropriate referrals to resources within the community as needed;
- Inquiring about known or potential mental health issues among individuals who may be relocated because of the disaster;
- Recommending housing arrangements for people displaced by the disaster if needed for mental health reasons;
- Assessing and informing the DMH chapter lead, the emergency services director or the DAT captain of the need for additional DMH support;
- Cooperating and coordinating with community mental health resources when necessary.

Staff mental health in chapters

DMH can assist with volunteers and staff before, during and after a disaster response in the following ways:

- Be available at all times to act as consultants to other disaster activities and to meet with disaster staff about mental health issues.
- Provide information and guidance to other disaster activities about stressors associated with the chapter's disaster responses and effective methods of coping with the stressors.
- Provide psychological first aid (PFA) training and other psychoeducation such as force health protection strategies for team members.
- Assess the level of stress experienced by disaster workers at all sites throughout the chapter's disaster response.
- Offer ongoing support to all workers, intervening as needed with individuals and groups to minimize the potentially harmful or excessive stress, and facilitate emotional well-being.
- Serve as a resource to the chapter's leadership on organizational development issues such as promoting effective group process and conflict resolution strategies.
- Inform the emergency services or disaster director of all mental health trends that

seem to affect the general mental health of workers.

Note: The Red Cross employee assistance program is responsible for the ongoing mental health of chapter employees.

Support workers preparing to deploy or returning from disaster operations

A critical task of DMH is to both prepare responders to cope with disaster response stress and provide post-deployment support after responders return home. Support should be coordinated with the chapter Health Reviewer and can include consultation on mental health issues or medications documented on the responder's Health Record. Read specific procedures for pre- and post-deployment support in the chapter on Staff Mental Health Services.

Wellness checks

DMH chapter workers can provide wellness checks for responders, individuals or families affected by disaster during the weeks following the disaster.

Integrated care teams

When a death occurs because of a disaster, an integrated care team (ICT) might be developed to arrange a visit (sometimes called a condolence call) with the family and friends of the deceased. As a DMH worker, you may participate on an ICT in your local chapter along with Health Services (HS) and Client Casework workers. Spiritual care partners may also be asked to become involved in an ICT.

Training by DMH responders

As a DMH responder, you can volunteer to teach the following two courses to all chapter responders and partner organizations:

- "Psychological First Aid: Helping Others in Times of Stress"
- "Mitigating Disaster Worker Risk: Force Health Protection Strategies"

You may also teach the "Foundations of Disaster Mental Health" course to prospective DMH responders.

If you have experience as a professional educator, talk to your chapter about taking a self-study class to become an instructor.

Training with other disaster activities

You may increase your capacity to provide support on a relief operation by attending training offered by other disaster activities. These training options include those offered by Client Casework, Sheltering, Feeding, Public Affairs, and the chapter's DAT.

Activities with Other Departments

Working with other departments

During times of non-disaster, you can support your chapter by using your mental health expertise in other departments (for example, Service to the Armed Forces and youth programs). The following are some possible avenues for collaboration.

Community disaster preparedness

DMH workers may work with chapter staff to prepare the public for a disaster by:

- Giving presentations to community groups on creating family disaster preparedness plans or community resilience;
- Developing and distributing disaster preparedness literature and information about the impact of disasters on emotional well-being and mental health;
- Offering to teach the "Coping in Today's World" course to increase community resilience and preparedness. Read more about Coping in Today's World in Appendix A.

Service to the Armed Forces

Service to the Armed Forces (SAF) provides emergency communication and support to service members and their families separated during a deployment. DMH workers may be asked to collaborate with SAF staff by:

- Providing support to the families facing an emergency when the service member is deployed;
- Participating in pre-deployment briefings;
- Teaching specialized training courses (e.g., "Coping with Deployment" or "Reconnection" workshops);
- Providing support for families whose service member is returning home;
- Providing services to injured service members and their families in some Veterans Administration hospital settings.

Other possibilities

You should work with DMH and emergency services leadership to learn about Red Cross participation or leadership in programs for youth, seniors and families at risk. You and other DMH volunteers are valuable assets for a chapter's full range of services when you have the time and energy to participate.

Chapter 3: Disaster Response

Chapter Overview

Introduction

In this chapter, you will learn about the DMH mission-critical tasks and elements of the disaster mental health response, including the approved disaster mental health interventions.

In this chapter

This chapter contains the following topics:

Section 1: Mission Critical Tasks

Introduction

To provide effective services, it is essential that you maintain an optimal level of mental health with minimal stress. Determining which tasks are most critical and which can be delayed will reduce stress and maximize your response capabilities. This section will guide you in prioritizing mission-critical work and maintaining realistic work expectations.

Mission-critical tasks

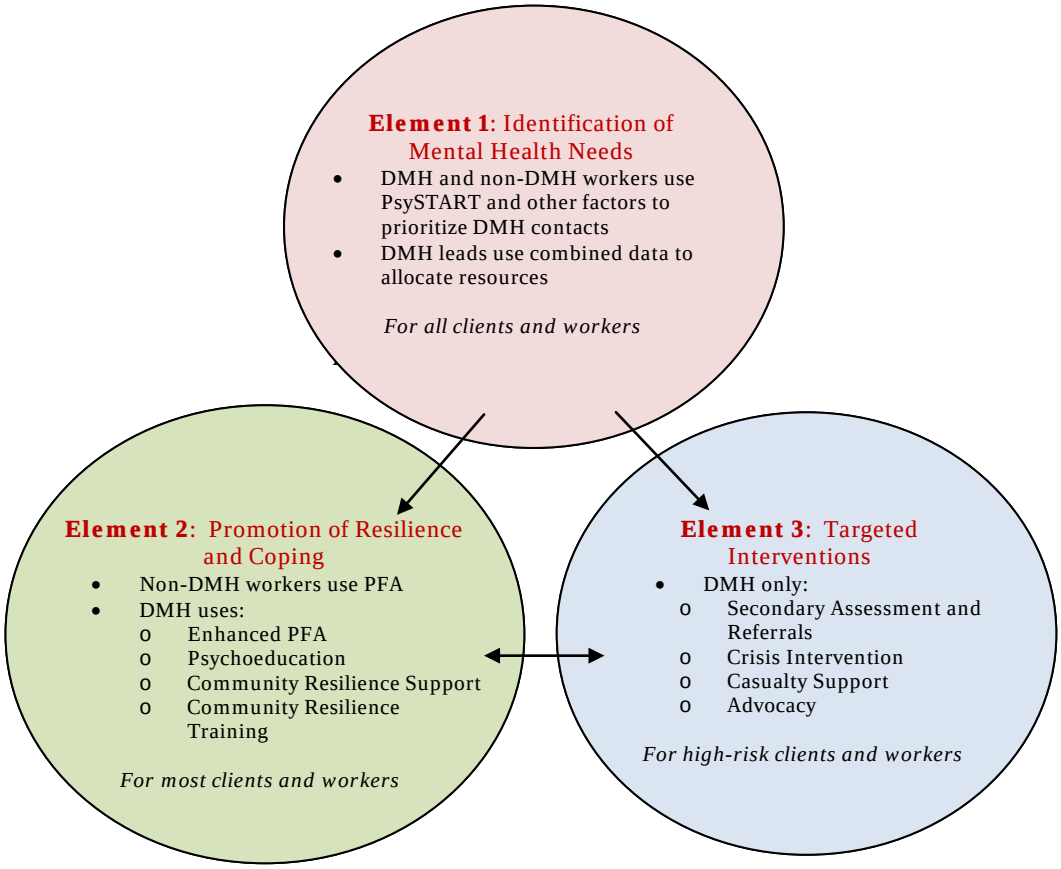
You should prioritize your work in accordance with the DMH mission-critical tasks listed below (Yin & Kukor, 2010) and discussed in detail in other sections of this handbook.

- Promote worker care (self and others) as the first priority. In a disaster response, failing to put worker care first often leads to neglecting it altogether. A strong and healthy work force provides and sustains the highest quality services.
- Prioritize clients with acute needs and at greatest risk. Use the PsySTART Mental Health Triage System and mental health surveillance tools to provide support first to individuals at greatest risk.
- Set realistic expectations. Consider these factors when setting your expectations:
  - Recognize that PFA-trained Red Cross workers are a "force multiplier;" you do not need to provide support to every client who is tearful or experiencing stress.
  - Anticipate that worker assignments and service delivery plans will change frequently.
- Stay in contact with your team and stay safe. Attend all worker briefings and follow all safety precautions and guidelines.
- Practice within the DMH activity guidance. The approved DMH interventions are evidenced-informed strategies that are consistent with your Red Cross training and appropriate to the disaster relief environment. Do not engage in critical incident stress debriefings, psychotherapy or other non-approved interventions. (See Approved Interventions in the next section.)
- Adhere to your professional code of ethics and the code of conduct of the Red Cross. As a licensed mental health professional, your work must comply with the standards and codes set forth by your professional licensing board. Your work must fall within your scope of practice. You must adhere to the Red Cross Code of Business Ethics and Conduct and understand the unique ethical challenges faced in disaster relief settings.

Section 2: Introduction to the Elements of the Disaster Mental Health Response

Using the elements of disaster mental health response

The elements of the disaster mental health response form a continuum of services from identifying mental health needs (individual triage and mental health surveillance: element 1) to providing clinical interventions appropriate to clients and workers in the disaster setting (promoting resilience and coping and providing targeted interventions, elements 2 and 3, respectively). In practice, these elements are fluid. In a single encounter, you might practice several elements at the same time or move from one element to another without intermediate steps. Although these services are most often offered during a disaster response, some will also be offered during preparedness and recovery phases as well.



Elements of the DMH response

The table on the next page describes the elements of a DMH response. For more detailed information on each element, see the sections in Appendix A linked to the element titles below.

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Elements of the DMH response (Continued)

Number	Element	Description
1	Identification of mental health needs	When providing DMH services, it is important to identify mental health needs and prioritize clients and responders at greatest risk. This section introduces strategies to use limited time and energy effectively through individual psychological triage and mental health surveillance of community needs.
2	Promotion of resilience and coping	As the second element in the continuum of disaster mental health services, you will be assisting clients and other Red Cross workers to cope effectively with the stress related to the disaster. You will learn how to use your clinical skills to go beyond the basic PFA actions and provide EPFA. Other interventions aimed at promoting resilience and coping include psychoeducation, community level support and community resilience training.
3	Targeted interventions	In this section, you will find the interventions that are frequently used for high-risk clients and those who need extra support, specifically secondary assessments, referrals, crisis intervention, casualty support and advocacy. Please note that the first two elements (triage/mental health surveillance and promoting resilience and coping skills) also contain guidance that is relevant to serving higher-risk clients.

Approved interventions

The only interventions approved for Red Cross DMH are those specifically listed in this section:

Element #1: Identification of Mental Health Needs:
- Individual psychological triage
- Mental health surveillance

Element #2: Promotion of Resilience and Coping:
- EPFA
- Psychoeducation
- Community resilience support
- Community resilience training

Element #3: Targeted Interventions :
- Secondary assessment
- Referrals
- Crisis intervention
- Casualty support
- Advocacy

Appendix A lists, defines and discusses all approved interventions. No other types of interventions (play therapy, critical incident stress debriefing (CISD) or eye movement desensitization reprocessing (EMDR), for example) may be conducted during a disaster response. Red Cross DMH workers may not provide any intervention that is not approved.

Section 3: Service Delivery Settings

Introduction

The basic elements of DMH services remain the same in all disaster service delivery settings. You will observe and triage to identify mental health needs, promote resilience and coping wherever possible, and conduct clinical interventions for higher-risk clients. Chapter 3, Section 2 and Appendix A provide more details on approved DMH interventions. However, the features of each setting present unique challenges and specific stressors that DMH workers need to be aware of to provide the most effective services possible. Included in each section is a list of suggested DMH practices for each setting.

In this section

This section contains the following topics:

Shelters

Description of shelters

When community members need to evacuate their homes because of dangerous or threatening conditions, the Red Cross and other agencies open shelters to house individuals and families on a temporary basis. Each Red Cross shelter should have both Health Services (HS) and DMH workers either onsite or immediately available by phone when opening its doors. Shelters are meant to be short-term accommodations for those affected until they can be housed either in their own homes or in other types of housing.

Shelters are microcosms of the community itself, with similar diversity in age, ethnicity, lifestyle and socioeconomic status. As such, they can be loud, chaotic and difficult as individuals and families bring their habits, belongings, attitudes and stress into the shelter environment. Generally, each individual is assigned a cot and keeps his or her belongings under that cot. Meals are served communally, and showers and bathrooms are shared. There is often a play area set up for children and a quiet area for individuals who may need it.

Unique features of shelters

The unique features of shelters that affect DMH service delivery include:

- Environmental stressors, such as noise, crowded conditions, smells and chaos;
- Challenges for clients, including the stress of being displaced from their homes, family conflict and the difficulties associated with beginning to recover from the disaster emotionally and financially;
- Functional and access needs and other potential difficulties of many community members living in close temporary quarters;
- Lack of adequate local support systems for shelter residents.

DMH practices in shelters

DMH practices at shelters include:

- EPFA for both staff and clients;
- Individual psychological triage and mental health surveillance of the shelter community;
- Crisis intervention strategies, casualty support, psychoeducation and advocacy;
- Education of staff regarding functional and access needs.

Additional roles for DMH workers may include:

- Making provisions for childcare or play areas;
- Finding quiet areas for distressed individuals;
- Supporting clients as they transition to other housing and arrange for long-term recovery;
- Identifying respite areas for staff to alleviate stress that may arise from assignment to a shelter with a significant number of residents who are struggling to cope;
- Performing other duties as requested, including general shelter tasks.

Functional and access needs of shelter clients

The Red Cross provides services to clients in shelters with functional and access needs including people with visual, hearing and cognitive impairments; mental illnesses; mobility restrictions; and other types of disabilities and needs.

Some clients cannot be safely accommodated in a Red Cross shelter and a referral to community resources should be considered for people with the following conditions:

- Needing continuous medical supervision
- Needing acute, life-sustaining medical care
- In danger to themselves or others

In December 2010, the Red Cross issued Functional Needs Support Services guidance to clarify how DMH and HS may assist shelter staff to identify and address client needs. A guiding principle for all services is to include the client in discussions about their needs and the various ways in which those needs could be met. Respect the client's request for the necessary accommodations to preserve his or her independence, dignity and previous level of functioning. An example of how DMH may be helpful in this process is consultation with shelter management to create "stress-relief zones" where people with certain disabilities can be free of the noise and the crowds typical in most shelters.

In Appendix B, you will find more information about vulnerable populations, including persons with disabilities that may be useful as you consider serving clients with functional and access needs. Additional information can be found in the Functional Needs Support Services FAQ and the Serving People with Disabilities and People with Functional and/or Access Needs in Red Cross Shelters Connection.

Shelter initial intake and assessment tools

When assigned to work at a shelter as your worksite, you should be available during the shelter registration process to assist in assessing client needs and appropriate placement in the shelter. DMH collaborates with HS to identify possible mental illness or cognitive impairment issues.

Shelter registration workers complete the Initial Intake and Assessment Tool at entry into the shelter or as soon as possible for each individual or family unit. The assessment tool consists of several questions for the families and observations of incoming clients. This tool allows Red Cross workers to determine whether individuals may be safely accommodated in the general population shelter and to clarify how functional and access needs may be met within the shelter or by referral. In cases where follow-up is needed, the family or individual is referred to HS or DMH to complete the assessment.

Unaccompanied minors arriving at shelters

If possible, Red Cross should designate licensed volunteer or paid staff (e.g., health or mental health professionals) to supervise unaccompanied minors until the minors are transferred to the custody of state or local authorities. If no licensed volunteer or paid staff is available to provide such assistance, an established chapter or Disaster Services Human Resources (DSHR) volunteer or paid staff member should supervise the minor. If possible, there should be at least two adults present with an unaccompanied minor, and the minor should not be left alone or with other unaccompanied minors without adult supervision. Staff members providing supervision must have passed a background check.

DMH services in non–Red Cross shelters

You may be called on to provide support in shelters that are managed by community partners. In these cases, you will receive onsite supervision from partner shelter managers, but will still receive technical guidance and support from the Red Cross DMH supervisor or manager assigned to that area.

Mobile and Fixed Feeding Sites

Description of mobile and fixed feeding sites

Mobile feeding involves a Red Cross emergency response vehicle (ERV) traveling through the affected area to bring meals to community members who are unable to travel or who are working to clean up and rebuild their homes. DMH workers may follow the ERVs in a separate car or may be stationed on the ERV itself. ERVs might also be stationed as fixed feeding sites near rescue and recovery sites to feed first responders and other disaster workers.

Unique features of mobile and fixed feeding sites

The unique features of mobile and fixed feeding sites that affect DMH service delivery include:

- Traveling in unfamiliar areas, often exposed to community devastation;
- Needing to work independently, with off-site supervision;
- Being exposed to community trauma, grief and loss;
- Working in a team setting with Mass Care workers.

DMH practices at mobile and fixed feeding sites

Appropriate DMH practices at mobile and fixed feeding sites include:

- Monitoring and assessment of the psychological needs of the community;
- Monitoring and assessment of the stress levels of the ERV staff;
- Providing EPFA for community and staff;
- Facilitating force health protection strategies for staff.

Description of kitchens

When it is necessary to feed large groups of people at shelters, service sites and other centers, the Red Cross opens kitchens, often with the Southern Baptist Missionary Board, to prepare meals to be distributed at specified times throughout the day. These kitchen tasks need to be performed both quickly and carefully to meet sanitation standards.

Unique features of kitchens

The unique features of kitchens that affect DMH service delivery include:

- Environmental stressors, such as heat, smells and other conditions associated with food preparation;
- The need to participate in nontraditional DMH tasks, such as assisting in food preparation or on loading trucks;
- A team setting with Mass Care workers.

DMH practices at kitchens

Appropriate DMH practices in kitchens include:

- Participating in morning and evening operational briefings;
- Assessing levels of staff stress;
- Assessing community mental health needs;
- Educating staff regarding stress reduction strategies;
- Obtaining information on client needs identified by ERV drivers;
- Identifying feeding routes where DMH workers should be assigned.
- Applying other approved DMH interventions, such as EPFA and force health protection strategies.

Service Centers, Emergency Aid Stations and Bulk Distribution Sites

Description of Red Cross service centers

Service centers are sites for clients to receive information regarding availability of resources. They are opened by the Red Cross or by other agencies, such as the Federal Emergency Management Agency (FEMA), near a disaster-affected area to provide casework or other individual assistance for the immediate needs of disaster survivors. Other federal, local or nongovernment agencies may also be present to provide assistance.

Unique features of service centers for DMH

The unique features of service centers that affect DMH service delivery include:

- Stressors related to administrative procedures involved in applying for and/or receiving limited assistance;
- Crowded conditions, noise, long lines, lack of child care;
- Confusing messages related to process and available resources.

DMH practices at service centers

Appropriate DMH practices at service centers include:

- Assessment of individual psychological needs on the basis of PsySTART risk factors and current conditions;
- Consultation with service center management regarding optimizing the conditions at the center to reduce or alleviate stress, including clarifying current resource availability and effective procedures to obtain assistance;
- EPFA and other approved interventions for both clients and workers.

Description of emergency aid stations

Emergency aid stations are usually ERVs or other trucks that are set up in disaster areas to provide basic supplies, such as cleanup kits, and to assess for immediate physical and mental health needs. Mass Care is on hand to provide supplies and feeding. Generally, basic medical services will be provided by an HS worker. A DMH worker will provide consultation, psychoeducation, EPFA and other interventions.

Unique features of emergency aid stations

The unique features of emergency aid stations that affect DMH service delivery include:

- Environmental stressors, such as heat or cold, proximity to areas of destruction and difficulty accessing toilets and food;
- The need to work independently with off-site supervision;
- The risk of secondary traumatization due to exposure to client experiences;
- A team setting with Mass Care and/or Health Services workers.

DMH practices at emergency aid stations

Appropriate DMH practices at an emergency aid station include:

- Assessment of individual psychological needs on the basis of PsySTART risk factors and current conditions;
- EPFA;
- Psychoeducation;
- Assessment of community resilience factors;
- Monitoring and supporting staff by using force health protection strategies.

Description of bulk distribution

Bulk distribution involves the disbursement of basic supplies to the affected neighborhood or community, such as sanitation items, clothes, infant and toddler supplies, cleanup kits, building supplies and other items that may be needed in that particular disaster. These supplies can be distributed by a crew in a roving ERV or box truck or at a fixed distribution site.

Unique features of bulk distribution

The unique features of bulk distribution that affect DMH service delivery include:

- Nontraditional DMH tasks such as loading trucks and distributing goods to community members;
- Environmental stressors, such as heat or cold, proximity to areas of destruction and difficulty accessing toilets and food;
- The need to work independently with off-site supervision;
- The risk of secondary traumatization due to exposure to client experiences;
- A team setting with Mass Care and/or Health Services workers.

DMH practices at bulk distribution sites

Appropriate DMH practices at an emergency aid station include :

- Assessment of individual psychological needs on the basis of PsySTART risk factors and current conditions;
- EPFA;
- Psychoeducation;
- Assessment of community resilience factors;
- Monitoring and supporting staff by using force health protection strategies.

Outreach, Home Visits and Integrated Care Teams

Description of Red Cross outreach

When it may be difficult for clients to reach service centers or if service centers are not appropriate in the event, the Red Cross may establish outreach teams that will go into neighborhoods to identify individuals and families in need of mental health, health and client casework services. An outreach team generally consists of a client caseworker and an HS or DMH worker who assesses the immediate emergency needs and physical or mental health needs.

Description of Red Cross home visits

Home visits occur when HS and DMH are notified by another activity that needs were identified for a particular family. In these cases, a team will travel directly to a client's home to assess their needs and provide support.

Description of integrated care teams

Integrated care teams (ICTs), or condolence call teams, are used to provide support to families whose loved one is seriously injured or deceased as a result of the disaster. When DMH workers are deployed to an ICT, DMH workers do not notify families of the death of their loved one, but may be asked to accompany and support workers from other agencies who are providing death notification. ICTs can consist of DMH with a HS worker, a client caseworker and a Disaster Spiritual Care worker. These teams go to hospitals, morgues or homes to provide support to individuals and families whose loved one is either deceased or very ill. If next-of-kin are not located in the area of the disaster, the ICT may facilitate a meeting of family members with HS and DMH workers from the chapter in their area.

Unique features of outreach teams, home visits and ICTs

The unique features of outreach, home visit and ICTs that affect DMH service delivery include:

- Travel in unfamiliar areas, perhaps over long distances;
- Exposure to community devastation;
- Risk of secondary traumatization due to exposure to grief, loss and destruction;
- The need to work independently with off-site supervision;
- The possibility of disruption to communication with headquarters (e.g., no cell phone or Internet reception);
- Working on a team with DSC, client caseworker and/or HS.

Appropriate DMH practices on outreach teams, home visits teams and ICTs

Appropriate DMH practices on outreach teams, home visit teams and ICTs include:

- Assessment of individual psychological needs on the basis of PsySTART risk factors and current conditions;
- EPFA for clients and workers;
- Casualty support;
- Crisis intervention;
- Secondary assessment and referral to a community agency;
- Psychoeducation.

Friends and Relative Reception Centers and Family Assistance Centers

Description of Red Cross friends and relative reception centers and family assistance centers

During a response to a mass casualty event, the Red Cross partners with government or private agencies to open reception or assistance centers for the families of victims. These centers, also known as Friends and Relatives Reception Centers (FRCs), are established to provide information and meet the immediate needs of families and friends who arrive at the scene looking for their loved ones. DMH services are critical to these centers. Depending on the severity and nature of the event, the National Transportation Safety Board (NTSB) may be the lead agency on the site. Other agencies, such as law enforcement, spiritual care services or offices that serve victims of crime may also be on scene. These situations are generally quite emotionally intense. Initially, an FRC is set up to welcome friends and families as they arrive to get information. Within a short period of time, if the event is large enough, the reception center will close and a Family Assistance Center (FAC) will open and will have expanded services for friends and relatives. Both the FRC and the FAC will be located near the disaster site. In some cases, the FRC will transition into an FAC. More information regarding the DMH role in transportation disasters is in Chapter 3, Section 4.

Unique features and DMH practices at FRCs and FACs

DMH workers play a central role in supporting FRCs and FACs that are opened after mass casualty incidents. Red Cross is specifically named as the organization that provides mental health and emotional support services in the Aviation Disaster Family Assistance Act of 1996. See Chapter 3, Section 4 for more detailed information about DMH roles and responsibilities in transportation disasters.

Unique features in this setting include:

- Risk of secondary traumatization due to exposure to loss, grief and trauma;
- A multiagency setting with different role structures than in typical natural disasters;
- A rapid trajectory for disaster response and termination.

Appropriate DMH practices in FRCs and FACs

Appropriate DMH practices in FRCs and FACs include:

- Assessment of individual psychological needs on the basis of PsySTART risk factors and current conditions;
- EPFA;
- Crisis intervention;
- Casualty support;
- Referral to community resources;
- Advocacy for both staff and survivors.

Respite Centers

Description of respite centers

In mass casualty events, emergency first responders and other disaster responders may need to work for long periods in rescue and recovery operations. To provide support to these individuals, a respite center may be opened very close to the disaster site and will contain areas for rest, food, communication with loved ones and information regarding the disaster response.

Unique features of respite centers

Features of respite centers that affect DMH service delivery include:

- A well-trained client base of disaster responders who are likely to resist psychological intervention;
- A belief that disaster responders are immune to the stress of a disaster;
- Risk of secondary traumatization for both DMH and other workers because of the proximity to site of mass casualty;
- Environmental stressors, such as chaos, temperature and possible environmental contaminants;
- A clearly defined and enforced chain of command.

DMH practices at respite centers

Appropriate DMH practices at respite centers include force health protection strategies to mitigate the stress of the work force. These strategies include:

- EPFA;
- Clear specifications of mission-critical tasks;
- Advocacy for worker self-care;
- Flexible and creative practices to alleviate stress, e.g. chair massage and humor;
- Collaboration with employee assistance programs for first responders.

Disaster Relief Operation (DRO) Headquarters

Description of DRO headquarters

When a disaster operation is established for a large disaster, a spacious site such as an empty warehouse is used to house all leadership of Red Cross activities and become the administrative hub for the disaster response. DMH leadership is housed in response headquarters. This area is where many new volunteers arrive and receive their assignments. Managers and support staff are situated here and coordinate the movement of human and material resources throughout the operation. DRO headquarters are usually very busy, sometimes quite noisy and seemingly chaotic environments where the needs of the disaster-stricken community are assessed and important decisions are made.

DMH roles and responsibilities in response headquarters

The primary DMH roles in headquarters are to coordinate DMH services with all other Red Cross activities and coordinate staff mental health coverage. DMH responders who work at the headquarters must continuously assess staff levels of stress and provide support and consultation to both individuals and to the organization. DMH at headquarters will promote the use of force health protection strategies to maintain a psychologically healthy work force and to ensure that the disaster operation run as smoothly as possible.

Some of the roles of DMH workers assigned to headquarters include the following:

Role	Responsibilities
Operations lead	Oversees the deployment and tracking of DMH workers as they in-process at relief operation headquarters and are deployed to service delivery sites; acts as the direct supervisor for DMH supervisors at service delivery sites or for DMH regional leads assigned to the affected areas.
Community liaison lead	Coordinates with local community mental health organizations, Medical Reserve Corps and other mental health partners.
Staff mental health lead	Has primary responsibility for staff mental health on the entire disaster operation, working closely with Staff Services, Staff Wellness and/or Staff Relations on personnel issues.
Administrative assistant	Coordinates in-processing, orienting and out-processing new staff; schedules community volunteers; and collects and reports PsySTART statistics and daily counts of client contacts for disaster administration.

Unique features of DRO headquarters

The features of headquarters that affect DMH service delivery include:

- Environmental stressors, such as noise, chaos and temperature;
- Distance from the site of the disaster, which could create difficultly for DMH workers who want to work directly with the affected clients;
- Bureaucratic stressors, such as confusion about the chain of command or proper authority, long wait times, paperwork and many meetings;
- Long work days;
- Conflicts or miscommunication among leadership;
- Pressure to quickly deliver services despite resource shortages.

DMH practices at DRO headquarters

Appropriate DMH practices at DRO headquarters include force health protection strategies to mitigate stress of the work force. These strategies include:

- Mental health surveillance;
- EPFA;
- Clear specifications of mission-critical tasks;
- Advocacy for worker self-care;
- Rotations of assignments and scheduling days off.

Staff/Volunteer Processing Centers

Staff/volunteer processing center

Sometimes a staff/volunteer processing center is set up separately from the headquarters. The activities of this center include reviewing worker credentials, conducting background checks and distributing site access ID badges. Workers are then sent to their various activity leads to await further instruction.

Unique features of staff/volunteer processing centers

The features of processing centers that affect DMH service delivery include the following:

- Environmental stressors, such as noise, chaos and temperature
- Long waiting times, sometimes in queues
- Bureaucratic stressors, with significant paperwork and sometimes confusion
- A sense of time pressure to provide services to people in need

DMH practices at staff/volunteer processing centers

Appropriate DMH practices at staff/volunteer processing centers include force health protection strategies to mitigate stress of the work force. These strategies include:

- EPFA;
- Advocacy for worker care;
- Individual psychoeducation;
- PFA training for incoming workers.

Section 4: Transportation Disasters

Introduction

This section provides guidance for responding to large transportation disasters covered by Federal statutes as well as smaller transportation disasters. Although there are important differences in this type of disaster from other types of disasters, the DMH intervention standards and limits are the same as those discussed in previous sections.

Each transportation disaster is unique in type, size, number of fatalities and community response. For large transportation disasters that neither involve air carriers nor Amtrak rail (e.g., bus accidents), the Red Cross can be asked to provide services similar to those outlined below. Conversely, for small transportation incidents, the local Red Cross may or may not be part of the community response. DMH should consult quickly with Operations Management (OM) to determine the planned level of response for each specific incident.

In this section

This section contains the following topics:

Memorandum of Understanding (MOU) Responsibilities for DMH

Overview of Red Cross MOUs with NTSB and Amtrak

The Aviation Disaster Family Assistance Act of 1996 and the Rail Safety Improvement Act of 2008 resulted in delegated responsibility for the Red Cross. The Memorandum of Understanding (MOU) between Red Cross and NTSB provides the details of the delegated responsibility as well as Red Cross responsibilities in other transportation events not covered by Federal acts. After large aviation and Amtrak rail disasters, the MOUs with the NTSB for airline disasters and Amtrak for train disasters outlines the general framework for the Red Cross response.

A clear understanding of the specific tasks required of Red Cross under the MOUs is important both to collaborate efficiently with the other response entities and to provide effective services to survivors, families and responders. Each transportation disaster is different, and DMH must coordinate with OM to determine whether all, some or none of the tasks outlined below will be part of the Red Cross response. An important factor in determining the tasks and service delivery sites will be the number of people directly affected by the incident.

DMH responsibilities

The responsibilities for a transportation response and the relevant activity that is expected to complete the tasks are outlined below. Language in italics is taken directly from the MOUs.

Responsibility	Primary	Secondary
Provide mental health counseling services, in coordination with the disaster response team of the domestic or foreign air carrier or Amtrak to:		
Activate local, state and national Red Cross personnel to provide crisis and grief counseling to survivors and family members of the deceased.	DMH	
At their request, provide families referrals to mental health professionals and support groups that are in the family members' local area.	DMH	
Coordinate and ensure the provision of appropriate disaster spiritual care to individuals affected through activation of relevant partner organizations.	OM ensures that DSC is available.	DMH coordinates with DSC.
Coordinate onsite child care services for families who bring young children.	OM requests	DMH advocates for child care and coordinates with child care providers.
Ensure the provision of appropriate psychological support to the staff of all responding organizations before their departure from the site.	DMH	
In coordination with NTSB and the airlines or Amtrak, initiate such actions as may be necessary to provide an environment in which families may grieve in private.		

Continued on next page

DMH responsibilities (Continued)

Provide a Red Cross representative to coordinate and manage the activities of the numerous organizations and personnel that will offer their counseling and support services to the organization.	DMH leads in close coordination with other activities.	DMH coordinates with OM, Community Partnership and other agencies.
Provide a liaison officer to the joint family support operations center to coordinate with other members of the operations center staff.	OM coordinates with the lead agency.	DMH requests adequate private space.
In coordination with the NTSB and air carrier or Amtrak, meet with the families who have traveled to the location of the accident, contact the families unable to travel to such location and contact all affected families periodically thereafter. This process will be performed until such time as the Red Cross, in consultation with the NTSB director of the Office of Transportation Disaster Assistance designated for the accident, determines that further assistance is no longer needed.	DMH coordinates with other activities (e.g., HS and DSC) and outside agencies and chapters.	NTSB director of the Office of Transportation Disaster Assistance collaborates with DMH
Arrange for a suitable memorial service(s) in consultation with the families, NTSB, the air carrier or Amtrak and appropriate local officials.	OM/DSC	DMH involved in planning and support.
Coordinate its (Red Cross) activities with the air carrier or Amtrak involved in the accident so that the resources of the carrier or Amtrak can be used to the greatest extent possible to carry out its (Red Cross) responsibilities	OM	DMH collaborates with the carrier and NTSB.
Establish a joint liaison with the air carrier or Amtrak at each supporting medical treatment facility to track the status of injured passengers and crew and provide assistance to them and their families.	HS	DMH involved in all planning and support activities.
Initiate ongoing measures to ensure that preparedness activities including training occur throughout the Red Cross to enable successful execution and completion of assigned responsibilities.	National headquarters and region/chapter disaster services directors	
Participate in drills, exercises and training activities with entities relevant to the Aviation Disaster Family Assistance Act and the Rail Safety Improvement Act.	Region/ chapter disaster services directors	DMH assists in developing and carrying out drills.

Service Delivery Sites and Tasks

DMH considerations for all sites

Service delivery sites in a transportation disaster response are usually not selected or administered by the Red Cross. Multiple response agencies are usually present at each site, and Red Cross must coordinate closely with these agencies. Service delivery sites are sometimes surrounded by a large media presence. In many cases, the media will have restricted access to protect survivors and families from intrusion.

Transportation disasters can draw a large influx of spontaneous volunteers, and the Red Cross is frequently designated as the lead agency for managing all volunteers. Some transportation disasters are also mass casualty events and the atmosphere in and around service delivery sites can feel overwhelming to family members.

It is important for DMH to provide low key and unobtrusive services by letting people know that DMH support is available, while being careful not to hover or be intrusive to private moments and conversations.

At service delivery sites, it is important for DMH to coordinate service delivery with OM, Health Services, DSC, Community Partnerships and other Red Cross workers.

If a criminal act is suspected, a crime scene perimeter and heightened security may be present. In these situations, local law enforcement or the FBI is usually the lead agency at the crash sites and other sites where information about the disaster is being gathered and disseminated.

In the event of a community mass casualty or terrorist event, the framework of our disaster response partnership with the law enforcement agency and the issues we encounter would be similar to those described in this section.

Short descriptions of each service delivery site follow, along with the DMH tasks relevant to that site.

Friends and Relatives Reception Center (FRC)

The FRC is a short-term multiagency setting designed to secure, protect and support friends and relatives while providing and obtaining information about their loved ones. The FRC can open within hours of the incident and can be led by any number of agencies including local law enforcement, the transportation carrier, NTSB, the FBI Office of Victims Assistance or the Red Cross.

Large numbers of people may congregate at an FRC to find out whether their loved one was involved in the incident or to find out more information about the crash. Authorities may provide the following information, if available:

- Confirmation that their family member was involved in the incident.
- Information about the number of survivors and injured.
- The location of the medical facility where their family member was taken for treatment.
- Guidance regarding the next steps in the process of identification or reunification.

DMH tasks include being available to provide support during all hours of FRC operation, especially at family briefings where family members receive important but difficult information about the investigation and body recovery and identification efforts. A consistent presence of the same workers allows family and friends to

develop a trust in DMH workers and allows DMH workers to be well-informed and prepared for questions and conversations with friends and family members. Be careful not to under- or over-staff with DMH workers. DMH workers should identify private spaces to provide support to family members and workers, although much of the support you will give will be "in the moment" and happen in public places where DMH has a presence. The FRC tasks described above can also be conducted at a Family Assistance Center (FAC), which is described in the next section.

Family Assistance Center (FAC)

An FAC is a multiagency site where family members of confirmed survivors and victims can receive additional assistance and support (although, family members of unconfirmed passengers may also show up at an FAC). In many cases, the FRC transitions quickly into an FAC. All of the tasks and activities described in the FRC may take place at the FAC, with the primary difference being that services are targeted only to confirmed family members. Additional assistance to family members can include resource referrals, financial assistance for family member travel and funeral expenses, information about the incident and emotional support. DMH workers should collaborate with Health Services workers and Disaster Spiritual Care workers to avoid unnecessary or duplicative outreach or support to family members.

Transportation hubs

Local Red Cross DMH workers may be asked to provide support to distressed families who are waiting for information about their loved ones at departing and receiving transportation hubs, both in state and out of state from the crash site. DMH should collaborate with OM to ensure that communications with family members are coordinated across all chapters and to designate a single Red Cross point of contact, where possible, to reach out to each family member. DMH workers providing support at transportation hubs are required to coordinate services with personnel from the transportation hub and with carriers. Ideally they will have engaged in planning and drills in advance of the disaster.

Incident/crash site

A secure perimeter with limited access is usually established around the disaster incident or crash site. This site can draw large numbers of people from the general public as well as family members of the survivors and victims. Spontaneous memorials are common and can draw large crowds. Although DMH workers can be assigned to provide support at these sites, more frequently, DMH workers (and DSC workers) are assigned to escort groups of family members as they travel to visit the crash site. As described above, it is critical that DMH offer comfort in a quiet and unobtrusive manner—letting family members know that DMH support is available, but not hovering or intruding on family members' quiet or private moments.

Memorial services

Memorial services are important times for family members, responders and community members to process the tragic events of the disaster. They also provide an opportunity for people to offer and seek support from others. DSC workers collaborate with the families, community leaders, the NTSB and the carrier to plan and convene a culturally appropriate interfaith memorial service. After large incidents, an events manager (part of OM) will lead the planning. DMH should be involved in the planning for the memorial service and should be available as escorts before, during and after the service to provide support to workers and family members as needed.

Morgue	Family members sometimes travel to the morgue to identify or visit the remains of their loved ones. Red Cross may also be requested to provide canteen services for the morgue workers. This is a good location for DMH support. The environment at the morgue can be difficult and emotionally charged for workers and family members. DSC and DMH workers can be assigned to provide support either inside or at the perimeter of a morgue, and special efforts should be taken to screen and rotate workers for this assignment. (See Chapter 4 for staff mental health considerations relevant to all sites.)
Staff/volunteer processing center	Red Cross can be assigned the task of administering a staff processing center for incoming staff and volunteers deployed from multiple agencies. Depending on the size of the disaster, the processing center could be separate from other service delivery sites. The center's activities include reviewing worker credentials, conducting background checks and distributing site access ID badges. It is critical for DMH members to be quickly and appropriately credentialed, so that they can have the necessary access to family members and workers. OM and Staff Services, with support from DMH, establish a process for managing, and sometimes turning away, large numbers of spontaneous volunteers. The DMH tasks are similar to tasks in a large headquarters and will include coordinating with community mental health agencies and other Red Cross workers, as well as screening and assigning spontaneous mental health volunteers. DMH also provides support, psychoeducation and PFA training to all workers and incoming/out-processing volunteers at this site.

Staff Mental Health in Transportation Disasters

Importance of staff mental health in transportation disasters

Providing high-quality disaster services after a transportation disaster requires first promoting and protecting the mental health of the responders. The MOUs with NTSB and Amtrak specify that the Red Cross is responsible for ensuring appropriate psychological support to the staff of all responding organizations before their departure from the site. DMH will collaborate with other response agencies to ensure that appropriate support is available when requested and needed.

Further considerations regarding the provision of mental health services to staff in other types of disasters is discussed in detail in Chapter 4. The following discussion of issues specific to transportation disasters supplements and does not supersede typical staff mental health procedures.

Screening and assigning staff

Some workers are not well-suited for assignment to a transportation disaster response, especially incidents that result in mass casualties. DMH should encourage chapter recruiters and relief operation supervisors to use pre-deployment screening tools and face-to-face conversations to inform the prospective worker of the unique challenges (e.g., exposure to catastrophic destruction and people struggling with grief) and to determine which assignment, if any, is appropriate for the worker.

Supporting workers during the relief effort

In a transportation disaster response, DMH leadership has enhanced latitude in making strong recommendations to reduce shift hours, ensure that breaks and days off are taken, implement staff assignment rotation schedules for difficult sites (e.g., the morgue), reassign staff who are struggling with their work and ensure that time and space is made available for workers to receive DMH support. Disaster PFA training should be offered and the full complement of "Coping with Disaster" brochures should be provided to all incoming workers. DMH workers should provide support to local responders who live or work near the incident/crash site and who may have been directly or indirectly exposed to the disaster.

Staff already deployed to the response effort should be reassigned to administrative tasks or sent home if they are not able to properly conduct themselves or carry out their responsibilities or if they express discomfort with their work or surroundings.

Providing post-deployment support

It is critical to offer support to workers both on the relief operation and when the workers return home, especially after a transportation disaster resulting in mass casualties. This scenario can be challenging because it is common to have large numbers of spontaneous volunteers deploying for short one- or two-day assignments. DMH should work closely with chapters, Staff Services and partner agencies at the outset of the relief operation to track out-processing dates and offer support to all workers before their return home. Chapters should offer DMH support upon workers' return home, including making the volunteer DMH post-deployment screening tool available. Post-deployment support should also be offered to all non–Red Cross workers before their return home.

Chapter 4: Staff Mental Health Services

Chapter Overview

Introduction

Disaster workers encounter considerable stress while providing services to people affected by a disaster. They also sometimes live in disaster-affected areas and may be exposed to the same risk factors that affect clients. A primary role of DMH is to provide support for disaster workers—before, during and after the response. DMH workers help other disaster workers manage their stress through education, individual or group contacts; surveillance of stressors and worker functioning within the working environment; and consultation with Red Cross leadership.

Because research and experience have shown that disaster workers are at risk for compassion fatigue, burnout and vicarious traumatization, Red Cross DMH workers have a critical responsibility to mitigate stressors and to intervene when needed to support workers who are experiencing disaster-related stress. The stressors and possible outcomes for staff are discussed in detail in Appendix B, Disaster Response Stress and Possible Outcomes for Workers.

In this chapter

This chapter contains the following topics:

Section 1: Force Health Protection

Introduction

Force health protection actions promote worker resilience and take place in all relief operation settings. Self-care is a crucial element in preventing compassion fatigue among disaster responders. However, in the face of intense need during disasters, self-care is often overlooked. Force health protection strategies are designed to help workers and supervisors overcome obstacles to self-care (Yin and Kukor 2010). These strategies span the pre-deployment, deployment and post-deployment phases of disaster.

In this section

This section contains the following topics:

Continuum of services to disaster staff

DMH provides support to disaster staff during three phases: 1) after staff have been assigned to a job and before they have left their home (pre-deployment), 2) during a worker's deployment and 3) when the worker is beginning to make arrangements to return home and after they have left the relief operation (post-deployment). These phases all present specific stressors for workers. The tables below provide examples of the supports and services that can be provided by DMH for each of the phases of the deployment cycle.

Pre-deployment support:

Challenges for disaster workers	DMH supports and services for workers
• Making travel and other types of arrangements • Local disaster personal impact • Traveling • Anticipation of the unknown • Difficulty accessing accurate information and resources • In-processing • "Hurry up and wait"	• Interviewing (screening) individuals for appropriateness for deployment • Building resilience • PFA training • "Coping with Disaster: Preparing for a Disaster Assignment" brochure.

Support during deployment:

Challenges for disaster workers	DMH supports and services for workers
• Environmental exposures • Work-related exposures • Managing common stress reactions • Burnout • Compassion fatigue	• Staff orientation: strategies to reduce stress • Self-care and coping strategies • Monitoring environmental and work-related stressors and triage of individual staff members who may be at risk because of certain experiences • Providing constructive feedback to appropriate activity leads for reducing staff stressors • Collaborating with Staff Wellness when appropriate

Post-deployment support:

Challenges for disaster workers	DMH supports and services for workers
• Transitioning back to pre-deployment lives and routines • Incorporating the deployment experience into day-to-day life in a meaningful way	• Providing opportunities to discuss experiences • Normalizing post-deployment reactions • Building resilience • Providing post-event triage and information about potential referral resources

Leadership and supervisory practices to reduce stress

Red Cross supervisors in all activities have usually taken supervisory training before being promoted. If issues involving progressive discipline or personnel matters arise, that training and Staff Services are the appropriate sources for information. In addition, DMH workers can offer consultation and reminders to other Red Cross activity supervisors to help them reduce the stress on their workers. Below are some suggestions that may reduce stress in the work environment.

- Divide work into mission-critical and mission-noncritical and make sure worker care appears at the top of the mission-critical list.
- Spend sufficient "up front" time training and supporting workers before their first assignment.
- Reduce worker shift lengths to 12 hours or less as quickly as possible.
- Rotate workers through assignments or service delivery sites that appear to produce the most stress, such as the most severely affected sites, morgues or condolence teams.
- Establish respite areas for workers.
- Ensure that staff take breaks and develop a staggered day off schedule by the third or fourth day of a deployment.
- Create a collaborative atmosphere where feedback and requests for help are welcome.
- Schedule overlapping meetings for in-coming and out-going teams to share information, avoid duplication and mitigate potential problems.
- Address conflicts as soon as they arise.
- Be flexible and maintain a positive outlook.
- Provide as much structure and routine to the daily schedule as possible.
- Listen, offer solutions and be prepared to make changes to your own actions.
- Be aware of your own reactions and be tolerant and patient with others.
- Recognize and reward worker efforts on a regular basis.
- Convene daily team meetings to share information and updates.

Minimizing DMH workload stress

During the aftermath of disaster, DMH workers may feel overwhelmed by the level of need for DMH support. DMH leadership can reduce the stress experienced by DMH workers and optimize time and resource use by using the following strategies:

- Ensure that all response workers are trained in disaster PFA. Doing so creates an emotional support "force multiplier." It also promotes use of the evidence-based PsySTART triage tool, which supports more efficient and timely referrals to DMH.
- Be as available as possible for consultation to their DMH workers and provide consultation and encouragement for all disaster workers who engage in PFA and triage.
- Use "on-call" support strategies when staff shortages create difficulties in attempting to provide 24/7 onsite coverage.
- Maximize the use of state and local partners to augment the Red Cross mental health relief efforts.

Pre-Deployment Support

Pre-deployment support for chapters (before workers leave home)

With the emphasis on rapid response, disaster workers' pre-deployment preparation and onsite training may be shortchanged. Sometimes staff may deploy when they are not emotionally prepared or are distracted by family needs or problems at home or work.

Both disaster workers and disaster operations benefit when chapters invest time into preparations and promote worker wellness as early as possible (Bills et al. 2008).

Pre-deployment training, boundary setting and goal setting have been found to promote worker self-care (Aten et al. 2008; Rosser 2008).

Pre-deployment support is a chapter responsibility. Chapter DMH workers can provide pre-deployment support by:

- Assisting chapter health reviewers in screening individuals for appropriateness for deployment;
- Promoting the use of self-screening tools to help the volunteer decide whether going on the proposed disaster assignment would be advisable at that time;
- Having a system in place for making DMH available for individuals who are concerned or uncertain about the work;
- Assisting chapter health reviewers and disaster workers when a condition is noted in the Health Status Record that may affect the appropriateness for an assignment;
- Assisting chapter health reviewers when restrictions are placed in the Health Status Record that raise questions about the disaster responder's ability to respond because of hardship codes for a specific disaster, or because the worker had been sent home from a previous disaster assignment for mental health reasons.

The Red Cross has prepared handouts that aim to help workers prepare for effective coping. "Coping with Disaster: Preparing for a Disaster Assignment" addresses issues for DMH workers to consider as they support and advise workers who are considering deployment. "Coping with Disaster: For the Families of Disaster Workers" is a brochure that addresses issues that family members may have. Finally, "Coping with Disaster: Returning Home from a Disaster Assignment" helps workers adjust to post-deployment life.

Stress management suggestions to offer staff preparing to deploy

The following are suggestions for all staff preparing to deploy to a disaster on ways to mitigate the stress of preparation:

Step	Suggestion	Instructions to workers
1	Gather information	Learn what you can about conditions at the disaster operation so you can bring appropriate clothing and supplies.
2	Gather sufficient self-care items	Make sure you have sufficient medication and similar self-care items to last several days beyond the expected length of your deployment, so that an unexpected delay will be covered.

Continued on next page

Stress management suggestions to offer staff preparing to deploy (Continued)

3	Make home and work arrangements	Establish with your employer how responsibilities will be managed during your absence, and arrange for the care of any dependent family members and pets.
4	Complete paperwork	Complete all of the necessary paperwork at your chapter.
5	Track deployment progress	Check for deployment updates immediately before departing and again upon arrival at your destination.
6	Set up support and communication	Provide your family with your chapter phone number so they will be able to access support and emergency communication services while you are deployed.

The disaster human resources system handbook is an important source of information for staff preparing to deploy.

Support during Deployment

Suggestions for workers to build their resilience during deployment

Successfully managing the challenges of disaster relief work requires workers to take care of themselves before, during and after their assignments. The good news is that we all have resilience—ways to help us bounce back after difficult times—even in the face of our greatest challenges. Disasters can bring forth strong emotions, even among experienced workers, and during the course of a deployment, such reactions will vary. Workers may experience strong feelings of frustration, disappointment, sadness, anger and fear, as well as memory slips and insomnia. Fortunately, such reactions are usually balanced by feelings of excitement, pride, joy, satisfaction and friendship. Focusing on these positives is one way of practicing resilience. Below are some resilience-building strategies to help disaster workers manage stress reactions while on an assignment. These recommendations also appear in the "Coping with Disaster" brochures.

Step	Suggestion	Action
1	Stay safe	The Red Cross is committed to maintaining a safe work environment for its workers. Be sure to attend all work orientations and briefings and follow all safety precautions and guidelines. If you have any concerns, talk with your supervisor. Knowing that you have done everything you can to stay safe can also help you and your team relax and focus on your work.
2	Prioritize your work	Disaster relief efforts create pressure to accomplish much in a short amount of time. Work with your supervisor to prioritize tasks and set achievable goals. Keep focused on what you are accomplishing, and do not let what remains to be done overwhelm or discourage you.
3	Make self-care your first priority	Disaster survivors are best served when you stay strong and energized. Try to get enough sleep. Take breaks, do not work through your assigned day off, exercise, eat healthy foods, drink plenty of water and make efforts to manage your stress. Excessive or high-risk behaviors such as drug and alcohol abuse can complicate an already challenging situation. Assert yourself and ask for help if you are uncomfortable with your assignment.
4	Stay connected	One of the best ways to stay positive is by connecting with other workers. We experience a common bond because of our shared mission. If you are inexperienced, partnering with someone else can be especially helpful. You will no doubt find ways of being of assistance to your "disaster buddy," too! For many workers, staying in touch with family and friends also serves as a means of support. Calling home each day has helped many workers release their daily stress.

Continued on next page

Suggestions for workers to build their resilience during deployment (Continued)

5	Maintain a hopeful outlook	Regularly remind yourself of what you are accomplishing: providing for the emergency needs of survivors and helping them along their path toward recovery. Destruction and despair may be present in the moment, but so is the spark of hope—that human thread that connects us all. Many people are being helped, and progress is being made.
6	Manage work relationships professionally	While on assignment, you will participate with teams of other workers and supervisors that you may have never met. This scenario can be exciting, but may also present challenges. Everyone has their own style of working and communicating. Some of these styles will feel comfortable, whereas others may feel irritating. In addition, you may not receive your preferred job assignment. You might have different ideas about how things should be done. Every disaster worker experiences these thoughts or feelings at some point. Keeping the larger disaster mission foremost in your mind can help you cope constructively with these challenges. Be patient, tolerant and flexible with your teammates. Communicate calmly, and remember to focus more on solutions than pointing fingers.
7	Use calming strategies	Consider the usual strategies you use to relax or calm yourself and how they might be helpful while on assignment. For example, some people like to tell a joke, have a good laugh, give someone a hug, exercise or take a walk around the block. Taking periodic breaks away from stressful surroundings can help you "catch your breath." Get a snack when you are hungry and drink plenty of water. If your situation begins feeling tense, slow down and take a few deep breaths. Notice which of your muscles are tight and stretch and release them, exhaling slowly as you do so. Finally, listen to your thoughts. If you find yourself feeling especially stressed, frustrated or pessimistic, focus more on the positive actions that you and others are taking right now that are helping others.
8	Watch for training opportunities	Feeling confident about your disaster work skills can contribute to your sense of strength and resilience. Some operations offer training in new skills. Working alongside experienced workers and supervisors on a disaster assignment also serves as an excellent training opportunity. Watch for such opportunities, and take advantage of them when possible.

DMH support during deployment

On a disaster relief operation, DMH staff mental health coverage is established for every Red Cross site where workers have been assigned. When possible, DMH provides support to staff on a 24/7 basis, with either onsite DMH presence or on-call phone availability. Support is limited to those practices outlined in DMH interventions and is consistent with the individual DMH staff member's professional capabilities. Approved DMH interventions are the same as those provided for disaster survivors. The same DMH and general Red Cross principles of confidentiality and informed consent also apply.

For DAT responses, chapters are advised to have established systems for staff mental

health coverage, typically either the DMH worker assigned to the DAT or an on-call DMH worker.

Work environment surveillance

The assigned DMH worker regularly observes environmental and work-related stress levels and promotes successful coping strategies. As with survivors, DMH workers will frequently need to be proactive and seek out responders needing assistance. However, sometimes a responder or his/her colleague will initiate a request for help. Assistance may also be provided in the form of presentations on self-care topics during regular meetings of staff groups.

Coordinating with the Training activity to support staff

DMH offers specialized training that needs to be coordinated with the training activity. The training includes the following:

Service	Description
Orientation for all Responders	In addition to general information about the relief operation, orientation for all responders should include information about self-care. Participants benefit from hearing about self-care from a DMH worker, who can provide education about stressors and coping skills that are relevant to the specific disaster and response effort. DMH works closely with the Training activity to coordinate the inclusion of this information in the orientation.
Psychological First Aid (PFA)	All staff is advised to take the "Psychological First Aid: Helping Others in Times of Stress" course for disaster workers. In doing so, all workers are then prepared to assist with a number of the emotional needs that arise during a disaster relief effort or DAT response. DMH coordinates offerings of this course with Training. This course includes a rapid triage segment to assist staff to identify risk factors in clients, coworkers and themselves.
Foundations of Disaster Mental Health (FDMH)	DMH workers coordinate with their local chapter's Training unit to offer the FDMH course. During a relief operation, DMH may offer the FDMH course for local qualified mental health professionals as a means of quickly infusing additional DMH workers into the operation.

Collaborating with other Red Cross activities to support staff

In the process of providing DMH support to responders, DMH frequently coordinates with Staff Services which includes Staff Wellness (formerly Staff Health) and Staff Relations. DMH may also coordinate with supervisors, OM or chapter deployment staff. DMH is responsible for both providing support to the responder and making disposition recommendations, when appropriate. It is important to note that the resolution of worker- and performance-related conflicts is primarily the domain of the responder's supervisor, Staff Services and, if necessary, OM.

When collaborating with other activities, all personal information should be kept confidential unless:

- The worker signs a release;
- In the event of casual informal information-sharing, the worker gives verbal
- permission; or
- In the event that another worker has a "business-need-to-know."

Considering the multiplicity and complexity of relationships in a disaster setting,

sometimes it is not clear whether the worker considers certain information confidential. During these complex situations, DMH workers should take extra care to find out what the worker considers confidential. Sometimes information becomes public through common knowledge rather than by means of a private confidential exchange. However, in the interests of the professional relationship, asking the worker's permission to discuss such information is advisable and promotes the trust critical for DMH work. The only exceptions to confidentiality are those required by law: reporting child/elder/disabled abuse and the potential of danger to self or others.

Keep in mind that in addition to collaboration during processing of specific cases, Staff Wellness and Staff Relations can serve as informational resources for DMH workers as they consider how to address the difficult and/or unique situations that may arise among staff.

Post-Deployment Support

Purpose of post-deployment support

Disaster workers on deployment often experience the sights, smells and sounds of the disaster and feel the impact in the same way as the people in the community. As a result, it is common for workers to have reactions, even strong reactions, to the disaster. These reactions will vary among individuals in type, onset and duration. Mental health support after a disaster aims to assist workers with coping, long-term well-being and personal growth. As a means of facilitating effective emotional support after disaster assignments, the DMH activity has developed post-deployment support guidance.

"Coping with Disaster: Returning Home from a Disaster Assignment" is a post-deployment handout for all disaster workers. It contains useful information about issues relevant to winding down from a disaster response. Some of the following information on post-deployment support comes from this document. Post-deployment support is provided by DMH at a relief operation, at the local chapter after deployment, or after DAT responses.

Goals of post-deployment DMH support

The goal of post-deployment DMH support is to assist workers as they do the following:

- Successfully transition back to their pre-deployment lives and routines; and
- Begin to incorporate their deployment experience into their lives in a meaningful way.

Principles for DMH workers providing post-deployment support

When delivering post-deployment support, DMH workers should adhere to the following principles:

- Participation in post-deployment support should always be voluntary.
- While it is usually offered by DMH at the end of a relief operation, post-deployment support should also be offered by DMH at the home chapter after deployments.
- The time and place of a contact should be convenient and suitable for the disaster worker.
- Post-deployment support contacts should not be debriefings in any form, nor should they specifically aim to elicit workers' feelings.
- Post-deployment support will most typically be provided in an individual one-to-one format.
- When provided in a group, post-deployment support should be psychoeducational and discussion oriented. (Note: This is the only acceptable Red Cross DMH group-intervention format; Critical Incident Stress Debriefing is not an approved DMH intervention.)

Objectives of the post-deployment support intervention

During a post-deployment support intervention, DMH workers focus on the following objectives:

- Offer workers an opportunity to talk and ask questions about their deployment.
- Prioritize staff with significant exposure-based risk factors, sub-threshold PTSD and/or substance abuse to identify individuals at risk for chronic reactions or new disorders from deployment.

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Objectives of the post-deployment support intervention (Continued)

- Provide information that may assist in identifying, anticipating and normalizing post-deployment reactions.
- Provide information that may assist in recognizing and building resilience—the worker's ability to bounce back and adapt after difficult experiences.
- Establish an understanding of when it may be helpful to seek additional support, providing information about potential referral sources and how resources may be accessed.

Arranging opportunities for post-deployment support

There are several natural points at which contact can be directly offered or made available: when out-processing from a deployment, at the local chapter immediately after a deployment, a few weeks after a deployment or after a DAT response. Workers may speak with DMH workers during any of these opportunities.

In cases where workers on a relief operation are asked to complete an out-processing sheet that includes a space to be initialed by a DMH worker, use the following guidance. The out-processing worker might or might not request post-deployment support when the DMH worker initials his or her out-processing sheet. The DMH worker should sign the sheet regardless of whether the worker wants to talk in detail about his or her experience. By signing the form when workers first approach, DMH is creating an environment in which workers will not feel pressured to discuss their experiences and may feel more at ease to seek support from the DMH worker. The DMH worker should identify any time and staff constraints at the beginning of the conversation, such as an impending flight departure or limited numbers of DMH workers helping a large number of workers. This step will put both the worker and the DMH worker in a position to make decisions about post-deployment support content.

At times, out-processing is completed outside of the relief operation headquarters, such as at a chapter or service delivery site. If no DMH workers have been assigned to these sites, deployment of a DMH worker may be needed to facilitate out-processing. Under these circumstances, DMH supervisors are asked to remind site leadership of post-deployment support availability and the possible need for coordination of scheduling between out-processing workers and DMH staff. Identifying out-processing dates in advance and coordinating with the Staff Services group will help DMH leadership plan for both headquarters and remote post-deployment support needs. If deploying DMH workers to remote sites is not possible, phone contact between headquarters DMH workers and out-processing staff is an acceptable alternative.

DMH workers are encouraged to collaborate with their local chapters to establish a system of post-deployment support whereby all disaster workers are informed before their deployment about the availability of post-deployment support when they return home.

Some workers will take advantage of post-deployment support at that time, but others may not experience difficulties until weeks after their return from deployment or may not feel ready to speak with someone until much later.

Local DMH workers may make phone calls to thank deployed workers, and ask if workers would like to share their overall experience with the DMH worker. The DMH worker can listen for worker risk factors and persistent stress reactions that may benefit from in-person contact with a DMH worker at the chapter on a voluntary basis.

After a DAT response, workers may experience reactions that are similar to those that

sometimes occur after relief operation assignments. Chapters should educate workers regarding post-deployment support and how to access it by applying the previously discussed guidelines.

Conversation content

There is no set series of questions to be asked during post-deployment support conversations, regardless of when post-deployment support takes place. However, some guidelines have been established regarding what to address, as well as what not to ask or elicit. DMH workers should integrate the following elements into their practice of post-deployment support:

- At the beginning of the session, DMH workers should explain what a post-deployment support conversation might entail, consistent with the guidelines below. This step helps establish informed consent.
- The DMH worker should use the conversation as an opportunity to thank the worker for his or her contribution.
- The worker chooses which aspects of the deployment experience will be discussed, if any.
- Post-deployment support contacts should not be debriefings in any form, nor should they specifically aim to elicit workers' feelings. When workers choose to share feelings relating to the experience, and time and privacy allow, the DMH worker may elect to help the individual process those feelings.
- There is not always sufficient time or privacy for effectively working through revealed feelings. In this case, the DMH worker is responsible for explaining these circumstances and helping the individual identify options for managing the feelings without fully processing them at that time. Given that post-deployment support—as with all DMH interventions—should not exceed three visits, issues that appear to need longer-term intervention should be referred out as soon as this circumstance is identified.
- If a worker has returned home, conversation content may focus more on transition and readjustment to life at home than on the deployment itself.
- The DMH workers should offer information about typical post-deployment reactions and reinforce risk factors from the PFA course as well as suggestions for making the transition as smooth as possible. The brochures referenced above can help facilitate such explanations. Discussion should include mention that the typical reactions listed are not exhaustive and that workers may experience other concerns or reactions.
- As the conversation draws to a close, the DMH worker should provide instructions for how to receive additional post-deployment support, should it be desired.

Tools and resources

As mentioned previously in this chapter, three different "Coping with Disaster" brochures are available to workers and families before, during or after deployment.

The Post-Deployment Stress Self-Assessment tool is an optional tool available to workers after an assignment and posted online. If the worker has performed the self-assessment at the time of a post-deployment support conversation, the DMH may provide additional information, materials, resources and/or referrals as indicated.

Section 2: Procedures for Addressing Distressed Workers

Worker distress

Disaster workers may become distressed for many reasons, including the following:

- A personal crisis while on assignment
- Reactions to the disaster aftermath or working conditions
- Exacerbation of pre-existing conditions
- Conflicts with other workers
- Being informed of a crisis at home
- Exposure to the same risk factors as clients because they live in the disaster-affected area
- Problems that are the same as among the general population

General DMH roles in assisting distressed workers

When meeting the needs of distressed workers, DMH workers:

- Provide support to the responder;
- Assess responder mental health needs and emotional fitness for work;
- Collaborate with Staff Wellness and Staff Relations and make recommendations as appropriate.

Cases may be referred by Staff Wellness, Staff Relations, a supervisor, an activity lead or Operations Mangement; may be identified as the distressed worker seeks DMH assistance; or may become apparent by means of DMH triage or mental health surveillance. If the issue is primarily related to physical or mental illness, Staff Wellness will be the lead activity. If the issue is related to conflict resolution, progressive discipline or other performance-related concerns, then Staff Relations will be the lead activity.

DMH often collaborates with Staff Wellness or Staff Relations when stressful situations arise involving staff, such as when distressing news from home needs to be delivered to a Red Cross worker, or when conflicts among staff need to be resolved. DMH workers should always consider the multiplicity of relationships in these often trying circumstances, protecting confidentiality and bringing in additional DMH workers to assist when conflict of interest is relevant. DMH may be asked to assist Staff Wellness or Staff Relations when workers return home to their chapters or in communicating with their chapters.

Mental health emergencies involving individual workers

In the event of a mental health emergency, and after conferring with Staff Wellness and Staff Relations, DMH will lead the effort to intervene with the responder. This may include:

- Conducting a secondary assessment;
- Performing crisis intervention;
- Referring the responder to a community mental health provider;
- Following local state laws for mental health professionals to address all reporting requirements.

After conferring with Staff Wellness and Staff Relations, DMH disposition recommendations may include :

- Time off;
- Reassignment to another activity or assignment setting;
- Compassionate release from the relief operation with no restriction;

- Immediate release with a recommendation that the worker not be assigned to future operations without further counseling or other treatment.

In circumstances where a worker may need to be released for a mental health reason, Staff Wellness will be the lead activity:

- Staff Wellness works with the individual and confers with DMH to determine whether the emotional or environmental circumstances can be alleviated sufficiently for the worker to remain on the disaster operation.
- If the DMH worker believes that the best option is for the person to return home, the DMH worker makes his or her final recommendation to the technical lead, who then consults with Staff Wellness and Staff Relations.
- If the worker does not concur with the recommendation to be released, he/she may need extra support from DMH.
- OM is notified of the recommendations of DMH and Staff Wellness.

Requirement: Mental health release administrative procedure

If, after all reasonable accommodations have been made, a worker is being considered for release from the disaster operation for a mental health reason, the procedures below must be followed. Confidentiality will be respected through actions described under Administrative Procedures in this document.

Actions by DMH include the following:

- Document the worker's mental health needs on the Staff Health Injury and Illness Record and recommend to Staff Wellness and Staff Relations that the worker be released from the operation.
- Confer with Staff Wellness and Staff Relations who will then notify OM.
- Notify the DMH lead at national headquarters.
- Confer with Staff Wellness, Staff Relations and the responder to decide whether the worker may travel alone or should be accompanied home by a DMH worker or another appropriate person.
- Recommend to Staff Wellness and Staff Relations whether contact should be made with a designated relative or other person to arrange for reception of the released worker at home.
- Connect the responder to local mental health resources if immediate treatment is indicated.
- Document the circumstances and/or condition, the basis for the recommendation and the exit plan or final outcome on the Staff Injury and Illness Record, which is located on the Red Cross intranet.

Staff Wellness and Staff Relations will follow established procedures for releasing workers for their activity. The Disaster Services human resources lead at national headquarters will consult with DMH and follow their established procedures after the worker returns home.

Worker declines treatment

If a worker has been evaluated as being mentally ill and declines treatment, Staff Wellness will be the lead activity. DMH will assist Staff Wellness in this process:

- A worker may decline a mental health intervention or choose not to follow up on a mental health–related referral, provided that no applicable law requires further intervention and the worker is not considered an immediate danger to self or others.

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Worker declines treatment (Continued)

- Declined treatment must be documented on the Staff Injury and Illness Record.
- The worker is required to sign a Declined Treatment Release form stating that he or she refuses to follow the advice of Staff Wellness and DMH.
- If there is evidence through work performance or public behavior to support action, Staff Wellness may recommend appropriate action up to and including recommending that the worker be released from the disaster operation or chapter response.
- If applicable laws require further intervention or the worker is considered an immediate danger to self or to others, DMH must take action consistent with the applicable laws. Staff Wellness and OM will be notified of the problem and pending action as soon as possible.
- In the event of a situation requiring the psychiatric hospitalization of a Red Cross worker, OM, Staff Wellness and the DMH activity lead at national headquarters must be notified.

The unit of affiliation will also be contacted by Staff Wellness so that family members can be offered support.

Substance abuse

Given that Red Cross workers represent a cross-section of society, in any given disaster setting, a certain number of workers may inappropriately use or abuse substances. On disaster operations, posting the dates/times and locations of the nearest 12-step meetings supports recovering substance abusers onsite. Promoting force health protection in general alleviates some stress that might result in maladaptive use of substances while on assignment. Supervisors should be encouraged to provide transportation and time off to workers who request assistance in attending 12-step meetings. DMH workers must protect the worker's anonymity if such a request is received.

DMH workers need to be familiar with Red Cross policies related to substance abuse to explain them to workers who bring these issues to DMH. Workers should be encouraged to contact Staff Relations themselves. DMH workers play a role in providing support as Staff Relations works with individuals who are suspected of inappropriate substance use. The substance use policy of the Red Cross can be found in the Human Resources Policies and Procedures Manual on the Red Cross intranet.

Harassment

The Red Cross is committed to a harassment-free work environment where everyone is treated with respect and dignity. All interactions among staff will be free of unlawful harassment of any kind. Workers are responsible for reporting any concerns they may have regarding unlawful harassment to OM and will not suffer retaliation for making their concerns know. The harassment-free work environment policy of the Red Cross can be found in the Human Resources Policies and Procedures Manual on the Red Cross intranet.

DMH workers need to be familiar with the policies related to harassment to explain them to workers who bring these issues to DMH. Workers should be encouraged to contact Staff Relations themselves. DMH workers may be asked by Staff Relations to provide emotional support to individuals involved. Additional responsibilities depend on the willingness of the harassed worker to make a formal complaint.

Medical emergency and other urgent situations affecting staff

When there is a death or medical emergency or other urgent situation in a worker's family, Staff Wellness is the lead activity and DMH may be requested to do the following:

- Assist in informing the worker;
- Provide emotional support and, depending on the circumstances, help the worker decide whether to remain on the disaster operation or return home;
- Facilitate the worker's return home if such assistance is requested;
- Arrange for an escort home if such support is indicated.

When a worker dies on a relief operation

In the event of a worker's death, the following steps should be taken:

- Staff Services and Staff Wellness should work with OM of the DRO to ensure close coordination among the relief operation, the staff member's unit of affiliation and the staff member's family, with particular attention paid to meeting the needs of the family and carrying out the family's wishes in making arrangements.
- DMH may assist as needed in these arrangements and notifications.
- DMH arranges for and conducts one or more voluntary sessions during which the staff member's coworkers may express their reactions to and feelings about the death. All coworkers will be invited and encouraged to attend.
- If members of the deceased staff member's family live in or travel to the area of the disaster operation, DMH provides emotional support, assists as requested by Staff Services to help the family make travel arrangements and arranges for escort of the family member(s), if such support is indicated.

Chapter 5: DMH Administrative Procedures

Chapter Overview

Introduction

This section provides the DMH procedures for protecting the privacy and confidentiality of disaster survivors and workers who receive DMH services. Recordkeeping is described, including the records and forms that you will use. Relevant legislation related to recordkeeping is presented. Red Cross procedures for protecting and sharing client and staff information are outlined along with procedures for providing financial assistance to clients for mental health–related expenses.

In this section

This section contains the following topics:

Protecting Client Information

The importance of client confidentiality

Safeguarding the trust of both disaster-affected clients and Red Cross staff is an important part of our obligation to the people and communities we serve. All Red Cross DMH workers must safeguard client confidentiality in obtaining, using, storing and releasing client information.

Requirement: Protecting privacy policy

All Red Cross workers are required to comply with the policy on protecting privacy and personal information in obtaining, protecting and releasing information about people, recognizing that such information is given to them as representatives of the Red Cross and is to be used only for the purpose of providing Red Cross services. No more information should be requested by the Red Cross than will be needed for the service that may be given.

For complete confidentiality and privacy information, see the Protecting Personal Information policy on the Red Cross intranet.

Health Insurance Portability and Accountability Act (HIPAA)

DMH workers follow the organization's guidelines pertaining to confidentiality and privacy, as previously stated. The Red Cross Office of the General Counsel has concluded that the Red Cross is not a covered entity within the regulations of the Health Insurance Portability and Accountability Act (HIPAA), and HIPAA provisions are not applicable to Red Cross services.

However, you should be aware that HIPAA 45 C.F.R. § 164.510(b) (4) covers entities such as hospitals and medical practices to disclose personal health information to organizations such as the Red Cross. In the relevant part, this provision states the following:

Use and disclosures for disaster relief purposes.
A covered entity may use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the uses or disclosures permitted by paragraph (b)(1)(ii) of this section.

As a DMH worker, rely on professional principles of confidentiality when sharing client information.

If you need to communicate about this issue with other health care providers, you may use the HIPAA clarification letter, which can be downloaded from the Red Cross intranet. Please reproduce this letter on organization letterhead.

Disclosure of client information

Occasionally, we must balance the concern for confidentiality with other important considerations. In certain limited circumstances, disclosure of information may be appropriate to comply with legal requirements and to protect Red Cross clients, staff and the communities we serve.

Requirement: Release of confidential information to an external organization	Red Cross responders must have written consent prior to releasing confidential client or responder information to an external, or written evidence that the client or responder has given the external organization permission to obtain the information from the Red Cross. Additionally, confidential information should be shared only in the following circumstances: • To assist the client or responder in obtaining needed service or benefits • To provide information about the client to a federal or state disaster agency to expedite the client's application for a disaster loan or other assistance • To provide information to an insurance agency, social services organization, or health/mental health organization providing disaster-related assistance to the client or responder
Requirement: Release of confidential information within the Red Cross	Red Cross responders are not required to have written consent prior to releasing confidential client or responder information to Red Cross responders who need the information to perform their job functions (have a "business-need-to-know"). Those needing such information typically include responders in Operations Management, Disaster Mental Health, Staff Services, Staff Wellness and Staff Relations. When such information is requested, only those details pertinent to further action will be disclosed.
Requirement: Computerized records	Computer records containing client or worker information are subject to the same confidentiality regulations and standards as other records. Access to such records is limited to individuals with a "business-need-to-know" for the information.
Requirement: Voice and email messages	When the process of providing services requires contact with another Red Cross activity, the information will be given only to another Red Cross worker. Information regarding clients or workers should not be left on voicemail, on answering machines or with answering services or transmitted through email.
Requirement: Abuse and neglect reporting	Mental Health professionals are mandated reporters under laws in each state and U.S. territory. Each DMH worker has the responsibility to report suspected child or elder abuse or neglect to the appropriate authority in the jurisdiction of the disaster operation. The laws in each state and territory may differ in the definition of abuse and neglect and in the assignment of authority for the investigation and determination of abuse and neglect. It is incumbent on each DMH worker to know the laws, regulations and procedures for such reporting in each state in which he or she is responding to a disaster. If you do not have that information, check with your DMH supervisor.

Client and Staff Records

Introduction

This section identifies the forms and records that Red Cross DMH workers use to document their work. In handling these records, DMH staff must follow the guidelines in the previous section for protecting client and staff privacy and personal information.

"Client" defined

The term "client" refers to any individual or family who seeks Red Cross assistance in recovering from a disaster. A client relationship is established when the individual or family has contact with the Red Cross, whether or not any assistance is given.

Red Cross "staff" defined

The term "staff" refers to both paid and volunteer workers. A Red Cross volunteer is an individual who, beyond the responsibilities of paid employment, freely assists the Red Cross in the accomplishment of its mission without expectation or receipt of compensation.

Using records and forms

The Red Cross client records and forms that you will use include the following. All records and forms are listed in Appendix D and posted on the Red Cross intranet.

Record	Purpose
Disaster Registration and Case Record (Form 901)	Paper record of client information and services provided. Used by Client Casework, HS and DMH workers.
Client Assistance Memorandum (F1475)	Used by Client Casework, HS and DMH workers when a verbal referral cannot be used. Should not include confidential information.
Client Health Record	Used by HS and DMH to record confidential information for clients and staff served by DMH.
Client Consent to Share Information	Records written evidence that a client or family has given the Red Cross consent for the release of specific information to a specific agency or written permission to an outside agency to request information from the Red Cross. Used by Client Casework, DMH, and HS workers.
Release of Confidential Information–Staff	Records written evidence that a worker has given the Red Cross consent for the release of specific information to a specific agency or written permission to an outside agency to request information from the Red Cross. Used by DMH and HS.
Emergency Welfare Inquiry Form	Used when there is no Internet connection available to create an emergency welfare case and when a family member states that his/her relative within the disaster-affected area has a medical concern, serious health problem or mental health problem. Used by all Red Cross staff assisting clients.
Declined Treatment Release	Used by DMH when a client or worker declines recommended mental health services. The form is attached to the Client Health Record.

Continued on next page

Using records and forms (Continued)

Disaster Referral Form	Used by DMH for referrals for mental health care to resources outside the Red Cross.
Staff Health Illness and Injury Record	Used by DMH, HS and Staff Services to record physical or mental health illness, injury or concern that may require follow-up or referral for assessment and/or treatment.

Requirement: DMH Client Health Record documentation

Complete the Client Health Record in any of these situations:

- When a referral for counseling is made to another agency, organization or private provider for a Red Cross client;
- When there is any concern that requires follow-up or referral for assessment and/or treatment;
- When a client is hospitalized for a mental health reason, whether or not Red Cross is paying the cost of the client's care;
- When a mandated report is made in accordance with state law.

Consult with your supervisor if you have any questions about creating this documentation.

If the Client Health Record is not available, you will document the following information and complete the Client Health Record as soon as possible:

- Name of person making the referral to DMH, if the referring person is willing
- Statement of the problem, including precipitating factors and a description of PsySTART risk factors, specific concerns, symptoms and behaviors
- DMH worker's assessment of the situation
- Actions taken by the DMH worker
- Recommendations, including a plan for carrying these out
- Plan for follow-up
- Date, time and signature of DMH worker for every separate entry

DMH Staff Health Illness and Injury Record documentation

Complete a Staff Health Illness and Injury Record when:

- A mental health illness or concern may require follow-up or referral for assessment and/or treatment;
- A referral for counseling is made to another agency, organization or private provider;
- A worker is hospitalized for a mental health reason;
- A DMH responder will be leaving the disaster operation and another DMH responder may need to provide follow-up support;
- A DMH worker accompanies a worker home and/or provides guidance to the worker's family or other caretaker;
- A mandated report is made in accordance with state law;
- It is requested by Staff Services.

Consult with your DMH supervisor if you have any questions about this documentation.

Requirement: Clients' rights to review Red Cross records

Clients and workers have the right to review their records to ensure that the information contained in the records is relevant and accurate. The right of access does not mean immediate, free and unsupervised access by a client or worker to such records. Information obtained from another source under the promise or implied expectation of confidentiality is exempt from access. Client and responder requests to review DMH records should be made in writing and addressed to the director of the relief operation, who will forward the request to the OM lead at national headquarters.

Financial Assistance

Introduction

DMH workers, with the approval of the DMH lead on the disaster operation or his or her designee may authorize a payment of not more than $500 (designated Class 5M assistance) for disaster-related mental health expenses. This section outlines the circumstance, restrictions and procedures for Red Cross mental health financial assistance to meet mental health expenses.

Financial assistance to meet mental health needs

As a DMH worker, you may recommend to your supervisor that Red Cross provide support for a client by paying for a disaster-related mental health need. An example of such an expense might be an insurance deductible payment for counseling. You should check with your supervisor before promising assistance to the client or if you have questions about the appropriateness of this request. Here are some basic guidelines related to DMH financial assistance:

- Financial assistance to meet mental health care needs, referred to as Class 5 monies is limited to $500 for each individual, not each family.
- The combined HS and DMH expenses cannot exceed $500 per individual (this includes funeral expenses). You should first discuss the case with HS to identify whether Class 5 monies for health related expenses have already been obligated for that client prior to spending Class 5M monies. Do not use Class 5M monies to assist a client to obtain mental health services that may have to be prematurely discontinued because the client lacks the resources to continue if needed ($500 will not pay for more than a few visits with most treatment providers).
- Please check with client casework or HS regarding other sources of financial assistance for the client before assuring the clients that we will pay their expenses for urgent mental health care for disaster-caused or disaster-aggravated conditions. Possible sources of assistance include private medical insurance, Medicare or Medicaid funds, Department of Veterans Affairs, FEMA or other available resources
- Check with your supervisor about the appropriate method to disburse financial assistance.

Client assistance system (CAS) referrals

It is recommended that all DMH workers be trained in the client assistance system (CAS) to access and manage DMH referrals that are initiated within CAS.

During a disaster operation, the DMH lead or delegate should request the activation and deactivation of DMH CAS user IDs from the Client Casework CAS lead. The DMH lead or delegate must oversee and manage DMH referrals in the CAS. Another option is to work with Client Casework leadership to identify a worker in the Client Casework activity who has CAS access and who can assist with this daily task.

Chapter 6: Job Responsibilities during Disasters

Chapter Overview

Introduction

In this section, you will learn about the specific tasks and responsibilities expected of all DMH staff during a disaster response. The various sections describe the different job duties of a DMH worker, DMH supervisor and the DMH lead of the response.

In this chapter

This chapter contains the following topics:

Section 1: Technical and Administrative Supervision of DMH

Introduction

You and other DMH workers are licensed to practice independently to provide basic psychological, psychosocial and counseling services. Your knowledge, self-motivation and assessment skills are necessary to determine the appropriate response. To assist you in your work, you will have both technical and administrative supervision. This section describes what type of assistance you will receive from each.

Technical and administrative supervision

There are two types of supervision for DMH workers:

- Technical supervision provided by your immediate disaster mental health supervisor
- Administrative supervision provided at each of the service delivery sites by the manager of that facility (e.g., shelter manager)

You must follow the appropriate lines of authority at all times. Immediately after a disaster, service sites may be quite chaotic and you may be required to work independently until the disaster operation is fully staffed. On smaller disasters, you may be working without local or onsite technical supervision throughout the event. The DMH leads at national headquarters are always available via phone.

Plan for technical supervision of staff

Technical supervision related to DMH-specific tasks is provided by DMH leads and supervisors, such as the following:

- Providing subject matter expertise on public mental health education;
- Ensuring that all DMH workers are practicing within the DMH intervention standards;
- Ensuring that DMH teams are coordinating activities with local mental health partners;
- Giving guidance on strategies for providing mental health support to staff;
- Providing technical oversight on all critical concerns and issues;
- Providing guidance on staffing patterns and service delivery plans.

Plan for administrative supervision of staff

Administrative supervision is provided by service site managers (e.g., shelters, feeding sites, service centers, etc.). While each service site manager's level of oversight of the DMH activity may vary, he or she is responsible for all services provided at the site and is therefore in charge of all of the activities listed below:

- Establishing opening and closing times;
- Ensuring effective and complete service delivery;
- Disseminating information to all of the Red Cross activities operating at the site;
- Arranging staff meetings;
- Setting and enforcing site-related policies and practices;
- Handling personnel issues;
- Overseeing site setup and dismantling;
- Approving days off for all activities;
- Approving requests for recruiting or releasing staff for all activities;
- Managing staff safety at the site.

Section 2: Responsibilities of Workers

Introduction

In this section, you will find the requirements and responsibilities for all DMH workers who are not in a supervisory or lead position. The section details the processes of in-processing to the disaster operation, receiving orientation to the disaster situation, gathering needed information, acquiring needed supplies, receiving an assignment, reporting contacts, receiving an evaluation and out-processing from the relief operation.

Requirement: In-processing

All DMH responders (local responders and those arriving from outside the region) must complete initial DRO registration tasks (this is called in-processing). Tasks include registering with the Staff Services activity at DRO headquarters or, in some cases, at an affected chapter or assigned service delivery site. During in-processing, you will be provided with information about your lodging (hotel, motel or staff shelter).

Orientation

You will receive an orientation to the relief operation at headquarters or a site location. The orientation will provide you with information about the following:

- The disaster
- Service delivery plans and status of health services, sheltering, feeding and all other components of the response
- The affected population and special considerations that will help workers to better assist clients
- Expectations for workers, including the need to be flexible, patient and attentive to self-care throughout the relief operation

In addition to the general orientation for all arriving disaster staff, your DMH supervisor will provide an overview of the affected communities and a review of DMH service delivery plans and community resources.

Receiving an assignment

You will receive an assignment from a DMH supervisor or a site manager (e.g., shelter manager). You may be asked for the following information prior to receiving an assignment:

- Human resources system position (e.g., DMH service associate)
- Disaster training
- Disaster experience
- Leadership and communication skills and experience
- Employment experience
- Worker interests
- Worker promotion and development plans

Your assignment should be based on:

- The need for DMH coverage at service delivery sites;
- Optimal opportunities for your job satisfaction and career development within the Red Cross.

Before you begin your work, you should understand the specific job expectations and chain of command at your assigned job site.

Gathering needed information

A useful tool for DMH workers is the Job Induction Checklist found on the Red Cross intranet. Use this tool to ensure that you have the following important information about your disaster relief assignment:

- Name and contact information of your immediate supervisor
- Name and contact information for the DMH lead or designee at DRO headquarters
- Specific assignment address and directions
- Name and contact information for the administrative supervisor or manager of a service delivery site
- Hours of operation for the site

Acquiring needed supplies

Before you travel to your assigned service site, obtain the supplies necessary to perform your function. The table below lists typical supplies that are given to DMH workers. You will not always receive all of these items; it will depend on the availability of the supplies and the specific needs of that operation.

Materials and supplies	Situations for Use
Cell phone	A cell phone will be assigned to each team and not to individual workers.
Rental car	When available and necessary for travel to service delivery sites, a rental car may be made available to the DMH activity. Rental cars are to be shared and can be reassigned to other activities at any time.
PsySTART Aggregated Worksheet and PsySTART Supervisor Daily Summary	These daily worksheets are used by field staff and supervisors to aggregate client risk factors and record contacts with clients and responders.
Client Consent to Share Information	This form is used for the informed consent process in working with clients and Red Cross staff.
Educational materials	DMH print materials are available to assist both clients and responders in coping with disasters.
Basic office supplies	Office supplies such as paper and pens are usually available at the DRO.
Maps and directions	Maps and directions to service delivery sites will be made available to help you navigate to and from your work sites.

Using PsySTART to report client contacts

As a DMH worker providing services directly to clients and responders, you are expected to use the PsySTART Aggregated Worksheet to record client risk factors and contacts with clients and responders. DMH supervisors use the PsySTART Supervisor Daily Summary to summarize risk factors and contacts reported by multiple DMH workers. Both forms contain instructions for use on the back side. Risk factor and contact data are summarized at DRO headquarters for all service delivery sites and affected counties.

Receiving a performance evaluation

Each DMH worker who serves on a disaster operation for seven or more days is required to receive a Disaster Relief Operation Work Performance Evaluation from his or her supervisor before leaving the disaster operation. You should review the evaluation form and discuss your assignment and performance expectations with your supervisor prior to beginning work. All performance reviews are confidential. DMH workers may be asked by the supervisor to complete the top section of the form. The evaluation process is a good time to discuss future training and opportunities for advancing your Red Cross career.

Out-processing from the relief operation

You should work closely with your supervisor as you begin the transition tasks and paperwork required prior to leaving the DRO (this is called out-processing). Out-processing tasks include:

- Making travel arrangements for returning home;
- Making sure any assigned rental vehicle is returned;
- Returning any cell phone assigned to you on the DRO;
- Reviewing the assigned Disaster Staff Card funds to assure that there are enough funds for the return trip home;
- Arranging for a performance review with your immediate technical supervisor or site supervisor if the technical supervisor is offsite;
- Planning for sufficient time to complete the tasks above.

Section 3: DMH Supervisor Responsibilities

Introduction

This section details the responsibilities for DMH workers who are in a supervisor role during a disaster operation, including information about adjusting worker assignments, scheduling DMH staff, conducting performance evaluations, responding to worker issues and concerns, recordkeeping and reporting.

DMH supervisor tasks

The DMH supervisor has the following responsibilities with regard to assigned workers:

- Ensuring the quality of client care
- Implementing the service delivery plan
- Mitigating worker risks of compassion fatigue or secondary traumatization
- Providing useful support, feedback and direction
- Clearly explaining expectations for job performance
- Providing technical supervision related to DMH interventions
- Answering questions about Red Cross DMH policies and procedures
- Ensuring that each worker receives a day off within every seven days of work
- Ensuring the safety of each worker on the disaster operation
- Providing updates on service delivery plans
- Personally thanking each DMH worker for his or her volunteer service

Additional information on supervisory responsibilities can be found in the "Disaster Frontline Supervisor" handbook.

Adjusting supervisee's assignments

As the service delivery plan changes, DMH worker assignments may change. Flexibility is a critical skill for all DMH staff. Workers may be asked to assume responsibilities that are not consistent with their preferences or expectations. Workers' assignments are subject to the needs of the disaster operation. Supervisors and the DMH lead should consider rotating DMH workers through less desirable or more stressful assignments.

Arranging days off

Supervisors are expected to be aware of the length of time each of their workers has been on duty. You will need to make sure that everyone is given a day off within every seven days of continuous work. Scheduling days off and maintaining DMH coverage can be challenging. A helpful strategy is to rotate or itinerate responders between service delivery sites. You should consult with the administrative supervisor at each site prior to making changes to DMH coverage.

Reporting to DMH leadership

The DMH chain of command ultimately reports to the DMH lead at DRO headquarters. You are expected to keep your immediate DMH supervisor (who may or may not be the DMH lead at headquarters) informed of your teams' successes and challenges so that this information is made available to DRO leadership. Important information includes client and responder issues and concerns. Inform your DMH supervisor of anticipated changes to needed DMH staffing levels (both increases and decreases) as soon as possible.

Regular communication with staff

Supervisors should hold regular meetings with workers to provide positive feedback and thank them for volunteering. Updates on the disaster operation and any DMH responder issues and concerns should be discussed at these meetings and addressed promptly. It is important to quickly report significant issues to your DMH supervisor.

Recordkeeping using PsySTART

As a supervisor, you are responsible for completing and submitting the PsySTART Supervisor Daily Summary to your DMH supervisor at the end of each 24-hour reporting period.

Using PsySTART to enhance service delivery

The PsySTART Supervisor Daily Summary shows the total number of client risk factors and client and responder contacts recorded by responders under your supervision. Several key pieces of information are:

- Number of DMH contacts with responders and clients recorded by each responder at each site;
- Number and type of PsySTART risk factors. (See Element #1: Identifying Mental Health Needs for more information on PsySTART);
- Sites with clients that have greater numbers of PsySTART risk factors;
- Responders who have been working with clients with greater numbers of PsySTART risk factors.

This information will allow you to enhance service delivery to clients and responders by:

- Deploying DMH workers and mental health partners first to sites with clients with greater numbers of risk factors (especially during a surge event where there are insufficient numbers of DMH staff);
- Deploying DMH workers with specialized training appropriate to the client needs and risk factors at each site (e.g., experience with children or family bereavement);
- Identifying community resources that are appropriate to client needs and risk factors;
- Providing additional DMH support or work assignment rotation for DMH responders who have been working with higher risk clients.

Conducting performance evaluations

As a supervisor you are responsible for completing a performance evaluation for each responder assigned to you. You should review job assignment expectations and performance evaluation criteria with responders prior to sending them to their job site. You are also expected to consult with the administrative supervisor for input before giving the evaluation to your worker, if applicable. You should also monitor job performance and provide ongoing feedback to all assigned workers.

Work performance evaluations are required for a worker who serves on a relief operation for seven days or longer. If a worker is assigned to the relief operation for three to six days, he or she may request a performance evaluation. It is important for workers who work less than seven days to receive evaluations to facilitate promotion within the Disaster Services human resources system when appropriate. The work performance review and the DRO Work Performance Evaluation are confidential. Additional guidelines for completing the evaluation process are in the "Disaster Frontline Supervisor" handbook.

Section 4: DMH Leadership Responsibilities

Introduction

In this chapter, the responsibilities of DMH leadership are described, including organization of service delivery, staffing, recordkeeping and working with other activities.

Working at the DRO headquarters and leading the DMH activity across many disaster sites can be a stressful and highly rewarding job. Depending on the size and scope of the disaster, you may need to divide supervisory responsibilities among multiple tiers of supervisors or you may have direct contact with all workers. The quality of DMH services provided on the relief operation is significantly influenced by the competence and skills of the DMH leader.

In this chapter

This chapter contains the following topics:

Organizing DMH Service Delivery

DMH leadership on a DRO

This section describes the leadership roles in establishing the DMH activity during the initiating stage of a disaster response. The DMH lead is the person who oversees all DMH activity during a disaster response. Depending on the size and scope of the DRO, the lead could be at any disaster responder level (e.g., service associate, supervisor, etc.). Each of the responsibilities listed below is a necessary part of leading the DMH response.

Establishing a leadership team

One of the early tasks of the DMH lead is to build a leadership team. The size and scope of the disaster will determine the size of the leadership team. Examples of some common DMH leadership positions and their duties are listed below. On smaller operations, one person may fill multiple roles.

Leadership position	Responsibilities
Operations lead	• Acts as the direct supervisor for DMH supervisors at service delivery sites or within a designated affected area • Screens, orients and assigns incoming DMH responders (also done by the overall DMH lead) • Oversees materials and resources—tracking, storage, distribution and ordering replacements • Assumes duties of the DMH lead during days off or absences • Assigns a DMH worker to oversee DMH referrals in the client assistance system (CAS)
Community liaison lead	• Coordinates with local community mental health organizations, Medical Reserve Corps and other mental health partners • Assesses the community's cultural composition and ensures that services are delivered in a culturally competent manner • Identifies local crisis hotlines, emergency facilities, mental health resources, local reporting and commitment laws and procedures • Assesses and works with affected school systems • Attends community meetings • Coordinates with Public Affairs to complete media interviews on request • Coordinates with the Community Partnerships and Government Liaison activities
Staff mental health lead	• Has primary responsibility for staff mental health on the entire disaster operation • Works closely with Staff Wellness and/or Staff Relations on staff health- and performance-related issues • Provides and oversees mental health out-processing support • Provides the mental health portion of general staff orientations when offered at response headquarters • Carries the DMH after-hours phone, or arranges for rotation of this responsibility

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Establishing a leadership team (Continued)

Administrative assistant	• Provides primary response headquarters DMH phone coverage • Registers newly arriving DMH responders and updates other elements of the DMH "job book" • Sets up schedules for community volunteers • Collects and reports statistics using the PsySTART system • Fields and distributes information that comes to DMH at response headquarters • Performs general office management tasks These duties can be performed by someone other than a fully qualified DMH worker (e.g., non-DMH volunteer, professional office temporary employee). For DMH responders interested in promotion, managing these administrative tasks at headquarters can be a helpful step towards promotion in the DMH activity.

Mentoring

Mentoring supports responder career development. Mentoring is a structured, sustained process for facilitating responder growth and promotion within the Red Cross. As the DMH lead, you should spend time with workers as they arrive to ask them if they are interested in providing or receiving mentoring support. If shortages of DMH responders make it difficult to assign a responder and mentor to the same site, consider arranging for telephonic or itinerant mentoring support.

Planning for service delivery

When a disaster operation scales up from a local to a national DRO, it is important to integrate the chapter's existing DMH efforts into service delivery efforts. Planning for service delivery involves the following:

- The chapter response
- General disaster operation structure
- Negotiating headquarters space for DMH
- Establishing relevant DMH sites and settings
- Developing the DMH service delivery plan

The chapter's response will vary depending on the capacity of the chapter, and the DRO DMH response builds on and complements what already has been done. The chapter DMH leadership and personnel should continue to be involved—the extent of which will vary from operation to operation.

Development of the DMH service delivery plan requires close coordination with other Red Cross activities, especially Health Services, Client Casework, Recovery Planning and Assistance, and Mass Care. The DMH plan is then integrated into the overall relief operation plan to ensure that the necessary logistics, transportation, supplies, technology and staff support are available to support the service plan and sites.

Disaster operations structure

DMH is part of Direct Services along with:

- Health Services;
- Client Casework;
- Recovery Planning and Assistance;
- Mass Care (Sheltering, Feeding and Bulk Distribution);
- Safe and Well Linking.

As a DMH lead you will work under the direction of Operations Management (frequently the assistant director for Direct Services). The assistant director for Support Services oversees important activities such as Staff Services, Logistics,

Disaster Services Technology and Community Partnerships. On smaller operations, you may report directly to the job director.

Headquarters space for DMH

You should consult with the Logistics activity regarding options, needs and preferences for DMH space at DRO headquarters. It is desirable for DMH to:

- Be located near the other direct services activities;
- Be located in a space that allows for confidential conversations, or be able to identify an alternative space that addresses privacy for confidential consultations and DMH out-processing support;
- Have space for the lead and staff, as well as for group staff meetings;
- Have space to store DMH supplies;
- Have wall or easel space for posting service delivery site and staff information;
- Have space that accommodates two landline phones and at least two computers;
- Have a locked area or lockbox to store confidential paperwork.

Staffing DMH

Determining staffing needs

In addition to the headquarters management team, DMH workers are needed to provide mental health services at all service delivery sites. DMH staffing needs are based on these elements of service delivery planning:

- Number of projected clients
- Number of injuries, fatalities and other PsySTART risk factors
- Demographics and pre-disaster high-risk clients, including clients with functional and access needs
- Size and geographic spread of the affected area
- Number and types of service delivery sites
- Number of relief operations staff and sites where workers will need support
- Type of disaster: human-caused versus natural disaster

Requesting staff

The initial staff members are mobilized by the affected chapter(s). You must follow these steps to request additional and/or replacement staff:

Step	Action
1	Use the factors listed above to estimate staffing needs for the next three to five days. A general rule of thumb is to have at least one DMH worker at each site where there are clients and/or other Red Cross staff.
2	Based on estimated staffing needs, complete a Staff Request form.
3	Have the Staff Request form signed by your supervisor.
4	Forward the request to the Staffing lead at operation headquarters for approval and processing.

The Staff Request form requires that you show the tasks to be completed, the number and levels of staff requested and the locations they will be assigned to.

Using DMH chapter-affiliated volunteers

Current DMH volunteers affiliated with the chapter in the disaster-affected area are valuable resources and are generally the first source of DMH staff. They will likely be familiar with the demographics, customs and culture of the affected population and the geography. Additionally, chapter-affiliated DMH volunteers both know and have contacts with the local and/or state mental health system, which is a valuable resource in service delivery. These volunteers need to be in-processed by Staff Services before being assigned to service sites.

Using spontaneous and local volunteers and partner responders

Spontaneous DMH volunteers are mental health volunteers from the community who are not yet trained or affiliated with the local Red Cross chapter. Local DMH volunteers are already affiliated, but may only be able to volunteer for one or two days before returning to their family or work commitments. Partner mental health responders (e.g., community crisis responders), with significantly varying capacities, can be a valuable part of the overall disaster mental health response.

Use the following guidance for these types of responders:

- When using spontaneous DMH volunteers, plan for the extra time it will take to complete a background check, conduct FDMH training, and facilitate registration orientation to the relief operation structure and services.
- Local DMH volunteers should be encouraged to commit to at least one full-day or

repeated half-days of time. Individuals who can offer only a few hours may still be able to provide out-processing support or make themselves available for pro bono mental health referrals. Local DMH volunteers can be invaluable in their ability to make connections with the local service providers and help visiting responders navigate unfamiliar terrain.

- Partner mental health responders can provide disaster mental health support to affected communities and Red Cross service delivery sites. Partner DMH providers are not required to meet DMH-eligibility requirements or to complete Red Cross DMH training (although FDMH and PFA training is recommended). They will wear their own agency identification and can provide an invaluable bridge for Red Cross clients to quickly connect with ongoing community mental health services. Partner DMH responders should be engaged prior to the disaster and must be clearly identified as members of a sponsoring organization that is part of the disaster Incident Command Structure (ICS). Red Cross DMH does not coordinate service delivery with loosely-affiliated mental health professionals who do not fit within the ICS structure.

Using PsySTART to determine staffing adjustments

As the DMH lead, it is your responsibility to maintain an overview of the changing mental health needs of the DRO. Use PsySTART risk factor data to inform your planning efforts. (See also, Using PsySTART to enhance service delivery).

Needed supplies

As the DMH lead, you are responsible for obtaining sufficient materials for the DMH response. You should inventory the DMH supplies and forms that may be available through the chapter, on the DRO computer and on the Red Cross intranet. Additional supplies can be ordered through Logistics. A lockbox is needed to store forms or materials that include confidential information. The following is a list of supplies and forms that are typically needed to begin DMH service delivery. A "best practice" for DMH leaders is to deploy with a "Go Kit" of the following forms and supplies so that you can organize the DMH activity and initiate DMH services as soon as you arrive on the DRO, even if internet connectivity, electrical power, computers or printers are not yet available.

Administrative forms

Form	Description
DMH After-Hours Roster	Used for documenting the 24-hour DMH phone numbers for after-hour client or staff mental health needs.
DMH Attendance Chart	Used for tracking arrival and departure dates, days off and attendance.
DMH Personnel Roster	Used for obtaining personal information, licensing data and verification, arrival and departure dates, job and personal cell phone information and rental car information.
PsySTART Aggregated Worksheet and PsySTART Supervisor Daily Summary	Used on all disasters to track client risk factors and client and staff contacts. On large DROs, leadership may synthesize PsySTART data using an Excel spreadsheet or web-enabled phone technology.
Daily Narrative Situation Report	Used for a brief reporting of DMH service delivery progress, plans and challenges.

Client forms

Form	Description
Client Health Record	Used by DMH workers to record confidential information regarding assessments and/or services provided to clients.
Client Assistance Memorandum	Used by DMH worker to refer clients to HS or Client Casework. (This form may be used to refer clients to DMH. It should not contain confidential information.)
Client Consent to Share Information	Used with clients to provide information to external agencies when referrals are made.
Disaster Registration and Case Record (Form 901)	Used by Client Casework to provide services to clients. May be used to note that a client is being referred to DMH.
Staff Health Illness and Injury Record	Used in collaboration with Staff Wellness to record incidents involving staff mental health.

Continued on next page

Needed supplies (Continued)

Educational materials

Material	Description
"Taking Care of Your Emotional Health After a Disaster"	This brochure is frequently distributed during a disaster operation and by chapters after a DAT response. Logistics can assist in ordering as a tear sheet in packages of 10 tablets (50 sheets per tablet) with a minimum order of two packages. It is available in English and Spanish.
"Helping Children Cope with Disaster"	This brochure is frequently used during a disaster operation and by chapters after a DAT response. The brochure is available in English and Spanish. Supplies of the as can be ordered from the Logistics activity. For the English version, order #658619, and for the Spanish version, order #658620.

Other materials

Supplies	Description
Suggested material supplies for children	• Generic coloring books • Newsprint • Crayons
Stuffed animals	• Stuffed animals for disaster survivors can be ordered through Logistics.
Special materials	• Supplies are available that address special needs, such as materials on coping with disaster printed in languages other than English. Check with Logistics to determine what is available.

Ordering supplies

Logistics is responsible for procuring and allocating necessary supplies. All supplies are ordered using the Disaster Requisition form.

Arranging supply distribution

Options for delivering supplies to service delivery sites include:

- Having workers take supplies to their sites as they are assigned from DRO headquarters;
- Using the disaster response courier service, if one is established;
- Dropping off supplies during leadership site visits;
- Sending supplies with non-DMH workers who are traveling from response headquarters to the site.

Managing rental cars and electronic equipment

The following procedures are for managing rental cars and electronic equipment assigned to DMH staff.

Equipment	Description
Rental cars	The Transportation activity tracks rental cars by the individual to whom the car is assigned and the specific activity. As noted earlier, rental cars are shared by multiple responders and multiple activities. To request a rental car, the DMH lead must complete a Disaster Requisition. A general rule of thumb is that there should not be more than one rental car for every two responders on the DRO.
Cell phones	Cell phones should be obtained for the DMH lead and all DMH managers, service delivery site DMH supervisors, the worker covering staff mental health and workers who will not have access to a site or team phone. A Disaster Requisition must be signed by the DMH lead and submitted to Disaster Services Technology (DST) to obtain a cell phone.
Computers	DST will provide one laptop computer for DMH at the DRO headquarters. For large disaster operations, two computers should be requested for DMH. These computers are preloaded with forms necessary for service delivery and activity use.

Reporting PsySTART data to DMH at national headquarters

When requested, PsySTART data should be sent periodically to national headquarters so that the DMH Disaster Operations Center (DOC) liaison can assist with tracking trends of mental health needs across the disaster operation.

Approval of financial client assistance

As the DMH lead on the disaster operation you must pre-approve all financial expenditures, including the $500 categorized as Class 5M. (See the section on Financial Assistance.)

Partnering with Internal Groups

Collaboration within the Red Cross

An effective disaster operation depends on collaborative relationships among all of the activities deployed to that community. As the DMH lead, it is your responsibility to forge and maintain good working partnerships with all of the other activity leads and Operations Management.

National headquarters DMH leadership

A DMH Disaster Operations Center (DOC) liaison at national headquarters will be assigned to support you in your role as DMH lead for the DRO. That liaison will ask you to report on the DMH needs in the community, client service delivery plans, staffing needs, partner organizations and on responder mental health trends. You may use this person for support and technical guidance. However, it is important to remember that DMH service delivery plans and staffing requests are approved by OM leadership on the DRO, not your liaison at national headquarters.

Chapter DMH leadership

As soon as possible, and in coordination with OM leadership on the DRO, you should contact the affected chapter's DMH lead to determine what that team has been doing so far and what DMH resources may be available. Remember that the workers at the chapter are always the first to respond and they may be tired, stressed or directly impacted by the disaster. There is sometimes a tendency for chapter personnel to feel that responders from outside the affected chapter jurisdiction are "outsiders" and are taking the disaster operation away from the local workers. It is important to be sensitive to these concerns and to engage local responders in the planning and service delivery efforts whenever possible. Remember that the chapter DMH lead will inherit follow-up DMH needs after the DRO transitions back to the chapters.

Operations Management

As the DMH lead, your administrative supervisor on a disaster operation is leadership from Operations Management, frequently the Assistant Director for Direct Services or the Job Director. This is the person to whom you will report your needs for staff or other resources. You will work closely with OM and other activity leadership to develop a plan to provide DMH services at all client service sites. If there are problems at a site noted by your DMH supervisors or workers, you should inform OM or the appropriate activity lead. Also, it is important to keep your OM supervisor apprised of any mental health trends that are observed among staff. This person will complete your evaluation with technical input from the national headquarters liaison.

You should keep your administrative supervisor informed about the following DMH activities:

- DMH service delivery plan
- Daily reports and situation reports
- Mental health issues and resources relevant to the community's long-term recovery
- Schedule for PFA training for relief operation workers
- Relationships with the community and the local chapter(s)
- Personnel issues and challenges
- Trends identified during out-processing support
- Transition plan
- DMH table of organization

Mass Care

DMH often works closely with Mass Care at feeding sites, in kitchens, on emergency aid stations and through bulk distribution. Mass Care workers who have been trained in PFA supplement the DMH work force in delivering emotional support to clients. A good working relationship is important in order to exchange the following kinds of information:

- Details about the opening and closing of shelters, kitchens, bulk distribution and other sites
- Levels of worker stress in these sites
- Possible referrals to DMH and information regarding community mental health needs

Client Casework

DMH needs to work closely with Client Casework on ICTs and outreach teams and at service sites. The Client Casework lead can inform DMH of potential client mental health issues and can support DMH when DMH needs to issue Class 5 monies for a client.

Health Services

DMH works most closely with Health Services to provide services to clients in shelters, especially those with functional or access needs, and on outreach teams. The HS lead can be helpful in assessing community mental health needs and collaborating with DMH to get those needs met.

Staff Services

DMH works with Staff Services (Staff Wellness and Staff Relations) in three ways:

- Assisting with training and orientation
- Providing emotional support for staff
- Assessing worker mental status and developing follow-up recommendations and plans of care

The Staff Relations lead may ask DMH to collaborate when staff members have conflicts or other performance-related issues surface. If accommodations are needed to decrease staff stress, DMH will work with Staff Relations to facilitate the changes.

Staff Wellness may ask DMH to collaborate on issues related to mental health or illness among staff.

Training

Training activity leadership at disaster headquarters may ask for DMH assistance in providing stress reduction or other related information for operational orientations. DMH staff can also offer to provide information to the Training activity for orientations. DMH may provide PFA courses on relief operations.

All training on relief operations should be coordinated with Training activity staff, who can assist with classroom space, obtaining materials and access to the Red Cross learning management system. The Training activity is responsible for collecting and reporting all training statistics needed for daily reports for the Disaster Operations Control.

DMH workers bring professional training and expertise to their roles in disaster response. This knowledgebase can be used to assist with training of other workers in areas affecting their psychological health. Training new DMH workers on the job is important for building chapter capacity as well as for providing an effective disaster

response. Following are courses that may be offered by DMH activity trainers:

Psychological First Aid (PFA)
All Red Cross workers are advised to take the "Psychological First Aid: Helping Others in Times of Stress" course for disaster workers. In doing so, all workers are then prepared to assist with a number of the mental health needs that arise during a disaster relief effort. This course may be offered at a DRO site for any workers who have not previously taken the course when the time and facilities are available.

Foundations of Disaster Mental Health (FDMH)
During a DRO, DMH may offer the "Foundations of Disaster Mental Health" course for local qualified mental health professionals. If it is not feasible to provide the course onsite with a live instructor, it may also be offered as a webinar. Consult with your national headquarters liaison about this option.

Force Health Protection Training
"Mitigating Disaster Worker Risk: Force Health Protection Strategies" is a 90-minute interactive workshop which can be offered to Red Cross and partner responders. The PowerPoint presentation is available on the DMH Disaster Services neighborhood. This training presents strategies to:
- Increase the physical and mental health fitness of the work force;
- Provide pre-deployment, deployment and post-deployment support;
- Reduce compassion fatigue, including burnout and secondary trauma.

The training is based on the assumption the recognition that a healthy work force is best positioned to achieve its mission. Focus beyond the individual worker to address obstacles and strategies for supervisors and the organization.

Community Partnerships and Government Operations

DMH works closely with the Community Partnerships (CPS) activity when collaborating with other mental health organizations in the community. CPS can inform DMH what they are hearing from other organizations about mental health needs in the community. CPS may link DMH with mental health organizations who approached Red Cross to become a partner. Or CPS may proactively search for local mental health partners. DMH needs to inform CPS on their partnering efforts so that CPS can maintain accurate records on each DRO.

DMH works with the Government Operations activity to facilitate connections to government agencies and programs such as behavioral health offices and Medical Reserve Corps. Government Operations can also disseminate information related to mental health needs and available resources.

Disaster Spiritual Care

Disaster Spiritual Care (DSC) is an organized body of board-certified chaplains who provide leadership and spiritual care services, along with local clergy. They are typically deployed in the following situations:
- Mass casualty events
- Aviation or transportation incidents
- Natural and human-caused local disasters
- Terrorist events
- By government request

DSC works closely with DMH. DSC leads may also be deployed to large relief operations to assist in supporting and coordinating the local spiritual care partner

response. DSC members are invaluable in protecting service delivery sites from exploitive, uninvited organizations that frequently descend on high-profile disasters. When there have been a large number of fatalities in a natural disaster, DSC may be involved in providing support through ICTs.

In other circumstances, the Red Cross is not a provider of spiritual care. While there is no Red Cross spiritual care activity when DSC is not activated, the chapter may partner with spiritual care groups on a community level.

Partnering with External Groups

Working with partners

State and local public mental health agencies (including Behavioral Health Emergency Response teams) hold primary responsibility for the community's disaster mental health response plan. However, the size and strength of these resources and teams vary greatly in each community. In keeping with the general Red Cross mandate, the DMH responsibility is to assist in the effort to fill the gaps and augment the community's disaster mental health response.

Establishing DMH local partners

The DMH lead should solicit from the DMH chapter lead and/or mental health partner agencies the following information:

- What can generally be expected of the community mental health system?
- What are the cultural resources of the community?
- What services are available to individuals with unique needs (e.g., limited English language proficiency)?
- Who are the trusted community organizations and "gatekeepers," and how can DMH partner with them?
- What generally can be expected from the community's spiritual care providers?
- Which service delivery sites will partner agencies be supporting?
- How do DMH services best fit with and augment the existing community services?
- How can the duplication of services be avoided?
- What are partner contact names and phone numbers?
- How can regular communication be established as recovery progresses?

Communication with local partners

DMH leadership should maintain regular and frequent contact with local partners for several reasons:

- To avoid duplicative service delivery efforts
- To identify gaps in services
- To fill service delivery needs, especially in surge situations when the DMH team is under-resourced
- To apprise partners of PsySTART risk factors, long-term mental health trends and long-term recovery needs
- To ensure that properly authorized individuals have access to their clients who may be shelter residents

Assisting with local grant proposals

If community mental health officials apply for a FEMA crisis counseling program grant, the proposal may require Red Cross data reflecting the DMH level of activity and identified mental health needs. You can share aggregate PsySTART data with local or state officials for this purpose.

Child care services

DMH works with Mass Care and Community Partnerships leadership to arrange for appropriate child care in Red Cross service delivery sites on large relief operations or mass casualty disasters. Children's Disaster Services is a frequent Red Cross partner that recruits, trains and maintains a disaster response team. There also may be occasions when the Red Cross will partner with another organization.

Scaling Down the DMH Activity

Transferring activities from the relief operation to local chapter

The timing of transferring leadership of the DMH activity back to the chapter is usually in concert with other direct services. As long as there are large numbers of DRO workers and clients, there is need for a robust DMH team. The visiting DMH team cannot scale down the response until the number of open DMH referrals can be managed by the local chapter's DMH volunteers.

DMH narrative

Before you leave the DRO, as the DMH lead, you will need to complete a narrative report that details the overall activities noting the successes and challenges of the DMH effort on the DRO and submit the report to OM and to the national headquarters Disaster Operations Center DMH liaison. A template for this form is located on the DR computer.

The narrative should cover the following topics:
- Relationships with other agencies
- Relationships with other Red Cross activities
- Significant and unusual factors in the disaster operation
- Summary
- Recommendations for the future

In addition, you should add a breakdown of the number of visiting and local DMH workers by discipline and number of days worked

Throughout the DRO, you have been talking with your workers to identify out-processing support trends and giving real-time feedback to OM. At the end of the disaster operation, your narrative should contain a comprehensive summary of those trends throughout the disaster response.

All DMH workers should be asked to submit a narrative to their supervisor. Ask workers if they prefer to have their narratives read only by national headquarters staff or if they are willing to let you review their narrative. Activities can be adjusted if necessary based on the feedback.

An example of a DMH narrative can be found on the DMH neighborhood.

Release of DMH staff

As service delivery plans change, so do your DMH staffing needs. The scope and size of the disaster operation and service delivery sites will become clear over time. The Staff Request form is also used to reduce or cancel outstanding staff requests.

Out-processing support with outgoing workers

At the end of the disaster operation, mental health out-processing support becomes an important DMH role. As the DMH lead, you should do the following:
- Ensure that sufficient DMH workers remain on the disaster operation to do out-processing support;
- If responders leave the operation without traveling through headquarters (sometimes called "virtual out-processing"), work with Staff Services to create a system to track when and where workers are leaving to be able to offer out-processing support;
- Consider assigning additional DMH workers to disaster headquarters if needed for

out-processing support;
- Consider deploying DMH workers to sites (e.g., large kitchens) where sufficient numbers of DMH workers may not be available to provide out-processing support.

Scaling down material resources

Leftover materials are typically left with the affected chapters to help them restock their pre-disaster supplies. Reallocation of materials must be coordinated with the Logistics activity for their tracking of all materials and supplies on the disaster operation.

Recordkeeping in the scaling down phase

DMH leadership will be asked to provide a written transition plan to the job director that will specify what DMH needs are anticipated after the DRO has closed and who will be responsible for continuing DMH support. Chapter DMH leadership should be a part of developing the plan. A template for the transition plan is on the computer assigned to DMH in the "forms needed for DROs" folder. The following components are included in the plan:

- Names and phone numbers of local mental health contacts if further interventions with clients or staff will be needed
- Plans for disposition of documents, including confidential records
- The name and contact information of the national headquarters liaison

Each person whose name is listed should be contacted to get permission to be included as part of the transition plan.

All confidential documents—Client Health Records, incident reports and individual narratives—should be sent to the DMH lead at national headquarters. Other elements of the DMH job book should be returned to the chapter (e.g., local resource lists, staff assignments, worker attendance, etc.).

Appendix A: Elements of Disaster Mental Health Response

Overview

Introduction

The elements of the disaster mental health response form a continuum of services from individual psychological triage and mental health surveillance to targeted interventions appropriate to clients and workers in the disaster setting. In practice, these elements are fluid. In a single encounter, you might practice several elements at the same time or move from one element to another without intermediate steps.

Elements of the DMH response

The following table describes the elements of a response that will be covered in this section.

Number	Element	Description
1	Identification of Mental Health Needs	When providing DMH services, it is necessary to identify and prioritize those in need of services. This section introduces strategies to conduct individual psychological triage and mental health surveillance of community needs.
2	Promotion of Resilience and Coping	As the second element in the continuum of disaster mental health services, you will be assisting clients and other Red Cross workers to cope effectively with the stress related to the disaster. You will learn how to use your clinical skills to go beyond the basic PFA actions and provide EPFA. Other interventions aimed at promoting resilience and coping include psychoeducation, community level support and community resilience training.
3	Targeted Interventions for Clients	In this section, you will find the targeted interventions that include: secondary assessments, referrals, crisis intervention, casualty support and advocacy.

Section 1: Element #1 – Identification of Mental Health Needs

Overview

Introduction

The identification of mental health needs during a disaster response can be difficult due to the scope and intensity of the setting. Traditionally, disaster mental health responders have focused primarily on people who appeared to be in the greatest emotional distress. However, symptoms exhibited in the immediate aftermath of a disaster are frequently transient and have limited utility in predicting the development of long-term psychological distress. In contrast, those with exposure-based and pre-disaster risk factors are at elevated risk for developing a new or aggravated clinical disorder. When determining how to prioritize your limited time and resources, you will use the guidance in this section to systematically identify and prioritize clients in need of services.

In this section

This section includes the following topics:

Individual Psychological Triage

Begin to provide DMH services

As a DMH worker, you will face a large number of clients and workers who might need your services. Use these guidelines to begin providing services (Young 2002):

- Check with your technical supervisor onsite, if available, about the best place to begin your work.
- If there is no technical supervisor at that location, the service manager and other workers at the site may be able to alert you to clients with emotional distress or risk factors.
- Observe the setting, noting environmental stressors and the general emotional tone of the population.
- Use your intuition to begin talking to clients. Engage them by asking practical questions, such as, "Can I get you a bottle of water?" or "Where are you from?"
- As you begin to hear the stories of individual clients or families, you will be able to use the triage tool described below to prioritize your services.

To prioritize services to clients and workers, you will need to be familiar with the guidance below, which includes the disaster exposure–based risk factors in the PsySTART Mental Health Triage System as well as the worker risk factors and stress reactions that are discussed in Chapter 4: Staff Mental Health Services.

Individual psychological triage and PsySTART

Triage allows for the ethical and rational allocation of limited DMH resources to individuals at greatest risk first. Triage addresses the priority of an individual to be seen by a DMH worker (and a community health provider for secondary assessment and/or support) not whether someone is seen by a DMH worker or not. Ultimately, as our resources allow, DMH workers see anyone that could benefit from DMH interventions.

Individual psychological triage is an adaptation of medical triage for use in disaster and emergency situations. The PsySTART Mental Health Triage System is a process of prioritizing clients on the basis of evidenced-based risk markers along a continuum of risk and resilience. (See Schreiber 2005; Schreiber et al., in press). See the next page for details on how to use the system.

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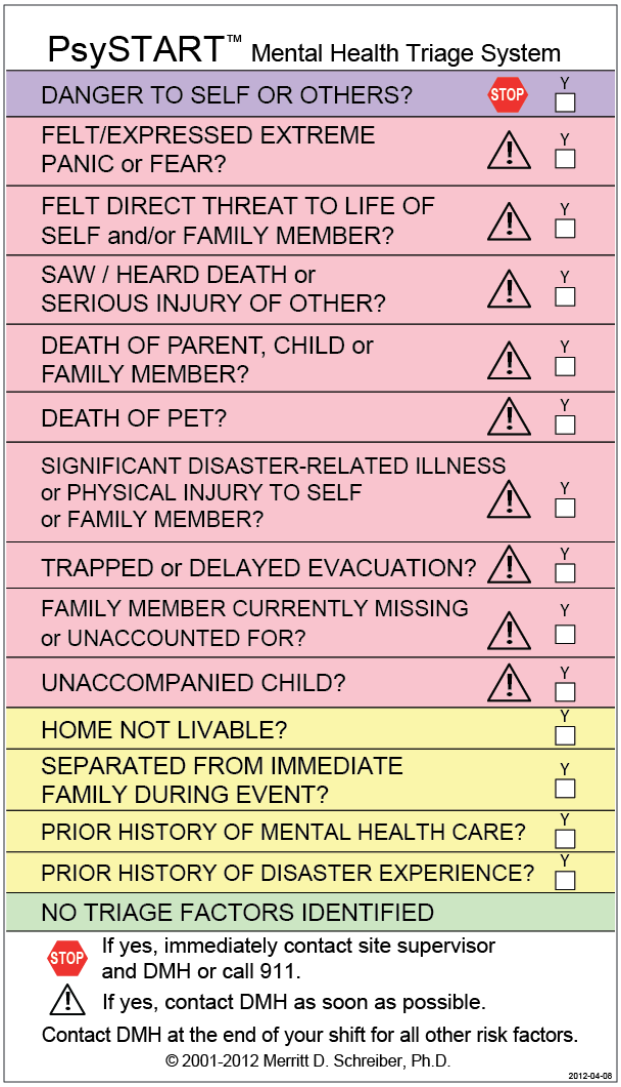
Individual psychological triage and PsySTART (Continued)

The PsySTART Mental Health Triage System:



The red (looks like pink on the card) triage risk factors convey independent risk. The greater the number of triage risk factors, the higher the likelihood the client will have a new or aggravated clinical disorder. Start with clients who have the greatest number of red triage risk factors present. After individuals with the greatest number of risk factors are seen, people with fewer factors can receive follow-up. For example, a client presenting with four red risk factors would receive follow-up ahead of a client with two red risk factors, unless other compelling reasons exist for a different strategy. Of course, mental health emergencies (individuals with the one purple triage risk factor) are always priorities and must be seen first.

Other situations requiring prompt DMH attention

In addition to the PsySTART risk factors above, your clinical judgment will point you to other situations that require prompt attention from a DMH worker. These circumstances include:

- A person is crying uncontrollably or withdraws over an extended period, or otherwise exhibits significant distress;

- A client is so distressed or has extreme limitations that require advocacy to get through the interview with the caseworker or access other critical disaster services;
- A client or worker behaves in such a way that makes it difficult for the service provider to provide services;
- A distressed worker or client asks for coping support, or has it requested for them by someone else.

In addition to triage by DMH workers, other Red Cross workers are trained in the PFA course to identify when to make referrals to DMH and how to provide emotional support to responders and clients.

Action steps for individual triage

The following are additional action steps for individual triage:

- Immediately contact local law enforcement and/or connect clients to acute care settings when they are at risk of harm to self or others and triaged as purple. The DMH lead at DRO headquarters will inform you of the local procedures for assessment and services for individuals at risk of harm to self or others.
- Prioritize clients for DMH support in order of the number of red then yellow risk factors.
- Prioritize children for secondary assessment when risk factors are present. Children, compared to other age-groups, have been found to be at increased risk after disaster (Norris et al. 2002b; Neria, Nandi, and Galea 2008; National Commission on Children and Disasters 2010).
- Conduct secondary assessments first with clients who have the greatest number of risk factors (See information on secondary assessment in this chapter.)
- Use your clinical judgment and common sense for deciding which emergent situations most critically require DMH intervention. Disaster leadership on a specific operation may also indicate circumstances that they believe are DMH priorities.

DMH surveillance using aggregated worksheets

An emerging national best practice is to use aggregated triage information to guide mental health disaster operations in real time based on actual patterns and levels of risk and needs.(See U.S. Department of Health and Human Services [DHHS] 2008; Gurwitch et al. 2004; Pynoos et al. 2005; Reissman et al. 2009; Schreiber et al., in press). Disaster mental health surveillance is accomplished through using worksheets that aggregate the individual client risk factor data that you report daily to your supervisor. These data guide DMH operations in several ways.

By using the combined triage information for a particular Red Cross service delivery site, the distribution of risk factors can be visually observed. Several different service sites can be compared at the same time to understand the relative distribution of levels of risk (e.g., red versus yellow versus green). Patterns of types of risk factors can be identified (e.g., shelter A has high numbers of clients who are children and lost their pets versus Shelter B, where many adult clients had delayed evacuation but they did not experience loss of loved ones or missing family members).

This information is useful at several levels described in the following table.

Role	Decision making from triage information
Worker	Triage information helps determine which clients need secondary assessment first and suggests areas of needed crisis intervention and other interventions by DMH workers.
Supervisor	When the combined triage information from several DMH workers is reviewed by the DMH supervisor, it helps the supervisor understand the levels and types of needs at particular service sites and also helps gauge the potential for secondary impact on DMH workers.
Leadership	Aggregated triage information across the entire disaster operation assists decision making regarding how many additional DMH workers are needed, where they need to be sent and what trends in mental health needs of clients are being observed. This information can also be shared with the DRO leadership and partners to help plan effective response and recovery efforts.

Section 2: Element #2 – Promotion of Resilience and Coping

Overview

Introduction

All clients and responders can benefit from support that focuses on increasing resilience and coping skills. In this section, we discuss psychological first aid as practiced by DMH responders and other strategies to promote resilience and coping for individuals and communities throughout the continuum of preparedness, response and recovery.

In this section

This section includes the following topics:

Enhanced Psychological First Aid

Enhanced psychological first aid (EPFA)

An important intervention that promotes resilience and coping is psychological first aid, currently seen as a best practice in disaster settings. PFA-trained lay disaster workers can effectively support individuals dealing with short-term distress while DMH workers provide EPFA for individuals at greater risk for long-term consequences. In this section, you will learn about the enhanced PFA actions that are practiced by DMH workers. This section is not a substitute for the "Psychological First Aid: Helping Others in Times of Stress" course; you should complete the basic PFA course to fully benefit from the following discussion on EPFA.

What is PFA?

The Red Cross disaster PFA course, "Psychological First Aid: Helping Others in Times of Stress" is a four-hour class that teaches all disaster workers the following:

- To identify disaster-caused stress symptoms in clients, coworkers and themselves;
- To provide immediate support to people experiencing stress by implementing PFA principles and actions;
- To obtain additional mental health support for clients, coworkers and themselves when needed.

PFA actions are organized into the following categories:

- Make a connection
- Help people be safe.
- Be kind, calm and compassionate.
- Meet people's basic needs.
- Listen.
- Give realistic reassurance.
- Encourage good coping.
- Help people connect.
- Give accurate and timely information.
- Make a referral to DMH.
- End the conversation.
- Take care of yourself.

All PFA-trained workers become an emotional support "force multiplier" as they provide support and triage to clients and other workers.

What is enhanced psychological first aid (EPFA)?

As a DMH worker, you provide EPFA by blending the PFA actions identified above with your professional knowledge and skills and the full range of DMH interventions. Whereas the Red Cross basic PFA (for all workers) and EPFA (DMH workers only) are clustered into the same 12 action categories, only DMH workers can perform EPFA actions that are discussed below.

Red Cross DMH interventions exist on a continuum of care from basic PFA to crisis intervention and referral. Accordingly, DMH workers use EPFA as the first step to engage clients who may or may not need a more formal intervention. Red Cross PFA and EPFA use a triage component that provides a bridge to secondary assessment and crisis intervention when indicated.

EPFA actions

The following table provides the actions to provide EPFA.

Action	Description
Make a connection	Introduce yourself by your first name and your role in the service setting in a non-intimidating manner. You can identify yourself generically as a disaster mental health worker or disaster counselor, or you can reference your professional discipline as a licensed psychologist, school counselor, etc. However, you should not identify yourself by using your professional title (e.g., "doctor"). Each community and disaster circumstance is different, and you should identify yourself in a way that is clear for each client and conveys that you will only be providing short-term support.
Help people be safe	There are times when clients or workers are overwhelmed or might decompensate or struggle to safely care for themselves. As a DMH worker, you assess the mental status of clients and determine whether he or she is oriented to person, place, time and circumstance and is able to safely care for themselves, or whether crisis intervention and/or an emergency referral is warranted.
Be kind, calm and compassionate	You can use relaxation and calming strategies with clients who are highly anxious or overwhelmed. Strategies can include deep-breathing exercises and activities to focus clients on the here-and-now or on anchoring feelings, thoughts and behaviors.
Meet people's basic needs	Before emotional support can be offered, people need to have food, water, shelter and safety. You may need to focus on basic needs before emotional needs can be met.
Listen	As a licensed mental health professional, you should already be skilled in active listening. Just paying close attention to a person's story may be the most effective healing strategy. This is your opportunity to listen for PsySTART risk factors as well.
Give realistic reassurance	While it is tempting to say, "Don't worry, it will be all right," as a DMH worker, you will use your clinical skills to offer only the reassurances that can be grounded, e.g., "The storm has passed and we are safe in the shelter for now."
Encourage good coping	As a DMH worker, you are uniquely positioned to identify dysfunctional coping strategies, such as substance abuse, violence and emotional withdrawal. You will want to encourage survivors and other workers to use healthy, effective coping strategies such as exercise, eating well and engaging in pleasurable activities.
Help people connect	Because we know that a person's connection to their social support system is a strong predictor of subsequent functioning, you will work with Safe and Well Linking, shelter registration and other activities to help people find their friends and family. Your professional mental health skills will help you listen for important support systems that have been underused and/or forgotten in the disaster aftermath.

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EPFA actions (Continued)

Give accurate and timely information	Accurate information imparts a sense of empowerment to survivors. Be aware that rumors often abound in disaster settings, especially in the early phases of the response. Be careful to only share information that has been grounded by the disaster response leadership.
Make a referral	In the Secondary Assessment and Referrals section, you will learn the appropriate procedures for making a referral to an external agency after a secondary assessment. Other Red Cross workers providing PFA will be referring to you at this step.
End the conversation	Because of the fluid nature of disaster settings and your responsibilities, you may have only one encounter with each client. Help the client to end the conversation feeling hopeful and with a plan in mind. You can provide a list of referral resources, but do not promise to reconnect with the client unless you are absolutely certain that you will have that opportunity.
Taking care of yourself (mission-critical)	Self-care is crucial for endurance and the avoidance of compassion fatigue, secondary traumatization and burnout. As a DMH worker, you will be listening to many difficult stories and exposed to a great deal of emotional pain. Model good self-care by taking breaks, using adaptive coping strategies and limiting your exposure to distressing sights and sounds. Please note that this is a mission-critical task, and refer to the Force Health Protection section in Chapter 4.

Referrals from non-DMH workers

DMH workers need to be prepared to perform secondary assessment of clients who are referred by non-DMH workers. Non-DMH PFA providers are trained to share the PsySTART triage risk factors they observed with DMH. Secondary assessment is discussed in detail in Element #3: Secondary Assessment and Referrals.

Individual Psychoeducation

Helping people understand their reactions to disaster

Reactions to disaster stress vary widely. One individual may become extremely task-oriented and appear to be coping very well. Another may become disoriented or distracted. DMH workers need to help individuals understand when their reactions are due to the expected stresses of the disaster. Reassuring both survivors and workers that they are functioning as well as can be expected given the circumstances will promote their resilience and lead to more adaptive coping strategies.

Action steps of individual psychoeducation

Types of Reactions to Disaster in Appendix B will help you determine whether an individual's reaction is outside the range of anticipated responses.

- If the person's response is within the range of typical reactions to disaster, provide educational brochures (e.g., "Taking Care of Your Emotional Health after a Disaster" or "Helping Children Cope with Disaster") and an opportunity to discuss his or her reactions with you.
- If the person is not calmed or reassured by your conversation, consider secondary assessment and further intervention strategies, such as crisis intervention or a referral to a mental health provider in the community.
- Use additional EPFA actions whenever appropriate.

Information that may be helpful for clients

Some of the information that may be helpful for clients (reproduced from "Taking Care of Your Emotional Health after a Disaster") includes the following:

What clients may be feeling: When we experience a disaster or other stressful life event, we can have a variety of reactions, all of which may be common responses to difficult situations. These reactions can include:

- Feeling physically and mentally drained;
- Having difficulty making decisions or staying focused on topics;
- Becoming easily frustrated, on a frequent basis;
- Experiencing frustration more quickly and more often;
- Arguing more with family and friends;
- Feeling tired, sad, numb, lonely, or worried;
- Experiencing changes in appetite or sleep patterns.

Taking action: Getting ourselves and our lives back in a routine that is comfortable for us takes time. Each positive action you take can help you feel better and more in control. Here are some tips that may help put your priorities in place and help you take care of yourself and your loved ones:

- Take care of your safety.
- Eat healthy.
- Get some rest.
- Stay connected with family and friends.
- Be patient with yourself and with those around you.
- Set priorities
- Gather information.
- Stay positive.

Community Resilience Support

Community resilience to disaster

Resilient communities can better sustain and support the recovery of individual disaster survivors. Working at the community level can have a profound impact and expand the reach of DMH support. Community resilience-building efforts are seen as an effective form of post-disaster community intervention (Padgett, 2002). Use the guidance below to engage in community resilience-building activities in the preparedness and recovery phases of disaster.

Importance of a community invitation

Bava et al. (2010) discuss the importance of a "community invitation" in which someone or some agency in the community requests consultation from mental health professionals. Providing services to the individuals in the community in the immediate aftermath of disaster may lead to an invitation from the community to provide broader support. DMH leadership should work with the affected chapter and relief operation leadership to facilitate and coordinate the services described below.

Community characteristics

Communities vary in size, pace, composition of residents, income levels, tax base, services rendered, types of agencies providing services to the population and level of cohesiveness, among other things. All of these variables can influence a community's response to a disaster.

In addition, there are some common phases through which a community passes after a disaster. Initially, there may be a suppression of any community conflict as disparate groups pull together to respond to the common "enemy." However, shortly after the disaster has ended, and the "honeymoon" period—with the abundance of emergency relief efforts—is over, social class differences and other preexisting issues will return and may be exacerbated. As relief efforts and resources come into the area and are mobilized, prior loyalties and divisions will reemerge.

Common community characteristics that may affect relief efforts and challenge a community's resilience include the following:

Characteristic	Description
Family	Understand how family networks and connections are influencing individual decisions and behaviors. Individuals with strong family networks may resist or not need outside assistance.
Level of integration	Consider the extent to which a person/family/group or neighborhood fits in with the larger community or with other groups in the community. Marginalized groups may not trust or be aware of organizations that provide recovery assistance. They may also be unable to access available assistance or resources.
Type of disaster	See Phases of Disaster Reactions for a description of the characteristic effects of different disasters.
Community's emergency response system	If the community has a well-trained, practiced system, the response will be more coordinated and will more likely be an effective response. A well-coordinated response facilitates psychological recovery.

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Community characteristics (Continued)

History of prior disasters	If a community has experience with similar prior disasters, their reactions will be different than if this is the first time; usually there will be a higher degree of coordination if the community has experienced a similar previous disaster. If there have been numerous disasters in a relatively short period of time, there may be less hope and resiliency.
Community mental health resources	Take into account both public and private resources and how these impact DMH services. A community with robust mental health resources will be able to collaborate more effectively during the immediate response. Pre-existing community mental health resources will also be crucial for long-term recovery.

Key approaches and techniques for promoting community resilience

As with individual and family interventions, there are a variety of ways to address community needs. Each of the following approaches can be adapted for different groups on the basis of their own characteristics, needs and requests. It is important to take time to learn what you can about the group with whom you will be working. Explore key historical events, facts, needs and requests. A good way to learn is to speak directly with group and community leaders.

Approach	Description
Psychoeducation	Psychoeducation is a frequently used approach for promoting community resilience. You should always adapt these presentations to the characteristics of the disaster and the audience. Examples include: • PFA for groups in the community; • PFA for disaster workers; • The "Coping in Today's World: Psychological First Aid and Resilience for Families, Friends and Neighbors" training program (if available); • Presentations about how people respond to disasters; • Presentations on disaster needs of specific populations.
Public messaging	Public mental health and disaster recovery information can help facilitate individual and community recovery. The Public Affairs activity collaborates with DMH to arrange and support these requests. You may be asked by your supervisor to do the following: • Be interviewed by a journalist • Be a guest on a televised show or event • Provide written materials to the media • Use social media to promote coping and resilience-building strategies

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Key approaches and techniques for promoting community resilience (Continued)

Community consultation	The Red Cross DMH program has expertise in the field of disaster mental health. After a disaster, groups or agencies within the affected community may request that DMH provide technical advice as a consultant to their organization. When performing as a disaster consultant to another group or agency, you should do the following: • Use Red Cross tip sheets and brochures; • Emphasize disaster recovery; • Normalize stress reactions; • Provide information on disaster-related resources.
Training professionals	To further build the capacity of a community to recover from the recent disaster and respond effectively to future disasters, you may be asked to teach any of the following courses to the affected community: "Foundations of Disaster Mental Health", "Psychological First Aid: Helping Others in Times of Stress" or "Mitigating Worker Risk: Force Health Protection Strategies".

Community partner relationships

There are a variety of community agencies and groups that DMH may partner with or provide services to during a disaster. The following table describes many of these potential partner groups.

Group	Description
Schools	Schools include K-12 and colleges/universities. Providing DMH services at schools can be a primary strategy for contacting and supporting children, young adults, families and school personnel affected by disasters. When delivering DMH services to schools, it is important to: 1) obtain prior approval from school administrators; and 2) collaborate with school counseling personnel during planning and service delivery efforts. More information on engaging schools and school districts can be found on the DMH neighborhood.
Local mental health agencies	It is important to develop partnerships with local mental health agencies (LMHAs). Engaging in joint disaster planning, exercising, and training activities with LMHAs can strengthen community-wide mental health services provided in the aftermath of a disaster. LMHA personnel affected by the disaster may also benefit from direct Red Cross DMH support.
Social service agencies	It is beneficial to make contact with social service agencies, such as the Administration on Aging, domestic violence agencies, crisis centers, drop-in centers for the seriously mentally ill, and homeless shelters. DMH support can take the form of services to individual workers or agency-wide collaboration, consultation or training activities.

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Community partner relationships (Continued)

Faith-based groups	Faith-based groups (e.g., local churches and synagogues) frequently provide disaster response and recovery services. It is important for DMH to both provide support to these groups and to coordinate planning and service delivery efforts. Some chapters may already have relationships with faith-based groups in the area. If that is the case, coordination should occur through those agreements.
Other community agencies	It is important to reach out to other community groups such as cultural centers, community advocacy groups, and immigrant/refugee agencies. These groups may provide language interpreters, cultural information and facilitate DMH entry into diverse communities.

Community Resilience Training

Community resilience training

Research shows that greater received and perceived social support is associated with less distress among disaster survivors (Norris et al., 2002a). Community resilience-building efforts are seen as an effective form of post-disaster community intervention (Padgett, 2002). Just as Red Cross chapters assist community members by providing physical first aid and CPR/AED training, a community PFA and resilience training program entitled "Coping in Today's World: Psychological First Aid and Resilience for Families, Friends and Neighbors" helps people cope with life's everyday stressors and prepare and recover from disasters.

Coping in Today's World: Psychological First Aid and Resilience for Families, Friends and Neighbors

"Coping in Today's World: Psychological First Aid and Resilience for Families, Friends and Neighbors" is a four-hour class that contains several components. Both the child and adult components incorporate positive coping strategies that address a broad range of stressors ranging from day-to-day challenges to large-scale disasters. The content of the course includes:

- Adult component—teaches participants how to build their own resilience and provide PFA;
- Child component—focuses on children's needs and teaches participants how to build resilience and provide PFA to children;
- A third component teaches participants how and when to seek additional support and community resources.

As of the writing of this handbook, "Coping in Today's World" is a pilot program that requires advanced approval from national headquarters before initiating community classes. For more information, contact the DMH staff at national headquarters.

Section 3: Element #3 – Targeted Interventions

Overview

Introduction

For some clients and workers, the actions of psychological first aid are not enough to alleviate their distress or mitigate long-term consequences. In those cases, additional interventions targeted to specific client and responder needs may be necessary. In this section we discuss how to make referrals to community providers, offer crisis intervention and casualty support, and advocate for needed resources. It is important to note that individuals who are not at high risk for adverse psychological consequences may also benefit from the interventions discussed below.

In this section

This section includes the following topics:

Secondary Assessment and Referrals

Secondary assessment of high-risk clients

For clients with a risk of long-term psychological consequences, e.g., people with at least one PsySTART red risk factor, you will need to perform a secondary assessment and determine the most appropriate type of intervention. The interventions described below should only be performed by individuals with professional clinical training (DMH workers). It is important to remember that disaster responders are exposed to significant stressors. Those deployed to areas where there has been significant death and destruction are at risk of secondary traumatization. The guidance on secondary assessment below is relevant to both to high risk clients and responders.

Step	Description
1	Assess the client's immediate needs using available information including his or her triage information as a guide to determine potential areas of intervention.
2	Assess the client's current level of distress and impairment within the disaster setting (which may be quite different than usual functioning).
3	Inquire about the client's interest in obtaining further DMH support.
4	Assess the client's current resilience factors, including current availability of a social support network. This is a priority area of discussion, since availability of a social support system is a key factor tied to the impact of risk on resilience (Norris et al., 2008; Ozer et al., 2003; Brewin et al., 2000).

If necessary, conduct crisis intervention that focuses on basic needs and problem solving following the Red Cross crisis intervention guidelines. (See Crisis Intervention in the next section.)

DMH referrals of clients to local mental health services

There is accumulating evidence that for individuals at risk, prompt secondary assessment, referral and linkage to certain evidenced-based interventions may result in improved outcomes (Roberts et al., 2010; Bryant, Moulds, and Nixon 2003; DHHS 2008; Brewin et al., 2010). It is important, therefore, to refer the client or responder to available community mental health resources if he or she remains in significant distress or has red risk factors after you've completed triage, secondary assessment and crisis intervention (if necessary).

Referrals are also made to external agencies or providers when the individual may require:

- A formal mental health evaluation;
- Ongoing counseling or psychotherapy;
- Medication (for replacement of client's existing medications lost or damaged during the disaster, contact Health Services);
- More than the brief support provided by DMH;
- Immediate hospitalization;
- Community support group services (e.g., grief or bereavement support, attention to problems experienced by children, etc.).

If the client agrees to a facilitated referral, you should have the client sign a Client Consent to Share Information form. You should also provide the information listed

below directly to the community mental health provider so as to improve subsequent assessment and treatment activities and highlight current needs that may result in improved client outcomes.

Some clients may not be ready to accept a referral. In these situations, you should provide local mental health resource information to the client and allow the client to contact the provider if and when he or she feels comfortable.

Components of the referral for mental health

When making a referral to a community mental health resource, you should complete a Client Health Record and include:

- Current client concerns;
- A complete listing of any PsySTART triage risk factors;
- Findings from the secondary assessment, including the client's current symptoms and level of distress;
- A summary of the results of all crisis intervention work with the client;
- Strengths and resilience factors evident from your assessment of the client;
- The completed written Client Consent to Share Information (needed only when DMH facilitates the referral).

Crisis Intervention

Crisis intervention defined

Conduct crisis intervention with clients and workers who are having significant difficulty coping with the stress of the disaster. Crisis intervention is a time-limited and goal-directed intervention to assist clients and Red Cross workers in resolving presenting problems, addressing stress, trauma and emotional conflicts resulting from a disaster.

This method is used to offer immediate, short-term help to persons who experience an event that causes emotional, mental, physical, and behavioral distress or problems. Crisis intervention techniques help to lower physiological arousal, increase clarity of the current situation, mitigate dysfunctional thinking and introduce adaptive coping mechanisms.

Purpose of crisis intervention

The purpose of crisis intervention is to offer short-term help to people experiencing a crisis during and after a disaster. Crisis intervention may prevent the development of a serious and long-term disability. You can help clients develop new coping patterns that will allow individuals and families to regain their equilibrium.

Red Cross crisis intervention

Crisis intervention in the Red Cross:

- Is time-limited (two to three contacts);
- Is focused on problems of daily living (immediate reactions to the disaster situation rather than intrapsychic conflict);
- Is oriented to the here and now (alleviating distress and enabling clients to regain equilibrium);
- Includes a high level of activity by the DMH worker (engaging with the client to identify immediate tasks for completion);
- Uses concrete tasks as a primary tactic of change efforts (the task development process involves clients in achieving a new state of equilibrium);
- Is more directive than approaches you may take in your non-disaster mental health work.

Steps in Red Cross crisis intervention

Providing support to clients in crisis can be accomplished in large part by the steps in enhanced psychological first aid. For those who need more support, supplement EPFA with the following crisis intervention actions:

Step	Description
Initiate support	Initiate crisis intervention by first: • Reducing the level of threat; • Rapidly establishing a rapport and promptly explaining to the client that your time-limited support will be focused on helping to resolve the immediate crisis; • Assuring that the client's basic needs are met; • Providing the client with information about what to expect from the crisis intervention process.

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Steps in Red Cross crisis intervention (Continued)

Evaluate the client's psychological state	Assessment includes: • The current crisis and relevant pre-disaster stressors; • The extent of mental health impairment in three domains—affective, behavioral and cognitive (Myer & Conte, 2006); • Prior problem-solving and coping abilities and perceived support systems; • Current coping ability; • Evaluation of the potential for self-injury. When appropriate, determine whether the client has the potential for self-injury by doing the following: • Asking direct questions about current suicidal thoughts and feelings; • Estimating the strength of the client's intent to inflict deadly harm; • Inquiring about suicidal history; • Considering risk factors such as depressed state, social isolation, level of losses as a result of the disaster and significant pre-disaster losses (e.g., recent divorce, unemployment, death of significant other, etc.).
Provide a calming presence	You can provide a calming presence by: • Using empathic responses; • Identifying crisis-related feelings; • Identifying crisis facts; • Assuring the client that his or her symptoms are a response to the disaster; • Instilling a feeling of realistic hope.
Be active, directive and focused	Directive strategies include: • Focus on the here-and-now (Roberts & Ottens, 2005); • Psychoeducation as appropriate for the individual's state of mind and the current crisis; • Identification of warning signs of maladaptive coping behaviors and responses; • Exploration of adaptive coping behaviors that may be substituted for behaviors being exhibited; • A description of the process of recovery; • An explanation of survivor guilt and anniversary reactions; • Identification of resources and support systems; • Recognition of the need for and process of obtaining additional mental health services.

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Steps in Red Cross crisis intervention (Continued)

Address feelings and emotions	Address feelings and emotions by following these guidelines: • Use active listening and a nonjudgmental posture to facilitate the individual's expression of emotions (Roberts, 1990). • Allow the client to express feelings and emotions about the current crisis situation (Roberts & Ottens, 2005), including feelings of guilt and responsibility associated with the disaster (Shelby & Tredinnick, 1995). • Refrain from assuming that the lack of expression of negative emotions is a form of denial (Mancini & Bonanno, 2006). • Share knowledge about the impact of the disaster to assist in correcting the individual's cognitive perception of the situation (Cohen, 1990). • Carefully use challenging responses such as reframing and interpretations to loosen clients' maladaptive beliefs and allow the client to consider alternatives (Roberts& Ottens, 2005). • Recognize cultural differences in the expression of emotions, particularly when the DMH worker differs in ethnicity, nationality or culture from the client.
Identify problems	The purpose of this step is to help the client develop awareness of the problems he or she is facing and help reduce the client's anxiety (Cohen, 1990). During the problem identification, you should: • Inquire about what happened; • Identify or define immediate and concrete problems; • Verify emotional readiness to begin problem identification and problem solving; • Clarify immediate needs in the current situation.
Explore coping strategies	When exploring past coping attempts, follow these guidelines: • Ask direct questions about the situation in which the client has had to cope with extreme stress, loss or disaster; • Explore successful strategies the individual has used in the past when confronted by a crisis; • Facilitate exploration of new coping strategies; • Suggest alternative coping methods (Roberts & Ottens, 2005).
Provide encouragement	When providing encouragement, you should: • Express confidence in the individual's or family's ability to manage the current situation; • Build on the individual's or family's strengths (Roberts & Ottens, 2005).

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Steps in Red Cross crisis intervention (Continued)

Identify possible solutions and resources	While exploring possible solutions and resources, keep in mind that clients are generally receptive to suggested alternatives. You should do the following: • Brainstorm with the client to generate a broad range of possible solutions and identify potential alternatives (Hepworth, Rooney, & Larsen, 2002). • Select possible solutions; • Develop plans for follow-through. Explore social support networks, including: • Key individuals or groups in the client's social network, including natural helping networks; • Areas of life in which the support occurs; • Whether the support is reciprocal or unidirectional; • The degree of personal closeness; • The frequency of contacts; • The length of the relationship (Hepworth, Rooney, & Larsen, 2002); • Whether the support person is likely to be able to offer help at this time.
Develop tasks	Clients in crisis can be overwhelmed and it is frequently helpful to break down goals into specific tasks. Consider the following: • Divide general tasks (e.g., relocate from the shelter to a rented apartment) into smaller manageable tasks (e.g., determine the target neighborhood for the relocation, identify available apartments, determine rent and utility charges, compare costs to the available housing budget). • Anticipate obstacles to task accomplishment and suggest remedies. It is important to develop tasks in a collaborative manner. The client's willingness to take on a task is directly related to task accomplishment (Reid, 1978).
Set an action plan	In setting an action plan with a client, you should: • Outline with the client the steps to accomplish tasks; • Express confidence in the individual's ability to achieve steps in the action plan; • Develop a realistic timeline for each step in the action plan.
Follow up	Depending upon the situation, developing a follow-up plan can be important. If the client is agreeable, you should: • Establish a follow-up schedule with the client to be completed in-person or by phone. • Clarify with the client the intent of the follow-up to check-in about accomplishment of the steps in the action plan. • Help the client develop a plan to obtain continuing support after your interaction, if necessary. • Keep in mind that DMH work is short-term and that you may not be available to see the client through the crisis.

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Steps in Red Cross crisis intervention (Continued)	Make referrals as indicated (See previous section)	Assess the need for immediate referral if the client's psychological state remains at a dangerous level; ongoing assessment will determine this need. See previous section for referral procedures.

Casualty Support

Casualty support introduction

In DMH, casualty support is the provision of a compassionate presence and emotional support to individuals affected by deaths or serious injuries due to a disaster. Intervention should be supportive and appropriate to the specific situation. In this section, you will learn about the principles of casualty support, the context of casualty support services, appropriate supports and referral principles. Often, casualty support occurs in conjunction with other DMH interventions, such as EPFA or crisis intervention.

Provision of casualty support services

Whereas DMH workers are expected to offer this support while working on ICTs or condolence visits, casualty support may also be offered to any client during any phase of DMH service delivery. In a disaster response, there may be a number of clients that experience the sudden and traumatic loss of loved ones. For some, this will entail an experience of traumatic grief. It is important to remember that local disaster responders also experience the death or serious injury of a loved one and that casualty support is provided to both disaster-affected clients and responders.

The core components of casualty support services include the following:

Core component	Description
Compassionate presence	Use EPFA techniques such as making a connection; being kind, calm and compassionate; listening to individuals who wish to share their story and responding to their concerns. An additional component of compassionate presence is being present in a way that communicates that the client is not alone, sometimes called "being with" or "bearing witness." Support is frequently nonverbal with the DMH responder listening more than conversing with the client.
Assist with practical needs	Use the EPFA technique of meeting people's basic needs: ensure that food, water, shelter and safety are available as needed. Clients may need assistance in gathering and providing materials requested by the authorities/medical examiner and making arrangements for receiving their loved one's remains. You may need to collaborate with Health Services regarding medical needs. DMH workers can assist clients in identifying necessary steps and making initial decisions about how to proceed.
Connect to support systems	Ask if there is anyone the client would like to connect with or have present; assist in arranging communication or visits with family, friends or other individuals identified by the client.
Aid in recognizing internal resources/coping skills	Identify internal strengths; support healthy choices for coping: connecting with others; staying hydrated; and use of religious or spiritual comfort if the client communicates that this is a personal resource.

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Provision of casualty support services (Continued)

Problem solving	Clients experiencing sudden loss may have temporary cognitive difficulties and may require assistance in identifying decisions that need to be made and determining initial problem-solving steps.
Supporting death notifications	Red Cross workers do not provide death notifications, but may be present when individuals/family/friends are receiving a death notification from the designated authority. The agency responsible for the death notification will determine if DMH can be present. Look for an opportunity to identify yourself to individuals responsible for providing death notifications and offer your services.
Hospital/morgue escort	If individuals/families are able to spend time with the deceased at a hospital or morgue, you can offer to accompany them. If the client accepts your offer, keep in mind the following: • In a large-scale event, there may be media present. You can assist affected individuals who wish to be shielded from the media and can also connect clients to the media if they request your help with this. • If children are present, you can prompt the adult(s) to consider if they should see the deceased. • You should ask affected individuals if they wish you to be present when they view the deceased or if they prefer to visit privately.
Assisting with family crisis communication	Clients may seek your assistance in how to inform family and friends of the loss of life and may ask for your presence when the information is shared. If family/friends who will receive this information are also hospitalized, you can recommend that the client discuss the timing of the notification with the hospital staff involved.
Guidance on supporting children	Use your clinical knowledge, training and understanding of the developmental stages to support clients who ask for guidance on how to inform and support children who are affected.
Referrals	Clients may benefit from referrals to local religious/spiritual providers or mental health workers for ongoing care.
Self-care	DMH self-care is mission-critical when providing casualty assistance. Prolonged exposure to intense levels of pain, despair or grief can be exhausting, and supporting others through the sudden loss of a loved one may trigger your own experiences with loss. You may have been exposed to the dead/dying and gruesome images and you may have supported colleagues and other agency personnel at the event. Be aware that your friends, family and colleagues may not want to hear the same amount of information about your experience that you are planning to share. Use EPFA self-care techniques, use your own internal resources and coping skills, engage in fulfilling activities if possible, or talk to another DMH worker if helpful.

Appropriate support for developmental stages

Appropriate support for individuals who have experienced major losses differs depending on the individual's developmental level (Slate & Scott, 2009). See Responding to the Needs of Children in Appendix B for more information about working with children and adolescents. In the following table you will find some suggestions for working with individuals of all ages.

Stage	Appropriate supports
Infant to 3 years old	Even though the very young do not yet understand the finality of death, they require some form of accurate explanation of why their loved one is no longer there. It is important to correct inaccurate beliefs (e.g., children can think that the deceased abandoned them). Terminology should be sufficiently concrete and simple, depending on what the specific child is able to understand.
Age 3–6 years	Honesty is again important, with increased detail provided only when it is important and can be comprehended by the particular child. Correct inaccurate beliefs (e.g., some children may feel that the death of a loved one or disaster-related losses were their fault because of something they thought, felt or did). As a referral, play and art therapies can be recommended for children who appear to be struggling with significant loss, since these exercises are useful for expressing emotions and processing grief (Glazer, 1998).
Age 6–12 years	Children in this age group begin to understand the finality of death and loss and the other potential consequences that may follow. Speculations over what might happen next may require extra reassurances that the child will be cared for, regardless of the losses and the aftermath. Opportunities to talk about their thoughts and feelings are helpful. If a death has occurred, allowing the child to participate in the planning of the service or memorial can be beneficial. In addition to possible referrals to play and art therapies, music and recreation therapies can be recommended as a referral resource for children of this age-group.
Age 13–18 years	Adolescents may feel torn between identifying with the emotional dependence and sadness of a child and needing to give the appearance of being strong and brave like an adult. Because reaching out to an adult might make them appear childlike, and reaching out to their peers may raise concerns of appearing weak, they are at risk for suppression of feelings and unhealthy independence. Unprocessed grief and bereavement during adolescence can lead to complications, such as depression, substance abuse, defiant behaviors, withdrawal and academic problems (Pottmeyer & Scott, 2008). Adolescents benefit from hearing that their feelings and confusion are normal. They often see themselves as invincible and loss of a loved one may disrupt this developmental process. A teen who is struggling may need to talk about this challenge to their self concept. Recommendations for counseling referrals include relaxation or yoga-type approaches, writing therapies, music and expressive (drama, projective arts, etc.) techniques. Depending on the individual, teens may also benefit from strategies recommended for adults.

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Appropriate support for developmental stages (Continued)

Adults	How adults experience and successfully process grief and bereavement varies widely. They may benefit from being encouraged to: • Attend support groups designed for people with similar losses; • Stay in touch with family and friends; • Talk about their episodes of weepiness and their loss-related triggers, as these occur; • Keep a journal; • Try relaxation techniques, yoga, meditation or prayer; • Eat well, get sufficient sleep and exercise; • Put off major decisions if possible until after they feel more stable; • Pursue personally comforting activities, such as past hobbies or things they have always wanted to do; • Consider and/or pursue any grieving-related practices that may be relevant to their specific culture or family tradition.
Elderly adults	Seniors have often already experienced loss, and they tend to be more reflective rather than looking forward toward how the loss will affect future goals. However, they can become discouraged if the loss is just one more in an ongoing series. Loneliness is common and is intensified when they suffer yet another loss of friend or family member. The loss of a loved can also reduce the elderly adult's network of trusted people available to talk to and process grief. Sadness and depression are common. Seniors benefit from the same strategies as recommended for other adults. However, they may require extra assistance in reworking or expanding their support network, since seniors are often not aware of services available to help them and may be reluctant to access this support. Seniors can become isolated when cognitive or physical challenges limit their abilities to get around on their own, and they may benefit from assistance with daily tasks.

Referral principles for grief reactions

You can expect a significant grief reaction when a person loses a loved one. Some individuals who are experiencing bereavement will require more than the basic supportive care offered immediately after a loss. These individuals should be referred for appropriate long-term intervention (Shear, 2007). See Secondary Assessment and Referrals above in this section for more information about that process.

Circumstances in which you should consider referring clients for additional care are described in the table on the following page.

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Referral principles for grief reactions (Continued)

Grief reaction	Description
Uncomplicated grief reaction	At times, referral is advisable for clients experiencing uncomplicated grief reactions, such as individuals who demonstrate limited coping skills, have a disability or are experiencing other ongoing conditions or circumstances that could impede coping and recovery. Also, an individual suffering a loss may have had exceptional interpersonal issues or attachments involving the deceased and thus could benefit from assistance in working through such issues.
Traumatic grief reactions	Individuals who experience the sudden loss of a loved one or person of significance in their lives in a traumatic manner, as sometimes occurs during a disaster, may develop what has been referred to as traumatic grief reactions. Typical symptoms of traumatic grief include: • Survivor guilt; • Feeling powerless over not having been able to prevent the death; • Self-blame, perceiving that a self-caused error somehow contributed to the death; • Anger, realistically or unrealistically perceiving that others are to blame; • Long-term emotional numbing as a means of coping; • Excessive feelings of vulnerability as a result of how the individual died.
Complicated grief reactions	If an individual continues to have significant difficulties six months following the loss, the possibility of complicated grief should be considered. If left untreated, such conditions can have negative effects not only on mental health, but also on physical well-being and interpersonal functioning. Symptoms of complicated grief may include (Prigerson et al., 1995): • Inability to stop thinking about the deceased; • Feeling upset by memories of the deceased; • Experiencing pain in the same areas as did the deceased; • Feeling drawn to places or items that remind them of the deceased; • Avoiding reminders of the death; • Feeling that life is empty; • Feeling stunned or dazed; • Experiencing a constant longing for the person; • Viewing death as unacceptable; • Experiencing disbelief that the death occurred; • Hearing the voice of the deceased; • Seeing the deceased; • Feeling anger or bitterness about the death; • Feeling envy of others; • Difficulty trusting others connected with the loss; • Difficulty caring about others.

Advocacy

Introduction

The last component of Element #3 is advocacy. Part of your job is to assist both clients and other disaster workers by helping them make their needs known and access needed support. You may need to be more directive than you have been in other professional settings to successfully advocate for resources and appropriate treatment in the disaster setting. Advocacy is especially important for high-risk clients who can benefit from timely access to community resources and treatment.

Advocacy for disaster clients

As a DMH worker, you will assess the disaster-related conditions with the client or family members to determine the need for advocacy. When dealing with sensitive issues, consult with your DMH supervisor before proceeding. Advocacy can enhance recovery by identifying client needs and, when necessary, communicating these needs to decision-makers, supervisors and/or providers of care, so that clients receive appropriate, culturally sensitive services. Advocacy involves educating and empowering clients to navigate resources and make important linkages, especially individuals who might otherwise avoid seeking help.

Advocacy also includes:

- Helping individuals affected by disasters communicate their needs to supervisors and/or care providers;
- Providing culturally competent services;
- Marshalling resources for people with functional and access needs;
- Providing information about relief programs and services available from the Red Cross, from local, state and federal agencies and from private organizations;
- Explaining and accompanying people as they go through the process of applying for services;
- Facilitating timely access to evidence-based community treatment such as trauma-focused cognitive behavioral therapy.

Advocacy for other Red Cross workers

In the process of assessing the stress of the workplace, you may find that you can sometimes facilitate Red Cross workers getting needed time off or make the case for improved working conditions. This step can be especially helpful for workers experiencing significant amounts of stress due to the disaster deployment or challenging circumstances at home. It is important to follow an appropriate chain of command and to make recommendations to your technical supervisor or to the site manager (your administrative supervisor). The Force Health Protection section in Chapter 4 provides more information on concerns related to the stresses that Red Cross workers experience and strategies for mitigating them.

In addition, you may be asked by Staff Services or Staff Wellness to assist Red Cross workers who are on assignment to get in touch with loved ones if there is an emergency at home. Read Procedures for Addressing Distressed Workers in Chapter 4 for a description of procedures for facilitating a volunteer's return home.

Appendix B: DMH Background and Context

Overview

Introduction

In this chapter, you will learn the factors that affect the community and their psychological needs after a disaster. The effect of disaster relief work on responders will also be described. Knowing the factors that determine how an individual copes with disaster will help you determine the appropriate type of intervention.

In this appendix

This appendix contains the following topics:

Typical emotional responses to disaster

Human reactions to disaster vary widely based on specific characteristics of the disaster, the organizational disaster response, the individual and the community. To be most effective as a Red Cross DMH worker, you will need to take these factors into account as you provide assistance.

Serving vulnerable populations

This section provides you with information on several populations that are considered to be "vulnerable" during a disaster (that is, they are more likely than others to experience adverse consequences due to the disaster). As you prioritize your work on a disaster, you need to take into account factors that are attributed to risk for poor mental health outcomes after natural and human-caused disasters. The Red Cross has a commitment to serving all community members, including individuals with access or functional needs, such as people with various disabilities, mental illnesses or chronic conditions needing care. As a DMH worker, we ask you to help other Red Cross workers understand the unique needs of these vulnerable groups. In addition, you may be asked to educate or support workers who have not had experience delivering services to these populations.

Section 1: Disasters and Human Reactions

Phases of Disaster Reactions

Introduction

Disasters can vary by type, size and key characteristics. People respond differently to disasters due to these characteristics. Understanding the range of likely responses will help you determine appropriate interventions. You will notice that the section describing common or expectable reactions to disaster is not extensive; this is because these reactions are very similar to responses you will see in many clinical settings and by people in many types of stressful situations. More detailed guidance is provided on the reactions of vulnerable populations or people in uncommon settings.

Characteristics of disasters

The characteristics of disasters vary with their onset, duration, scope and impact. This table provides you with information about each of these variables. Think about how your reaction to a disaster might differ based on these characteristics. For instance, if you have advanced warning, you may feel and be more prepared than if a disaster occurs suddenly, without time to prepare. The magnitude of a disaster is a combination of all of these factors, especially scope and impact. For example, although the scope of a tornado may be small if it occurs in a limited area, the impact may be great if it destroys essential services, such as hospitals or government buildings.

The Red Cross categorizes disasters based on the financial losses incurred by a community. These levels are helpful indicators of the impact of a disaster on the community, but do not describe the profound effect on an individual or family.

Stage	Description
Onset	A disaster can occur: • Suddenly and without warning; • With minimal advance notice; • Slowly and progressively over an extended period of time.
Duration	The duration of a disaster is measured from the time it starts to the time the immediate crisis has passed. Different disasters may: • Begin and end quickly; • Occur over hours, days or months.
Scope	The scope of a disaster is the geographic area or region that is affected. Disasters can occur in: • A relatively concentrated area; • A large geographic region.
Impact	The impact or intensity of the disaster is the extent to which the population or community infrastructure has been affected. Characteristics of the impact of a disaster include: • Number of injuries or deaths; • Loss of or damage to property; • Affect on the community's infrastructure (telecommunications, travel limitations, loss of major buildings, etc.).

Differences between natural and human-caused disasters

The U.S. Department of Health and Human Services' "Mental Health Response to Mass Violence and Terrorism: A Training Manual (2007)" offers characteristic differences between natural and human-caused disasters and their impact on survivors. Human-caused events often have a more devastating psychological impact on a community than natural disasters although either type of disaster may create profound human and material losses.

Dimension	Human-caused	Natural
Causation	Event includes a deliberate sociopolitical act, human cruelty, revenge, hate, bias against a group and/or mental illness.	Event is an act of nature, and severity of the impact may result from interaction between natural forces and human error or actions
Appraisal of event	Event seems incomprehensible and senseless. Some view it as uncontrollable and unpredictable; others view as preventable. Social order is violated.	Expectations are defined by disaster type. Awe is expressed about nature's power and destruction. Disasters with warnings increase a sense of predictability and controllability; recurring disasters pose an ongoing threat.
Subjective experience	Victims are suddenly caught unaware in a dangerous, life-threatening situation. They may experience terror, fear, horror, helplessness and a sense of betrayal and violation. Resulting distrust, fear of people, or being "out in the world" may cause withdrawal and isolation. Outrage, blaming the individual or group responsible, desire for revenge and demand for justice are common.	Separation from family members, evacuation, lack of warning, life threat, trauma and loss of irreplaceable property and homes contribute to disaster stress and reactions. Anger and blame may be expressed toward agencies and individuals responsible for prevention, mitigation and disaster relief.
World view/basic assumptions	Assumptions about humanity are shattered; individuals no longer feel that the world is secure, just and orderly. Survivors are confronted with the reality that bad things can happen to good people. People lose their illusion of invulnerability; anyone can be in the wrong place at the wrong time.	Spiritual beliefs may be shaken. There is loss of security that the earth is solid and dependable. People lose their illusion of invulnerability; anyone can be in the wrong place at the wrong time.

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Differences between natural and human-caused disasters (Continued)

Stigmatization of victims	Some victims may come to feel humiliation, responsibility for others' deaths, survivor guilt and self-blame and feel unworthy of assistance, thus assigning stigma to themselves. The larger community, associates, friends and even family may distance themselves to avoid confronting the idea that crime victimization can happen to anyone. Well-meaning loved ones may urge victims and the bereaved to "move on," causing them to feel rejected and wrong for continuing to suffer. Hate crimes reinforce the discrimination and stigma that targeted groups already experience.	Disasters tend to have a greater impact on people with fewer economic resources because they live in lower-cost, structurally vulnerable residences in higher-risk areas. Survivors from cultural, racial and ethnic groups; single-parent families; people with disabilities; and the elderly on fixed incomes experience greater barriers to recovery, causing double jeopardy and potential stigma.
Media	The media shows more interest in events of greater horror and psychological impact. Excessive and repeated media exposure puts people at risk for secondary traumatization. Risk includes violation of privacy.	Short-term media interest fosters a sense in the community that "the rest of the world has moved on." Media coverage can result in violations of privacy; there is a need to protect children, victims and families from traumatizing media exposure.
Secondary injury	Victims' needs may conflict with necessary steps in the criminal justice process. Steps required to obtain crime victim compensation and benefits can seem confusing, frustrating, bureaucratic, and dehumanizing and trigger feelings of helplessness. Crime victims may suffer prejudice and blame. Victims may feel that the remedy or punishment is inadequate in comparison to the crime and their losses.	Disaster relief and assistance agencies and bureaucratic procedures can be seen as inefficient, fraught with hassles, and impersonal. Disillusionment can set in when the gap between losses, needs, and available resources is realized. Victims rarely feel that they have been "made whole" through relief efforts.

Phases of disaster response

Disasters and their aftermaths can be categorized into five phases. Reactions that tend to occur in relation to certain phases of disaster are described for you in the table on the next page. It is important to note that survivors do not all go through every phase. There is significant variability in how people react and this will be described in detail in the next section.

Phase	Description
Warning or threat	During the warning or "threat" phase at the beginning of the disaster, many people feel vulnerable, unsafe, apprehensive and as if they have no control. Others may defend against it with an attitude of being invincible, which can develop into a state of despair if they do not adequately prepare and are severely affected.
Rescue	During the "rescue" or "heroic" phase, people are in "fight-or-flight" mode, rushing to save themselves or others, protecting or rescuing possessions, finding a place of safety or perhaps engaging in community activities such as sandbagging as they watch the waters rise.
Honeymoon	During the "honeymoon" phase, people are often relieved to have made it through the crisis, proud of how they handled it, feeling thankful, empowered and bonded with their community. They may dive whole-heartedly into cleaning and salvaging and begin working on their disaster recovery plan. Disaster relief operations are in full swing and many organizations have arrived to provide support and assistance.
Disillusionment	Over time, "disillusionment" begins to set in. People begin to realize the true impact of the event and how much they really have to do to recover. They also discover the extensive procedures they must go through to find help and the limitations of what helping agencies and organizations can do while assisting them. As the disaster event recedes into the past, media coverage can drop off and disaster relief agencies may be present in smaller numbers. Individuals may begin to feel abandoned or may become angry or depressed and blame those trying to help for not doing more.
Reconstruction/recovery	Eventually, people move on to "reconstruction" and "recovery," coming to terms with their circumstances and the recovery tasks before them. However, emotional recovery and reconstruction of homes and livelihoods may continue for years. Stress reactions are common during disaster anniversary dates or other circumstances which trigger memories of the disaster.

Types of Disaster Reactions

Emotional response to disaster

The emotional response to a disaster may vary widely from individual to individual, population to population and community to community (DeWolfe, 2000; Norris et al., 2002a; Ursano, McCaughey, & Fullerton, 1994). Most of the frequently observed adverse reactions to disaster are considered common or expectable. Fortunately, a robust display of resilience is also common and expectable among individuals affected by disaster (American Psychological Association, 2006; Bonanno, 2004; Neria, DiGrande, & Adams, 2011; Watson, Brymer, & Bonanno, 2011).

Resilience and posttraumatic growth

People are amazingly resilient; each individual getting through adversity by using his or her own unique strategies for coping with challenging situations. Most survivors do not go on to develop psychiatric conditions as a result of their disaster experience or early adverse reactions (Foa, Stein, & McFarlane, 2006; Silver et al., 2002).

Although adverse reactions are common, you should bear in mind that resilience and positive life changes are expected. Many disaster survivors actually report positive experiences and posttraumatic growth, at times occurring in tandem with posttraumatic stress symptoms (Holgersen, Boe, & Holen, 2010; McMillen, Smith, & Fisher, 1997). Be aware that an individual may experience both posttraumatic growth and a negative emotional response at different times and that one does not preclude the other.

Common adverse reactions to disasters

Adverse reactions to a disaster are classified as physical, emotional, cognitive, behavioral and spiritual ("International Society for Traumatic Stress Studies, 2005;" Young, Ford, & Watson, 2007a). During your disaster work, you will see many of these responses. It is likely you have also seen people with reactions like these in other clinical settings. Most people who experience these reactions will recover and return to previous functioning within a short period of time and will not progress to a diagnosable condition.

Adverse reaction	Description
Physical	Muscle tremors, fatigue, chills, sweating, nausea, shock symptoms, gastrointestinal distress, dizziness, difficulty breathing, chest pain, headaches, elevated blood pressure, a feeling of hollowness, weakness and sensitivity to noise
Emotional	Impatience, fear, anxiety, anger, irritability, numbness, loneliness, sadness, guilt, shame and lack of enjoyment in everyday activities
Cognitive	Difficulty concentrating or remembering things, confusion, limited attention span, decreased ability to make decisions, decreased ability to solve problems, calculation difficulties, recurring dreams or nightmares about the disaster, mentally reconstructing the events surrounding the disaster in an effort to make it come out differently and repeated thoughts or memories of the disaster that are difficult to stop

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Common adverse reactions to disasters (Continued)

Behavioral	Overprotecting self and family, isolating self from others, startling easily, sleeping problems, avoiding activities that serve as a reminder of the disaster, increased conflict with family members, keeping excessively busy to avoid thinking about the disaster, tearfulness, crying for no apparent reason, changes in appetite and increased alcohol and drug use
Spiritual	Crisis of faith, questioning basic religious beliefs ("Why did God let this happen?") and displaced anger toward authority figures

Exposure-based risk factors

While a display of resilience is common among individuals affected by disaster, a significant minority of direct disaster victims are at risk for a new or aggravated clinical disorder (Galea, 2005). Several exposure-based risk factors have been identified as contributing to the likelihood that an individual will experience long-term psychological complications as a result of a disaster.

The following exposure-based risk factors from the PsySTART tool are primary considerations when assessing an individual's reaction to disaster. The order below generally reflects the highest to lowest risk. Also, individuals experiencing multiple risk factors are at greater risk than individuals who experience only one or none.

- Danger to self or others
- Felt/expressed extreme panic or fear
- Felt direct threat to life of self and/or family member
- Saw/heard of serious injury of other
- Death of parent, child or family member
- Death of pet
- Trapped or delayed evacuation
- Unaccompanied child
- Significant disaster-related illness or physical injury to self or family member
- Family member currently missing or unaccounted for
- Home not livable
- Separated from immediate family during the event
- Prior history of mental health care
- Prior history of disaster experience

Grief reactions

Grief reactions are common as people adjust to the many losses that occur following a disaster, from minimal loss to death of loved ones and substantial property losses. In addition to losing personal belongings or a home, disaster survivors may lose their entire neighborhood or community, either due to its destruction or because they must relocate. They may lose friends and neighbors who relocate or pets that become separated from them or die as a result of the disaster. Their employment may be temporarily or even permanently disrupted. On a more existential level, survivors can experience the loss of their feelings of personal identity, or personal security and ability to take care of themselves (Dugan, 2007).

During the immediate aftermath of a disaster, survivors may feel numb or have difficulty accepting their loss. They may experience shock, anxiety or depression. Initial grief reactions to a disaster typically subside over time, as survivors process their grief similarly to individuals who face losses in other circumstances (Bonanno, 2004; Shear, 2007). Traumatic grief may occur after the death of someone important to the individual (adult or child) when they perceive the experience as traumatic.

Unlike more common grief reactions, clients with traumatic grief will likely need more DMH intervention. "The distinguishing feature of ...traumatic grief is that the trauma symptoms interfere with the individual's ability to go through the typical

process of bereavement. They can experience a combination of trauma and grief symptoms so severe that any thoughts or reminders—even happy ones—about the person who died can lead to frightening thoughts, images and/or memories of how the person died (National Child Traumatic Stress Network).

Trauma reaction processes

When people have experiences that produce strong emotional reactions and seem overwhelming, it is common for some aspects of cognitive or emotional processing to shut down (this is both an adaptive and protective response). After the crisis is over and the individual is feeling more able to cope with the circumstances, the previously shut down areas usually reengage and the individual can proceed towards "working through" or integrating the experience. The timing of this reengagement process differs from person to person and is easier for some than others, depending on the severity of the experience and the individual's strengths and weaknesses. For a minority of people affected by disaster, the cognitive or emotional processes may remain shut down and they may not successfully work through their traumatic experience. Individuals in this circumstance are at risk of developing serious conditions such as major depression or PTSD. In addition to disaster survivors, disaster workers are not immune to these processes (Fullerton, Ursano, & Wang, 2004; Van der Kolk, McFarlane, & Weisaeth, 1996).

Anniversary reactions

Some disaster clients and staff report having increases in stress-related feelings on or near the anniversary date of an incident for which they had participated in relief efforts (Daly et al., 2008; Elhai et al., 2006). Individuals having suffered a trauma tend to identify the month one year after the incident as the most difficult over the year or two that follow (Morgan et al., 1999). This phenomenon is often referred to as having an "anniversary reaction" (Bornstein & Clayton, 1972).

Anniversary reactions often involve common trauma symptoms such as:

- Arousal;
- Avoiding reminders of the trauma experienced during the relief effort;
- Re-experiencing thoughts and feelings that occurred at the time of the incident.

Most individuals feel better within a week or two after the anniversary. However, for some, anniversary reactions may trigger significant symptoms relating to the original trauma, and professional help may be advised (Hamblen, Friedman, & Schnurr, 2010). When significant anniversary dates for past disaster responses occur, affected chapters may choose to publicize DMH services or arrange a gathering that includes availability of DMH workers, to provide an opportunity for workers to process any new or lingering reactions.

Psychiatric diagnoses associated with disaster

People affected by disaster experience many of the same diagnoses commonly associated with trauma. Clients with preexisting behavioral health conditions may experience exacerbation of or other changes in symptoms (Amstadter et al., 2009; Ellick & Paradis, 2004; Foa, Stein, & McFarlane, 2006; McLeish & Del Ben, 2008; Pandya & Weiden, 2001).

On average, 30–40 percent of people who are direct victims of the disaster experience one or more psychiatric disorders after the event, such as PTSD, depression and anxiety (Galea, Nandi, & Vlahov, 2005; Bonanno et al., 2010; DiGrande et al., 2011). Research shows significant variability in these rates based on the following factors: severity of disaster exposures, traumatic loss of loved ones, other variables associated

with the trauma, and loss of social support. Prevalence rates higher than 30–40 percent can be anticipated after higher-intensity disasters, especially when multiple risk factors are present. For populations affected by lower-intensity disasters, research suggests that 5–10 percent of people in the community-at-large and 10–20 percent of responders will experience a disorder.

The following table describes some of the psychiatric diagnoses that have been reported by people affected by disaster. It is not within the DMH scope of approved interventions to diagnose survivors. However, it is helpful to be aware of the possible long-term implications of disaster as you are providing services.

Diagnosis	Description
Acute stress disorder	Some stress symptoms may occur almost immediately after a disaster. This occurrence can be a predictor of later development of PTSD. Acute stress disorder is conceptually similar to PTSD and shares many of the same symptoms. However, most people who display such symptoms during the immediate aftermath of a disaster usually recover within the following few months (Bryant, 2008).
Post Traumatic Stress Disorder (PTSD)	PTSD is the most commonly studied diagnosis associated with disaster (North, 2007). However, it should not be considered a "normal" response to traumatic events and disasters. Most of the time, when PTSD-like symptoms appear, they are transitory and the person recovers. Most clients are seen by Red Cross workers before the one-month duration required for a diagnosis of PTSD. Clients showing PTSD-like symptoms during that first month may be exhibiting symptoms of acute stress disorder. Research suggests that individuals most at risk for developing PTSD are those who experience the PTSD cluster called "avoidance"- or "numbing"-type symptoms during the first month following the incident (McMillen, North, & Smith, 2000; North, 2007). These include symptoms such as avoidance of discussions about the experience, numbed emotions, feeling detached from others, amnesia and substance abuse. An additional risk factor is having experienced an extreme emotional reaction at the time of the actual event.
Major depression	Risk of major depression after a disaster is also one of the more significant concerns (Nandi et al., 2009). Comorbidity with PTSD is common. Acute depression immediately after a disaster can be a strong predictor of severity of subsequent impairment. Individuals who have suffered significant personal losses or injuries are especially likely to develop a depressive disorder.
Substance use disorders	Whereas there is some association between experiencing a disaster and an increase in substance abuse, this appears more likely to be due to continuation, exacerbation or recurrence of preexisting substance use difficulties rather than new diagnoses as a result of the disaster (North et al., 2010).

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Psychiatric diagnoses associated with disaster (Continued)

Generalized anxiety disorder	Distress and anxiety are common reactions to disaster, but some may linger and become sufficiently ingrained to warrant a diagnosis of generalized anxiety disorder (Ghafoori et al., 2009).
Brief psychotic disorder	Disaster survivors may experience disruptions in their ability to distinguish between what is real and not real. However, these situations are relatively uncommon (Katz et al., 2002).

Section 2: Disaster Response Stress and Possible Outcomes for Disaster Workers

Disaster response stress

You may encounter considerable stressors even before arriving at your assignment location. During a deployment, the stressors you may encounter are categorized into two types of risk factors: 1) work-related risk factors (e.g., difficult living and working conditions), which can lead to increased risk for burnout and depression; and 2) trauma-related risk factors (e.g., exposure to serious or fatal injuries or vast community devastation), which can lead to increased risk for compassion fatigue, secondary traumatization and posttraumatic stress disorder (PTSD) or depression.

Pre-response stressors

Pre-response stressors include the following:

Potential stressors	Description
Responding locally	Responding at night to local disasters, personal worries about one's home and family, the community and degree of impact
Making arrangements at home	Changing appointments and arranging coverage for other previous commitments, selecting clothes and supplies, packing and getting needed information from the chapter for responding to national disasters
Travel	Stressors associated with long-distance travel and unfamiliarity of the community to which the worker is deployed
Anticipation of the unknowns	Questions about how badly the community has been affected and about responding to the disaster. For example: What hardship conditions will be required during the response? Will working with others assigned to the operation be easy or difficult? Will the operation be successful?
Arriving	Accessing information and resources for getting from the airport to the hotel or headquarters; unfamiliar surroundings with the potential for street signs and landmarks having become damaged or missing due to disaster impact
In-processing procedure	Completing forms, meeting with managers and receiving assignments, arranging for transportation, getting directions, tracking down material resources needed to do the job
"Hurry up and wait"	Waiting in line to accomplish in-processing tasks, or needing to wait for some time before being given disaster assignment

Common stress reactions of disaster workers

Although some workers develop significant adverse conditions, similar to disaster survivors, most will experience only transitory distress reactions. Workers use their usual resilience practices and regain their pre-disaster status, or perhaps even experience personal growth in the process.

The major issues emerging from investigation of stress reactions in disaster workers are shock, fatigue, anger, sadness, sleep disturbances and frustration with relief organization and agency effectiveness (Clukey, 2010). In general, however, stress reactions are similar to and as varied as reactions experienced by disaster survivors,

including anniversary reactions. The table below lists several areas of stress reactions commonly experienced by disaster workers (Young, Ford, & Watson 2007a).

Reactions	Description
Emotional	Temporary (up to a couple of weeks) feelings of shock, fear, grief, anger, resentment, guilt, shame, helplessness, hopelessness, apathy or emotional numbness (difficulty feeling love and intimacy or difficulty taking interest and pleasure in day-to-day activities)
Cognitive	Confusion, disorientation, indecisiveness, worry, shortened attention span, difficulty concentrating, memory loss, unwanted memories, self-blame
Physical	Tension, fatigue, edginess, difficulty sleeping, body aches or pain, startling easily, racing heartbeat, nausea, change in appetite and change in sex drive
Interpersonal	Relationships affected at school, work, in friendships, in relationships or as a parent; reactions such as distrust, irritability, conflict, withdrawal, isolation, feeling rejected or abandoned; being distant, judgmental or controlling

Work-related risk factors

The following are examples of deployment work-related risk factors that put workers at risk for burnout and depression:

- Delays in getting to work and not feeling fully productive on the disaster operation
- Working conditions that are difficult (such as exposure to harsh weather and temperatures, noise, crowded conditions, long hours, and other hardship conditions
- Sleeping conditions that are difficult (such as a staff shelter with noise, shared restrooms and showers and lack of privacy)
- Conflicts with coworkers or supervisors
- Exposures to unfamiliar culture, language, customs or foods
- Difficulties staying in touch with family and friends back home or having concerns about what is happening at home
- Discouragement about progress in accomplishing the mission
- Struggles related to prioritizing work and the perception that all tasks are urgent

Trauma-related risk factors

As with disaster survivors, some deployment risk factors are known to put workers at increased risk for compassion fatigue, secondary traumatization or new incidence disorders such as PTSD and/or major depression (West et al., 2008; Galea, Nandi, & Vlahov, 2005). Workers should take special care to note the presence of such risk factors, since individuals who encounter them are more likely to benefit from intervention. Examples of trauma-related risk factors include:

- Talking with many grieving or upset people who experienced significant losses from the disaster (e.g., loved ones, homes, belongings, etc.) or who have missing family members;
- Witnessing many serious or fatal injuries, particularly involving children, teammates and/or other workers;
- Witnessing catastrophic destruction of the physical infrastructure of communities;
- Feeling as if your life was in danger, such as experiencing aftershocks following

earthquakes or floodwaters continuing to rise, or worrying about additional possible terrorist attacks;
- Feeling concerned about potential adverse health effects from the deployment, particularly where there may be chemical, biological, radiological or nuclear exposure;
- Experiencing a disaster-related injury or illness.

Burnout

Burnout is a largely transitory condition produced by stress and overwork that involves exhaustion and diminishing interest in work-related activity (Maslach & Leiter, 2008). Burnout can also arise from the work-related risk factors described above. Staff who are beginning to burn out may exhibit the following conditions:

Reactions	Description
Work productivity	Quality or quantity of work drops off; disengaging from job priorities by spending more time socializing than working while on the job, finding excuses not to move forward in the job assignment or even show up at all
Interpersonal relationships	Insensitivity, including less interest or caring about people being served, coworkers or the response mission; withdrawal; excessive complaining, focus on blaming others rather than looking for solutions, or repeatedly bringing up specific unfortunate experiences
Attitudes	Sounding excessively cynical and irritable; engaging in emotional outbursts; seeming "stuck"
Cognitive	Difficulty with memory, information processing or decision making; feeling drained and emotionally exhausted; excessively focusing on specific unfortunate experiences
Physical	Difficulty relaxing or sleeping, feeling tired, having changes in appetite, experiencing various aches and pains or becoming susceptible to illness or being accident prone
Behavioral	Greater use of alcohol, caffeine or other substances that serve to alter state of consciousness; engaging in risky behaviors

Remedies for burnout include (Maslach & Leiter, 1997; Maslach et al., 2001):
- Some time off or a change in job assignment or setting;
- Stress management;
- Problem-based coping strategies;
- Social support;
- Organizational change addressing issues of inequities, or working toward making practices and policies more consistent with organizational values.

Compassion fatigue and secondary traumatization

Compassion fatigue in the form of secondary traumatization is a product of repeatedly hearing about others' traumatic experiences, such that the worker begins experiencing feelings of fear, pain or suffering similar to feelings that may occur among individuals who are directly affected. Compassion fatigue can result from the trauma-related risk factors described above.

The impact on the disaster worker goes beyond job-related behaviors and attitudes and may include:
- Impaired ability to feel empathy toward anyone;

- Impaired ability to relate to friends and family;
- Loss of sense of vision or purpose in life;
- Diminished creativity and sense of humor;
- Depression, stress-related disorders and some physical ailments.

Compassion fatigue has also been referred to as "secondary traumatic stress" and "vicarious stress." Some propose that the symptoms and internal processes for such workers are identical to those seen among individuals directly affected by a traumatic event. However, evidence suggests that workers who develop more severe conditions from vicarious exposures may actually do so because of additional independent risk factors such as having experienced trauma and/or the symptoms or conditions at other times in their lives (Figley, 2002; Sabin-Farrell & Turpin, 2003; Spinhoven & Verschuur, 2006).

Compassion fatigue appears more likely to trouble workers who are younger or less experienced, have preexisting histories of psychopathology, have a generally lower quality of life or feel less reassured about disaster aftermath outcome (Craig & Sprang, 2010; Spinhoven & Verschuur, 2006).

Force health protection strategies may mitigate or prevent compassion fatigue. However, for workers who develop compassion fatigue, recovery typically requires more than a vacation or change of job position. Workers who appear to have or believe they have compassion fatigue are best advised to consult with their personal health care providers.

Post-disaster psychological disorders and severe stress reactions

Although most disaster staff will experience resilience, some will experience psychological disorders after their disaster response experiences. These disorders typically are not addressed during a disaster response. As many as 10–20 percent of disaster workers of various types and roles will experience PTSD in the first year after the disaster. (For a review, see Galea, Nandi, & Vlahov, 2005). This rate is about half that of community members directly exposed to disaster.

PTSD is the most commonly reported new incidence disorder but is certainly not the only disorder that occurs either by itself or co-morbid with other disorders. For example, PTSD, major depression and/or alcohol abuse often co-occur in individuals who develop a post-disaster new incidence disorder. Other outcomes include anxiety disorders and substance abuse and other family role differences (Tucker et al., 1997). Findings from the events of September 11 indicated that 45 percent of workers not experiencing the criteria for PTSD nonetheless experienced significant stress reactions up to five years after their disaster response (Stellman et al., 2008).

Risk for psychological disorders is tied to the traumatic stressors described above. Deployments that involve chemical, biological, radiological or nuclear materials may result in more complicated and extended risk for new disorders (Slottje et al., 2007). Other risk factors for development of disorders after response can include a prior episode of the same disorder, trauma history (Evans et al., 2009) and past alcohol use. Lack of prior disaster experience or training is also a risk factor (Perrin et al., 2007).

As with compassion fatigue, these conditions are beyond the scope of what can be addressed using DMH practices alone. When encountered on the job, workers with these conditions can benefit from usual compassionate support and EPFA; however,

workers who experience these conditions are advised to consult with their primary health care provider and/or mental health care provider when they return home. Detailed discussion of addressing severe reactions to deployment or response appears later in this segment.

When working with a Red Cross worker who may have developed a deployment-induced or deployment-aggravated disorder, stressors or concerns that may involve their family members and their children should be addressed. Workers who developed PTSD also reported increased posttraumatic stress symptoms in their children (Stellman et al., 2008). Whereas staff mental health support should be brief and disaster deployment focused, psychoeducation and referral information can be provided to workers who have concerns about their family members.

Resilience factors and posttraumatic growth

Finally, it is important to note that although some staff will be at risk, many will be resilient; they will experience transitory distress reactions and then "bounce back" to their pre-disaster status. Importantly, despite challenging experiences and transitory distress, others will experience "posttraumatic growth". For example, positive deployment experiences include a feeling of being part of an important response effort or team, a sense of personal pride ("I was there when needed") and a deepening of their personal relationships and values based on their deployment experience (Alexander & Wynia, 2003; Tedeschi & Kilmer, 2005).

Section 3: Vulnerable Populations

Responding to the Needs of Children

Children as a high-risk group

After disasters, children are considered among the highest risk groups for mental health difficulties. The child's direct exposure to the disaster and related stressors influences his or her level of risk (Norris et al., 2002a). Other factors that determine the level of impact on children include how well the parents are coping and prior history of traumatic experience or mental health difficulties. A number of disaster-specific features, including levels of death, injury and destruction in the community and interruption in vital lifelines serving families (e.g., continuity of school attendance) are also significant (Norris et al., 2002a). For many children, depending on the factors above, distress will be short-lived.

However, the more immediate the intervention, the better the high-risk children will fare in the long-run after a disaster. PFA, described in Chapter 3 is a first step. For others, a timely referral to a community resource is important.

Key assumptions in working with children

When considering how to best help children after a disaster, there are four key assumptions:

- Children must be viewed from a developmental perspective.
- The family system is the primary source of support; it is important to build on family resilience and support parental coping.
- Multiple child-serving systems can support children and families and influence children's responses.
- After disasters, there is a continuum of risk to resilience for children; it is important to quickly identify high-risk children for secondary assessment and, if indicated, evidence-based treatment.

Developmental perspective

The developmental perspective includes the following principles:

- As with adults, children's reactions and likelihood of problems are influenced by their risk factors, including the degree of exposure to the event.
- The greater the number of risk factors a child has, the greater his or her likelihood for having significant reactions. These risk factors include those exposure-based factors listed in Appendix B, Section 1.
- A child's developmental level affects his or her level of understanding about the event: what happened, the current situation and his or her understanding of the ongoing danger.
- In turn, a child's understanding of the event and its aftermath affects his or her emotional and behavioral reactions.
- A child's development is fluid and ever-changing, and after a disaster, the developmental stage through which the child is progressing continues.
- A child's coping style and ability is tied to his or her developmental level, life experiences and personal strengths, including previous experiences in coping with adversities. Therefore, very young children, such as preschoolers, are significantly less likely to have experience coping with difficult and stressful situations than would be expected of an older child.

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Developmental perspective (Continued)

The following table illustrates for you common reactions of children after a disaster according to developmental phases.

Developmental phase	Common reactions of children after a disaster
Birth through 3 years	Infants do react to disasters. It is unclear whether infants and young children can truly process a disaster event or whether they are reacting to the distress in their caregivers and changes in their daily routine. They often have sleep and feeding problems that may result in medical concerns such as weight loss. They are more irritable and more difficult to console. Meeting developmental milestones may also be compromised.
4–6 years	Preschool children often become clingier and anxieties associated with separation and changes in routine are heightened. Increased behavior problems, increased activity levels and problems with attention are common. Children may show regression in previously achieved developmental progress.
7–10 years	Older children can understand the permanence of loss. They may become preoccupied with the details of the traumatic event and want to talk about it continuously. This preoccupation can interfere with their concentration at school and affect their academic performance. Children may hear inaccurate information from their peers, or misunderstand or make misattributions about the event. They may fear that the disaster will happen again. Emotions such as sadness, anger, guilt and shame may be present; these emotions can negatively affect their coping and behaviors. Concerns about safety and security may be heightened.
11–18 years	As children mature, their responses become more similar to those of adults. Much of adolescence is focused on moving out into the world. After a disaster, that world can seem far more dangerous and unsafe. Teenagers may react by becoming involved in dangerous, risk-taking behaviors, such as reckless driving and alcohol or drug use. Others may become fearful of leaving home and avoid social activity. Feelings of guilt and shame can be high. Teenagers can feel overwhelmed by their intense emotions, but not know how to communicate these to others. Sleep and appetite problems can emerge. Increased irritability and withdrawal (above the normal teenage behaviors) are often seen. Brief declines in school performance are common.

Family focus in DMH disaster response

Children and families represent perhaps the largest segment of the disaster-affected population that you as a DMH worker will encounter. After any disaster, children are considered a vulnerable and high-risk population. Because the child and family systems are intimately connected, DMH support for children is accomplished in large part by helping parents understand what to expect and what they might do to support their children. The handout "Helping Children Cope with Disaster" can guide parents to respond to the needs of their children and improve overall family coping.

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Family focus in DMH disaster response (Continued)

The following principles are helpful when educating the family and caregivers about children's reactions to disasters:

- When the family is stressed, the child is affected. When a child is stressed, it affects the family.
- For most children, connection with their family or caretakers will be the most crucial element for helping them recover after a disaster.
- When parents and caregivers work on building and maintaining their own resilience, they help their children.
- When parents and caregivers help their children cope and build resilience, they help manage their own stress.

As with adults, with appropriate care and support, children can and do recover from trauma, even when the trauma is severe.

Common adverse reactions to disaster

Children's reactions to disasters can be classified similarly to adult reactions: emotional, cognitive, behavioral, physical and spiritual. The following table provides children's common reactions in each of these categories. Children's reactions will vary and be influenced by age and development. Reactions may increase and decrease over time, which underscores the need for ongoing resource availability for families and the importance of strategies that can enhance resilience.

Children's reactions	Stress symptoms in children
Emotional	Fear, terror; helplessness; loss of interest; anger, rage; anxiety; guilt and shame; irritability; sadness; mood swings
Cognitive	Difficulty concentrating and thinking; difficulty learning new information; self-blame or thinking they are responsible for what happened; intrusive thoughts or memories, flashbacks; worry about the safety of themselves/others; preoccupation with death, suicidal ideation (adolescents); difficulty making decisions
Behavioral	Crying and whining; trembling; difficulty getting along with siblings, parents and friends; aggressive or disruptive behavior; temper tantrums (young children); irritability; reliving events through play (young children); avoiding people, places, situations; regressive behaviors (thumb sucking, bedwetting, not wanting to sleep alone); withdrawal; refusal to attend school or day care; clinging to parents and caregivers; becoming argumentative, defiant; asking a lot of questions or telling stories related to the disaster; using drugs and alcohol or other high-risk behaviors (adolescents)
Physical	Fatigue, sleep problems, including nightmares; increased activity level, hyperactivity; easily startled; physical complaints (e.g., headaches, stomach aches, etc.); changes in appetite; agitation; hyper-vigilance or being "on guard" for potential problems
Spiritual	Changes in relationship with and/or beliefs about a higher power; changes in involvement in spiritual activities and acceptance of spiritual outreach; questioning of beliefs; struggle with a sense of fairness

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Supportive child serving systems

In addition to the family system, adults within other social systems (e.g., teachers) frequently provide support in a child's life. Providing information about child disaster reactions to these adults can increase the effectiveness of support provided to the child. When parents and caregivers can activate support from these systems, children's abilities to cope and recover from a disaster are enhanced. These systems include the following:

- Schools
- Child care programs
- Extended family systems
- Faith-based groups and programs
- Cultural groups and programs
- Community-sponsored programs
- Extracurricular activities

Community referrals for high-risk children

For those children at high risk of experiencing a new or aggravated clinical disorder after the disaster, follow the guidance in Secondary Assessment and Referrals in Appendix A to work with the parent or caretaker to consider a referral to evidenced-based or evidence-informed treatment. When the child is not in any significant distress, both the child and parent may understandably be reluctant to pursue treatment. In these situations, providing education and information about future referral options may suffice. One example of a plan to meet the needs of children is the National Children's Disaster Mental Health Concept of Operations (Schreiber 2011).

Some examples of evidence-based or evidence-informed child-focused interventions are:

- Trauma-Focused Cognitive Behavior Therapy (TF-CBT), a national best-practice intervention for children of all ages. TF-CBT has repeatedly shown significant improvements in children who have experienced traumatic events and includes a focus on children who experience traumatic loss of loved ones.
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS), a short-term intervention that is conducted in a group format in school settings. CBITS has been successfully used with middle school– and high school–aged children in the aftermath of disasters.
- Healing After Trauma Skills (HATS), an intervention based on the scientific literature for use with children after disasters. HATS is conducted by lay professionals (e.g., teachers) or mental health professionals in a group setting (usually schools). This intervention has also been used after disasters.

Building resilience in children after disasters

Psychological resilience is the ability to recover quickly and effectively from challenges, adversity and difficult times. Children's resilience is influenced by their prior experiences and coping strategies and by the guidance and support received from parents, caregivers and others. After disasters, children can be helped to enhance their resilience, which may result in posttraumatic growth (moving to a higher level of functioning and coping than before the disaster).

The American Psychological Association's 10 tips for building resilience in children and teens are listed in the table on the following page.

Continued on next page

Building resilience in children after disasters (Continued)

Tip	Description
Make connections with others	When children are connected to others through family, friends and other activities, they are better able to cope with challenges.
Help children and teens help others	Disasters often leave children feeling helpless or overwhelmed. They can begin to feel more empowered when they find a single way to reach out and help others who may also be in distress.
Maintain a daily routine	The structure of a routine, in any setting, can increase a sense of security, comfort and predictability in a child's life that is disrupted by disaster.
Take a break	When a child's focus is consumed by the disaster, reactions to the disaster may increase. Therefore, it is important for parents and caregivers to encourage children to engage in non disaster-related conversations and activities. It is always important to limit children's exposure to media coverage of the disaster.
Teach children self-care	When children can help take care of themselves (e.g., eating well, getting exercise, dressing themselves, playing alone for a limited time), they can reduce feelings of stress caused by the disaster and feel more empowered to take control of their lives.
Help children and teens set and move toward their goals	Setting small goals and defining the steps needed to reach these goals is an important way to build children's resilience. As goals are accomplished, provide encouragement and praise. Meeting goals is one important way to increase children's self-confidence.
Nurture a positive self-view	When parents and other caregivers foster a belief in their children's abilities to cope with difficult situations and challenges, resilience is enhanced.
Keep things in perspective and maintain a hopeful outlook	Helping children take an appropriate perspective of the disaster in their lives can help them from becoming overwhelmed by the disaster. The disaster can be seen as a "change for now" rather than a "change forever." Identifying positive coping strategies can help children develop a more optimistic view of the future.
Look for opportunities for self-discovery	Helping children recognize efforts they make and how they use positive coping strategies will support their self-esteem and reinforce a sense that they can successfully cope with difficult and challenging situations.
Help children accept that change is a part of living	Although change is not always easy, helping children identify other times of change they have met with success (e.g., moving from grade to grade, advancements in extracurricular activities, developing new skills) will help them accept and cope with changes due to a disaster situation.

Role of parents and caregivers in promoting resilience in children

Parents and other caregivers are essential in helping children build resilience. Parents and caregivers enhance resilience when they serve as positive role models (practicing what they teach).

One resource that may be helpful for parents is the Department of Homeland Security website, Ready.gov/Kids that assists parents, schools and children prepare for disaster. The website includes a stand-alone brochure entitled "Listen, Protect, Connect" that offers parents instruction on how to provide PFA for their children.

The Frail Elderly

The frail elderly

Another group that may need special attention from DMH is the frail elderly. Frail elderly individuals have unique needs after a disaster because their health and functional status may delay their response. In this section, you will also learn about risk and resilience factors related to the needs of the frail elderly and intervention considerations for this population.

Population definition and risk factors

The term "frail elderly" refers to a subset of the older adult population suffering from the effects of physical, mental and sensory deterioration due to age and chronic diseases (Inderscience Publishers, 2009).

This population might be severely affected in their ability to recognize and respond to a disaster. Factors such as declining health and increased chronic diseases; limitations in sight, hearing and mobility; limited access to health care resources; low economic status; and restricted social networks increase the risk a person faces in a disaster (Inderscience Publishers, 2009).

The frail elderly may lack the social supports needed during a disaster because of the loss of loved ones or separations from spouses or partners, children and others who are often their caregivers (American Counseling Association, 2009). The cumulative effect of multiple losses and the devaluation of the elderly in some cultures may compound these losses.

Resilience factors for the frail elderly

Adults who are among the frail elderly have acquired memories, cognitions, material things, accomplishments and spiritual realizations and often have experienced multiple losses (e.g., jobs, health, independence, social roles, loved ones, etc.). These experiences can increase their risk of disaster stress or contribute to their resilience during disaster.

It is important to meet the needs of the frail elderly population who require special help. It is also important to engage the strengths and skills of older individuals and empower them to contribute to the disaster relief effort and assist in their own recovery. Many frail elderly people have a rich history of coping with past crises. They possess a repertoire of coping responses that facilitate their successful adaptation to a disaster (Phifer, 1990).

Psychiatric disabilities and the frail elderly

This group of adults may require special care if they are suffering from any of the following psychiatric disabilities:

Psychiatric disability	Symptoms
Dementia/Alzheimer's disease	An organic mental syndrome characterized by cognitive (memory) impairments; problems with abstract thinking, judgment or insight; language; ability to carry out familiar movements or properly use common objects; possible changes in mood, personality and behavior

Continued on next page

Psychiatric disabilities and the frail elderly (Continued)

Delirium	A sudden and temporary change in mental functioning or acute confusion that may affect attention; clouded consciousness; difficulty paying attention; frequent disorientation; usually involves rapid onset rather than the slow progression of dementia
Depression	A constellation of physiological, affective and cognitive manifestations with symptoms that include loss of interest or pleasure in usual activities; changes in appetite and weight; disturbed sleep; motor agitation or retardation; fatigue and loss of energy; feelings of worthlessness, self-reproach or excessive guilt; suicidal thoughts; and difficulty with thinking or concentration

Intervention considerations with the frail elderly

Frail elderly people in a disaster need:

- Reassurance of safety by providing strong and persistent verbal reassurance (Oriol, 1999);
- Accommodations for sight, hearing, cognition and mobility;
- Respect of the person's dignity;
- Recognition of the strengths and abilities of older individuals;
- Understanding of the person's reluctance to seek help, particularly mental health assistance (Oriol, 1999).

In providing mental health services to the frail elderly, it is important for the DMH worker to collaborate with the HS activity. In work with this population, it is important to inquire about:

- Physical health issues, medications and assistive devices (e.g., walkers, wheelchairs, canes, hearing aids, glasses, etc.) (ask specific questions about the availability of medications and assistive devices and refer to HS for assistance with replacements);
- The individual's prior living situation and essential care-giving services from a family member, friend, neighbor or paid caregiver;
- Pre-disaster social supports for assistance with shopping or running errands, listening to problems, helping out when the individual is sick, providing transportation, fixing things around the home, completing household chores, etc.;
- The community services the individual may have used before the disaster (e.g., home-delivered meals, transportation, etc.).

Additionally, you should:

- Assess cognition to determine if the person may become agitated or feel overwhelmed by crowding, noise and lack of privacy in a shelter or other service setting;
- Help the individual reestablish contacts with social supports and caregiver resources;
- Pay attention to a suitable relocation of the frail elderly, preferably in a familiar location that most closely matches their needs for care and assistance as well as level of independence;
- Assist the individual in accessing needed medical and financial assistance.

People with Preexisting Psychiatric Disorders

Issues related to preexisting psychiatric disorders

During disaster responses, you might encounter individuals with preexisting psychiatric disorders. This population has unique needs and may cause concern for other Red Cross disaster workers because of difficulty communicating by the client, lack of understanding by the responder, and stigmatization of mental illness that results in marginalization of the client. DMH workers will be called upon to intervene with this population directly and will also be expected to support other disaster response workers during the response operation.

Population definition

Individuals with psychiatric disorders are people who live independently or in congregate living situations such as hospitals, group homes, assisted living or homeless service programs (shelters, transitional living programs, permanent housing for people with persistent mental illness) and who may:

- Have a diagnosis of a serious and persistent mental disorder (schizophrenia and other psychotic disorders, mood disorders, anxiety disorders and personality disorders);
- Be experiencing active psychiatric symptoms (e.g., hallucinations, experiencing tactile or kinesthetic sensations, disordered thinking, social withdrawal, extreme apathy, blunted emotional expression) for a significant period of time before the disaster;
- Have functional deficits in two of three life skills areas, such as basic living skills (eating, maintaining personal hygiene), instrumental living skills (managing money, negotiating transportation, taking medications as prescribed) and functioning in social, family and vocational or educational contexts.

Disaster risk factors and psychiatric disorders

Individuals with mental illness are more likely to have experienced trauma at some point in their lives before the disaster; many of them have experienced multiple traumatic events (Goodman et al., 2001; Mueser et al., 1998). You will be asked to educate other workers about people with mental illness and provide direct support to them as well. Symptoms that may surface, such as confusion or anxiety about the future, or grief or sadness related to loss, may be expectable reactions to the circumstances of a disaster rather than symptoms of a preexisting psychiatric illness. Factors associated with the disaster that may exacerbate symptoms include:

- Dislocation or evacuation stress because of disruptions in routine, loss of familiar service providers and familiar environment and inability to obtain medication;
- Chaotic, noisy environments such as in shelters;
- Unavailability of previous services, e.g., community programs that are temporarily closed;
- Unclear messaging that may be confusing as to when and where services will resume or be offered;
- Insensitivity by disaster workers and others to the individual's appearance and behavior;
- Lack of knowledge by disaster workers surrounding psychiatric disorders.

Specific risk factors and disaster response

Individuals with psychiatric disorders in disasters have the same basic needs as other individuals affected by the disaster. However, they are at greater risk for post-disaster stress reactions than the disaster community at-large. Some specific risk factors associated with mental illness include:

- Deficits in communication, social and coping skills;
- Isolation from sources of positive social supports such as family, caregivers and support services workers;
- Lack of a perceived social support system;
- Poverty and marginalization;
- Previous history of trauma (e.g., child abuse, sexual abuse, domestic violence, etc.);
- Need for adherence to a medication regimen to address psychiatric symptoms.

Individuals with psychiatric disorders often function well when in familiar environments with a structured routine. Predictability leads to a person's sense of control over his or her environment. In the aftermath of a disaster, the predictability, familiar daily routines and structure may be disrupted. When effective supports such as outpatient programs (day treatment, assertive community treatment teams, partial hospitalization programs), residential programs (permanent or supportive housing, transitional housing programs) or nonresidential programs (sheltered workshops, case management, clubhouses, peer support, etc.) are disrupted, the individual's symptoms may be exacerbated.

In addition, symptoms may surface (e.g., confusion, anxiety, grief, sadness) that are expected reactions to the disaster rather than symptoms of preexisting psychiatric disorders. These reactions may include disorientation, fear and exacerbation of symptoms, including anxiety and obsessive-compulsive symptoms and suspiciousness of relief staff.

Intervention considerations for individuals with psychiatric disorders

A primary consideration of DMH for supporting individuals with psychiatric disorders is to ensure that other disaster workers understand the nature of the client's behavior and how to respond appropriately.

Individuals with psychiatric disorders in a disaster need the following:

- Reassurance of safety;
- Respect of the person's dignity;
- Patience from Red Cross workers.

As a DMH worker, you should assure that these individuals have access to:

- Communication with primary service providers;
- Prescribed medications that are consistent with the individual's medication regimen;
- Communication with family members or other supportive people including peer support groups.

In providing Red Cross DMH services to people with psychiatric disorders during a disaster, it is important that you:

- Practice patience in communicating;
- Do not talk down to them, yell or shout;

Show interest and concern by using appropriate body language (e.g., face the client directly rather than turning away);

- Ask how the Red Cross can help them (medications, support system contacts,

contacts with family, contacts with peer support groups, connecting to other resources);
- Provide basic necessities, such as shelter, food and water.

Appropriate interventions with people with psychiatric disorders

People with psychiatric disorders can benefit from the adaptive communication and intervention strategies described below. Remember that clients may not always disclose that they have a psychiatric disability.

The following table shows symptoms or characteristics of mental illness and the corresponding adaptations for intervention:

Symptom or characteristic	Adaptation
Confusion about what is real	Be simple and straightforward; do not give multiple commands; ask and state one thing at a time.
Difficulty in concentrating	Be brief, repeat often.
Disorientation or rambling	Try to avoid interrupting; clearly inform the person what needs to happen next.
Over-stimulation	Limit external input; do not force discussion.
Poor judgment	Do not expect or insist on rational discussion.
Preoccupation with internal world	Get the individual's attention first.
Agitation	Recognize agitation and allow the person an exit.
Fluctuating emotions	Do not take words or actions personally.
Fluctuating plans	Focus on one plan.
Little empathy for others	Recognize lack of empathy as a symptom.
Withdrawal	Initiate conversation.
Belief in delusions	Do not argue with the individual; do not try to talk the individual out of the delusion; let the individual know you are there to help.
Fear	Stay calm and reassure the individual.
Insecurity	Be caring and accepting.
Low self-esteem	Stay positive and respectful.

Adapted from Rothman (2003).

People with Substance-Related Disorders

People with substance-related disorders in disaster

People with substance-related disorders also may need special attention from DMH workers. People who abuse or are addicted to alcohol or other drugs may be present in disaster sites and may be experiencing withdrawal or other complications due to substance use. As a DMH worker, it is important that you be aware of substance-related issues and withdrawal symptoms. You may need to collaborate with Health Services and other activities to provide appropriate services.

Population description

Many people may use alcohol and other drugs as a negative coping mechanism during the aftermath of a disaster to avoid or overcome certain emotions such as anxiety, fear, depression, hopelessness, shame and guilt. However, the consequences of increased drug and alcohol use are different for people with preexisting substance abuse–related disorders. The focus of DMH services should be on encouraging positive coping strategies and reducing reliance on negative strategies that include the increase of substance use and misuse.

There are two substance-related disorders you may encounter in people affected by disaster: substance abuse and substance dependence (also referred to as "addiction" in this handbook). Both substance abuse and dependence involve psychoactive substances including alcohol, illicit drugs, prescription medicines, over-the-counter medicines, dietary supplements and herbal and botanical medicines. Psychoactive substances bring about physiological, emotional or behavioral changes. If the substance changes the way the individual acts, feels or thinks, it could lead to a pattern of substance abuse that results in at least one of four consequences: 1) failure to fulfill role obligations, 2) substance use placing the person in danger (e.g., driving under the influence), 3) legal consequences or 4) interpersonal or social problems (Center for Substance Abuse Treatment 2007).

Individuals with substance abuse disorders often have co-occurring mental illness that may be exacerbated by a disaster.

Withdrawal during disaster

A disaster may put people who actively abuse substances or are in the beginning stages of recovery from substance abuse at risk for withdrawal symptoms.

Withdrawal refers to the voluntary (through seeking treatment) or involuntary (through not being able to obtain the substance) absence of substance use after a tolerance has been established through prolonged and/or heavy use. When an individual is described as "going through withdrawal," he or she may exhibit mild, moderate or severe physical and psychological symptoms depending on the level of previous use, the substance used and the person's condition (Center for Substance Abuse Treatment, 2007).

Withdrawal symptoms refer to the physical and psychological effects of withdrawal (Center for Substance Abuse Treatment, 2007). See the table on the next page for some of the psychological and physical symptoms of alcohol withdrawal.

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Withdrawal during disaster (Continued)

Psychological and physical systems of alcohol withdrawal:

Psychological	Mild to moderate	• Feelings of jumpiness or nervousness • Feeling of shakiness • Anxiety • Irritability or excitability	• Emotional volatility • Depression • Fatigue • Difficulty thinking clearly • Bad dreams
	Severe	• State of confusion • Visual	• Hallucinations • Agitation
Physical	Mild to moderate	• Headache • Sweating (especially palms and face) • Nausea • Loss of appetite • Insomnia and sleep difficulties	• Paleness • Rapid heart rate • Enlarged pupils • Clammy skin • Hand tremors or eyelid twitching • Vomiting
	Severe	• Fever • Convulsions	• Blackouts

Red Cross DMH should identify individuals at risk for withdrawal from substance misuse or substance abuse or substance abuse treatment. A major concern for people affected by a disaster is the unavailability of substance abuse treatment and supportive services such as 12-step programs.

Individuals addicted to opioid pain medications may begin to experience withdrawal symptoms after a disaster because of unavailability of pain medication. The symptoms begin 6–12 hours after the last dose and last for 5–10 days for morphine, hydromorphone or oxycodone. Symptoms in people taking methadone generally occur three to four days after the last dose, and the withdrawal period will take longer than with other types of opioid medications. Symptoms of withdrawal from opioid drugs include (The National Pain Foundation, 2005):

- Sweating
- Tearing of the eyes
- Runny nose
- Abdominal cramps
- Nausea and/or vomiting
- Diarrhea
- Weakness
- Muscle twitching, muscle aches and pains
- Goose bumps
- Dilated pupils
- Anxiety
- Insomnia
- Increased pulse
- Increased respiratory rate
- Elevated blood pressure

Intervention considerations for people with substance-related disorders

DMH workers should recognize the symptoms of withdrawal as distinct from trauma reactions. If withdrawal symptoms are present, collaborate with HS to monitor, assess and refer to community resources, if necessary.

If, through a secondary assessment, you identify an individual with a substance-related disorder, you should follow the procedures described in Secondary Assessment and Referrals in Appendix A to provide referrals to community-based

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mental health or substance abuse recovery treatment for anyone who needs more support. You should also make the phone number and meeting list for local 12-step groups available for disaster clients.

Specific risk and resilience factors during disaster

Previous services may be disrupted for people in recovery from substance abuse or with co-occurring disorders, placing them at risk for relapse or other psychiatric consequences. They are also more likely to have suffered previous trauma, which places them more at risk for trauma-related disorders. Finally, stigma associated with substance abuse could prevent these individuals from receiving services that they may need during a disaster.

One factor suggesting resilience is that people with substance abuse disorders who are sober and are recovering have already shown resilience in their lives. DMH workers can help clients identify and reengage successful coping and recovery strategies from their past.

People with Disabilities

Serving people with disabilities

Another group that needs special attention from DMH workers during a disaster is people with disabilities. Individuals with physical, sensory, cognitive and intellectual impairment and people with various types of chronic disease are particularly vulnerable during disasters. Because of the Red Cross policy of serving everyone without acute medical needs in service settings such as shelters, it is important for you to understand the specific issues related to people with disabilities.

Population definition

According to the Americans with Disabilities Act of 1990, an individual with a disability is a person who:

- Has a physical or mental impairment that substantially limits one or more major life activities;
- Has a record of such impairment; or
- Is regarded as having such impairment.

Disabilities refer to individual functioning, including physical, sensory, cognitive and intellectual impairment in addition to various types of chronic disease.

Disability	Description
Physical or mobility	Physical disabilities can include the upper or lower limb(s), manual dexterity and coordination with different organs of the body. People with physical or mobility limitations may use assistive devices such as canes, walkers or wheelchairs.
Spinal cord injury and diseases	The injury can be either complete or incomplete; often the result of an accident but can also be the result of a birth defect (e.g., spina bifida) or other disease (e.g., spinal stenosis) and may include partial or full paralysis. People with spinal cord injuries use assistive devices such as wheelchairs and may have additional physical limitations.
Head injuries	Brain disability can be acquired or traumatic (the result of an accident). Traumatic brain injury results in emotional and behavioral challenges.
Vision	Vision impairments may range from blindness and ocular trauma to scratched cornea, sclera and diabetes-related eye conditions, including low vision. Vision impairments may be total or partial. Individuals with visual disabilities may use a range of assistive devices from a cane to a guide dog.
Hearing	Hearing disabilities include partial or complete deafness. Deafness can be evident at birth or occur later in life. Individuals with hearing disabilities may use interpreters, assistive listening devices, amplification systems and/or text-to-speech synthesizers.

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Population definition (Continued)

Cognitive or intellectual disabilities	These individuals could have diagnoses including, but not limited to, mental retardation, autism spectrum disorders, genetic disorders or traumatic brain injury. Depending on the severity of their limitations, individuals with intellectual disabilities may rely on their caregivers to assist them in their activities of daily living.
Invisible disabilities	Disabling conditions may not immediately be apparent to others (e.g., chronic fatigue or pain, Crohn's disease, Fibromyalgia, rheumatoid arthritis and epilepsy).

Because shelters tend to be microcosms of the larger community, you may expect to encounter people with disabilities in the same proportion. According to the U.S. Bureau of the Census (2008), about 54 million people in the U.S. have a disability. Of that number, 35 million have a disability classified as severe and 11 million need assistance as a result of the disability. It is estimated that 10 percent of the U.S. population has a medical condition that is considered a type of invisible disability that impairs normal daily activities.

Disaster risk factors and people with disabilities

A person with a disability may need adaptations such as alternative methods of communication or transportation to evacuate a disaster. There may be great stress placed on family or other caregivers at the time of the disaster to protect the individual with a disability. In addition to the person with the actual disability, the caretakers are also vulnerable to the stress of the disaster.

Intervention considerations for people with disabilities

Red Cross workers at all service delivery sites must make every effort to accommodate individual with disabilities. In addition, DMH workers should follow these guidelines:

- Verbally reassure the individual and their caregivers of their safety.
- Advocate for reasonable accommodations for sight, hearing, cognition and mobility as well as invisible disabling conditions.
- Recognize the strengths and abilities of people with disabilities.
- Respect the individual's dignity and worth.
- Inquire about physical health issues, assistive devices and medications by asking specific questions about the availability of medications and devices.
- Ask about the individual's prior living situation and the level of independence the person experienced in daily living.
- Ask about social supports and assist the person in reestablishing contact with support systems.
- When it is necessary to help a person relocate following a disaster, pay attention to a suitable relocation of the person with a disability in a supportive environment that most closely matches his or her needs and level of independence.
- Assist the individual in accessing needed medical and financial assistance.

In working with people who are visually impaired, you should do the following:

- Announce your presence, speak out and then enter the area;
- Speak naturally and directly to the person without shouting;

Continued on next page

Intervention considerations for people with disabilities (Continued)

- Offer assistance first, but let the person explain what help is needed (e.g., holding your arm or shoulder for guidance).

When working with people who are deaf or hard of hearing, you should:

- Establish eye contact;
- Use facial expressions and hand gestures as visual cues;
- Check to see if you have been understood and repeat if necessary;
- Offer pencil and paper; write slowly and let the individual read as you write;
- Offer to text the person on his or her cell phone if the technology and reception is available.

Additionally, for people with cognitive or intellectual disabilities, DMH workers should:

- Clearly introduce themselves and tell the individual why they are there;
- Speak directly to the person;
- Help the individual adjust to changes in their environment;
- Speak slowly and clearly, using simple, direct language;
- Give extra time for the person to process what they are saying and to respond;
- Clarify the individual's emotions as well as the emotions of those around them to reduce anxiety or agitation, since the person may not understand social cues and may misinterpret others' actions or communications.

Additional Red Cross information pertinent to assisting individuals with disabilities is available on the Red Cross intranet.

Information regarding working with people with mental illness can be found above in People with Preexisting Psychiatric Disorders.

Section 4: Culturally Sensitive DMH Services

Cultural factors in disaster

You will encounter a range of disaster-affected individuals and families who differ from your own cultural and ethnic identity. Cultural identity and background play an important role in shaping the emotional responses of disaster survivors. Culture is important when it comes to mental health, resilience and recovery from a disaster.

The way you prepare yourself to provide services to a disaster-affected community is determined by your own culture. Culture affects your orientation to the community and how you see yourself as a service provider. Without a culturally competent orientation, DMH workers run the risk of misinterpreting culturally mediated emotional responses, mislabeling culturally normative behaviors, having our services rejected or inadvertently harming the very people we seek to assist.

Further, cultural competence in disaster situations improves access to care, helps to build trust and promotes engagement and retention in care. Cultural perspectives help us differentiate between normative and maladaptive behaviors (Harris et al., 2010).

What is culture?

Culture is a common heritage or set of beliefs, norms and values that a group of people share. Being of the same racial or ethnic group does not necessarily signify that all members share the same cultural attitudes. Culture is a fluid concept relevant to infinite subpopulations (Harris et al., 2010). Cultural identity can include:

- Ethnicity and nationality;
- Spirituality and religion;
- Gender and age;
- Family roles;
- Sexual orientation;
- Occupation, education, socioeconomic status;
- Other group affiliations.

Culture can influence mental health in numerous ways, such as (Surgeon General, 2001):

- Communication (spoken and nonverbal);
- Manifestation of symptoms;
- Family and community support;
- Help-seeking behaviors;
- Support systems and protective factors;
- How people perceive and cope with mental illness;
- How providers interact with people with mental illness;
- Stigma and shame associated with mental illness;
- Spirituality (predestination, views of illness, etc.).

What is cultural sensitivity and competence?

Cultural sensitivity means knowing that cultural differences as well as similarities exist, without assigning values to those differences (e.g., better or worse, right or wrong) (National Maternal and Child Health Resource Center on Cultural Competency, 1997). Cultural competence is not a single endpoint but a state that is constantly evolving and changing. One example of the many definitions of cultural competence is:

The delivery of services responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, beliefs and values (Surgeon General, 2001).

Cultural competence incorporates the concepts of cultural sensitivity; however, it goes further in that it has to do not just with awareness and understanding, but with all our behaviors, attitudes and polices that enable us to effectively operate within a cross-cultural situation (Center for Effective Collaboration and Practice, 2011).

Refugees/ immigrants

Working with recent immigrants or refugees may pose additional challenges to you. These individuals have already experienced displacement and possibly trauma and significant loss, which may leave them particularly wary of authority, hesitant to seek or accept help and more vulnerable to the distress and adverse reactions associated with disaster. Refugees may have previously experienced the destruction of their social support systems. Loss of social supports from a disaster may be particularly difficult (DHHS, 2003).

Refugees and immigrants may be at increased risk for psychological stress and mental illness as a result of factors such as (Jablensky et al., 1992):

- History of political or religious persecution (including experiencing violence, imprisonment or war);
- Foreign language, customs and acculturation stressors;
- Social isolation and rejection and a lack of social supports;
- Racism and prejudice;
- Difficulty securing employment and housing;
- Limited health care access.

Social and economic inequity

Three important social and cultural influences that can affect the success of DMH services include:

- The importance of community;
- Racism and discrimination;
- Social and economic inequality (NYDIS, 2007).

There is considerable historical evidence that non-white populations have experienced a myriad of traumas, ranging from overt racism (e.g., micro-insults and micro-aggressions) to unprovoked shootings and internments. In addition, because of poverty, discrimination and neighborhood conditions, many non-whites have had traumatic experiences. These historical trials collectively place a considerable burden on these groups.

Social and economic inequality as variables in disaster

Poverty or low socioeconomic status is an individual-level risk factor for poor mental health outcomes after a disaster (Norris, Friedman, & Watson, 2002b).

People of certain racial or ethnic groups who experience poverty are particularly vulnerable to post-disaster mental health concerns because of their experiences of:

- Poverty;
- Homelessness;
- Chronic disease and disability;
- Criminal justice system involvement;
- Victimization;
- Child maltreatment and foster care.

(Surgeon General, 2001)

How culture influences resilience

Culture, through both perceived social support and strong ethnic identity, is an important factor in resilience, particularly among diverse ethnic and racial minority groups (Harris et al., 2010). Culture has been shown to "influence and modify behavioral and emotional response to trauma, the cognitive beliefs regarding the trauma itself, impact of the societal roles of the family and the community's individual and collective response to trauma" (Harris et al., 2010).

One cultural factor that affects resilience is the importance of the family unit in the community. The role of family members varies across cultures, but family is often responsible for its members and often is the essential factor in recovering from trauma and grief (DHHS, 2003). As a DMH worker, you can facilitate support by reuniting family and friends and other community resources that were in place before the disaster. However, despite the important supportive role of the family, the extreme stress and loss during a disaster can cause families to fragment. It is important that you be aware that prior conflicts and new realizations can hinder family members' abilities to help one another.

Frequent assumptions of cultural bias

Frequently, mental health professionals hold assumptions that are culturally biased. These biased assumptions are listed below to help you understand mistakes that are often made in cross-cultural mental health work. Often we:

- Assume a common measure of "normal" behavior;
- Place an emphasis on individualism and independence;
- Focus on a specific definition of the problem as the traumatic response to the present disaster and ignore past history of individual or group trauma;
- Use abstract and technical words in communications;
- Neglect naturally existing support systems as important sources of support;
- Emphasize a change in the individual and not in the service delivery system;
- Neglect the history of trauma and adaptation by the individual, family and community;
- Rely on linear thinking in the problem-solving process.

As you provide services during a disaster, you will want to maintain self-awareness and consciousness of the factors that follow below (New Jersey Division of Mental Health Services, 2010).

DMH worker–client relationship

Reflecting on the questions below will increase your effectiveness in working with individuals who have different ethnic, racial and cultural backgrounds.

Continued on next page

DMH worker–client relationship (Continued on next page)

- Do I understand the client's situation? What is my cultural identity versus the client's cultural identity?
- What is the client's level of comfort with Western mental health practices?
- What are the client's issues with shame and "saving face"?
- What are the client's issues with control?
- What are the client's prior experiences with racism?
- What are the client's issues with trust?
- How effectively can I authentically demonstrate an understanding of the client's racial/ethnic reality?
- How effectively can I communicate a sense of understanding of the client's situation?
- How effectively can I communicate respect of the client and the client's history?

Use of cultural brokers and community spiritual caregivers

Cultural brokers are community leaders who represent diverse groups. Cultural brokers can help DMH workers gain an understanding of the community and make contacts with and gain the trust of survivors. These brokers might include local officials, community spiritual leaders, teachers or long-term community residents (DHHS, 2003). By engaging and using these cultural brokers, awareness of mental health and reduction of stigma about disaster services is more likely.

Spiritual caregivers are another source for gaining an understanding of and entry into the community. Empathy, involving an active listening presence, is a key resource that spiritual caregivers bring to a disaster response.

Guiding principles for cultural competence in DMH services

The following are guiding principles for cultural competence in DMH programs (DHHS, 2003).

- Recognize the importance of culture and respect diversity.
- Maintain a current profile of the cultural composition of the community.
- Recruit disaster workers who are representative of the community or service area.
- Provide ongoing cultural competence training to DMH workers.
- Ensure that services are accessible, appropriate and equitable.
- Recognize the role of help-seeking behaviors, customs and traditions and natural support networks.
- Engage "cultural brokers" such as community leaders and organizations representing diverse cultural groups.
- Ensure that services and information are culturally and linguistically competent.
- Assess the level of cultural competence of the provision of DMH services and make adjustments accordingly.
- Apply basic principles of PFA, such as creating a sense of safety and calm, sense of self, community efficacy, connectedness and hope (all important aspects in disaster response) (Hobfoll et al. 2007).

Appendix C: References

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Appendix D: DMH Tools and Resources

Forms referenced in the text

Client Assistance Memorandum (F1475)

Client Consent to Share Information

Client Health Record

Daily Narrative Situation Report

Declined Treatment Release

Disaster Referral (F5855)

Disaster Operations Control

Disaster Relief Operation Work Performance Evaluation

Disaster Requisition (F6409)

DMH After-Hours Roster

DMH Attendance Chart

DMH Personnel Roster

Emergency Welfare Inquiry form

Initial Intake and Assessment Tool

Job Induction Checklist

Post-Deployment Stress Self-Assessment

PsySTART Card (black and white and color)

PsySTART Aggregated Worksheet

PsySTART Supervisor Daily Summary

Release of Confidential Information – Staff

Staff Health Illness and Injury Record

Staff Request

DMH resources referenced in the text

Disaster Mental Health Position Requirements

"Coping with Deployment: Psychological First Aid for Military Families"

"Coping with Disaster: For the Families of Disaster Workers"

"Coping with Disaster: Preparing for a Disaster Assignment"

"Coping with Disaster: Returning Home from a Disaster Assignment"

"Foundations of Disaster Mental Health"

"Helping Children Cope with Disaster"

"Mental Health Response to Mass Violence and Terrorism: A Training Manual (2007)"

"Mitigating Disaster Work Risk: Force Health Protection Strategies"

"Psychological First Aid: Helping Others in Times of Stress"

"Reconnection Workshop"

"Taking Care of Your Emotional Health After a Disaster"

Other resources referenced in the text

Aviation Disaster Family Assistance Act of 1996

Disaster Frontline Supervisor Handbook

Serving People with Disabilities and People with Functional and/or Access Needs in Red Cross Shelters

Functional Needs Support Services FAQ

Fundamental Principles of the International Red Cross and Red Crescent Movement

HIPAA 45 C.F.R. § 164.510(b) (4)

Red Cross Human Resources Policies and Procedures Manual

"Listen, Protect, Connect"

Continued on next page

Other resources referenced in the text (Continued)	Memorandum of Understanding (MOU) between the American National Red Cross and the National Transportation Safety Board Ready.gov/Kids Rail Safety Improvement Act of 2008 Red Cross Code of Business Ethics and Conduct Red Cross Protecting Personal Information Policy