Appendix C- 1

Memorandum Of Understanding

This document was prepared by the Greater New York Hospital Association. This document was supported by Grant number U3RMC01549-01, from the Health Resources and Services Administration (HRSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA.

Prepared by GNYHA 2004

MODEL
MEMORANDUM OF UNDERSTANDING REGARDING SHARING OF PERSONNEL DURING A DISASTER*

This Memorandum of Understanding (the "Agreement") is made and entered into as of this ____ day of _____, 2004, by and between _____ ("Hospital A") and _____ ("Hospital B"). "Hospital A" and "Hospital B" are collectively referred to as "Hospitals" or "parties." **

RECITALS

WHEREAS, "Hospital A" is a hospital with its main campus located at _____;

WHEREAS, "Hospital B" is a hospital with its main campus located at _____;

WHEREAS, the parties acknowledge that each party may from time to time require personnel to optimally meet the needs of patients due to the occurrence of a disaster; and

WHEREAS, the parties have determined that a Memorandum of Understanding, developed prior to a sudden and immediate disaster, is needed to facilitate the sharing of personnel in the event of a disaster;

NOW, THEREFORE, in consideration of the above recitals, the parties agree as follows:

1. **Definitions.**

   a. "Borrowing Hospital" is the party that requests personnel from the other party in the event of a Disaster.

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* This document was supported by Grant number U3RMC01549-01, from the Health Resources and Services Administration. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA or the New York City Department of Health and Mental Hygiene.

** This document is designed as a model. The names of the hospitals entering into this agreement should be inserted in place of "Hospital A" and "Hospital B."

b. "Designated Representative" is the individual or position designated by each party to communicate with the other party.

c. "Disaster" means an event in which the hospital's emergency management plan has been activated and the hospital is unable to handle immediate patient care needs. Disasters include, but are not limited to, natural disasters, such as hurricanes, and other events, such as acts of terrorism that generate mass casualties. A Disaster may affect the entire facility or only a portion of the facility.

d. "Lending Hospital" is the party that is available to provide personnel to the other party in the event of a Disaster.

2. **Identification of Designated Representative**. Each party agrees to identify a Designated Representative and at least one back-up individual to communicate with the other party prior to and in the event of a Disaster. The names and contact information for the parties' Designated Representatives and back-up individuals is attached hereto as Exhibit "A" and is incorporated herein by this reference.

3. **Sharing of Information Regarding Personnel**. Prior to a Disaster, each party agrees, to the best of its ability, to share information regarding the personnel that may be available to be shared in the event of a Disaster. Such information may include: the name, employment status, licensure, training, and the individuals'specific delineation of clinical privileges.

4. **Lending of Personnel**. The Lending Hospital agrees to use its best efforts to make personnel available to the Borrowing Hospital in the event of a Disaster, upon request. The Lending Hospital shall be entitled to use its own reasonable judgment regarding the personnel it can provide without adversely affecting its own ability to provide services. Personnel subject to this agreement may include professional staff such as physicians and nurses, as well as ancillary staff (such as housekeeping and food service workers).

5. **Communication of Request for Personnel**. After a Disaster has occurred, the Borrowing Hospital's Designated Representative may initially request personnel from the Lending Hospital's Designated Representative verbally. The request must be confirmed in writing as soon as possible. This should ideally occur prior to the arrival of personnel at the Borrowing hospital. To the extent practicable, the Borrowing Hospital will identify to the Lending Hospital the following:

   a. the type and number of requested personnel;
   b. an estimate of how quickly the personnel are needed;
   c. the location where the personnel are to report; and

d. an estimate of how long the personnel will be needed.

6. **Response to Request for Personnel**. In response to the request, the Designated Representative of the Lending Hospital will provide the Borrowing Hospital with the following information for the personnel that the Lending Hospital is able to send: the number, names, licensure status, types of personnel, and when applicable, the specific delineation of clinical privileges.

7. **Documentation**. The arriving personnel will be required to present their Lending Hospital identification badge at the site designated by the Borrowing Hospital's Designated Representative. The Borrowing Hospital will be responsible for the following:
   a. confirming the personnel's identification card with the list of personnel provided by the Lending Hospital; and
   b. providing additional identification, e.g., "visiting personnel" badge, to the arriving donated personnel.

8. **Responsibility for Personnel**. The parties agree that the personnel made available to the Borrowing Hospital shall be totally under the supervision and control of the Borrowing Hospital while performing any actions in response to the Borrowing Hospital's request for personnel. [Hospitals should insert specific provisions regarding indemnification and malpractice insurance coverage for personnel that are borrowed/loaned pursuant to this agreement. Following is an example of such language: "Borrowing Hospital agrees to notify its professional liability insurer of the circumstances under which personnel from the Lending Hospital will be performing services pursuant to this agreement. Borrowing Hospital shall use commercially reasonable efforts to extend its professional liability insurance to cover the services performed by such personnel while they are acting pursuant to this agreement."]

9. **Recall of Staff**. The Lending Hospital may recall its personnel at any time in its sole discretion. If feasible, adequate notice will be provided to allow the Borrowing Hospital to arrange staffing from other facilities or agencies.

10. **Term**. The term of this Agreement shall be _____year (s) from the date of execution, and this Agreement shall be self-renewing for additional ____-year terms; provided, however, that this Agreement may be terminated with or without cause, by either party giving sixty (60) days prior written notice of termination to the other party.

11. **Effect of Agreement**. The execution of this Agreement shall not give rise to any liability or responsibility to either party for failure to respond to any request for assistance, lack of speed in responding to such a request, or the abilities or actions of the responding personnel.

EXHIBIT A

Name of Hospital A:_____

Name of Designated Representative:_____

_____

Title of Designated Representative:_____

_____

Contact Number of Designated Representative:_____

_____

E-Mail of Designated Representative:_____

_____

Name of Back-Up Individual:_____

_____

Title of Back-Up Individual:_____

_____

Contact Number of Back-Up Individual:_____

_____

E-Mail of Back-Up Individual:_____

_____

Name of Hospital B:_____

Name of Designated Representative:_____

_____

Title of Designated Representative:_____

_____

Contact Number of Designated Representative:_____

E-Mail of Designated Representative:_____

Name of Back-Up Individual:_____

Title of Back-Up Individual:_____

Contact Number of Back-Up Individual:_____

E-Mail of Back-Up Individual:_____

Appendix C-2

Mental Health Assessment Tool

Appendix D: Provider Worksheets

National Child Traumatic Stress Network and National Center for PTSD *Psychological First Aid: Field Operations Guide, 2nd Edition.* July 2006. Available on www.nctsn.org and www.ncptsd.va.gov.

Survivor Current Needs

Date: _____Provider: _____ Survivor Name: _____Location _____

This session was conducted with (check all that apply):
☐ Child ☐Adolescent ☐ Adult ☐Family ☐ Group

Provider: Use this form to document what the survivor needs most at this time. This form can be used to communicate with referral agencies to help promote continuity of care.

1. Check the boxes corresponding to difficulties the survivor is experiencing.

BEHAVIORAL	EMOTIONAL	PHYSICAL	COGNITIVE
☐ Extreme disorientation ☐ Excessive drug, alcohol, or prescription drug use ☐ Isolation/withdrawal ☐ High risk behavior ☐ Regressive behavior ☐ Separation anxiety ☐ Violent behavior ☐ Maladaptive coping ☐ Other _____	☐ Acute stress reactions ☐ Acute grief reactions ☐ Sadness, tearful ☐ Irritability, anger ☐ Feeling anxious, fearful ☐ Despair, hopeless ☐ Feelings of guilt or shame ☐ Feeling emotionally numb, disconnected ☐ Other _____	☐ Headaches ☐ Stomachaches ☐ Sleep difficulties ☐ Difficulty eating ☐ Worsening of health conditions ☐ Fatigue/exhaustion ☐ Chronic agitation ☐ Other _____	☐ Inability to accept/cope with death of loved one(s) ☐ Distressing dreams or nightmares ☐ Intrusive thoughts or images ☐ Difficulty concentrating ☐ Difficulty remembering ☐ Difficulty making decisions ☐ Preoccupation with death/ destruction ☐ Other _____

2. Check the boxes corresponding to any other specific concerns

☐ Past or preexisting trauma/psychological problems/substance abuse problems
☐ Injured as a result of the disaster
☐ At risk of losing life during the disaster
☐ Loved one(s) missing or dead
☐ Financial concerns
☐ Displaced from home
☐ Living arrangements
☐ Lost job or school
☐ Assisted with rescue/recovery
☐ Has physical/emotional disability
☐ Medication stabilization
☐ Concerns about child/adolescent
☐ Spiritual concerns
☐ Other: _____

3. Please make note of any other information that might be helpful in making a referral.

_____

_____

4. Referral

☐ Within project (specify) _____
☐ Other disaster agencies
☐ Professional mental health services
☐ Medical treatment
☐ Substance abuse treatment
☐ Other community services
☐ Clergy
☐ Other: _____

5. Was the referral accepted by the individual? ☐ Yes ☐ No

This work was funded by the Substance Abuse and Mental Health Services Administration (SAMSHA), US Department of Health and Human Services (HHS). The views, opinions and content are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Appendix D: Provider Worksheets

Psychological First Aid Components Provided

Date: _____ Provider: _____ Location: _____

This session was conducted with (check all that apply):
☐ Child ☐Adolescent ☐ Adult ☐Family ☐ Group

Place a checkmark in the box next to each component of Psychological First Aid that you provided in this session.

Contact and Engagement
☐ Initiated contact in an appropriate manner
☐ Asked about immediate needs

Safety and Comfort
☐ Took steps to insure immediate physical safety
☐ Attended to physical comfort
☐ Attended to a child separated from parents
☐ Assisted with concern over missing loved one
☐ Assisted with acute grief reactions
☐ Attended to spiritual issues regarding death
☐ Provided information about funeral issues
☐ Helped survivors regarding death notification
☐ Helped with confirmation of death to child
☐ Gave information about the disaster/risks
☐ Encouraged social engagement
☐ Protected from additional trauma
☐ Assisted after death of loved one
☐ Helped with talking to children about death
☐ Attended to traumatic grief
☐ Helped survivors after body identification

Stabilization
☐ Helped with stabilization
☐ Used grounding technique
☐ Gathered information for medication referral for stabilization

Information Gathering
☐ Nature and severity of disaster experiences
☐ Concerns about ongoing threat
☐ Physical/mental health illness and medication(s)
☐ Extreme guilt or shame
☐ Availability of social support
☐ History of prior trauma and loss
☐ Death of a family member or friend
☐ Concerns about safety of loved one(s)
☐ Disaster-related losses
☐ Thoughts of harming self or others
☐ Prior alcohol or drug use
☐ Concerns over developmental impact
☐ Other: _____

Practical Assistance
☐ Helped to identify most immediate need(s)
☐ Helped to develop an action plan
☐ Helped to clarify need(s)
☐ Helped with action to address the need

Connection with Social Supports
☐ Facilitated access to primary support persons
☐ Modeled supportive behavior
☐ Helped problem-solve obtaining/giving social support
☐ Discussed support seeking and giving
☐ Engaged youth in activities

Information of Coping
☐ Gave basic information about stress reactions
☐ Taught simple relaxation technique(s)
☐ Assisted with developmental concerns
☐ Addressed negative emotions (shame/guilt)
☐ Addressed substance abuse problems
☐ Gave basic information on coping
☐ Helped with family coping issues
☐ Assisted with anger management
☐ Helped with sleep problems

Linkage with Collaborative Services
☐ Provided link to additional services service(s): _____
☐ Promoted continuity of care _____
☐ Provided handout(s) _____

Appendix D- 1

Coping With Fears About Avian Influenza

Pandemic Alert Phase

Coping with the News of a New Health Risk

Fear of the unknown is common for people of all ages and cultures. Fear and anxiety can become very powerful emotions when health risks are unknown. Many people are beginning to hear about birds and other animals becoming sick in other parts of the world. Even though this may be happening in far away places, the risks can feel close to home. It is important to understand the risks, our emotional reactions, and ways of coping in order to effectively deal with the stress that such situations can cause.

Changes in Our World

Change is constant in our world and can bring different physical and emotional challenges for many people. The current changes in bird and animal health may affect everyone's health or may continue as a bird and animal problem only. But simply knowing of this risk, it is natural and normal for people to experience emotional changes.

Emotional Reactions

We each have different ways of reacting to trying events in our lives. It is quite normal and natural for people to experience stress reactions in ways you may not think of as "physical", for example, you may find that you are:

- Preoccupied with thoughts or interest in health-related news stories
- Unable to concentrate at work or school
- Becoming irritable or tense with people
- Having difficulty sleeping
- Feeling hopeless or depressed
- Feeling more distrustful
- Worrying about your and your family's safety

Psychosocial Considerations – Appendix 5

Ideas for Coping

Public health officials are closely watching how birds and animals are affected by this new health risk. It is important that you get your news about any health risks from trusted sources of information. Occasional checks for updates in the news can be helpful, but know when to put down the newspaper or turn off the television. Right now there are things that can help you cope with the physical and emotional stresses you may feel due to the changing health news.

- Stay informed, but not preoccupied with the news
- Stay physically and mentally busy
- Keep to your normal daily routines
- Communicate openly with friends and family
- Rely on your normal sources of support
- Follow expert advice for personal and family preparedness
- Reach out for emotional support or professional help if necessary

Changes in our world are inevitable, and as with other changes and challenges, we will work together to meet and overcome them. Understanding and managing your emotions during stressful times is part of any change. If you or someone you know is having difficulty coping with the stress associated with the changing health news, please reach out for help.

A toll-free phone number is available for emotional support at (877) 294-HELP (4357) and for TTY Assistance at (877) 294-4356. You can also find more ideas for coping online at http://www.disastermentalhealthnj.com.

Heightened Pandemic Period

Managing the Emotional Challenges of the Influenza Pandemic

The current influenza pandemic has caused serious physical as well as emotional challenges for many individuals and families across the U.S. and around the world. Dealing with the stress of caring for sick loved ones, as well as taking care of oneself can be overwhelming. For those who have lost loved ones during this crisis, the emotional impact of the situation can be even greater.

In order to best help yourself and others around you, it is important that you pay attention to your own feelings and take care of your own emotional needs. (recognize some of the emotional challenges brought on by the pandemic, as well as some ideas about how to cope with those challenges.)

Emotional and Behavioral Reactions

Each individual and family has its own way of reacting, and coping with (the strong emotions triggered by) a serious illness or death in the family. (Some of the more common reactions experienced during an outbreak like the current pandemic include) these are normal reactions:

- Physical aches and pain unrelated to the illness
- (Extreme) fear, panic and dread
- Inability to focus on work or school (trouble concentrating)

- Helplessness and/or hopelessness
- Depression (Inability to engage in productive activity)
- (Acute) grief and sadness
- Disorientation (feeling dazed, memory loss,
- inability to recall events of the past 24 hours or understand what is happening) and confusion
- Overwhelmed with self-doubt and uncertainty (Feeling overwhelmed)

Coping

During the peak of a disease outbreak, life can change in many ways. Remaining flexible is important. It may also be helpful to:

- Find alternative ways to do normal activities if isolation is necessary
- Explore alternative means of communicating Stay connected (e.g. phone, e-mail) with loved ones if separated
- Learn and use relaxation techniques that can help calm your mind and body
- Talk and share your feelings with others
- Find comfort in your spiritual and personal beliefs

Helping Children

There are a number of useful ideas that can help parents and caregivers in dealing with their children's emotional response to this phase of the pandemic. These include:

- Provide only age-appropriate information to children (Respond to questions in terms they can comprehend.)
- Be honest, but don't vent your frustrations or overwhelm the child
- Provide children with opportunities to talk about what they are seeing or hearing in the news and the community
- Provide play experiences to help relieve tension. Younger children in particular may find it easier to share their ideas and feelings about the event through non-verbal activities such as drawing.
- Don't be afraid to admit that you can't answer all of their questions
- Allow children to discuss other fears and concerns about unrelated issues
- Monitor children's television viewing. Limit your child's exposure to graphic or troubling scenes. Watch news reports with your child so that you are available to answer their questions and to monitor their reactions
- Keep regular schedules for activities such as eating, playing and going to bed to help restore a sense of security and normalcy.

Psychosocial Considerations – Appendix 5

You're Not Alone

Contagious diseases often prevent people from having close contact with friends and neighbors. During this difficult time, it is important to remember that you are not alone. Assistance in coping with the emotional challenges of the pandemic is available from many sources.

A toll-free phone number is available for emotional support at (877) 294-HELP (4357) and for TTY Assistance at (877) 294-4356. You can also find more ideas for coping online at http://www.disastermentalhealthnj.com.

Pandemic Period

The Emotional Impact of the Influenza Pandemic

The current influenza pandemic has resulted in serious illness and many flu-related deaths. Many families are experiencing the loss of one or more loved ones. Many of these loses feel very unfair, since young people, as well as the old or sick die from the flu. Stress and grief reactions are *normal* aspects of the emotional process in such situations. These reactions often include:

Physical reactions, such as:

- Fatigue
- General malaise and tiredness
- Susceptibility to illness (all which may easily be confused with early symptoms of influenza)

Emotional disruption –

- Sadness
- Anxiety
- Loneliness
- Guilt and shame
- Feeling isolated and alien from others

Changes in thinking –

- Impaired concentration
- Problems with short-term memory
- Disrupted problem-solving abilities

In general, many individuals and families will experience a sense of physical and emotional exhaustion.

Psychosocial Considerations – Appendix 5

When a loved one dies

A pandemic disease does not discriminate. It can take the life of the young and the old, the healthy and the sick, the rich and the poor. When a loved one dies, common reactions include:

- Feeling confused, numb, disbelief, bewildered, or lost
- Feeling angry at the person who died or at the people considered responsible for the death
- Strong physical reactions, such as nausea, fatigue, shakiness, and muscle weakness
- Intense emotions, such as extreme sadness, anger or fear
- Increased risk for physical injury or illness

Coping with grief and loss: What helps

There are several useful approaches to managing the powerful emotional reactions that can follow the serious illness or death of a loved one. These include:

- Talking to another person for support or spending time with others
- Engaging in positive distracting activities (hobbies, reading, etc.)
- Getting adequate rest and eating healthy meals
- Exercising in moderation
- Trying to maintain a normal schedule
- Focusing on something practical that you can do right now to manage the situation better
- Using relaxation methods (breathing exercises, meditation, calming self-talk, soothing music, etc.)
- Keeping a journal
- Seeking counseling

You're Not Alone

These powerful emotional reactions can further isolate us from others. During this difficult time, it is important to remember that you are not alone. Assistance in coping with the emotional challenges of the pandemic is available from many sources.

A toll-free phone number is available for emotional support at (877) 294-HELP (4357) and for TTY Assistance at (877) 294-4356. You can also find more ideas for coping online at http://www.disastermentalhealthnj.com.

Appendix D-2

Psychological First Aid Training For The Faith Community

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The Tower of Ivory Meets the House of Worship: Psychological First Aid Training for the Faith Community

O. Lee McCabe
Department of Mental Health and Center for Public Health Preparedness
The Johns Hopkins Bloomberg School of Public Health
and
Department of Psychiatry and Behavioral Sciences
The Johns Hopkins School of Medicine

Adrian M. Mosley
The Johns Hopkins Health System

Howard S. Gwon
The Office of Emergency Management,
The Johns Hopkins Hospital

George S. Everly Jr.
Center for Public Health Preparedness
The Johns Hopkins Bloomberg School of Public Health

Jeffrey M. Lating
Loyola College in Maryland

Jonathan M. Links
Center for Public Health Preparedness
The Johns Hopkins Bloomberg School of Public Health

Michael J. Kaminsky
Department of Psychiatry and Behavioral Sciences
The Johns Hopkins School of Medicine

Abstract: *Clergy and laity have been a traditional source of support for people striving to cope with everyday tragedies, but not all faith leaders have the specialized knowledge required for the challenges of mental health ministry in the aftermath of widespread trauma and mass casualty events. On the other hand, some mental health professionals have acquired high levels of expertise in the field of disaster mental health but, because of their limited numbers, cannot be of direct help to large numbers of disaster survivors when such events are broad in scale. The authors have addressed the problem of scalability of post-disaster, crisis mental health services by establishing an academic/faith partnership for psychological first aid training. The curriculum was piloted with 500 members of the faith community in Baltimore City and other areas of Maryland. The training program is seen as a prototype of specialized first-responder training that can be built upon to enhance and extend the roles of spiritual communities in public health emergencies, and thereby augment the continuum of deployable resources available to local and state health departments. [International Journal of Emergency Mental Health, 2008, 9(3), pp. 171-180].*

Key words: *Terrorism; disaster mental health; psychological first aid; faith community; faith and disaster, spiritual caregiver; religion and health; public health preparedness.*

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The Problem: Disaster-Induced Demand for Behavioral Health Services

There is increasing recognition that surges in demand for medical services in the immediate aftermath of disasters and large-scale public catastrophes can rapidly overwhelm health care resources. An important dimension to this problem is the volume of individuals presenting to hospital emergency departments and other health care settings who are more psychologically affected than physically injured. For example, disproportionate rates of acute and chronic psychological (vs. somatic) post-trauma sequelae have been documented following a broad range of terrorist incidents, including the SCUD missile attacks in Israel (Golan, Arad, Atsmon, Shemer, & Nehema, 1992), Sarin gas release in Tokyo (Ohbu et al., 1997), bombing of the Murrah federal office building in Oklahoma City (North et al., 1999), the September 11 attacks on the World Trade Center and Pentagon (Schlenger et al., 2002) and the release of Anthrax in the District of Columbia (Dougall, Hayward, & Baum, 2005). Compounding the concerns about meeting disaster-driven medical and behavioral health surge demands is the reported reluctance of many health personnel to report to duty under certain emergency scenarios; for example, although there were moderators linked to specific job responsibilities, nearly half of workers in a local health department indicated that they were unlikely to report to work during an influenza epidemic (Balicer, Omer, Barnett, & Everly, 2006).

Accompanying the evidence of the need for disaster-related services for acute psychological crises, there are also reports documenting the necessity of managing the longer-term psychological consequences of traumatic events, especially terrorist incidents (Galea et al., 2001; Kawana, Ishimatsu, & Kanda, 2001; Silver, Holman, McIntosh, Poulin, & Gil-Rivas, 2002). Although post-incident effects are a function of multiple mediating factors, including *proximity to* (Foy, 1992), *extent of fear during* (Tucker, Pfefferbaum, Vincent, Boehler, & Nixon, 1998), *perceived ability to exert control over* (Slovic, 1987), and *level of media exposure following* (Pfefferbaum et al., 2001) such events, exposure to disasters and other trauma can have a lasting impact on child and adolescent development (Nader & Pynoos, 1992; Pynoos & Nader, 1993; Shaw, 1996). Other populations demonstrated to be at greater risk for development of acute and chronic post-trauma problems are first-responder rescue workers (Weiss, Marmor, Metzler, & Ronfeldt, 1995) and urban minorities (Norris, Friedman, & Watson, 2002), especially those of Hispanic ethnicity (Galea et al., 2002).

Toward a Solution: Specially Prepared Faith Communities

The underlying construct of the program to be described is that faith-based organizations (FBOs) — both their clergy and laity — have a significant, but not fully actualized, potential for meeting acute, disaster-driven, behavioral health surge demands on care delivery systems, and for providing longer-term psychological support of individuals affected by traumatic events.

Rationale: It is well known that FBOs routinely respond to community disasters with vital material resources, such as food, clothing, shelter, equipment, and supplies, and with important human services, such as death notification, prayer/worship leadership, communication with families of victims, and general fellowship (Koenig, 2006). This work is often performed shoulder-to-shoulder with disaster relief workers from government and private social service agencies. The premise of this project is that, in addition to providing such tangible services and resources, FBOs have extraordinary potential for delivering crisis intervention services to survivors of disasters—naturally-occurring and intentionally-provoked. The scale of the populace's impulse to seek spiritual and pastoral support under conditions of exceptional stress is highlighted by a survey noting that 90% of respondents reported turning to religion for help coping with stress associated with the terrorist attacks of September 11 (Schuster et al., 2001). Other studies not only confirm that FBOs can play a significant role in responding to the psychological needs of disaster survivors (Bradfield, Wylie, & Echterling, 1989) but that clergy and lay leaders of faith congregations are routinely sought out for counsel with personal problems (Verhoff, Kulka, & Couvan, 1981), particularly in African-American and Hispanic communities (Galea et al., 2002). The severity of these problems for which help is sought is purportedly equivalent to the disorders treated by mental health professionals (Larson et al., 1988).

The specific pathways through which faith-related benefits accrue to victims of disasters would seem to be two-fold, institutional and personal; the former presumably through the framework of comforting theology, ceremony, ritual, sacraments, images, and other ecclesiastical forms and functions; and the latter through face-to-face ministry by clergy whose use of relevant scripture, empathic listening, or physical presence alone may bring considerable consolation to those in crisis. Harold Koenig, noted researcher of the relationship between faith and health, has offered no fewer

than ten reasons that religion and spiritual caregivers can benefit people trying to cope with crises. These salutary effects of religious and spiritual activities on personal stress revolve around positive worldview; meaning and purpose; psychological integration; hope and motivation; personal empowerment; sense of control; role models for suffering; guidance for decision making; answers to ultimate questions; and social support (Koenig, 2006).

A report issued several years ago by the Institute of Medicine (IOM) offers general support for an expanded role in disaster response for the faith community but with a noteworthy proviso:

> "A broad spectrum of professional responders is necessary to meet [terrorism-related] psychological needs effectively. Those outside the mental health professions, who may regularly interface with the public, can contribute substantially to community healing. These professionals include...faith-based and other community leaders. *However, these professionals will require knowledge and training in order to provide effective support*" (IOM, 2003, p. 15).

Certainly, if spiritual caregivers are to become optimally prepared to engage as active partners in disaster mental health response and to fit formally into local, state, and federal emergency response systems, numerous preparatory tasks must be successfully addressed. These tasks include the creation of alliances through which expert training in the requisite knowledge, skills, and abilities (KSAs) may be delivered; the development of databases of qualified trainees that can serve as registries of potential responders; and the establishment of practical government/community interface mechanisms to facilitate efficient system activation (rapid call-up, targeted deployment, etc).

Psychological First Aid (PFA): A Promising Intervention for Pastoral Application

A conceptual framework for PFA training of public health professionals functioning outside the formal mental health workforce has been developed at the Johns Hopkins Center for Public Health Preparedness (CPHP; Everly & Flynn, 2006; Parker, Barnett, Everly, & Links, 2006). The model assumes that training in basic, crisis-oriented, mental health interventions can enhance the effectiveness of (presumably otherwise adept) non-mental health personnel providing direct interventions to affected populations in a disaster and/or to facilitate their connection with needed care. The authors adapted an earlier form of this crisis-interventionist/gatekeeper model for application to the immediate project.

To accomplish a practicable adaptation of the PFA model to the faith community, there were three fundamental questions to answer.

- Can an academic health center (AHC) and local faith leaders collaborate to develop a training curriculum for spiritual caregivers that successfully integrates technical disaster/mental health content (psychological first aid principles and practices) with spiritual health values and perspectives?
- If so, can such an integrated curriculum be tailored to fit the spiritual and cultural characteristics, learning styles, and overall needs of populations in an urban area comprised of African-American and Latino residents predominantly of the Christian faith?
- Can the training experience measurably enhance the participants' sense of preparedness and self-efficacy in key competency domains intrinsic to disaster ministry in general, and to PFA in particular?

An opportunity for answering these questions was afforded the authors in the form of a competitive "Special Projects" grant from the state of Maryland's Bio-Terrorism Hospital Preparedness Program funded by the U.S. Health Resources and Services Administration (HRSA; Romanosky, 2005). This grant program encouraged applicant institutions to collaborate with other organizations and community-based preparedness resources in the state, and to develop projects that were innovative and potentially portable to other geographic regions.

The Program

The key elements of the program were the following.

Partners and Management Structures

The AHC partners were The Johns Hopkins University School of Medicine [Department of Psychiatry and Behavioral Sciences] acting on behalf of the Johns Hopkins Hospital, the Johns Hopkins Bloomberg School of Public Health [the Center for Public Health Preparedness (CPHP)], and the University of Maryland School of Medicine [Department of Psychiatry and Behavioral Sciences]. The FBO partners

were the Archdiocese of Baltimore - Office of Hispanic Ministry, the Clergy United for Renewal in East Baltimore (CURE), and the Institute for Mental Health Ministry, Inc.

Three principal mechanisms for project implementation were established: a Partnership Steering Committee that initially met monthly and subsequently bi-monthly; a Community Advisory Board, responsible for recruiting clergy to participate in scheduled training, which met on a monthly schedule; and a Curriculum Development Committee, composed of at least one representative from all partnering organizations, which met on a weekly schedule and designed the content of the Microsoft PowerPoint (PPT) slide presentation.

Goals and Objectives

The long-term goal of the program is to have a public health infrastructure in Maryland that formally recognizes specially-trained faith congregations as a vital component of its continuum of disaster workforce responders. The purpose of the project was to determine the feasibility of a relatively brief training experience enhancing spiritual caregivers' perceived self-efficacy (Bandura, 1997) in responding to members of their communities who might need (psychological) trauma-related support following disasters. The primary project objectives were to design the curriculum and conduct the training sessions with a minimum of 240 members of the clergy.

Philosophy and Values

In order to create an enduring AHC/FBO alliance, an explicit "partnership philosophy" was articulated that recognized the following principles.

- Participants function in distinct cultures, and thus need to be committed to developing a working alliance that is mutually supportive of other partner needs.
- The principles of trust, respect, communication, flexibility, and mutual benefit are critical to the success of the partnership.
- Collaborators are committed to sharing resources, and to developing compatible goals, realistic plans, clear objectives, specified tasks, and shared credit among partners.

An effort was made to avoid creating a top-down program of "academics training clergy," and, in acknowledgment of the crucial spiritual values, knowledge base, and skill set that the faith community would bring to the project, the authors developed the training curriculum **with** the faith partners. The intent was to have a program that would be a unique integration of spiritual and disaster mental health content — a jointly-developed, bi-cultural curriculum that could impart principles of what one of the authors (JML) termed, "therapeutic spirituality." Specifically, the goal was to create an overarching model of trauma response that would transcend more secular approaches to crisis intervention. This would require not only a pointed effort to braid technical and spiritual content together, but also the development of a curriculum that consistently emphasized the special value of transcendent spiritual perspectives to provide succor to survivors of catastrophic events. To be true to this philosophy, curriculum content was designed to be transmitted through the vehicle of two-person teams [see 'Trainers ...' next page], composed of an AHC-based disaster mental health expert and an FBO-based spiritual caregiver. Moreover, as part of the commitment to promote a customized, personalized curriculum with which the clergy could identify, faith leaders were given an opportunity to incorporate into the PPT slides personally-chosen, disaster-relevant, scriptural passages and prayers, as well as their preferred religious images, local church photographs, etc. To assure optimal value of the program for the Latino community, Spanish-language translations of the 200-slide PPT program and of the program evaluation forms were created.

Curriculum Training Modules: Organization and Content

The broad topics covered in the four training modules, listed in the sequence in which they were presented during the seven-hour training day, were as follows:

- Stress Reactions of Mind, Body & Spirit: a) Acute Stress; b) Chronic/Cumulative Stress & Burnout; c) PTSD
- Psychological First Aid and Crisis Intervention: a) Incident Command System; b) Individual Psychological First Aid; c) Large Group Psychological First Aid and Congregational Communications

- Pastoral Care and Disaster Ministry: a) Fundamental Aspects of Disaster Ministry; b) Differentiating Traditional Pastoral Care and Disaster Pastoral Care; c) Responses: Pastoral and Prophetic
- Self Care and Practical Resources for Spiritual Caregivers: a) Recognizing and Preventing Burnout in Oneself; b) Self-Help Strategies; c) Disaster Planning and Resources for Families: Yours and Theirs.

Topics subsumed under "Individual PFA" were: differentiating between normal and severe signs/symptoms of stress; making appropriate triage/referral decisions; providing effective emotional support, spiritual guidance, and crisis communication; accessing available psychosocial and psychiatric resources; and understanding the importance of self-care strategies for caregivers.

Real world applicability: To enhance the likelihood that training would lead to the acquisition of viable competencies transferable to actual disaster settings, the lecture format was complemented by knowledge-application and skill-building exercises. Among these were: descriptions of personal accounts by the trainers of actual, field experiences providing PFA to victims at disaster sites; formal case studies; table-top exercises; and participation in role-playing scenarios.

Educational Materials and Resources

To assure participants had tangible materials to retain and share with their parishes, family, and friends, a disaster "Tool Kit" was assembled that incorporated a comprehensive collection of practical resources, including: hard copies of the PPT slides from the training program; a bibliography of generic disaster mental health literature references; lists of "all-hazards" preparedness educational materials, including videos, posters and brochures [that addressed preparedness activities for fires, chemical emergencies, hurricanes, floods, heat waves, winter storms, etc]; protocols for family disaster planning, including recommendations for assembling survival kits, i.e., 'Go-Packs'; copies of journal articles on pastoral crisis intervention; and guidelines on loss-, grief-, and bereavement support.

Trainers and Training Sessions

Trainers: A total of eight trainers were used in the two-person teams, viz., two doctoral-level disaster mental health experts and six members of the clergy, one of whom was an ordained minister and board-certified psychiatrist.

Training sessions - format, venues, etc: Training sessions were conducted using a professional CME/CEU format, i.e., one-day in length [9 a.m. through 4 p.m.] with morning, lunch, and afternoon refreshment breaks. Each session opened and closed with a prayer. Program evaluations were completed at the end of the day, following which a "commissioning" of participants was performed by distributing certificates of attendance.

Assessments and Data Analysis

Interpretations of the success in meeting the objectives of the program were inferred from *process data* (number of persons trained, number of congregations represented, etc.) and *outcome data*, the latter derived from trainee responses to questions in a structured evaluation form administered immediately after each training session. The scope of the evaluation approach spanned perceptions of the success of the program in meeting specific PFA learning objectives [8 items], and overall program quality [10 items]. These 18 variables were measured using a 5-point Likert scale. Additionally, there were structured opportunities to provide open-ended responses to specific queries, e.g., "What were the most effective and least effective aspects of the training? [2 items]; Which elements of the program deserved more coverage and less coverage?" [2 items], and others.

Evaluation: Data And Discussion

Feasibility of the Model

Two important questions the project sought to answer were the fundamental ones of whether an academic/faith partnership could work together with sufficient effectiveness to craft a disaster mental/spiritual health training curriculum that fit the cultural characteristics of the targeted communities, and whether such a training program could be delivered to a sufficient number of clergy members to assure an adequate scale of community impact. Essentially, these are questions of feasibility best answered with the data in Table 1.

Table 1.
Process Evaluation and Feasibility Data Related to Program Training

Program Process Items	N
Number of training sessions	9
Number of trainers	8
Number of Clergy trained	500*
Mean number of attendees at training sessions [*SD* = 28]	55
Number of clergy trainees in Baltimore City	294
Number of clergy trainees elsewhere in Maryland	206
Number of participants receiving English-language trainings	423
Number of participants receiving Spanish-language trainings	73
Total number of Churches & Parishes represented	100+

*__Note__: *Four (4) of the clergy trainees also functioned as members of the trainings teams.*

That there was a desire for such training lies in the observation that more than double [500] the number of anticipated participants [240] volunteered for training, and that more than 100 church and congregational affiliations were represented in that population. Mean attendance at the nine training sessions was 55.1 participants [Standard Deviation = 28.1]. One Spanish-language training was delivered to 73 priests and laity from the local Hispanic community. Training sessions were delivered in diverse venues ranging from auditoria of academic medical centers with state-of-the-technology A/V equipment to small community churches where attendees sat in pews and trainers presented their slides on a small projection screen positioned in front of the altar.

Effectiveness of the Model

Two outcome questions of interest were whether the training program could be delivered with sufficient effectiveness by the trainer-dyads to enhance recipients' perceived self-efficacy in administering the PFA in future emergency contexts, and whether the trainers could create in trainees the general and hopefully demonstrable belief that they had participated in a program of estimable quality and future usefulness.

Self-efficacy in applying PFA principles. Table 2 provides a summary of data on 384 participants who submitted fully-completed program evaluation forms. The results speak to the program's effectiveness in enhancing trainees' perceived self-efficacy performing the component-activities of PFA with persons in crisis.

Table 2.
Percent of Respondents Rating Program as 4 ['Very Good'] or 5 ['Excellent'] for Enhancing Trainees' Perceived Self-Efficacy with PFA-Related Competencies [*N* = 384]

Competency Items Specific to PFA and Disaster Ministry	Percent
Recognizing signs and symptoms of stress and acute stress disorder	90.6
Recognizing the essential characteristics of posttraumatic stress syndrome	91.5
Understanding the relationship between trauma and substance use conditions	82.7
Understanding the principles of providing Individual Psychological First Aid	85.5
Understanding the principles of providing group/Congregational Psychological First Aid	81.5
Awareness of key features of Disaster Ministry	85.9
Accessing psychosocial and psychiatric resources	77.1
Planning and self-care strategies for the Spiritual Care Giver	89.6

Except for one item, the frequency with which trainees provided ratings of either 4 ('Very Good') or 5 ('Excellent') regarding the program's success in achieving its PFA-related learning objectives ranged from 81.5% ('Understanding principles of group PFA') to 91.5 % ('Recognizing the essential characteristics of post-traumatic stress syndrome'). The lowest rating, 77.1%, was given to the program's success in imparting information on "How to access psychosocial and psychiatric resources." In retrospect, given the relatively limited time devoted to this topic, it is understandable that respondents' assessment of that item was lower than others.

Overall impressions of the program. A summary of the data on trainee perceptions of the overall quality of program is provided in Table 3.

Table 3.
Percent of Respondents Rating Program as 4 ("Very Good") or 5 ("Excellent") in Effectiveness Meeting Overall Quality Standards and Practical Usefulness [N=384]

General Criteria Items for Program Quality and Usefulness	Percent
Program organization	85.9
Program content	85.4
Likely usefulness in the event of a disaster or large-scale critical incident	84.3
Likely usefulness in the event of a Congregational or neighborhood crisis	82.3
Quality of presentations: Disaster mental health experts	91.8
Quality of presentations: Clergy members	73.6*
Success integrating mental health and spiritual perspectives	78.9
Quality of PPT slides	79.2
Quality and usefulness of Tool Kit	90.6
Overall program	89.1

*__Note__: *See discussion immediately below.*

The data indicate that the majority of participants considered the training either very good ['4'] or excellent ['5'] in overall quality and in accomplishing its learning objectives. The evaluation item receiving the lowest score, 73.6, was "Quality of trainers: Clergy members." In large measure, this was due to the relatively poor rating of *one* trainer's performance on *one* training day. In the interest of safeguarding the identity of the trainer, the message to be taken away is that "the Christian faith community" is not such a homogeneous population that the "goodness-of-fit" between the cultural backgrounds and teaching/learning styles of trainers/trainees can be ignored.

The evaluation process ended with two questions: Have you acquired any important information that you see being of help to you in the future as a leader in the clergy community? The percent of participants responding "Yes" was 98.4. The final question, 'Have you acquired any important information that you see being of help to you in the future as a leader in the clergy community?' yielded a 98.4 % "Yes" response rate.

Summary And Conclusions

Through a grant made possible by the Maryland/HRSA Bio-Terrorism Hospital Preparedness Program, members of an academic/faith partnership developed a training program in disaster mental health for spiritual caregivers. Participants' self-report data on curriculum content and implementation indicated that the majority of trainees perceived the program as having significantly enhanced their knowledge of a model of crisis intervention known as *Psychological First Aid*, and increased their confidence in disaster ministry with their congregations and others persons who might be future victims of trauma. While the project had its limitations [see below], the unanimous opinion of the partners is that the project demonstrated that AHCs and FBOs can enter into mutually-gratifying collaborations for the public good.

Keys to Effective Partnering

Obviously, the buy-in of religious leadership in the community is crucial to the success of such an enterprise. On the academic side, a key element for efficiencies in achieving project objectives was the availability of a person within the institution who had pre-existing relationships with key leaders in the spiritual community. Having someone with knowledge of *both* the academic and faith community cultures is ideal, as that person can support partnership development and strive for a mutually gratifying alliance. This role was served by one of the authors [AMM].

Knowing to whom in the community to reach out and managing to get collaborators in the same room are necessary but insufficient ingredients for success. Any success the program enjoyed in meeting its objectives was made possible only through a process of cross-cultural socialization between participating AHC and FBO collaborators. The partnership evolved through stages of mutual-learning — from an "us and them" to a "we" culture. To fully actualize what became a workable partnership, all participants engaged in give and take. For example, faculty members acceded to the preference of faith leaders to have meetings of the Community Advisory Board in the evenings; however, faith members met on Hopkins time when the Partnership Steering and Curriculum Development committees assembled. Other examples of between-group osmotic influences of customs and values were seen to occur over time, e.g., faculty members honored the wish of the clergy to begin and end all joint meetings with prayer, as partners prayed for the success of the project. Correspondingly, faith partners gradually appreciated the importance of, and accommodated to, the faculty's sensitivity to the fixed (seven-month) timetable for meeting grant deliverables and reporting deadlines.

Clergy Outreach and Trainee Recruitment

Although the project originally was designed for members of disadvantaged, urban minority populations, members of other spiritual communities throughout the state learned of, requested, and were granted opportunities for training. Such groups included two academically accredited pastoral counseling programs and a professional association for parish nurses. Because of the eager response from the faith community, little effort was required to recruit trainees after the initial program promotion efforts. The numbers of faith communities responding for training represented a wide spectrum of religious denominations and affiliations.

Curriculum Customization Issues

Because members of the Christian faith were over-represented in the targeted geographic area surrounding the Johns Hopkins Hospital, efforts to embed the disaster mental health content in a spiritual context incorporated the use of only Christian scripture and images into the PowerPoint slides and Tool Kit content. On those occasions when members of other faiths participated in the training sessions, the level of satisfaction with the training was compromised — despite considerable effort devoted immediately before mixed-faith training sessions to explain the single-faith emphasis by describing the original rationale for focusing on Christianity. Thus, prospective designers of similar programs elsewhere have three basic options for avoiding such problems: use professional experts to conduct "pure" (without spiritual content) disaster mental health trainings; create customized trainings with faith-/denomination-specific content; or develop a chaplaincy model of training – an approach that could be experienced as too spiritually diluted, generic, etc.

Caregiver Appreciation for "Mini-Disaster" Crisis-Management Skills

Participants were effusive in their expressions of interest in and gratitude for the kind of information conveyed in the trainings. Especially appreciated were the efforts to *integrate* the technical disaster mental health content with the spiritual. Interestingly, despite all trainees being acutely aware of terrorist events on American soil within recent years, as well as major weather events that affected many citizens of our country (particularly Hurricane Isabel, locally), most participants valued the learning experience as much for application to their immediate, concrete needs in pastoral ministries (or, as one trainee offered, for 'my everyday *mini-disasters*') as for its value in true public disaster contexts which, no doubt, seemed more remote and abstract.

Program Limitations and Future Directions

The open-ended questions in the evaluation form, as well as direct conversations with participants following the training sessions, yielded information that disclosed unmet needs and guidelines for future work with the faith community. This input emphasized the wish for: opportunities for more advanced training in PFA; specialized training in loss/grief/bereavement support; guidance in developing concrete, practical, community disaster plans (and for community empowerment in general); and clarification of specific respondent roles under various disaster and activation/deployment scenarios.

In conclusion, the above-described program seems to be a practical and eminently portable model for actualizing the latent but typically unrealized potential for disaster services inherent in the already established relationship between vulnerable urban populations and faith leaders (and probably rural residents for whom access to disaster mental health experts is limited). By advancing and implementing this model of training on a broader scale, the faith community may be able to realize its full potential of being an indigenous, effective, and durable resource for victims of large-scale disasters, with benefits accruing both to individual recipients of direct psycho-spiritual services and to leaders of health care facilities who are struggling with the problem of how to cope with disaster-driven surges in service demand under various hazard circumstances, particularly when front-line clinical staffing may be significantly reduced.

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Appendix E- 1

A Guide For Emergency Response And Public Safety Workers

Tips for Managing and Preventing Stress

A Guide for Emergency Response and Public Safety Workers

Engaging in response efforts in the wake of a traumatic event is inevitably stressful for those involved in the emergency response. While the work is personally rewarding and challenging, it also has the potential for affecting responders in harmful ways. The long hours, breadth of needs and demands, ambiguous roles, and exposure to human suffering can adversely affect even the most experienced professional. Too often, the stress experienced by responders is addressed as an afterthought. With a little effort, however, steps can be taken to minimize the effects of stress.

Stress prevention and management should be addressed in two critical contexts: the organization and the individual. Adopting a preventive perspective allows both workers and organizations to anticipate stressors and shape responses, rather than simply reacting to a crisis when it occurs. Suggestions for organizational and individual stress prevention and management approaches are presented below.

Organizational Approaches for Stress Prevention and Management

1. Provide effective management structure and leadership. Elements include:
   - Clear chain of command and reporting relationships.
   - Available and accessible supervisors.
   - Disaster orientation for all workers.
   - Shifts of no longer than 12 hours, followed by 12 hours off.
   - **Briefings at the beginning** of shifts as workers enter the operation. Shifts should overlap so that outgoing workers brief incoming workers.
   - Necessary supplies (e.g., paper, forms, pens, educational materials).
   - Communication tools (e.g., mobile phones, radios).
2. Define a clear purpose and goals.
3. Define clear intervention goals and strategies appropriate to the assignment setting.
4. Define roles by function.
5. Orient and train staff with written role descriptions for each assignment setting. When a setting is under the jurisdiction of another agency, inform workers of each agency's role, contact people, and expectations.
6. Nurture team support.
7. Create a buddy system to support and monitor stress reactions. Promote a positive atmosphere of support and tolerance with frequent praise.
8. Develop a plan for stress management. For example:
   - Assess workers' functioning regularly.
   - Rotate workers among low-, mid-, and high-stress tasks.
   - Encourage breaks and time away from assignment.

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- Educate about signs and symptoms of worker stress and coping strategies.
- **Provide individual and group defusing and debriefing.**
- **Develop an exit plan for workers leaving the operation, including a debriefing, reentry** information, opportunity to critique, and formal recognition for service

Individual Approaches for Stress Prevention and Management

1. Manage workload.
   - Set priority levels for tasks with a realistic work plan.
   - Delegate existing workloads so workers are not attempting disaster response in addition to their usual jobs.
2. Balance lifestyle.
   - Get physical exercise, and stretch muscles when possible.
   - Eat nutritiously, and avoid excessive junk food, caffeine, alcohol, or tobacco.
   - Get adequate sleep and rest, especially on longer assignments.
   - Maintain contact and connection with primary social supports.
3. Apply stress reduction techniques.
   - Reduce physical tension by activities such as taking deep breaths, meditating, and walking mindfully.
   - Use time off for exercise, reading, listening to music, taking a bath, talking to family, or getting a special meal.
   - Talk about emotions and reactions with coworkers during appropriate times.
4. Practice self-awareness.
   - Learn to recognize and heed early warning signs for stress reactions.
   - Accept that you may need help to assess problematic stress reactions.
   - Avoid overly identifying with survivors' and victims' grief and trauma, which may interfere with discussing painful material.
   - Understand differences between professional helping relationships and friendships.
   - Examine personal prejudices and cultural stereotypes.
   - Be mindful that vicarious traumatization or compassion fatigue may develop.
   - Recognize when a personal disaster experience or loss interferes with effectiveness.

Normal Reactions to a Traumatic Event

- No one who responds to a mass casualty event is untouched by it.
- Profound sadness, grief, and anger are normal reactions to an abnormal event.
- **You may not want to leave the scene until the work is finished.**
- You likely will try to override stress and fatigue with dedication and commitment.
- You may deny the need for rest and recovery time.

Helpful Resources

National Mental Health Information Center
Toll-Free: 1-800-789-2647 (English and Español)
TDD: 1-866-889-2647
Web Site: www.mentalhealth.samhsa.gov

National Clearinghouse for Alcohol and Drug Information
Toll-Free: 1-800-729-6686 (English and Español)
TDD: 1-800-487-4889
Web Site: www.ncadi.samhsa.gov

Treatment Locators

Mental Health Services Locator
Toll-Free: 1-800-789-2647 (English and Español)
TDD: 1-866-889-2647
Web Site: www.mentalhealth.samhsa.gov/databases

Substance Abuse Treatment Facility Locator
Toll-Free: 1-800-662-HELP (4357)
(24/7 English and Español)
TDD: 1-800-487-4889
Web Site: www.findtreatment.samhsa.gov

Hotlines

National Suicide Prevention Lifeline
Toll-Free: 1-800-273-TALK (8255)
TTY: 1-800-799-4TTY (4889)
Web Site: www.suicidepreventionlifeline.org

Office for Victims of Crime
Toll-Free: 1-800-851-3420
TTY: 1-877-712-9279
Web Site: www.ojp.usdoj.gov/ovc/ovcres/welcome.html

Other Resources

Centers for Disease Control and Prevention
National Institute for Occupational Safety and Health
Phone: 404-639-3311
Toll-Free: 1-800-311-3435
Web Site: www.cdc.gov/niosh/unp-trinstrs.html

Department of Veterans Affairs
National Center for Post-Traumatic Stress Disorder
Phone: 802-296-6300
Web Site: www.ncptsd.va.gov

Note: Inclusion of a resource in this fact sheet does not imply endorsement by the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration, or the U.S. Department of Health and Human Services.

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Signs That You May Need Stress Management Assistance

- Disorientation or confusion, and difficulty communicating thoughts.
- Difficulty remembering instructions. Difficulty maintaining balance.
- Becoming easily frustrated and being uncharacteristically argumentative.
- Inability to engage in problem solving and difficulty making decisions.
- Unnecessary risk taking.
- Tremors, headaches, and nausea.
- Tunnel vision and muffled hearing.
- Colds or flu-like symptoms.
- Limited attention span and difficulty concentrating.
- Loss of objectivity.
- Inability to relax when off duty.
- Refusal to follow orders or to leave the scene.
- Increased use of drugs or alcohol.
- Unusual clumsiness.

Ways to Help Manage Your Stress

- Limit on-duty work hours to no more than 12 hours per day.
- Rotate work from high-stress to lower stress functions.
- Rotate work from the scene to routine assignments, as practicable.
- Use counseling assistance programs available through your agency.
- Drink plenty of water, and eat healthy snacks such as fresh fruit, whole grain breads, and other energy foods.
- Take frequent, brief breaks from the scene, as practicable.
- Talk about your emotions to process what you have seen and done.
- Stay in touch with your family and friends.
- Participate in memorials and rituals, and use of symbols as a way to express feelings.
- Pair up with another responder so that you may monitor one another's stress.

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Appendix E-2

Psychological First Aid Provider Care

Appendix C: Psychological First Aid Provider Care

Providing care and support in the immediate aftermath of disaster can be an enriching professional and personal experience, enhancing satisfaction through helping others. It can also be physically and emotionally exhausting. The following sections provide information to consider before, during, and after engaging in disaster relief work.

Before Relief Work

In deciding whether to participate in disaster response, you should consider your comfort level with this type of work and your current health, family and work circumstances. These considerations should include the following:

Personal Considerations

Assess your comfort level with the various situations you may experience while providing Psychological First Aid:

- Working with individuals who are experiencing intense distress and extreme reactions, including screaming, hysterical crying, anger, or withdrawal
- Working with individuals in non-traditional settings
- Working in a chaotic, unpredictable environment
- Accepting tasks that may not initially be viewed as mental health activities (e.g. distributing water, helping serve meals, sweeping the floor)
- Working in an environment with minimal or no supervision or being micro-managed
- Working with and providing support to individuals from diverse cultures, ethnic groups, developmental levels, and faith backgrounds
- Working in environments where the risk of harm or exposure is not fully known
- Working with individuals who are not receptive to mental health support
- Working with a diverse group of professionals, often with different interaction styles

Health Considerations

Assess your current physical and emotional health status, and any conditions that may influence your ability to work long shifts in disaster settings, including:

- Recent surgeries or medical treatments
- Recent emotional or psychological challenges or problems
- Any significant life changes or losses within the past 6-12 months
- Earlier losses or other negative life events
- Dietary restrictions that would impede your work
- Ability to remain active for long periods of time and endure physically exhausting conditions
- If needed, enough medication available for the total length of your assignment plus some extra days

Family Considerations

Assess your family's ability to cope with you providing Psychological First Aid in a disaster setting:

- Is your family prepared for your absence, which may span days or weeks?
- Is your family prepared for you to work in environments where the risk of harm or exposure to harm is not fully known?
- Will your support system (family/friends) assume some of your family responsibilities and duties while you are away or working long hours?
- Do you have any unresolved family/relationship issues that will make it challenging for you to focus on disaster-related responsibilities?
- Do you have a strong, supportive environment to return to after your disaster assignment?

Work Considerations

Assess how taking time off to provide Psychological First Aid might affect your work life:

- Is your employer supportive of your interest and participation in Psychological First Aid?
- Will your employer allow "leave" time from your job?
- Will your employer require you to utilize vacation time or "absence-without-pay time" to respond as a disaster mental health worker?
- Is your work position flexible enough to allow you to respond to a disaster assignment within 24-48 hours of being contacted?
- Will your co-workers be supportive of your absence and provide a supportive environment upon your return?

Personal, Family, Work Life Plan

If you decide to participate in disaster response, take time to make preparations for the following:

- Family and Other Household Responsibilities
- Pet Care Responsibilities
- Work Responsibilities
- Community Activities/Responsibilities
- Other Responsibilities and Concerns

During Relief Work

In providing Psychological First Aid, it is important to recognize common and extreme stress reactions, how organizations can reduce the risk of extreme stress to providers, and to how best to take care of yourself during your work.

Common Stress Reactions

Providers may experience a number of stress responses, which are considered common when working with survivors:

- Increase or decrease in activity level
- Difficulties sleeping
- Substance use
- Numbing
- Irritability, anger, and frustration
- Vicarious traumatization in the form of shock, fearfulness, horror, helplessness
- Confusion, lack of attention, and difficulty making decisions
- Physical reactions (headaches, stomachaches, easily startled)
- Depressive or anxiety symptoms
- Decreased social activities

Extreme Stress Reactions

Providers may experience more serious stress responses that warrant seeking support from a professional or monitoring by a supervisor. These include:

- Compassion stress: helplessness, confusion, isolation
- Compassion fatigue: demoralization, alienation, resignation
- Preoccupation or compulsive re-experiencing of trauma experienced either directly or indirectly
- Attempts to over-control in professional or personal situations, or act out a "rescuer complex"
- Withdrawal and isolation
- Preventing feelings by relying on substances, overly preoccupied by work, or drastic changes in sleep (avoidance of sleep or not wanting to get out of bed)
- Serious difficulties in interpersonal relationships, including domestic violence
- Depression accompanied by hopelessness (which has the potential to place individuals at a higher risk for suicide)
- Unnecessary risk-taking

Organizational Care of Providers

Organizations that recruit providers can reduce the risk of extreme stress by putting supports and policies in place. These include:

- Limiting shifts so that providers work no more than 12 hours and encourage work breaks
- Rotation of providers from the most highly exposed assignments to lesser levels of exposure
- Mandate time off
- Identify enough providers at all levels, including administration, supervision and support
- Encourage peer partners and peer consultation
- Monitor providers who meet certain high risk criteria, such as:
  - Survivors of the disaster
  - Those having regular exposure to severely affected individuals or communities
  - Those with pre-existing conditions
  - Those with multiple stresses, including those who have responded to multiple disasters in a short period of time
- Establish supervision, case conferencing, staff appreciation events
- Conduct trainings on stress management practices

Provider Self-Care

Activities that promote self-care include:

- Manage personal resources
- Plan for family/home safety, including making child care and pet care plans
- Get adequate exercise, nutrition, and relaxation
- Use stress management tools regularly, such as:
  - Accessing supervision routinely to share concerns, identifying difficult experiences and strategizing to solve problems
  - Practicing brief relaxation techniques during the workday
  - Using the buddy system to share upsetting emotional responses
  - Staying aware of limitations and needs
  - Recognizing when one is Hungry, Angry, Lonely or Tired (HALT), and taking the appropriate self-care measures
  - Increasing activities that are positive
  - Practicing religious faith, philosophy, spirituality
  - Spending time with family and friends
  - Learning how to "put stress away"
  - Writing, drawing, painting
  - Limiting caffeine, cigarette, and substance use

As much as possible, providers should make every effort to:

- Self-monitor and pace their efforts

- Maintain boundaries: delegate, say no, and avoid working with too many survivors in a given shift
- Perform regular check-ins with colleagues, family, and friends
- Work with partners or in teams
- Take relaxation / stress management / bodily care / refreshment breaks
- Utilize regular peer consultation and supervision
- Try to be flexible, patient, and tolerant
- Accept that they cannot change everything

Providers should avoid engaging in:

- Extended periods of solo work without colleagues
- Working "round the clock" with few breaks
- Negative self-talk that reinforces feelings of inadequacy or incompetency
- Excess use of food/substances as a support
- Common attitudinal obstacles to self-care:
  "It would be selfish to take time to rest."
  "Others are working around the clock, so should I."
  "The needs of survivors are more important than the needs of helpers."
  "I can contribute the most by working all the time."
  "Only I can do x, y, z."

After Relief Work

Expect a readjustment period upon returning home. Providers may need to make personal reintegration a priority for a while.

Organizational Care of Providers

- Encourage time off for providers who have experienced personal trauma or loss
- Institute exit interviews to help providers with their experience – this should include information about how to communicate with their families about their work
- Encourage providers to seek counseling when needed, and provide referral information
- Provide education on stress management
- Facilitate ways providers can communicate with each other by establishing listservs, sharing contact information, or scheduling conference calls
- Provide information regarding positive aspects of the work

Provider Self-Care

Make every effort to:

- Seek out and give social support
- Check in with other relief colleagues to discuss relief work
- Increase collegial support

- Schedule time for a vacation or gradual reintegration into your normal life
- Prepare for worldview changes that may not be mirrored by others in your life
- Participate in formal help to address your response to relief work if extreme stress persists for greater than two to three weeks
- Increase leisure activities, stress management, and exercise
- Pay extra attention to health and nutrition
- Pay extra attention to rekindling close interpersonal relationships
- Practice good sleep routines
- Make time for self-reflection
- Practice receiving from others
- Find things that you enjoy or make you laugh
- Try at times not to be in charge or the "expert"
- Increase experiences that have spiritual or philosophical meaning to you
- Anticipate that you will experience recurring thoughts or dreams, and that they will decrease over time
- Keep a journal to get worries off your mind
- Ask help in parenting, if you feel irritable or are having difficulties adjusting to being back at home

Make every effort to avoid:

- Excessive use of alcohol; illicit drugs or excessive amounts of prescription drugs
- Making any big life changes for at least a month
- Negatively assessing your contribution to relief work
- Worrying about readjusting
- Obstacles to better self-care:
    - Keeping too busy
    - Making helping others more important than self-care
    - Avoiding talk about relief work with others.

Appendix E-3

Principles and Practical Procedures for Acute Psychological First Aid Training For Personnel Without Mental Health Experience

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Principles and Practical Procedures for Acute Psychological First Aid Training for Personnel Without Mental Health Experience*

George S. Everly, Jr.
The Johns Hopkins University School of Medicine; and
The Johns Hopkins University Bloomberg School of Public Health, Center for Public Health Preparedness

RADM Brian W. Flynn
Assistant Surgeon General of the United States, Retired; and
Uniformed Services University of Health Sciences

Abstract: *Most authorities agree that mass disasters leave in their wake a need for some form of acute mental health services. However, a review of current literature on crisis intervention and disaster mental health reveals differing points of view on the methods that should be employed (Raphael, 1986; NIMH, 2002). Nevertheless, there appears to be virtual universal endorsement, by relevant authorities, of the value of acute "psychological first aid" (American Psychiatric Association, 1954; USDHHS, 2004; Raphael, 1986; NIMH, 2002; Institute of Medicine, 2003; WHO, 2003; DoD/ VAPTSD, 2004; Ritchie, et al., 2004; Friedman, Hamblin, Foa, & Charney, 2004). Psychological first aid (PFA), as an acute mental health intervention, seems uniquely applicable to public health settings, the workplace, the military, mass disaster venues, and even the demands of more well circumscribed critical incidents, e.g., dealing with the psychological aftermath of accidents, robberies, suicide, homicide, or community violence . In this document, we shall introduce the notion of psychological first aid (PFA) as one aspect of a psychological continuum of care, offer a rudimentary definition of PFA, and provide the reader with a practical framework for its implementation utilizing the individual psychological first aid (iPFA) format. The goal of this paper is to better prepare public health, public safety, and other disaster response personnel who do not possess formal clinical mental health degrees or specialized training to provide iPFA services to primary and secondary disaster victims. [International Journal of Emergency Mental Health, 2006, 8(2), pp. 93-100].*

Key words: *psychological first aid, crisis intervention, disaster mental health, public health, peer support*

In 1954, the American Psychiatric Association published the monograph entitled *Psychological First Aid in Community Disasters* (APA, 1954). That document therein defined and argued for the development of an acute mental health intervention referred to as "psychological first aid" (PFA). This early exposition noted, "In all disasters, whether they result from the forces of nature or from enemy attack, the people involved are subjected to stresses of a severity and quality not generally encountered...It is vital for all disaster workers to have some familiarity with common patterns of reaction to unusual emotional stress and strain. These work-

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ers must also know the fundamental principles of coping most effectively with disturbed people. Although [these suggestions have] been stimulated by the current needs for civil defense against possible enemy action... These principles are essential for those who are to help the victims of floods, fires, tornadoes, and other natural catastrophes" (APA, 1954, p. 5). This seminal document delineated three important points:

1. The constituents of PFA consist of the ability to recognize common (and one might assume uncommon) reactions post disaster;
2. The constituents of PFA further consist of the fundamentals of coping; and
3. That ALL disaster workers should be trained, not just mental health clinicians.

In this paper we describe a practical set of guidelines for the implementation of psychological first aid. These guidelines are specifically designed for disaster workers, public health and safety personnel, and others who do not possess traditional mental health training or expertise.

In the first truly integrative disaster mental health text, *When Disaster Strikes*, Beverley Raphael noted, "...in the first hours after a disaster, at least 25% of the population may be stunned and dazed, apathetic and wandering—suffering from the disaster syndrome—especially if impact has been sudden and totally devastating...At this point, psychological first aid and triage...are necessary..." (Raphael, 1986, p.257). More recently, the Institute of Medicine (2003) has written, "In the past decade, there has been a growing movement in the world to develop a concept similar to physical first aid for coping with stressful and traumatic events in life. This strategy has been known by a number of names but is most commonly referred to as psychological first aid (PFA). Essentially, PFA provides individuals with skills they can use in responding to psychological consequences of [disasters] in their own lives, as well as in the lives of their family, friends, and neighbors. As a community program, it can provide a well-organized community task to increase skills, knowledge, and effectiveness in maximizing health and resiliency" (IOM, 2003, p. 4-5). Finally, W. Walter Menninger (2002), based upon the work of Karen Horney, has stated that the goal of psychological first aid is to reduce feelings of isolation, helplessness, and powerlessness.

Norris and her colleagues (Norris, Byrne, Diaz, & Kaniasty, 2001) reviewed 130 distinct samples of disaster survivors composed of more than 50,000 individuals from 80 different disasters. Based upon those data, she estimated that:

- 9% showed *minimal impairment*
- 52% showed *moderate impairment*,
- 23% showed *severe impairment*,
- 16% showed *very severe impairment*
- School-aged youth were most likely, and rescue/recovery workers least likely, to show severe impairment: 62% of the school-aged samples experienced severe impairment, compared to 39% of the adult survivor samples and 7% of the rescue/recovery samples (Norris, et al., 2001, p. 3).

Thus, those data would suggest that Raphael's estimates of the need for some form of psychological first aid may be underestimated.

As we face threats such as pandemic influenza, terrorist attacks, and natural mass disasters, the need to respond to the psychological needs of primary victims becomes essential. As psychological status appears to predict behavioral response, addressing psychological needs may not only serve to reduce distress, but may serve to improve compliance with governmental directives regarding personal and public health practices. It is unlikely that there will be sufficient mental health resources available to meet these public health needs. Therefore, it would seem important, consonant with the aforementioned recommendations, to train those outside of the mental health fields to provide some form of psychological first aid in order to meet psychological and behavioral challenges. (APA, 1954; Raphael, 1986; NIMH, 2002; Institute of Medicine, 2003; WHO, 2003; DoD/VAPTSD, 2004; Ritchie, et al., 2004; Friedman, et al., 2004; National Child Traumatic Stress Network and National Center for PTSD, 2005). In this paper, we shall introduce the notion of psychological first aid (PFA) with distressed individuals as one aspect of a psychological continuum of care, offer a rudimentary definition of PFA, and provide the reader with a practical framework for its implementation. The goal of this paper is to better prepare public health and public safety personnel to provide PFA services to primary and secondary victims.

Defining Psychological First Aid: A Clinical Perspective

The definition of psychological first aid may be best initiated by way of a comparison to physical first aid. As the **goals of physical first aid** are to:

1) stabilize physiological functioning,
2) mitigate physiological dysfunction/ distress,
3) achieve a return to acute adaptive physiological functioning, and/or
4) facilitate access to the next level of care;

the **goals of psychological first aid** are to:

1) stabilize psychological and behavioral functioning through meeting basic physical needs, then addressing the most basic of psychological needs,
2) mitigate psychological distress and dysfunction,
3) achieve a return to acute adaptive psychological and behavioral functioning, and/or
4) facilitate access to continued care.

From a more tactical perspective, psychological first aid may be intended to achieve any of the following:

- the provision of information/education
- the provision of comfort and support (Intervention based upon providing soothing human contact is legitimate and can be universally applied.)
- an acceleration of recovery
- the promotion of mental health
- the facilitation of access to continued or escalated care.

While psychological first aid has yet to benefit from careful research and evaluation, we are hopeful that it may hold promise in the items enumerated above.

According to the Institute of Medicine (2003), "Psychological first aid is a group of skills identified to limit distress and negative health behaviors...PFA generally includes education about normal psychological responses to stressful and traumatic events; skills in active listening; understanding the importance of maintaining physical health and normal sleep, nutrition, and rest; and understanding when to seek help from professional caregivers" (IOM, 2003, p.7).

The National Institute of Mental Health document *Mental Health and Mass Violence* (2002) has enumerated the functions of psychological first aid as including the need to...

"Protect survivors from further harm,

Reduce physiological arousal,

Mobilize support for those who are most distressed,

Keep families together and facilitate reunions with loved ones,

Provide information and foster communication and education,

Use effective risk communication techniques" (p. 13).

The U. S. Department of Health and Human Services (USDHHS, 2004) has compiled a list of "immediate mental health interventions." Within that list resides "psychological first aid." The components of psychological first aid include providing comfort, addressing immediate physical needs, supporting practical tasks, providing anticipatory information, listening and validating feeling, linking survivors to social support, normalizing stress reactions, and finally, reinforcing positive coping mechanisms.

Raphael (1986) suggests that psychological first aid consists of the following:

1. Comfort and consolation.
2. Physical protection.
3. Provision of physical necessities.
4. Channeling energy into constructive behaviors.
5. Reuniting victims with friends, family.
6. Provision of behavioral and/or emotional support, especially during emotionally taxing tasks.
7. Allowing emotional ventilation.
8. Re-establishing a sense of security.
9. Utilization of acute social and community support networks.
10. Triage and referral for those in acute need.
11. Referral to sub-acute and on-going support networks.

Raphael (1986) goes on to note that the provision of such acute psychological support is designed to achieve certain goals:

1. encourage the "working through" process by reinforcing adaptive coping,
2. helping victims re-establish a sense of mastery (self-efficacy),
3. facilitating access to the next level of care, if necessary, and
4. facilitating social reintegration.

Within the context of this paper, we view a central tenant of psychological first aid (PFA) as *"a supportive and compassionate presence designed to reduce acute psychological distress and/or facilitate continued support, if necessary."* PFA may be used in a wide variety of circumstances including the stressors of daily life, in family problems, in medical emergencies, in cases of loss and grief, and even in mass disasters. Although there are numerous volumes on the topic of physical first aid, psychological first aid is a relatively new concept. While the World Health Organization (2003) and the National Institute of Mental Health (2002) recognize the importance, and recommend the practice, of psychological first aid, there currently exist few practical guidelines on how it may be implemented. A clinically useful set of guidelines for PFA are those provided by National Child Traumatic Stress Network and National Center for PTSD (2005). This document defined PFA as follows: "Psychological First Aid is an evidence-informed modular approach for assisting children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism. Psychological First Aid is designed to reduce the initial distress caused by traumatic events, and to foster short- and long-term adaptive functioning. Principles and techniques of Psychological First Aid meet four basic standards. They are: (1) consistent with research evidence on risk and resilience following trauma; (2) applicable and practical in field settings; (3) appropriate to developmental level across the lifespan; and (4) culturally informed and adaptable" (National Child Traumatic Stress Network and National Center for PTSD, 2005, p.4). However, these initial published guidelines stated that PFA was to be practiced by "mental health specialists." In this current document, we view PFA in the broader context as originally prescribed by the American Psychiatric Association (1954).

The Principles of Psychological First Aid (PFA)

When someone is in acute physical distress, intervention based upon the principles of physical first aid would apply. One formulation of the basic psychological first aid process follows what may be referred to as the **"ASACC Principles:"**

- Assessment of need for intervention (level one assessment) [Note that the present use of the term "assessment" is not intended to refer to formal mental health assessment per se. Rather, it is designed to refer more to an appraisal of functional psychological and behavioral status.]
- Stabilize – Subsequent to an initial assessment and determination that intervention of some form is warranted, act so as to prevent or reduce a worsening of the current psychological or behavioral status.
- Assess and triage (level two assessment) – Once initial stabilization has been achieved, further assessment is indicated with triage as a viable option. Assessment of functionality is the most essential aspect of this phase.
- Communicate – Communicate concern, reassurance, and information regarding stress management.
- Connect – Connect the person in distress to informal and/or formal support systems, if indicated.

The Practice of Psychological First Aid (PFA): Tactical Guidelines (see Appendix A)

Let us take a closer look at these rudimentary elements of PFA.

Assessment (level one)

The goal of this phase of the intervention model is to make an initial assessment of need. To reiterate, the present use of the term *assessment* is not intended to refer to formal mental health assessment per se. Rather, it is designed to refer more to an appraisal of functional psychological and behavioral status. If the determination is made that there exists a need for behavioral or psychological intervention, stabilization is the next task requiring attention. In cases where no immediate need for assistance exists, continued monitoring may be appropriate for those in high risk conditions. In its most rudimentary form, this level one assessment addresses the basic physical and psychological needs described by Abraham Maslow (1943, 1954). When such needs are identified as being insufficiently met, they are directly attended to in the "stabilization" phase of this model.

Stabilize

Simply stated, the goal of this phase of the intervention model is to attempt to *keep things from getting worse*. These processes are intended to diminish the likelihood of an escalating spiral of distress while potentiating a return to psychological homeostasis. This may be initially achieved by the following:

- Establish "rapport." Rapport is often best founded on the process of psychological alignment. Psychological alignment is borrowed from the work of Jerome Frank (Frank & Frank, 1996) and simply stated means don't argue, don't confront, find something to initially agree upon.
- Stabilization is literally based upon the findings of the initial assessment. The most important initial determinations to be made are of:

  Identification of any medical needs that must be immediately addressed. Basic skill in physical first aid will be useful here.

  Meeting any basic physical needs (food, water, shelter, reduction of physical pain, referral for medical care).

  Determination of the level of functionality, i.e., is there evidence of functional impairment? If functional impairment is present to a significant degree, appropriate support must be sought.
- Reduce acute situational stressors, if possible
- Provide a sense of safety, security

Assess and triage (level two)

Having stabilized the acute phase response of the individual, further assessment of psychological and behavioral status seems indicated. From the perspective of psychological first aid, the greatest assessment challenge becomes differentiating commonly experienced *distress* from the more severe *dysfunction* (clinically significant functional impairment). *Distress* subsequent to disasters is to be expected in the majority of the those exposed, with estimates varying from 91% in a national survey 3 to 5 days after September 11 (Schuster, Stein, et al., 2001), and 76.7% in Israelis exposed to terrorism (Bleich, Gelkopf, & Solomon, 2003) to 63% in samples of a wide variety of natural and human-made disasters (Norris, et al, 2001). Minimal if any intervention beyond observation is typically required, unless requested, in the case of *distress*. In the case of *dysfunction*, on the other hand, the point prevalence is expected to be lower with estimates ranging from 49% (Norris, et al, 2001), 45% (North, et al., 1999) and 46% (North, Smith, & Spitznagel (1997) to perhaps 20% (CDC, MMWR, 2004). More structured intervention is called for in the case of *dysfunction*, with serious consideration given to facilitating access to interpersonal support and continued care. Beyond addressing medical issues and meeting basic needs, functionality becomes the key assessment issue to focus upon. The magnitude, or intensity, of the following intervention elements of psychological first aid will depend upon the level of manifest functionality. In addition, beyond its obvious face validity, functional impairment has been shown to be a predictor of PTSD (North, et al.,2002; Norris, McCutcheon, Spitznagel, & Smith, 2002) and therefore of prospective concern.

Communicate

The goal of this phase is to establish a *supportive and compassionate presence*. Effective intervention is often based upon active "outreach." Specific interventions could include the following and may be recalled using the mnemonic **EARN** (**E**mpathetic listening; **A**pply stress management; **R**eassurance; and **N**ormalization):

Empathic listening. Allow people to talk, to tell their story, but don't force conversation and do not pry. [Note: If the interventionist senses that the recipients may be resistant to intervention directly towards them, it may be of value to utilize the concept of "intervention by proxy". By this we mean that the comments of the interventionist and other group members may be directed towards assisting those other than those individuals in the current group. Thus, discussions may focus on recognizing the needs of others and on methods for assisting others who may have difficulty dealing with the aftermath of the current situation. Such "third party" discussions may reduce tension or ambivalence related to directly receiving assistance.]

Apply stress management. The application of appropriate stress management techniques may include cognitive reframing, problem-solving, suggestions concerning nutrition, exercise, relaxation, and interpersonal support.

Reassurance. A confident and compassionate presentation tends to reduce anxiety in others.

Normalization. The provision of psychoeducational material to aid in normalization, self-assessment, anticipatory guidance, and to foster resiliency and self-efficacy may be useful.

Connect

The goal of this phase is to assist the individual in connecting with an appropriate psychosocial support system if desired or otherwise indicated.

> Informal support systems include family, friends, and co-workers.
>
> More formalized support systems include community mental health programs, employee assistance programs, student assistance programs, hospitals, and faith-based resources.
>
> In this final stage, psychological first aid means establishing effective human contacts (APA, 1954).

In general, it is important for the interventionist to keep in mind the following points and cautionary notes:

1. The majority of individuals exposed to a traumatic event will not need formal psychological intervention, beyond being provided relevant information.
2. The focus should be upon the *individual* more so than the event; assessment is essential. Assessment is an on-going dynamic process, rather than a discrete, static stage. Assessment should focus on functionality.
3. Unless the magnitude of impairment is such that the individual represents a threat to self or others, crisis intervention should be voluntary.
4. The interventionist must be careful not to interfere with natural recovery or adaptive compensatory mechanisms.
5. Individuals should not be encouraged to talk about or relive the event, unless they are comfortable doing so.
6. Psychological first aid should be developed and conducted in a culturally competent manner, respecting such factors as cultural beliefs; the way in which emergencies and traumas are defined; cultural considerations of how distress is expressed and dealt with; which providers are viewed as credible; and many other important considerations. Significant and credible guidance is available on providing culturally competent services in crisis settings (USDHHS, 2003)
7. Psychological first aid should be viewed as one point on a continuum of disaster mental health care that spans the spectrum from pre-disaster preparation through psychotherapy, and even psychopharmacotherapy.

Summary

"[An] acute distress following exposure to traumatic stressors is best managed following the principles of psychological first aid. This entails basic, non-intrusive pragmatic care with a focus on listening but not forcing talk; assessing needs and ensuring that basic needs are met; encouraging but not forcing company from significant others; and protecting from further harm. This type of aid can be taught quickly to both volunteers and professionals" (Sphere Project, 2004, p. 293). From both the acute clinical and public health preparedness perspectives, acute psychological first aid represents a potentially valuable skill set that is easily applied in the wake of mass disasters. Arguably, wherever there is a need for the application of physical first aid, there can be a need for the application of psychological first aid. This chapter has offered an introduction to psychological first aid as a public health tool in the wake of disasters and as such may be of interest and value to all those interested in public health issues. Although operationally basic compared to the practice of psychotherapy, we believe that competence in iPFA still requires specialized training.

APPENDIX A

Operational Steps in the Model

1. ASSESS need for intervention based upon:
   a. Medical needs
   b. Basic physical needs
   c. Psychological/ behavioral impairment
2. STABILIZE by:
   a. Attending to medical needs
   b. Satisfying basic physical needs

c. Directly addressing

i. Affective spirals via cognitive distraction tecniques

ii Erratic behavior

iii Delaying acting upon impulsive urges

3. ASSESS need for continued intervention based upon funtionality.

4. COMMUNICATE

a. Allow the person in crisis to tell their "story" if he she desires to do so. Be careful not to urge ego dystonic catharsis. The story consists of:

i. Event please reduce spacing between roman numeral and text

ii. Reactions to the event

b. Normalize

c. Offer reassurance, as appropriate.

d. Apply stress management techniques, as indicated.

5. CONNECT to friends/ family, or other support systems. Triage to the next level of care, as needed

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Appendix E-4

Planning Checklist for Individuals and Families

Pandemic Flu Planning Checklist for Individuals & Families

You can prepare for an influenza pandemic now. You should know both the magnitude of what can happen during a pandemic outbreak and what actions you can take to help lessen the impact of an influenza pandemic on you and your family. This checklist will help you gather the information and resources you may need in case of a flu pandemic.

1. To plan for a pandemic:

- ❑ Store a two week supply of water and food. During a pandemic, if you cannot get to a store, or if stores are out of supplies, it will be important for you to have extra supplies on hand. This can be useful in other types of emergencies, such as power outages and disasters.
- ❑ Periodically check your regular prescription drugs to ensure a continuous supply in your home.
- ❑ Have nonprescription drugs and other health supplies on hand, including pain relievers, stomach remedies, cough and cold medicines, fluids with electrolytes, and vitamins.
- ❑ Talk with family members and loved ones about how they would be cared for if they got sick, or what will be needed to care for them in your home.
- ❑ Volunteer with local groups to prepare and assist with emergency response.
- ❑ Get involved in your community as it works to prepare for an influenza pandemic.

2. To limit the spread of germs and prevent infection:

- ❑ Teach your children to wash hands frequently with soap and water, and model the current behavior.
- ❑ Teach your children to cover coughs and sneezes with tissues, and be sure to model that behavior.
- ❑ Teach your children to stay away from others as much as possible if they are sick. Stay home from work and school if sick.

3. Items to have on hand for an extended stay at home:

Examples of food and non-perishables	Examples of medical, health, and emergency supplies
❑ Ready-to-eat canned meats, fish, fruits, vegetables, beans, and soups	❑ Prescribed medical supplies such as glucose and blood-pressure monitoring equipment
❑ Protein or fruit bars	❑ Soap and water, or alcohol-based (60-95%) hand wash
❑ Dry cereal or granola	❑ Medicines for fever, such as acetaminophen or ibuprofen
❑ Peanut butter or nuts	❑ Thermometer
❑ Dried Fruit	❑ Anti-diarrheal medication
❑ Crackers	❑ Vitamins
❑ Canned juices	❑ Fluids with electrolytes
❑ Bottled water	❑ Cleansing agent/soap
❑ Canned or jarred baby food and formula	❑ Flashlight
❑ Pet food	❑ Batteries
❑ Other nonperishable foods	❑ Portable radio
	❑ Manual can opener
	❑ Garbage bags
	❑ Tissues, toilet paper, disposable diapers

Appendix E-4

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❑ Canned juices	❑ Fluids with electrolytes
❑ Bottled water	❑ Cleansing agent/soap
❑ Canned or jarred baby food and formula	❑ Flashlight
❑ Pet food	❑ Batteries
❑ Other nonperishable foods	❑ Portable radio
	❑ Manual can opener
	❑ Garbage bags
	❑ Tissues, toilet paper, disposable diapers

Appendix E-5

Family Health Information Sheet

Family Emergency Health Information Sheet

It is important to think about health issues that could arise if an influenza pandemic occurs, and how they could affect you and your loved ones. For example, if a mass vaccination clinic is set up in your community, you may need to provide as much information as you can about your medical history when you go, especially if you have a serious health condition or allergy.

Create a family emergency health plan using this information. Fill in information for each family member in the space provided. Like much of the planning for a pandemic, this can also help prepare for other emergencies.

1. Family Member Information:

Family Member	Blood Type	Allergies	Past/Current Medical Conditions	Current Medications/ Dosages

2. Emergency Contacts:

Contacts		Name/Phone Number
Local personal emergency contact		
Out-of-town personal emergency contact		
Hospitals near:	Work	
	School	
	Home	
Family physician(s)		
State public health department (See list on www.pandemicflu.gov/state/statecontacts.html)		
Pharmacy		
Employer contact and emergency information		
School contact and emergency information		
Religious/spiritual organization		
Veterinarian		

Appendix E-6

Developing Cultural Competence in Disaster Mental Health Plans

Developing Cultural Competence in Disaster Mental Health Programs

GUIDING PRINCIPLES AND RECOMMENDATIONS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

Developing Cultural Competence in Disaster Mental Health Programs:

Guiding Principles and Recommendations

2003

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

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Disclaimer

The views, opinions, and content of this publication are those of the authors and do not necessarily reflect the views, opinions, or policies of SAMHSA or DHHS. The authors and the staff of CMHS acknowledge, appreciate, and respect the diverse terminology associated with cultural competence and related issues, and regret any inadvertent omission of information or inclusion of statements that may be unfamiliar to our readers.

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Contributors and Reviewers: Lourdes Arellano-Carandang, Ph.D.; Robert Benedetto, D.P.A., L.C.S.W.; Marisa Brown, M.S.N., R.N.; Nan Carle, Ph.D.; Deborah DeWolfe, Ph.D., M.S.P.H.; Kana Enomoto, M.A.; Linda Fain; Renee Georg; Elzbieta Gozdziak, Ph.D.; Rachel Guerrero, L.C.S.W.; Robert Hammaker, Ed.D.; Angelia Hill; Joseph Hill; Carol Kardos, M.S.S.W.; E'layne Koenigsberg; Harriet McCombs, Ph.D.; Patricia Mendoza, Ph.D.; Mary Elizabeth Nelson, M.S.W.; Wanetta Noconie; Gladys Padro, M.S.W.; Constance Peters, M.S.P.A.; Steven Shon, M.D.; Anthony Simms, Ph.D.; Karen Stengle; Suganya Sockalingam, Ph.D.; Cecilia Rivera-Casale, Ph.D.; and Katherine White, M.Div., R.N., C.C.C.

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Foreword

Disasters—earthquakes, hurricanes, chemical explosions, wars, school shootings, mass casualty accidents, and acts of terrorism—can strike anyone, regardless of culture, ethnicity, or race. No one who experiences or witnesses a disaster is untouched by it.

Peoples' reactions to disaster and their coping skills, as well as their receptivity to crisis counseling, differ significantly because of their individual beliefs, cultural traditions, and economic and social status in the community. For this reason, workers in our Nation's public health and human services systems increasingly recognize the importance of cultural competence in the development, planning, and delivery of effective disaster mental health services.

The increased focus on cultural competence also stems from the desire to better serve a U.S. population that is rapidly becoming more ethnically and culturally diverse. To respond effectively to the mental health needs of all disaster survivors, crisis counseling programs must be sensitive to the unique experiences, beliefs, norms, values, traditions, customs, and language of each individual, regardless of his or her racial, ethnic, or cultural background. Disaster mental health services must be provided in a manner that recognizes, respects, and builds on the strengths and resources of survivors and their communities.

The Crisis Counseling Assistance and Training Program (CCP) is one of the Federal Government's major efforts to provide mental health services to people affected by disasters. Created in 1974, this program is currently administered by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMSHA), and the Federal Emergency Management Agency (FEMA). The Program provides supplemental funding to States for short-term crisis counseling services to survivors of federally declared disasters. Crisis counseling services provided through the Program include outreach, education, community networking and consultation, public information and referral, and individual and group counseling. The CCP emphasizes specialized interventions and strategies that meet the needs of special populations such as racial and ethnic minority groups.

The purpose of this guide is to assist States and communities in planning, designing, and implementing culturally competent disaster mental health services for survivors of natural and human-caused disasters of all scales. It complements information previously published by FEMA and CMHS on disaster mental health response and recovery. FEMA provided the funding for this guide as part of the agencies' ongoing effort to address the needs of special

No one who experiences or witnesses a disaster is untouched by it.

populations in disaster mental health response and recovery. *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations* is part of a series of publications developed by CMHS.

In developing this guide, CMHS recognized that cultural competence is a complex subject—one that has varying terminologies, opinions, expectations, models, and paradigms. The authors sought to identify common concepts and to suggest guiding principles and recommendations for primary and behavioral health care providers working with disaster survivors in multicultural communities. Although it is the hope of CMHS that readers will find the guide useful, the authors also recognize that it is by no means intended to provide comprehensive information on cultural competence.

The guiding principles are based on standards, guidelines, and recommendations established by SAMHSA, the Office of Minority Health, and the Health Resources and Services Administration in the U.S. Department of Health and Human Services (DHHS), although the guiding principles do not necessarily represent these agencies' specific views. *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General* (DHHS, 2001) informed our efforts to ensure consistency with fundamental practice and theory.

To produce this guide, the authors invited input from State and local disaster mental health coordinators and consultants as well as from reviewers at the national, State, and community levels. The publication also incorporates information gathered through an extensive literature review. Vignettes from CMHS grant applications and grantee reports illustrate the range of promising practices, experiences, and challenges of State and local disaster mental health programs nationwide. As work on the guide continued, CMHS became increasingly aware that the principles and values underlying cultural competence parallel those historically espoused by disaster mental health service providers.

This publication is a first step toward developing a framework for the design of culturally competent disaster mental health programs. It also is the hope of CMHS that the information it provides will improve understanding and increase the ability of State, local, and community mental health and human service administrators, planners, trainers, and other staff to respond sensitively and effectively to the needs of all disaster survivors.

Introduction

BACKGROUND AND OVERVIEW

Disasters affect hundreds of thousands of people in the United States annually. Between 1993 and 1998, the American Red Cross responded to more than 322,000 disaster incidents in the United States and provided financial assistance to more than 600,000 families (American Red Cross, 2000). In 1997 alone, the Federal Emergency Management Agency (FEMA) responded to 43 major disasters in 27 States and three western Pacific Island territories (FEMA, 2000). In recent years, human-caused disasters have been a major challenge. Such events include the 1992 civil unrest in Los Angeles, the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City, and the September 2001 terrorist attacks on the World Trade Center in New York and the Pentagon in Arlington.

Disaster crisis counseling is a specialized service that involves

Because of higher birth and immigration rates, the Hispanic population is growing faster than any other ethnic minority group

rapid assignment and temporary deployment of staff who must meet multiple demands and work in marginal conditions and in unfamiliar settings such as shelters, recovery service centers, and mass care facilities. The major objective of disaster mental health operations is to mobilize staff to disaster sites so that they can attend to the emotional needs of survivors. In the past, these responses tended to be generic; little or no effort was made to tailor resources to the characteristics of a specific population. With time and experience, however, service providers and funding organizations have become increasingly aware that race, ethnicity, and culture may have a profound effect on the way in which an individual responds to and copes with disaster. Today, those in the field of disaster mental health recognize that sensitivity to cultural differences is essential in providing mental health services to disaster survivors.

Integrating cultural competence in the temporary structure and high-intensity work environment of a disaster relief operation is a challenge. Increasing cultural competence, not a one-time activity, is a long-term process that requires fundamental changes at the institutional level. Because both culture and the nature of disasters are dynamic, these changes must be followed by ongoing efforts to ensure that the needs of those affected by disaster are met.

The primary purpose of this guide is to provide background information, guiding principles, recommendations, and resources for developing culturally competent disaster mental health services. Disaster mental health providers and workers can use and adapt the guidelines set forth in this document to meet the unique characteristics of individuals and communities affected directly or indirectly by a full range of natural and human-made disasters.

Designed to supplement information already available through CMHS, SAMHSA, and other sources, *Developing Cultural Competence in Disaster Mental Health Programs* highlights important common issues relating to cultural competence and to disaster mental health. It provides guidance for improving cultural competence in support of disaster mental health services.

The following issues are key to the recommendations set forth in this guide:

■ Cultural competence requires system-wide change. It must be manifested at every level of an organization, including policy making, administration, and direct service provision. Therefore, for disaster mental health services to

Precise definitions of the terms "race," "ethnicity," and "culture" are elusive.

be effective, cultural competence must be reflected in disaster mental health plans. For additional information on building mental health systems capacity for disaster mental health response and recovery, readers may wish to review *Disaster Response and Recovery: A Strategic Guide* (DHHS, Rev. ed, in press).

■ Cultural competence requires an understanding of the historical, social, and political events that affect the physical and mental health of culturally diverse groups. Issues such as racism, discrimination, war, trauma, immigration patterns, and poverty—which reinforce cultural differences and distinguish one cultural group from another—must be considered (Hernandez and Isaacs, 1998). For a descriptive summary of historical background, patterns, and events, as well as detailed demographic and health profiles of individual cultural groups, readers may wish to refer to *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General* (DHHS, 2001) and to *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/ Underrepresented Racial/Ethnic Groups* (DHHS, 2000b).

■ Precise definitions of the terms "race," "ethnicity," and "culture" are elusive. As social concepts, these terms have many meanings, and those meanings evolve over time (DHHS, 2001). This guide espouses a broad definition of culture that includes not only race and ethnicity but also gender, age, language, socioeconomic status, sexual orientation, disability, literacy level, spiritual and religious practices, individual values and experiences, and other factors. This guide uses the phrases "cultural groups" and "racial and ethnic minority groups"[1] to refer to the Nation's diverse, multicultural groups and individuals.

■ The operational definition of cultural competence provided in this guide is based on the principles of cultural competence described in *Towards a Culturally Competent System of Care* (Cross et al., 1989). Many Federal, State, and local public mental health systems, as well as organizations in the private sector, have adopted the principles presented in this document.

[1] The major racial and ethnic minority groups referred to in this publication are African Americans (blacks), American Indians and Alaska Natives, Asian Americans, Native Hawaiian and Other Pacific Islanders, and Hispanic Americans (Latinos). The authors recognize that opinions about which labels are appropriate differ and acknowledge that heterogeneous subpopulations exist within each of these populations. These categories, which were established by the Office of Management and Budget in 1997, are used because they are widely accepted and used by service providers in the public and private sectors.

Organization of This Guide

This guide includes two sections and six appendices.

SECTION ONE explores the nature of culture and disaster. It begins by defining culturally related terms, discussing diversity within racial and ethnic minority groups, and describing cultural competence. It then discusses cultural competence in the context of disaster mental health services. Section One also presents the Cultural Competence Continuum and a list of questions to address in a disaster mental health plan. Readers seeking more detail about crisis counseling or disaster response and recovery may refer to other CMHS/FEMA publications. For example, the *Training Manual for Mental Health and Human Service Workers in Major Disasters* (DHHS, 2000e) provides a comprehensive overview of and essential information on training concepts on crisis counseling, including a training curriculum. *Disaster Response and Recovery: A Strategic Guide* (DHHS, Rev. ed., in press) also is a useful resource.

SECTION TWO sets forth nine guiding principles for culturally competent disaster mental health services and related recommendations for developing these services. It also presents the key concepts of disaster mental health; important considerations when working with people of other cultures; staff attributes, knowledge, and skills essential to the development of cultural competence; and a cultural competence self-assessment for disaster crisis counseling programs. In addition, Section Two provides suggestions for working with refugees and guidelines for using interpreters.

The appendices provide additional information that may be useful in developing cultural competence in disaster mental health.

APPENDIX A is an annotated bibliography of cultural competence resources and tools. Many of these resources provide detailed information about individual populations' histories, immigration patterns, and experiences with stress and trauma.

APPENDIX B lists disaster mental health technical assistance resources and publications available through CMHS. Some of these materials discuss the needs and provision of services for special populations.

APPENDIX C lists online resources that provide community-specific demographic and statistical information.

APPENDIX D lists Federal, private-sector, professional, and other organizations with cultural competence expertise.

APPENDIX E is a glossary of terms associated with disaster mental health and cultural competence.

APPENDIX F is a Cultural Competence Checklist for Disaster Crisis Counseling Programs. Based on concepts discussed throughout this guide, the checklist covers essential principles for ensuring a culturally competent disaster mental health program.

Since its founding, the United States has been a nation of diversity. In the years to come, fertility and mortality rates, immigration patterns, and age distributions within subgroups of the population will contribute to an increasingly diverse national population (Day, 1996). Data from the 2000 U.S. Census reveal that Hispanics have replaced African Americans as the second largest ethnic group after whites.[2] Because of higher birth and immigration rates, the Hispanic population is growing faster than any other ethnic minority group (DHHS, 2001). The population of Asian Americans is also growing and is projected to continue growth throughout the first half of the 21st century, primarily because of immigration (DHHS, 2001). As shown in Table 1-1, by 2010, Hispanic Americans will comprise 14.6 percent of the U.S. population, African Americans will comprise 12.5 percent, Asian Americans will comprise 4.8 percent, and Native Americans will comprise less than 1 percent (U.S. Department of Commerce, 2000).

These demographic changes have given the United States the benefits and richness of many cultures, languages, and histories. At the same time, the Nation's growing diversity has made it more important than ever for health and human service providers—including disaster mental health service providers—to recognize, understand, and respect the diversity found among cultural groups and subgroups. Service providers must find ways to tailor their services to individuals' and communities' cultural identities, languages, customs, traditions, beliefs, values, and social support systems. This recognition, understanding, respect, and tailoring of services to various cultures is the foundation of cultural competence.

UNDERSTANDING CULTURE

Culture influences many aspects of our lives—from how we communicate and celebrate to how we perceive the world around us. Culture involves shared customs, values, social rules of behavior, rituals and traditions, and perceptions of human nature and natural events. Elements of culture are learned from others and may be passed down from generation to generation.

Many people equate race and ethnicity with culture; however, the terms "race" and "ethnicity" do not fully define the scope and breadth of culture. Race and ethnicity are indeed prominent elements of culture, but there are important distinctions between

[2] This publication uses the term "whites" to denote non-Hispanic white Americans.

these terms. For example, many people think of "race" as a biological category and associate it with visible physical characteristics such as hair and skin color.

Physical features, however, do not reliably differentiate people of different races (DHHS, 2001). For this reason, race is widely used as a social category. Different cultures classify people into racial groups on the basis of a set of characteristics that are socially important (DHHS, 2001). Often, members of certain social or racial groups are treated as inferior or superior or given unequal access to power and other resources (DHHS, 2001).

"Ethnicity" refers to a common heritage of a particular group. Elements of this shared heritage include history, language, rituals, and preferences for music and foods. Ethnicity may overlap with race when race is defined as a social category. For example, because Hispanics are an ethnicity, not a race, ethnic subgroups such as Cubans and Peruvians include people of different races (DHHS, 2001).

"Culture" refers to the shared attributes of a group of people. It is broadly defined as a common heritage or learned set of beliefs, norms, and values (DHHS, 2001). Culture is as applicable to groups of whites, such as Irish Americans or German Americans, as it is to racial and ethnic minorities (DHHS, 2001). People can share a culture, regardless of their race or ethnicity. For example, people who work for a particular organization, people who have a particular physical or mental limitation, or youth in a particular social group may share cultural attributes.

TABLE 1-1

Percentage Distribution of the Population By Race and Hispanic Origin

(Includes foreign and native-born populations)

	Race				Hispanic/ Latino Origin*
Year	White	Black/ African American	American Indian/ Alaska Native**	Asian and Pacific Islander	
1995	73.6	12.0	0.7	3.3	10.2
2000	71.4	12.2	0.7	3.9	11.8
2010	67.3	12.5	0.8	4.8	14.6
2050	52.8	13.2	0.8	8.9	24.3
2100	40.3	13.0	0.7	12.6	33.3

* Persons of Hispanic/Latino origin may be of any race. Groups listed under "Race" are not of Hispanic origin.

** Includes American Indians, Alaska Natives, and Aleuts.

Source: U.S. Department of Commerce, Bureau of the Census. (2000). Projections of the resident population by race, Hispanic origin, and nativity: Middle series, 1999 to 2100. Washington, DC: U.S. Department of Commerce.

A culture can be defined by characteristics such as:

- National origin;
- Customs and traditions;
- Length of residency in the United States;
- Language;
- Age;
- Generation;
- Gender;
- Religious beliefs;
- Political beliefs;
- Sexual orientation;
- Perceptions of family and community;
- Perceptions of health, well-being, and disability;
- Physical ability or limitations;
- Socioeconomic status;
- Education level;
- Geographic location; and
- Family and household composition.

Did You Know . . .

Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General (DHHS, 2001) notes that:

- Approximately 12 percent of the U.S. population—34 million individuals—identify themselves as African American.
- Six percent of all blacks in the United States today are foreign-born. Most of those who are foreign-born come from the Caribbean.
- Since 1983, more than 100,000 refugees have come to the United States from African nations.
- The U.S. Census Bureau estimates that 4.1 million American Indians and Alaska Natives (Indians, Eskimos, and Aleuts) lived in the United States in 2000, representing less than 1.5 percent of the total U.S. population.
- Alaska Natives comprise approximately 4 percent of the combined American Indian and Alaska Native population.
- By the year 2020, the combined Asian American and Pacific Islander population will reach approximately 20 million, or about 6 percent of the total U.S. population.
- Approximately 35 percent of Asian Americans and Pacific Islanders live in linguistically isolated households. For some Asian American ethnic groups—including Hmong, Cambodian, Laotian, Vietnamese, Korean, and Chinese American households—the rate is much higher than this percentage.
- By the year 2050, Latinos will constitute nearly one-fourth of the U.S. population, and nearly one-third of persons under 19 years of age will be Hispanic.
- Nearly two-thirds of Hispanic Americans were born in the United States.
- Nearly two-thirds of Latinos are persons of Mexican origin, and the remaining one-third are primarily persons of Puerto Rican, Cuban, or Central American origin.

Culture changes continuously. For example, immigrants to the United States bring with them their own beliefs, norms, and values, but through the process of acculturation gradually learn and adopt selected elements of the dominant culture. An immigrant group may develop its own culture while becoming acculturated. At the same time, the dominant culture may change as a result of its interaction with the immigrant group (DHHS, 2001).

DIVERSITY AMONG AND WITHIN RACIAL AND ETHNIC MINORITY GROUPS

Four racial and ethnic minority groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans—accounted for approximately 30 percent of the U.S. population in the year 2000 and are expected to account for nearly 40 percent of the U.S. population by 2025 (DHHS, 2001). Although there are important differences among these four groups, there also is broad diversity within each group. In other words, people who find themselves in the same racial or ethnic group—either by census category or through self-identification—do not always have the same culture. Examples follow:

- American Indians and Alaska Natives may belong to more than 500 tribes, each of which has a different cultural tradition, language, and ancestry (DHHS, 2001).
- Asian Americans and Pacific Islanders may identify with any of 43 subgroups and speak any of 100 languages and dialects (DHHS, 2001).

■ Hispanics may be of Mexican, Puerto Rican, Cuban, Central and South American, or other heritage (DHHS, 2001).

Furthermore, the broad category labels are imprecise (DHHS, 2001). For example, people who are indigenous to the Americas may be called Hispanic if they are from Mexico or American Indian if they are from the United States (DHHS, 2001). In addition, many people in a particular racial or ethnic minority group may identify more closely with other social groups than with the group to which they are assigned by definition (DHHS, 2001). Finally, many people identify with multiple cultures that may be associated with factors such as race, ethnicity, country of origin, primary language, immigration status, age, religion, sexual orientation, employment status, disability, geographic location, or socioeconomic status. Table 1-2 identifies Federal Government categories for race and ethnicity.

Recognizing the limitations of the traditional broad groupings, the U.S. Census Bureau revised the categories used to report race and ethnicity in the 2000 Census. For the first time, individuals could identify with more than one group (U.S. Office of Management and Budget, 2000). The U.S. Census Bureau anticipated that this change would result in approximately 63 categories of racial and ethnic identifications (DHHS, 2001).

Appendix C lists additional resources offering statistical and demographic data on racial and ethnic populations and subpopulations.

TABLE 1-2

Federal Government Categories for Race and Ethnicity

The U.S. Office of Management and Budget (1997) announced revised standards for Federal data on race and ethnicity. The new categories for race are:

American Indian or Alaska Native refers to a person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.

Asian refers to a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American refers to a person having origins in any of the black racial groups of Africa.

Hispanic or Latino refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Native Hawaiian and Other Pacific Islander refers to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White refers to a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Some Other Race was included for those who identify with one or more races.

CULTURAL COMPETENCE: SCOPE AND TERMINOLOGY

We use many terms to refer to concepts associated with cultural competence and with interactions between and among people of different cultures including "cultural diversity, cultural awareness, cultural sensitivity, multiculturalism, and transcultural services." Although the differences in the meanings of these terms may be subtle, they are extremely important. For example, the term "cultural awareness" suggests that it may be sufficient for one to be cognizant, observant, and conscious of similarities and differences among cultural groups (Goode et al., 2001).

"Cultural sensitivity," on the other hand, connotes the ability to empathize with and understand the needs and emotions of persons of one's own culture as well as those of others and to identify with emotional expressions and the problems, struggles, and joys of someone from another culture (Hernandez and Isaacs, 1998).

The term "cultural competence" suggests a broader concept than "cultural sensitivity" implies. As previously defined in this section, the word "culture" refers to the shared attributes—including beliefs, norms, and values—of a group of people (DHHS, 2001). The word "competence" implies the capacity to function effectively, both at the individual and organizational levels. "Competence" is associated with "culture" to emphasize that being aware of or sensitive to the differences between cultures is not sufficient. Instead, service providers must have the knowledge, skills, attitudes, policies, and structures needed to offer support and care that is responsive and tailored to the needs of culturally diverse population groups.

Many people and organizations have developed definitions of cultural competence. The following definition blends elements of definitions used by SAMSHA (DHHS, 2001), the Health Resources and Services Administration (DHHS), the Office of Minority Health (DHHS, 2000a), and definitions found in the literature (Bazron and Scallet, 1998; Cross et al., 1989; Denboba, 1993; Evans, 1995; Roberts et al.,1990; Taylor et al., 1998):

Cultural competence is a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.

Cross and colleagues (1989) note that culturally competent organizations and individuals:

- Value diversity;
- Have the capacity for cultural assessment;
- Are aware of cross-cultural dynamics;
- Develop cultural knowledge; and
- Adapt service delivery to reflect an understanding of cultural diversity.

At the individual level, cultural competence requires an understanding of one's own culture and worldview as well as those of others. It involves an examination of one's attitudes, values, and beliefs, and the ability to demonstrate values, knowledge, skills, and attributes needed to work sensitively and effectively in cross-cultural situations (Goode et al., 2001).

At the organizational and programmatic levels, cultural competence requires a comprehensive, coordinated plan that cuts across policymaking, infrastructure building, program administration and evaluation, and service delivery. Culturally competent organizations and programs acknowledge and incorporate the importance of culture, assess cross-cultural relations, are aware of dynamics that can result from cultural differences and ethnocentric attitudes, expand cultural knowledge, and adopt services that meet unique cultural needs (DHHS, 2000d).

THE CULTURAL COMPETENCE CONTINUUM

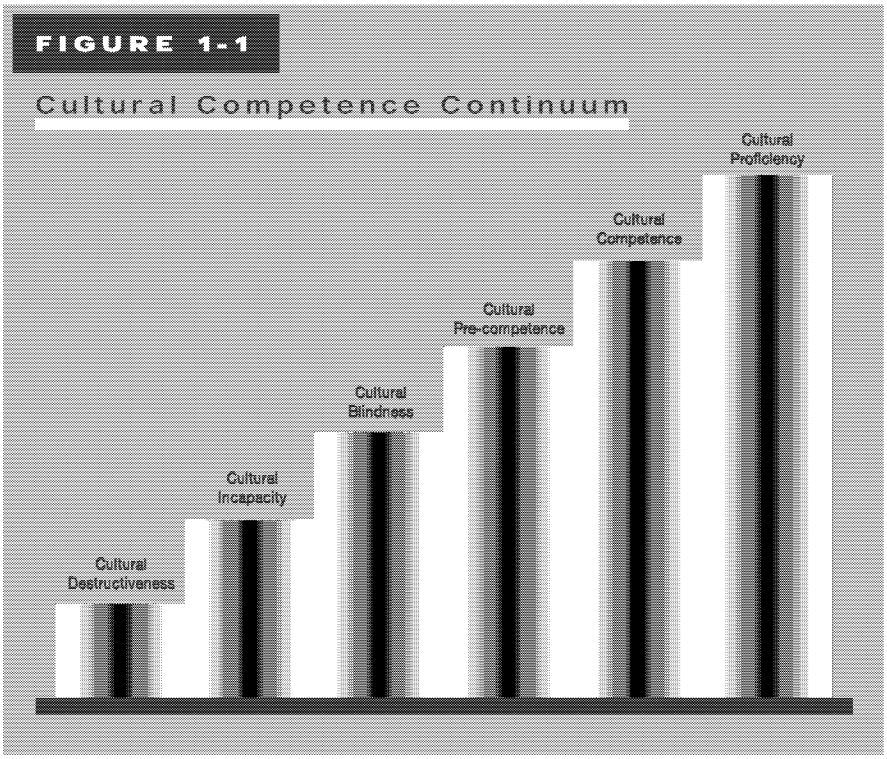
Cultural competence is not a matter of being politically correct or of assigning one person to handle diversity issues, nor does it mean simply translating materials into other languages. Rather, it is an ongoing process of organizational and individual development that includes learning more about our own and other cultures; altering our thinking about culture on the basis of what we learn; and changing the ways in which we interact with others to reflect an awareness and sensitivity to diverse cultures.

The Cultural Competence Continuum depicted in Figure 1-1 was developed by Cross et al. (1989) for mental health professionals. Today, many other public health practitioners and community-based service providers also find it a useful tool. The continuum assumes that cultural competence is a dynamic process with multiple levels of achievement. It can be used to assess an organization's or individual's level of cultural competence, to establish benchmarks, and to measure progress.

Cultural Destructiveness

The negative end of the continuum is characterized by cultural destructiveness. Organizations or individuals in this stage view cultural differences as a problem and participate in activities that purposely attempt to destroy a culture. Examples of destructive actions include denying people of color access to their natural helpers or healers, removing children of color from their families on the

FIGURE 1-1



The continuum includes six stages: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence, and cultural proficiency (Cross et al., 1989).

basis of race, and risking the well-being of minority individuals by involving them in social or medical experiments without their knowledge or consent. Organizations and individuals at this extreme operate on the assumption that one race is superior and that it should eradicate "lesser" cultures.

Cultural Incapacity

Organizations and individuals in the cultural incapacity stage lack the ability to help cultures from diverse communities. Although they do not intentionally seek to cause harm, they believe in the superiority of their own racial or ethnic group and assume a paternalistic posture toward "lesser" groups. They may act as agents of oppression by enforcing racist policies and maintaining stereotypes. Employment practices of organizations in this stage of the continuum are discriminatory.

Cultural Blindness

Cultural blindness is the midpoint of the continuum. Organizations and individuals at this stage believe that color or culture makes no difference and that all people are the same. Individuals at this stage may view themselves as unbiased and believe that they address cultural needs. In fact, people who are culturally blind do not perceive, and therefore cannot benefit from, the valuable differences among diverse groups. Services or programs created by organizations at this stage are virtually useless to address the needs of diverse groups.

Cultural Pre-competence

Culturally pre-competent organizations and individuals begin to move toward the positive end of the continuum. They realize weaknesses in their attempts to serve various cultures and make some efforts to improve the services offered to diverse populations. Pre-competent organizations hire staff from the cultures they serve, involve people of different cultures on their boards of directors or advisory committees, and provide at least rudimentary training in cultural differences. However, organizations at this stage run the risk of becoming complacent, especially when members believe that the accomplishment of one goal or activity fulfills the obligation to the community. Tokenism is another danger. Organizations sometimes hire one or more workers from a racial or ethnic group and feel that they have done all that is necessary.

Cultural Competence

Culturally competent organizations and individuals accept and respect differences, and they participate in continuing self-assessment regarding culture. Such organizations continuously expand their cultural knowledge and resources and adopt service models that better meet the needs of minority populations. In addition, they strive to hire unbiased employees, and seek advice and consultation from representatives of the cultures served. They also support their staff members' comfort levels when working in cross-cultural situations and in understanding the interplay between policy and practice.

Cultural Proficiency

Culturally proficient organizations hold diversity of culture in high

REPORT

Cultural Competence Necessary from Project Initiation

After the Great Flood of 1993 devastated the economy of rural Minnesota, the State developed a program of supportive services, including crisis counseling for rural residents. Ethnic populations affected by the flood included Hispanics, African Americans, Southeast Asians (Vietnamese, Hmong, Laotians), and Somalians. Some of these populations were relatively new to rural Minnesota, and they were not well integrated into the communities. Trust between cultures was tenuous at best, and many of the minority groups were somewhat socially isolated.

The crisis counseling project faced barriers of language, culture, and mistrust that had to be overcome in order to provide services. The challenge was difficult. Virtually all coordinators and outreach workers initially hired were white and middle class. While a concerted effort was made to provide culturally competent services once the program got underway, the final project report, with great candor, concluded that success in providing services to the various ethnic populations was spotty. It stated that the project might have been more effective had a focus on cultural competence been integrated into the program from the beginning.

Minnesota Final Report, 1994

esteem. They seek to add to the knowledge base of culturally competent practice by conducting research, developing new therapeutic approaches based on culture, and publishing and disseminating the results of demonstration projects. Culturally proficient organizations hire staff members who are specialists in culturally competent practice.

Achieving cultural competence and progressing along the continuum do not happen by chance. Policies and procedures, hiring practices, service delivery, and community outreach must all include the principles of cultural competence. For these reasons, a commitment to cultural competence must permeate an organization before a disaster strikes. If the concepts of cultural competence and proficiency have been integrated into the philosophy, policies, and day-to-day practices of the mental health provider agency, they will be much easier to incorporate into disaster recovery efforts.

CULTURAL COMPETENCE AND DISASTER MENTAL HEALTH SERVICES

Culture as a source of knowledge, information, and support provides continuity and a process for healing during times of tragedy (DeVries, 1996). Survivors react to and recover from disaster within the context of their individual racial and ethnic backgrounds, cultural viewpoints, life experiences, and values. Culture offers a protective system that is comfortable and reassuring. It defines appropriate behavior and furnishes social support, identity, and a shared vision for recovery. For example, stories, rituals, and legends that are part of a culture's fabric help people adjust to catastrophic losses by highlighting the mastery of communal trauma and explaining the relationship of individuals to the spiritual. Despite the strengths that culture can provide, responses to disaster also fall on a continuum. Persons from disadvantaged racial and ethnic communities may be more vulnerable to problems associated with preparing for and recovering from disaster than persons of higher socioeconomic status (Fothergill et al., 1999).

Because of the strong role that culture plays in disaster response, disaster mental health services are most effective when survivors receive assistance that is in accord with their cultural beliefs and consistent with their needs (Hernandez and Isaacs, 1998). As disaster mental health service providers seek to become more culturally competent, they must recognize three important social and historical influences that can

affect the success of their efforts. These three influences are the importance of community, racism and discrimination, and social and economic inequality.

The Importance of Community

Disasters affect both individuals and communities. Following a disaster, there may be individual trauma, characterized as "a blow to the psyche that breaks through one's defenses so suddenly and with such brutal force that one cannot react to it effectively" (DHHS, Rev. ed. in press). There also may be collective trauma—"a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of community" (DHHS, Rev. ed., in press). Cultural and socioeconomic factors contribute to both individual and community responses to the trauma caused by disaster.

The culture of the community provides the lens through which its members view and interpret the disaster, and the community's degree of cohesion helps determine the level of social support available to survivors. In other words, a community that is disrupted and fragmented will be able to provide less support than a cohesive community.

A classic example is presented by sociologist Kai Erikson, who studied the impact of the devastating 1972 flood in Buffalo Creek, West Virginia (Erikson, 1976). The flood led to relocation of the entire community. Erikson describes a "loss of community," in which people lost not only their sense of connection with the locale but also the support of people and institutions. Results of this community's fragmentation included fear, anger, anxiety, and depression.

Other studies have emphasized positive effects that can result from disaster experiences in communities that perform a protective role and cushion the stress of the disaster (Dynes et al., 1994). Compared with nondisaster-related suffering, which is isolating and private, the suffering of disaster survivors can be collective and public (Dynes et al., 1994). However, devastating disasters can have positive outcomes. They can bring a community closer or reorient its members to new priorities or values (Ursano, Fullerton et al., 1994). Individuals may exhibit courage, selflessness, gratitude, and hope that they may not have shown or felt before the disaster.

Community often is extremely important for racial and ethnic minority groups, and it may dramatically affect their ability to recover from disaster. For example, a racial or ethnic minority community may provide especially strong social support functions for its members, particularly when it is surrounded by a hostile society. However, its smaller size may render it more fragile and more subject to dispersion and destruction after a disaster. Members of some racial and ethnic minority groups, such as refugees, previously have experienced destruction of their social support systems, and the destruction of a second support system may be particularly difficult (Beiser, 1990; Van der Veer, 1995).

Racism and Discrimination

Many racial and ethnic minority groups, including African Americans, American Indians, and Chinese and Japanese Americans, have experienced racism, discrimination, or persecution for many years. Both legally sanctioned and more subtle forms of discrimination and racism are an undeniable part of our Nation's historical fabric. Despite improvements in recent decades, evidence exists that racial

REPORT

Disaster Projects Confront Distrust

Several disaster crisis counseling projects supported by the Federal Government have had to address the distrust of ethnic minority groups and their reluctance to use available resources. For example, following the 1994 California earthquake, the disaster crisis counseling project found that many immigrants' distrust of government posed a barrier to their use of disaster services. Likewise, some of the survivors of a hurricane in Alabama were immigrants from Asian Communist countries who did not trust any government and were not accustomed to receiving Government assistance.

California Final Report, 1995 • Alabama Final Report, 1999

REPORT

Damage from Mississippi Tornadoes Unequal

In the late 1950s, several tornadoes struck rural Mississippi. The only persons killed were black. A subsequent study found that many people in the black community had great difficulty in coming to terms with this disaster. They did not understand how a just God could discriminate in such a fashion between white and black.

Perry and Perry, 1959

discrimination persists in housing rentals and sales, hiring practices, and medical care. Racism also takes the form of demeaning comments, hate crimes, and other violence by institutions or individuals, either intentionally or unintentionally (DHHS, 2001).

As a result of past or present experiences with racism and discrimination, racial and ethnic minority groups may distrust offers of outside assistance at any time, even following a disaster. They may not be accustomed to receiving support and assistance from persons outside of their own group in non-disaster circumstances. Therefore, they may be unfamiliar with the social and cultural mechanisms of receiving assistance and remain outside the network of aid.

Particularly during the "disillusionment phase" of the disaster, when intragroup tensions are typically high, racial and ethnic minority groups can face the brunt of anger and even blame from members of the larger culture. Such psychological assaults and experiences with racism and discrimination can result in increased stress for individuals and groups.

Social and Economic Inequality

Poverty disproportionately affects racial and ethnic minority groups. For example, in 1999, 8 percent of whites, 11 percent of Asian Americans and Pacific Islanders, 23 percent of Hispanic Americans, 24 percent of African Americans, and 26 percent of American Indians and Alaska Natives lived in poverty (DHHS, 2001). Significant socioeconomic differences also exist within racial and ethnic minority groups. For example, although some subgroups of Asian Americans have prospered, others remain at low socioeconomic levels (O'Hare and Felt, 1991).

Social and economic inequality also leads to reduced access to resources, including employment; financial credit; legal rights; and education, health, and mental health services (Blaikie et al., 1994). Poor neighborhoods also have high rates of homelessness, substance abuse, and crime (DHHS, 2001).

Poverty makes people more susceptible than others to harm from disaster and less able to access help (Bolin and Stanford, 1998). Low-income individuals and families typically lose a much larger part of their material assets and suffer more lasting negative effects from disaster than do those with higher incomes (Wisner, 1993). Often, disadvantaged persons live in the least desirable and most hazardous areas of a community, and their homes may be older and not as sound as those in higher income areas. For example, many low-income people live in apartment buildings that contain unreinforced masonry, which is susceptible to damage in a disaster (Bolton et al., 1993).

Although disaster relief activities can help ameliorate some of the damage rendered by a disaster, some groups cannot readily access such services. Negative perceptions derived from pre-disaster experiences may serve as a barrier to seeking care. Lack of familiarity with sources of community support or lack of transportation are common barriers for many immigrants and unwillingness to disclose their immigration status is a major barrier.

Middle-class disaster survivors are more likely than lower-income people—including those from other cultures—to know how to complete forms, communicate adequately, talk to the "right" people, or otherwise maneuver within the system. Thus, they may be more likely to receive aid than survivors with fewer means or those from different cultures (Aptekar, 1990). On the other hand, affluent groups may find it difficult to accept assistance from mental health and

social service agencies. They may fear a loss of control and find it humiliating to accept emergency assistance such as clothing, food, loans, and emotional support from disaster workers.

In some instances, people of lower socioeconomic status exhibit strong coping skills in disaster situations because they have seen difficult times before and have survived. In other instances, the loss of what little one had may leave an individual feeling completely hopeless.

REPORT

Tornadoes Destroy Homes in Sioux Nation

In 1999, tornadoes ravaged the Oglala Sioux Nation in South Dakota. Housing units are scattered throughout this vast reservation; one home may be 10 to 20 miles from the nearest neighbor or community. Many roads on the reservation are unimproved. Only 10 percent to 15 percent of the homes have telephone service. Because of the lack of adequate housing, multiple family units reside in one dwelling. In some situations, 20 family members live in a two-bedroom home with no running water or sewage system. Outhouses are commonplace.

South Dakota Application, 1999

DISASTER PHASES AND RESPONSES

Survivors' reactions to and recovery from a disaster are influenced by a number of factors, including:

- The disaster's unique characteristics, such as its size and scope, and whether it was caused by human or natural factors (see Table 1-3);
- The affected community's unique characteristics, including its demographic and cultural make-up and the presence of pre-existing structures for social support and resources for recovery; and
- The individual's personal assets and vulnerabilities that either reduce or exacerbate stress (DHHS, 2000e).

Despite the differences in disasters, communities, and individuals, survivors' emotional responses to disaster tend to follow a pattern of seven "disaster phases" (National Institute of Mental Health, 1983; DHHS, 2000e):

- Warning or threat;
- Impact;
- Rescue or heroic;
- Remedy or honeymoon;
- Inventory;
- Disillusionment; and
- Reconstruction or recovery.

The characteristics of the disaster, as well as those of the community and its individual residents, affect the duration and nature of the seven phases. The phases do not necessarily move forward in linear fashion; instead, they often overlap and blend together. Furthermore, individuals may experience a given phase in different ways (DHHS, 1999), and different cultural groups may respond differently during these phases. Below are brief descriptions of each phase, including examples of responses of different cultural groups during each phase.

For further information about disaster characteristics and phases, refer to the *Training Manual for Mental Health and Human Service Workers in Major Disasters* (DHHS, 2000e).

REPORT

Disaster Resurfaces Emotional Reactions to Prior Stressors

Flooding occurred in Clovis, California, in 1995, when a canal and ponding basins overflowed. Many families, mostly Hmong, who lived near the canal were displaced. The Hmong population is a low-income community with immigrants from Southeast Asia who have a history of war and severe losses. Many were suffering from Post-Traumatic Stress Syndrome prior to the flood. The flood increased financial stress and anxiety, and exacerbated their existing symptoms.

California Final Report, 1995

TABLE 1-3

Characteristics of Disasters

Researchers have identified several common characteristics of disasters that are particularly important when discussing emotional distress and recovery (Bolin, 1985; DHHS, 2000a, p. 6). These characteristics are as follows:

- *Intensity of the impact:* Disasters that wreak intense destruction within a short period of time are more likely to cause emotional distress among survivors than are disasters that work their effects more slowly.
- *Impact ratio (i.e., the proportion of the community sustaining personal losses):* When a disaster affects a significant proportion of a community's population, few individuals may be available to provide material and emotional support to survivors.
- *Potential for recurrence of other hazards:* The real or perceived threat of recurrence of the disaster or of associated hazards can lead to anxiety and heightened stress among survivors.
- *Cultural and symbolic aspects:* Changes in survivors' social and cultural lives and routine activities can be profoundly disturbing. Both natural and human-caused disasters can have symbolic implications.
- *Extent and types of loss sustained by survivors:* Property damage or loss, deaths of loved ones, injury, and job loss all affect emotional recovery.

Warning or Threat Phase

The warning or threat phase occurs with hurricanes, floods, and other disasters for which there is warning hours or days in advance. Lack of warning can make survivors feel vulnerable, unsafe, and fearful of future unpredicted tragedies. The perception that they had no control over protecting themselves or their loved ones can be deeply distressing.

Racial and ethnic groups sometimes differ in the ways in which they receive information about risks and in the credence they place on such information. For example, Hispanics are more likely than non-Hispanics to use social networks for disaster information (Blanchard-Boehm, 1997; Perry and Mushkatel, 1986) and to believe information obtained through these networks (Perry and Lindell, 1991) than are members of other groups. Furthermore, some marginalized communities do not have adequate or functioning warning systems. When disaster warning information is not provided in multiple languages or is not closed-captioned, people who do not understand English or who are deaf or hard of hearing may not receive adequate warning.

Impact Phase

The impact phase occurs when the disaster actually strikes. This phase can vary from the slow, low-threat buildup associated with some types of floods to the violent and destructive outcomes associated with tornadoes and explosions. Depending on the characteristics of the disaster, reactions range from confusion, disbelief, and anxiety (particularly if family members are separated) to shock or hysteria.

Rescue or Heroic Phase

In the rescue or heroic phase, individuals' activity levels are typically high and oriented toward rescue operations, survival, and perhaps evacuation. People generally work together to save lives and property; pre-existing tensions between racial and ethnic or cultural groups are set aside. However, if family members are separated, anxiety may be heightened.

Remedy or Honeymoon Phase

During this phase, optimism may reign as the community pulls together and government and volunteer assistance become available. The interactions between relief workers and survivors from different cultures can be very important and can influence people's long-term perceptions of the disaster relief effort. Perceptions and beliefs about how healing occurs also may influence recovery. Frequently, however, disaster workers who have had no orientation to local cultures and lack sensitivity to them are brought in to help out during this phase. Such workers may exacerbate, rather than mitigate, cultural differences.

Inventory Phase

During the inventory phase, survivors recognize the limits of help and begin to assess their futures. They become exhausted because of multiple demands, financial pressures, and the stress of relocation or living in a damaged home. Initial optimism may give way to discouragement and fatigue. This also is a time characterized by high levels of grief and loss. Families who lose loved ones will grieve and cope in different ways.

Disillusionment Phase

The disillusionment phase occurs when survivors recognize the reality of loss and the limits of outside relief. This phase is characterized by a high level of stress that may be manifested in personally destructive behavior, family discord, and community fragmentation. Obtaining assistance from relief agencies can be extremely difficult, and survivors may feel helpless and angry. Hostility between neighbors and among groups is common, and tensions may erupt among different cultural, racial, and ethnic groups.

Reconstruction or Recovery Phase

The final phase, reconstruction or recovery, may last for years. This phase involves the structural rebuilding of the community as well as the integration of changes occasioned by the disaster into one's community and one's life. A common problem is a lack of housing, particularly if the disaster destroyed much of the low-income housing stock. In such situations, the private market typically hinders rebuilding of low- and moderate-income rental units (Fothergill et al., 1999). Therefore, housing shortages and rent increases disproportionately affect racial and ethnic minority groups (Bolin and Stanford, 1991; Peacock and Girard, 1997). It is not unusual for local political issues to create friction and fragmentation in the impacted community during the disparate reconstruction progress and buyouts between neighboring counties.

REPORT

Civil Unrest Causes Emotional Problems for Refugees

The civil unrest and fires in Los Angeles that came in the wake of the Rodney King verdict affected a community inhabited by many refugees from Central America and Asia. For immigrants who came from war-torn countries, the Los Angeles disturbances reactivated fears and emotions associated with their homeland. Many experienced increased agitation, depression, confusion, and recollections of prior bereavements.

California Final Report, 1994

CULTURAL COMPETENCE AND DISASTER MENTAL HEALTH PLANNING

Providing culturally competent mental health services to survivors requires action before, during, and after a disaster. The disaster mental health plan, which should be part of a State or community emergency management plan, can help ensure an efficient, coordinated response to the mental health needs of the affected population (DHHS, Rev. ed., in press). These plans specify roles, responsibilities, and relationships among agencies and organizations in responding to a community's mental health needs following a disaster (DHHS, Rev. ed., in press).

REPORT

Disaster Strikes a Highly Diverse Community

On January 17, 1994, a major earthquake struck Los Angeles and Ventura Counties. The Northridge earthquake was the largest and most violent to hit an urban area in the United States since the 1906 San Francisco quake. The post-disaster recovery effort provided mental health services to 1.9 million persons, representing myriad ethnic groups, special populations, and lifestyles.

The size and scope of the two affected counties, as well as the ethnic diversity of their residents, constituted a challenge to disaster mental health providers. For example, Ventura County is home to many undocumented migrant farm workers, the majority of whom do not speak English and are mistrustful of government at any level. Language and cultural barriers had to be overcome for persons from several Asian cultures as well. The diverse population in the affected areas also included other special populations, such as physically challenged persons and runaway youth, two groups that required special outreach strategies.

The disaster mental health program staff recognized from the beginning of the project the need to develop and provide culturally relevant and linguistically appropriate services, covering a multitude of cultures and languages.

California Final Report, 1995

Well-designed disaster mental health plans enhance coordination and minimize chaos, thereby helping to ensure that survivors receive assistance in a timely, helpful, and culturally sensitive manner should a disaster occur. Disaster mental health plans that identify and address diverse needs within a community can save valuable time and avert many problems. In the absence of such planning, disaster relief is disorganized, especially in the immediate aftermath. Confusion and inefficiency can prevail when survivors attempt to gain access to services.

Successful program planners recognize that creating culturally competent environments requires more than recruiting bilingual and bicultural mental health workers, sponsoring a single diversity management class, sending a few employees to a cultural competence workshop, or hiring a "token" racial or ethnic minority group representative. Rather, cultural competence must be a part of the program values; included in the program's mission statement; and encouraged in attitudes, policies, and practices at every level.

To develop a culturally competent disaster mental health plan, planners must:

- Assess and understand the community's composition;
- Identify culture-related needs of the community;
- Be knowledgeable about formal and informal community institutions that can help meet diverse mental health needs;
- Gather information from and establish working relationships with trusted organizations, service providers, and cultural group leaders and gatekeepers; and
- Anticipate and identify solutions to cultural problems that may arise in the event of a disaster.

Table 1-4 presents questions that should be addressed in the mental health plan. For further information about disaster mental health planning, refer to *Disaster Response and Recovery: A Strategic Guide* (DHHS, Rev. ed., in press).

TABLE 1-4

Questions to Address in a Disaster Mental Health Plan

Community demographic characteristics

- Who are the most vulnerable persons in the community? Where do they live?
- What is the range of family composition (i.e., single-parent households)?
- How could individuals be identified and reached in a disaster?
- Are policies and procedures in place to collect, maintain, and review current demographic data for any area that might be affected by a disaster?

Cultural groups

- What cultural groups (ethnic, racial, and religious) live in the community?
- Where do they live, and what are their special needs?
- What are their values, beliefs, and primary languages?
- Who are the cultural brokers in the community?

Socioeconomic factors

- Does the community have any special economic considerations that might affect people's vulnerability to disaster?
- Are there recognizable socioeconomic groups with special needs?
- How many live in rental property? How many own their own homes?

Mental health resources

- What mental health service providers serve the community?
- What skills and services does each provider offer?
- What gaps, including lack of cultural competence, might affect disaster services?
- How could the community's mental health resources be used in response to different types of disasters?

Government roles and responsibilities in disaster

- What are the Federal, State, and local roles in disaster response?
- How do Federal, State, and local agencies relate to one another?
- Who would lead the response during different phases of a disaster?
- How can mental health services be integrated into the government agencies' disaster response?
- What mutual aid agreements exist?
- Do any subgroups in the community harbor any historical or political concerns that affect their trust of government?

Nongovernmental organizations' roles in disaster

- What are the roles of the American Red Cross, interfaith organizations, and other disaster relief organizations?
- What resources do non-government agencies offer, and how can local mental health services be integrated into their efforts?
- What mutual aid agreements exist?
- How can mental health providers collaborate with private disaster relief efforts?

Community partnerships

- What resources and supports would community and cultural/ethnic groups provide during or following a disaster?
- Do the groups hold pre-existing mutual aid agreements with any State or county agencies?
- Who are the key informants/ gatekeepers of the impacted community?
- Has a directory of cultural resource groups, natural helpers, and community informants who have knowledge about diverse groups been developed?
- Are the community partners involved in all phases of disaster preparedness, response, and recovery operations?

Developing cultural competence requires a concerted effort by disaster mental health planners and front-line workers. Successful programs share common practices that are defined by nine guiding principles. These principles, listed here, have been identified by CMHS.

This section discusses each of the nine guiding principles and suggests ways to integrate them into disaster mental health planning and crisis counseling programs. The guiding principles, in many ways, overlay the Key Concepts of Disaster Mental Health (DHHS, 2000e), presented in Table 2-1. The Cultural Competence Checklist for Disaster Crisis Counseling Programs, presented in Appendix F, summarizes key content in a convenient form for use in program planning.

GUIDING PRINCIPLES FOR CULTURAL COMPETENCE IN DISASTER MENTAL HEALTH PROGRAMS

Principle 1: Recognize the importance of culture and respect diversity.

Principle 2: Maintain a current profile of the cultural composition of the community.

Principle 3: Recruit disaster workers who are representative of the community or service area.

Principle 4: Provide ongoing cultural competence training to disaster mental health staff.

Principle 5: Ensure that services are accessible, appropriate, and equitable.

Principle 6: Recognize the role of help-seeking behaviors, customs and traditions, and natural support networks.

Principle 7: Involve as "cultural brokers" community leaders and organizations representing diverse cultural groups.

Principle 8: Ensure that services and information are culturally and linguistically competent.

Principle 9: Assess and evaluate the program's level of cultural competence.

PRINCIPLE 1: RECOGNIZE THE IMPORTANCE OF CULTURE AND RESPECT DIVERSITY

Culture is one medium through which people develop the resilience that is needed to overcome adversity. Following a disaster, culture provides validation and influences rehabilitation. However, when daily rituals, physical and social environments, and relationships are disrupted, life becomes unpredictable for survivors. Disaster mental health workers can help reestablish customs, rituals, and social relationships and thereby help survivors cope with the impact of a disaster. When doing so, these workers need to recognize that diversity exists within as well as across cultures (Cross et al.,1989). In disasters, individuals within a given cultural group may respond in very different ways; some will be receptive to disaster relief efforts, while others will not. Older adults and young people within a particular culture may react to losses or seek help in different ways, depending on their degree of acculturation. Disaster mental health workers also must be aware of and sensitive to issues stemming from biculturalism; these issues include conflict and ambivalence related to identity and the need to function in cross-cultural environments (Hernandez and Isaacs, 1998).

Recognizing the importance of culture and respecting diversity require an institution-wide commitment. To meet this commitment, disaster mental health workers must understand their own

TABLE 2-1

Key Concepts of Disaster Mental Health

The following concepts should be adopted by all disaster mental health providers, including those serving culturally diverse survivors. The concepts can also help administrators and service providers set program priorities. The concepts deviate in some ways from those on which mental health work has traditionally been based. However, their validity has been confirmed again and again in disasters of various types that have affected a broad range of populations (DHHS, 2000a).

- No one who sees a disaster is untouched by it.
- There are two types of disaster trauma—individual and community.
- Most people pull together and function adequately during and after a disaster, but their effectiveness is diminished by the effects of the event.
- Stress and grief in disasters are normal reactions to abnormal situations.
- Many emotional reactions of disaster survivors stem from problems of daily living brought about by the disaster.
- Disaster relief assistance may be confusing to some survivors. They may experience frustration, anger, and feelings of helplessness related to Federal, State, and private-sector disaster assistance programs.
- Most people do not see themselves as needing mental health services following a disaster and will not seek such services.
- Survivors may reject disaster assistance of all types.
- Disaster mental health assistance is often more practical than psychological in nature.
- Disaster mental health services must be tailored to the culture of communities where they are provided.
- Mental health workers should set aside traditional methods, avoid mental health labels, and use an active outreach approach to intervene successfully in disaster.
- Survivors respond to active, genuine interest, and concern.
- Interventions must be appropriate to the phase of the disaster.
- Social support systems are crucial to recovery.

REPORT

Concerns About Child Care Heightened by Bombing

Following the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City, local mental health agencies mobilized to provide services to the survivors. One Latino child perished in the Murrah Building and several Latino children were wounded at the YMCA day care center. Mental health workers realized that they would have to address the concerns and guilt of Latino parents regarding child care because in this culture individuals generally resist using babysitters or placing their children in day care.

Oklahoma Application, 1995

REPORT

Indigenous Outreach Workers Provide Community-Appropriate Services in Guam

In the aftermath of the 1997 super-typhoon, Paka, the Territory of Guam partnered with the University of Guam College of Life Sciences to provide culturally appropriate crisis counseling services. Strategies such as paying special attention to racial tensions, matching workers to the population served, and providing training on culturally respectful interactions helped the outreach workers gain entry to the island's diverse population.

The demographics of the staff mirrored that of the community, and the mental health providers were an integral part of the community. Culture-specific training provided a forum for interacting with representatives of helping agencies on the island and from neighboring Saipan. Outreach tools and strategies included a monkey hand puppet used to engage children, a program for hotel workers, and a program for seniors that used symbolism and activities to encourage recovery. Broadcast and print media, as well as personal conversations, were used to educate the public about the project and the emotional effects of disaster.

Guam Site Visit Report, 1998

cultures and world views; examine their own attitudes, values, and beliefs about culture; acknowledge cultural differences; and work to understand how cultural differences affect the values, attitudes, and beliefs of others. Table 2-2 examines important considerations mental health workers should keep in mind when dealing with people from other cultures.

PRINCIPLE 2: MAINTAIN A CURRENT PROFILE OF THE CULTURAL COMPOSITION OF THE COMMUNITY

No one knows when or where disaster will strike. For this reason, a predisaster assessment of a community's composition and familiarity with cultural traditions and customs during times of loss, trauma, and grief can provide invaluable knowledge in the event of a disaster. The range of cultural diversity—ethnic, religious, racial, and language differences among subgroups—should be assessed and described in a comprehensive profile of the community. A comprehensive community profile describes the community's composition in terms of:

- Race and ethnicity;
- Age;
- Gender;
- Religion;
- Refugee and immigrant status;
- Housing status (i.e., number of single-parent households, type of housing, rental versus ownership, number of persons per household);
- Income and poverty levels;
- Percentage of residents living in rural versus urban areas;
- Unemployment rate;
- Languages and dialects spoken;
- Literacy level;
- Number of schools; and
- Number and types of businesses.

TABLE 2-2

Important Considerations When Interacting with People of Other Cultures

Giger and Davidhizar's "transcultural assessment and intervention model" was developed to assist in the provision of transcultural nursing care. It is currently used by several other health and human services professions. The model identifies five issues that can affect the interactions of providers and service recipients. These issues, adapted below to apply to disaster crisis counseling, illustrate the importance of acknowledging culture and of respecting diversity. A complete description of the model can be found in *Transcultural Nursing: Assessment and Intervention* (Giger and Davidhizar, 1999).

Communication: Both verbal and nonverbal communication can be barriers to providing effective disaster crisis counseling when survivors and workers are from different cultures. Culture influences how people express their feelings, as well as what feelings are appropriate to express, in a given situation. The inability to communicate can make both parties feel alienated and helpless.

Personal Space: "Personal space" is the area that immediately surrounds a person, including the objects within that space. Although spatial requirements may vary from person to person, they tend to be similar among people in a given cultural group (Watson, 1980). A person from one subculture might touch or move closer to another as a friendly gesture, whereas someone from a different culture might consider such behavior invasive. Disaster crisis counselors must look for clues to a survivor's need for space. Such clues may include, for example, moving the chair back or stepping closer.

Social Organization: Beliefs, values, and attitudes are learned and reinforced through social organizations, such as family, kinships, tribes, and political, economic, and religious groups. Understanding these influences will enable the disaster crisis counselor to more accurately assess a survivor's reaction to disaster. A survivor's answers to seemingly trivial questions about hobbies and social activities can lead to insight into his or her life before the disaster.

Time: An understanding of how people from different cultures view time can help avoid misunderstandings and miscommunication. In addition to having different interpretations of the overall concept of time, members of different cultures view "clock time"—that is, intervals and specific durations—differently. Social time may be measured in terms of "dinner time," "worship time," and "harvest time." Time perceptions may be altered during a disaster. Crisis counselors acting with a sense of urgency may be tempted to set timeframes that are not meaningful or realistic to a survivor. The result may be frustration for both parties.

Environmental Control: A belief that events occur because of some external factor—luck, chance, fate, will of God, or the control of others—may affect the way in which a survivor responds to disaster and the types of assistance needed. Survivors who feel that events and recovery are out of their control may be pessimistic regarding counseling efforts. In contrast, individuals who perceive that their own behavior can affect events may be more willing to act (Rotter, 1966). Disaster crisis counselors need to understand beliefs related to environmental control because such beliefs will affect survivors' behavior.

Information about the values, beliefs, social and family norms, traditions, practices, and politics of local cultural groups, as well as the history of racial relations or ethnic issues in the community, should be included in the community profile, because these cultural characteristics may take on additional significance in times of stress (DeVries, 1996). This information should be gathered with the assistance of and in consultation with community cultural leaders ("key informants") who represent and understand local cultural groups.

Other sources of data incorporated in the community profile include the city hall or the county commissioner's office, as well as the resources listed in Appendix C. Finally, information included in the community profile should be updated frequently, because such data can change rapidly.

PRINCIPLE 3: RECRUIT DISASTER WORKERS WHO ARE REPRESENTATIVE OF THE COMMUNITY OR SERVICE AREA

Disaster mental health programs are most effective when individuals from the community and its various cultural groups are involved in service delivery as well as in program planning, policy, and administration and management. Recruiting staff whose cultural, racial, and ethnic backgrounds are similar to those of the survivors helps ensure a better understanding of both the survivors and the community and increases the likelihood that survivors will be willing to accept assistance. For example, if American Indian or Alaska Native populations have experienced a disaster, tribal leaders, elders, medicine persons, or holy persons might be recruited to serve as counselors or in some other capacity. The community profile can be reviewed when recruiting disaster crisis counseling workers to ensure that they are representative of the community or service area.

If indigenous workers are not immediately available, coordinators can attempt to recruit staff with the required racial or ethnic background and language skills from other community agencies or jurisdictions (DHHS, Rev. ed. in press).

Recruitment based solely on race, ethnicity, or language, however, may not be sufficient to ensure an effective response. People who are racially and ethnically representative of the community are not necessarily culturally or linguistically competent. The ability to speak a particular language is not necessarily associated with cultural competence. For example, a well-educated, Spanish-speaking Hispanic professional may not understand the problems and cultural nuances of an immigrant community whose members are living in poverty (DHHS, 2000d).

Table 2-3 highlights the attributes, knowledge, and skills essential to development of cultural competence that should be considered when recruiting disaster mental health staff.

REPORT

Migrant Farm Workers Employed as Outreach Workers

In 1998, El Niño caused a series of storms that devastated many California communities. The storms affected a large number of migrant farm workers, including many in Ventura County. The migrant workers were unwilling to seek help because of cultural proscriptions and language barriers. Some were illiterate.

To improve its ability to assist the migrant workers, Ventura County's disaster crisis counseling project hired peer farm laborers. These workers, who had contacts and credibility within the migrant community, enabled the project to establish a unique communication model to reach farm laborers. The peer counselors went into labor camps and met with the victims of the rains and their indigenous leaders. Local residents noted that these were the first "government" workers in recent memory to be allowed in the farm workers' camp.

California Final Report, 1998

TABLE 2-3

Staff Attributes, Knowledge, and Skills Essential to Development of Cultural Competence

Personal Attributes

- Genuineness, empathy, and a capacity to respond flexibly to a range of possible solutions
- Acceptance and awareness of cultural differences and cross-cultural dynamics
- Willingness to work with survivors of different cultures
- Ability to articulate one's own values, stereotypes, and biases and to identify how they may accommodate or conflict with the needs of culturally diverse disaster survivors
- Openness to learning about the cultures of diverse groups

Knowledge

- History, tradition, values, and artistic expressions of culturally diverse disaster survivors
- Help-seeking behaviors, informal helping supports, and natural healing practices of survivors of various cultures
- Role of language, speech patterns, and communication styles in culturally distinct communities
- Psychosocial stressors relevant to diverse groups (e.g., migration, acculturation stress, legal and illegal discriminatory patterns, racism, and socioeconomic status)
- Community resources (e.g., agencies, informal helping networks) and their availability to special populations

Skills

- Ability to discuss cultural issues and to respond to culturally-based cues
- Ability to assess the meaning of culture for the disaster survivor
- Ability to interview and assess survivors on the basis of their personal, psychological, social, cultural, political, or spiritual models

(Adapted from: Benedetto, 1998; DHHS, 1998)

PRINCIPLE 4: PROVIDE ONGOING CULTURAL COMPETENCE TRAINING TO DISASTER MENTAL HEALTH STAFF

Cultural competence is an essential component of disaster mental health training programs. Training should be provided to help mental health workers acquire the values, knowledge, skills, and attributes needed to communicate and work in a sensitive, nonjudgmental, and respectful way in cross-cultural situations. Such training should be provided to direct services staff, administrative and management staff, language and sign-language interpreters, and temporary staff.

Cultural competence training programs work particularly well when they are provided in collaboration with community-based groups that offer expertise or technical assistance in cultural competence or in the needs of a particular culture. Involving such groups not only enables program staff to gain firsthand knowledge of various cultures, but also opens the door for long-term partnerships (Hernandez and Isaacs, 1998).

Training should cover basic cultural competence principles, concepts, terminology, and frameworks. For example, training should include discussion of:

- Cultural values and traditions;
- Family values;
- Linguistics and literacy;

REPORT

Innovative Program Developed for Seniors

Following civil unrest in Los Angeles in 1993, a crisis counseling program was developed to assist the community. One element of this program was peer counseling with senior adults, including a group of elderly Samoans. No mental health professionals from the Samoan population could be found to help address the needs of these monolingual older adults in South Bay. Project staff worked with the head of the Samoan Council of Chiefs to offer a first-of-its-kind peer counselor training delivered via simultaneous translation. It worked beautifully. Twenty Samoans became deeply committed to counseling seniors in their community.

California Final Report, 1994

- Immigration experiences and status;
- Help-seeking behaviors;
- Cross-cultural outreach techniques and strategies; and
- Avoidance of stereotypes and labels (DHHS, 2000e).

Even if the initial training period is of limited duration, participants should have an opportunity to examine and assess values, attitudes, and beliefs about their own and other cultures. Self-assessment helps identify areas where skills need to be developed (DHHS, 1998). Training should stress that people of a given cultural group may react quite differently to disaster, depending on their level of acculturation.

Cultural competence training is a developmental process. Ongoing education—through in-service training and regularly scheduled meetings with project staff to discuss cultural competence issues—is essential (Hernandez and Isaacs, 1998).

PRINCIPLE 5: ENSURE THAT SERVICES ARE ACCESSIBLE, APPROPRIATE, AND EQUITABLE

Survivors are not always receptive to offers of support. For example, some members of cultural groups may be reluctant to take advantage of services because of negative past experiences. Undocumented immigrants may not seek services because they fear deportation. Such individuals may be reluctant or refuse to move to temporary shelters, to accept State or Federal assistance, or to discuss information that they think could be used against them.

Inequitable treatment following disasters may reinforce mistrust of the public services and disaster assistance systems. Following the 1989 Loma Prieta earthquake in California, shelter services in the more affluent neighborhoods had more community volunteers than survivors. The mayor visited the disaster site in these areas. Less affluent neighborhoods had fewer volunteers, and some volunteers made remarks that the survivors felt were offensive. The mayor did not visit these areas (Dhesi, 1991). Moreover, food and meal preparation in shelters was not culturally appropriate following the earthquake, and many Latinos reported that they became sick from eating the food prepared by the Anglo relief workers (Phillips, 1993).

In studies of Hurricane Andrew's aftermath, racial and ethnic minority group survivors were less likely to have insurance than were white survivors because of practices that exclude certain communities from insurance coverage at affordable rates. Survivors from minority groups were also more likely to receive insufficient settlement amounts (Peacock and Girard, 1997). Concerns related to gender also were investigated after Hurricane Andrew. Many non-English-speaking women of color, especially single women, were subjected to dishonest practices of construction contractors (Enarson and Morrow, 1997).

The delivery of appropriate services is a frequent problem. Racial and ethnic discrimination, language barriers, and stigma associated with counseling services have a negative effect on many individuals' access to and utilization of health and mental health services (Denboba et al.,1998). Families who participated in focus groups reported problems with cultural

and ethnic biases and stereotypes, offensive communication and interactions based on such biases and stereotypes, lack of cross-cultural knowledge, and lack of understanding of the values of various cultural groups (Malach et al., 1996).

Disaster mental health programs must take special care to exercise culturally competent practices. They should make efforts to ensure that staff members speak the language and understand the values of the community. Providing food that has cultural significance can be important. Involving cultural group representatives in disaster recovery committees and program decision making (for example, as members of planning boards or other policy-setting bodies) can help ensure that disaster services are accessible, appropriate, and equitable.

Culturally sensitive outreach techniques also can help ensure that services are accessible and appropriate to all survivors. For example, outreach workers should:

- Allow time for and devote energy to gaining acceptance, take advantage of associations with trusted organizations, and be wary of aligning their efforts with those of agencies and organizations that are mistrusted by cultural groups;
- Determine the most appropriate ways to introduce themselves;
- Recognize cultural variations in expression of emotion, manifestation and description of psychological symptoms, and views about counseling; and
- Assist in eliminating barriers by carefully interpreting facts, policies, and procedures.

Table 2-4 addresses special considerations that should be taken into account when counseling refugees.

REPORT

Hurricane Response Designed to Be Culturally Competent

Hurricane Hortense struck Puerto Rico in 1996 with devastating impact. The disaster crisis counseling program was designed to be particularly sensitive to the Puerto Rican culture. For example, recognizing that this culture encourages strong ties with friends and neighbors, the program provided group debriefing sessions.

The project also used cultural celebrations to advance its goals. For example, the festival of the Three Kings Day, which occurs in early January, was used as an opportunity for special outreach in which project staff went door to door "giving asaltos"—a tradition of singing Christmas carols and giving donated gifts—as a way to identify needs and provide information and social support. The project also used dramatization to inform persons in the community about disaster phases and disaster planning.

Puerto Rico Final Report, 1997

PRINCIPLE 6: RECOGNIZE THE ROLE OF HELP-SEEKING BEHAVIORS, CUSTOMS AND TRADITIONS, AND NATURAL SUPPORT NETWORKS

Culturally competent disaster mental health services proactively respond to the culturally defined needs of the community. Disruption of many aspects of life and the need to adapt to difficult circumstances cause stress and anxiety in many survivors. In some cases, these problems can be as difficult as the disaster itself. Effective response requires familiarity with help-seeking behaviors; customs and traditions related to healing, trauma, and loss; and use of natural support networks of various cultural groups.

Help-Seeking Behaviors

Different cultures exhibit different help-seeking behaviors. In many cultures, people turn to family members, friends, or cultural community leaders for help before reaching out to government and private-sector service systems. They may prefer to receive assistance from familiar cultural community leaders or groups rather than unfamiliar service systems. In most communities, churches and other places of worship play a role similar to that of an extended family, and

TABLE 2-4

Special Considerations When Working with Refugees

Refugees may differ from each other and from native populations on several dimensions, including:

Language: Refugees frequently do not speak English well, if at all. This issue presents communication challenges throughout all phases of a disaster.

Culture: Refugees have their own cultures. Because they are new to the United States, they usually are less well-versed in Western culture than are immigrants, who have had more time to understand it.

Economic marginalization and differences: When they arrive in the United States, many refugees can barely manage economically. Many are supporting relatives left at home. On the other hand, some refugees—especially those with education and highly sought skills—find well paying jobs quickly. Thus, although poverty is common among refugees, not all refugees are poor.

Fractured social relations: The communities of origin of many refugees have failed to provide needed security. In addition, many refugees have experienced personal attacks by representatives of their community or the larger society. Some become so disillusioned by this experience that they are reluctant to form new community bonds. In addition, refugees often face within-group schisms. Preexisting ethnic, religious, and political divisions of the society of origin are frequently reinstituted in refugee communities formed in the new country.

Some refugees solve the problem by restricting new relationships to the safest ones, for example, by forming or joining small groups of people who emigrated from the same geographic area. When a disaster forces relocation, it can break up this small community and make recovery more problematic (Athey and Ahearn, 1991).

The negative experiences of many refugees also make them suspicious of government. They may be reluctant to seek out or accept assistance following a disaster. Undocumented migrants may fear deportation, but even refugees who have achieved legal status may fear that accepting assistance following a disaster will put them at risk of deportation. Thus, refugees often are the last group to obtain assistance following disaster.

Experience of traumatic stressors and of loss: Refugees often have experienced horrific events that cause symptoms of Post-Traumatic Stress Disorder. They may have lost family members, their homes, and their possessions, and some have been deprived of sufficient food or water, lacked medical care, or lived in inadequate housing for long periods of time. A disaster can lead to the emotional re-experiencing of these events (Van der Veer, 1995). On the other hand, some refugees may have gained strength and resilience from their previous experiences and bring that strength to the new disaster.

Family dynamics and role changes: Another challenge for many refugee families is that of new family dynamics upon resettlement. Children may have seen their parents fearful, helpless, and stressed during the flight and—upon resettlement—anxious, powerless, and exhausted. Children may come to believe that adults are not to be trusted because they have not seen adults playing a protective and nurturing role.

Intergenerational conflict resulting from differing rates of acculturation presents another family problem. Finally, parents may feel deprived of their role as family heads when they find they must depend on children as language translators or navigators within the new culture (de Monchy, 1991).

De Monchy (1991) identifies three principles for effective service delivery with refugees:

1. Trauma experiences need to be acknowledged.
2. Refugees need to be recognized as successful survivors, and their wisdom and strengths affirmed.
3. Empowerment and the recovery of control need to be encouraged, especially for refugees who are reestablishing parental roles with their children.

survivors turn to them first for assistance.

Many survivors may be reluctant to seek help or may reject disaster assistance of all types. Some people feel shame in accepting assistance from others, including the government, and equate government assistance with "welfare." Members of racial and ethnic minority groups, including refugees and immigrants, also may be reluctant or afraid to seek help and information from service systems because of historical mistrust of the health, mental health, and human services systems or because of fear of deportation (Aponte, Rivers, and Wohl, 1995). Other groups may prefer to suffer or even perish rather than seek help from people they mistrust. Therefore, building trusting relationships and rapport with disaster survivors is essential to effective crisis counseling.

Those who do seek help may find relief procedures confusing. Feelings of anger and helplessness and loss of self-esteem can result from survivors' encounters with relief agencies. These feelings result from the survivors' lack of understanding of the disaster relief system as well as government and private agencies' often bureaucratic procedures.

Customs and Traditions in Trauma and Loss

Religious and cultural beliefs are important to survivors as they try to sort through their emotions in the aftermath of traumatic events. Beliefs may influence their perceptions of the causes of traumatic experiences. For example, in many cultures, people believe that traumatic events have spiritual causes. These beliefs can affect their receptivity to assistance and influence the type of assistance that they will find most effective. Different populations may elaborate on the cultural meaning of suffering in different ways, but suffering itself is a defining characteristic of the human condition in all societies. In most major religions, including Christianity, Judaism, Islam, Hinduism, and Buddhism, the experience of human misery—resulting from sickness, natural disasters, accidents, violent death, and atrocity—also is a defining feature of the human condition.

Different cultural groups also handle grief in different ways. Family customs, beliefs, and degree of acculturation affect expressions of grief. Disaster mental health workers must recognize that grief rituals, although diverse in nature, can help people return to a reasonable level of functioning. For example, Western tradition holds that grief should be "worked through." This process includes acceptance of the loss; extinction of behaviors that are no longer adaptive; acquisition of new ways of dealing with others; and resolution of guilt, anger, and other disruptive emotions.

If a community remains intact after a disaster, cultural norms, traditions, and values determine the strategies that the survivors use to deal with the effects. When the entire community is affected, however, cultural mechanisms may be overwhelmed and unable to fulfill their customary functions of regulating emotions and

REPORT

Shamans Counter Bad Luck

In 1995, northern California experienced a series of storms that led to flooding, landslides, and mud debris flow. The State implemented a FEMA-funded crisis counseling program for the victims of the storms. One group affected were Hmong immigrants, persons with a history of war and severe losses. In serving the Hmong population, the program utilized the color red in many printed materials and supplies because Hmong culture includes a belief that red symbolically wards off evil spirits. Another consideration involved the Hmong belief that floods are an omen of doom and that shaman cleansing rituals are needed to counter the bad luck that this omen portends. As a way of acknowledging and respecting this belief, the staff developed and provided a referral list of shamans in the local area.

California Final Report, 1996

REPORT

Alaska Villagers Helped by Tribal Elders

In 1994, severe rains in Alaska resulted in extensive flooding of the Koyukuk River. Three native villages experienced tremendous damage and residents had to be temporarily evacuated. With FEMA funding, the State of Alaska developed a disaster crisis counseling project that included among its staff professionals and paraprofessionals, Alaska Native and non-native staff, and tribal elders. Among the counselors were individuals with cultural sensitivity and respect for the wisdom of the elders. The project organized sewing circles and birchbark basket-making circles in order to use the mechanisms of the culture's social life to assist in its recovery.

Alaska Final Report, 1995

REPORT

Importance of Culturally Competent Ethnic Workers

Flooding in Florida displaced many residents in 1998. One area that was flooded included a community with a high percentage of African Americans, a majority of whom were living in rental property. Unfortunately, the landlords were less than prompt, thorough, or enthusiastic in making repairs.

The disaster crisis counseling program that was developed in response to the flood employed an African American team leader from the county where most of the affected people lived. She was especially important in accessing community leaders and gatekeepers, helping identify needs of the community, and providing services.

Florida Final Report, 1999

providing identity, support, and resources (DeVries, 1996). Disaster mental health workers can support the healing process by helping rebuild the community's cultural support system. Workers will be most effective when they recognize and understand the importance of culture in the lives of disaster survivors and the beliefs, rituals, and level of acculturation of the community in which they work.

Customs and Traditions for Healing

Many cultural groups hold beliefs about illness and healing that differ sharply from those held by Western society. People in every culture share beliefs about the causes of illness and ideas about how suffering can be mitigated. For example, members of some cultures believe that physical and emotional problems result from spiritual wrongdoings in this life or a previous one. They believe that healing requires forgiveness from ancestors or higher spirits. Some people believe that suffering cannot be ameliorated (DeVries, 1996). Others demonstrate stress and emotional conflict through complaints about their physical health.

Traditional healers, such as local herbalists, faith healers, and acupuncturists, play important roles in recovery of mental and physical health within some cultures. In general, the work of healers is based on the principle that the body cannot be isolated from the mind, and the mind cannot be removed from its social context. Disaster mental health workers who interact with cultures in which healers play a key role in health must understand the concepts of integration of body, mind, and spirit when they provide disaster crisis counseling services to diverse populations. They must be able to integrate traditional methods of healing into service delivery (de Monchy, 1991). Although the crisis counselor may not subscribe to certain cultural healing beliefs, he or she must acknowledge their existence and recognize their importance to some disaster survivors. At the same time, the worker must be alert for any use of dangerous healing practices, such as ingestion of harmful mixtures containing lead or other toxic substances, and take corrective measures. Reestablishing

rituals in appropriate locations is another way to help survivors in the recovery process. Symbolic gathering places, such as churches, mosques, trees, and safe places for meeting after sundown are important in some cultures and are required for certain rituals. After a disaster, survivors may lose access to symbolic places, and this loss may limit their ability to mobilize healing resources. Identifying new locations for rituals can foster social support and facilitate coping mechanisms following disaster (DeVries, 1996).

Disaster mental health workers also may help organize culturally appropriate anniversary activities and commemorations as a way to help survivors mark a milestone in the healing process. Cultural and religious traditions, including special ways of both celebrating and mourning, can be incorporated into such events and may enrich their symbolic meaning and healing potential. Any attempts to facilitate activities involving customs and traditions must be undertaken carefully and only after consultation with members of the involved cultural groups.

Natural Support Networks

In many cultures, the family or kin group is chiefly responsible for its members, and support from kin may be essential in helping individuals overcome grief and trauma. However, when disaster strikes, all members of the extended family may be affected, leaving many people without this customary support network.

Traditions concerning the role of the family, who is included in the family, and who makes decisions vary across cultures (DHHS, 2000e). Elders and extended family play a significant role in some cultures, whereas in other cultures, isolated nuclear families are the decision makers (DHHS, 2000e). Households in racial and ethnic communities are, on average, larger than white households (O'Hare, 1992); they also are more likely to be multigenerational. Asians, for example, are more than twice as likely as whites to live in extended families (O'Hare and Felt, 1991).

Disaster mental health workers must recognize that family support may not be available when entire kin groups are affected. Helping families and friends reunite is one way to ensure mutual support. Likewise, formal support groups can help assure those with limited access to relatives and acquaintances that they are not alone. Individuals who do not relate to support groups because of cultural and linguistic differences may need more individualized services.

Disaster mental health workers also must recognize that in many cultures, the individual cannot be separated from the family and community (Reichenberg and Friedman, 1996). In such cultures, unlike those of Western society, the individual does not exist apart from the group; outreach efforts focused on individuals are, therefore, neither comprehensible nor effective. For example, among some Asian American and Pacific Islander populations, intervention strategies that diffuse the power of family relationships are especially inappropriate. Mental health workers can assess who is significant in a survivor's family structure by asking the survivor to describe his or her home, family, and community (Managua, 1998).

PRINCIPLE 7: INVOLVE AS "CULTURAL BROKERS" COMMUNITY LEADERS AND ORGANIZATIONS REPRESENTING DIVERSE CULTURAL GROUPS

Involving "cultural brokers"—community leaders and groups that represent diverse groups—is vital to the success of disaster mental health efforts. Collaborating with organizations and leaders who are knowledgeable about the community is the most effective way of gaining information about the community. Collaboration can assist in assessing needs, creating community profiles, making contact with and gaining the trust of survivors, establishing program credibility, integrating cultural competence in training, and ensuring that strategies and services are culturally competent (DHHS, 1998).

In most communities, and in diverse communities in particular, some of the most influential individuals are cultural group

Did You Know . . .

According to 1990 census data, nearly 14 percent of the Nation's population—32 million people—speak a language other than English in their homes. More than 300 languages are spoken in the United States (Goode et al., 2001).

leaders who possess "insider" knowledge of the community and are willing and able to articulate that knowledge (Hernandez and Isaacs, 1998). These individuals, who may not be immediately visible, can include spiritual leaders, members of the clergy, teachers, civic leaders, local officials, or long-term residents who have the respect and confidence of their neighbors. They often can provide outsiders with the best insights into a local culture's values, norms, customs, conventions, traditions, and expectations (Hernandez and Isaacs, 1998).

Organizations representing various cultural groups and other special interest groups in the community should be invited to participate in disaster mental health programs. These organizations can provide valuable insight during the planning process, serve as a point of entry to the survivor community, and enhance cultural relevance of service delivery. Including individuals from various cultures on planning task forces and committees will help ensure that they concur with the selected strategies.

Should a disaster occur, community-based organizations can provide an important communication link with the cultural groups they represent. For example, churches do much more than serve the spiritual needs of the African American community. They are also the center of political, social, educational, and cultural activities. Therefore, African American ministers may play an important part in mental health outreach and recovery efforts.

Informal, culture-specific groups such as sewing circles and youth sports teams can also be sources of support to disaster survivors. The crisis counseling program staff should identify the most effective ways to work with such groups. Community-based organizations that should be involved include:

- Civic associations;
- Social clubs;
- Neighborhood groups;
- Faith-based organizations;
- Interfaith groups;
- Mutual aid societies;
- Voluntary organizations;
- Health care and social service providers; and
- Nonprofit advocacy organizations (Hernandez and Isaacs, 1998).

To ensure effective use of resources, crisis counselors should coordinate their work with that of other public and private agencies responding to the disaster. The coordinating agency should recognize unique jurisdictional situations that may arise when working with various American Indian and Alaska Native cultures. American Indian and Alaska Native tribes are federally recognized sovereign nations. Disaster mental health agencies should acknowledge the need for a partnership that includes various agencies within tribes, different levels of government, and many tribes working together to improve access to disaster assistance. Although under the Stafford Act, a State government must request a Presidential disaster declaration on behalf of a tribe, agencies subsequently can work directly with the tribe and with existing authorities and resources to tailor disaster plans to the tribe's unique needs and jurisdictional requirements.

PRINCIPLE 8: ENSURE THAT SERVICES AND INFORMATION ARE CULTURALLY AND LINGUISTICALLY COMPETENT

Language can be a major barrier to service delivery. Survivors who are monolingual, limited in their English, or deaf or hard of hearing

may be at a particular disadvantage. Emergency response programs generally have few or no staff trained to work with bilingual populations (Phillips and Ephraim,1992). For example, most of the information provided immediately after Hurricane Andrew in Florida was available only in English (Yelvington, 1997). As a result, many Latinos and Haitians did not receive needed food, medical supplies, and disaster mental health assistance information.

"Linguistic competence" ensures accurate communication of information in languages other than English. This capability enables an organization and its personnel to communicate effectively with persons of limited English proficiency, those who are illiterate or have low literacy skills, and individuals who are deaf or hard of hearing (Goode et al., 2001). Elements of linguistic competence include the availability of trained bilingual and bicultural staff, translations of educational materials and documents, and sign-language and language interpretation services. Although linguistic competence and cultural competence involve distinct skills, they are intrinsically connected (DHHS, 1999).

Availability of Trained Bilingual and Bicultural Staff

Ideally, disaster mental health workers should be bilingual, bicultural, and from the affected community. However, in many circumstances, workers who are bilingual but not from the affected culture and community must be hired. In such situations, communication challenges may arise, even though the disaster worker or interpreter speaks the same language as the survivors. Examples or related issues follow.

- Disaster mental health workers may be responsible for assisting survivors who have a language pattern that is different from their own. Dialects, in addition to colloquialisms and accents, can be difficult to understand and communication barriers can result.

- Words may have different meanings even among people who share a language. Rogers (1992) noted difficulty in communicating disaster information between members of the United States Army and people in a native Polynesian culture because, although they both spoke English, the two groups did not assign a common meaning to certain words and phrases. The language differences led to frustration and a breakdown of credibility.

- Bilingual disaster survivors who primarily speak Spanish may be more withdrawn when interviewed in English rather than in Spanish. An individual's speech pattern may be halting or disrupted and expression of affect may be reduced when the person is required to speak in a language other than his or her primary language. In such situations, the disaster worker's assessment of the survivor's issues and needs can be distorted. Ideally, the preferred or primary language of bilingual disaster survivors should be used in delivering outreach and other services (Aponte et al., 1995).

REPORT

Multiple Methods Employed to Communicate with Asian Groups

Hurricane George caused extensive damage in Alabama in 1998, leaving many people homeless and others with major losses to their homes and businesses. Included among the disaster survivors was an Asian population. The disaster crisis counseling program used several methods to reach and serve them. For example, it developed leaflets in the Cambodian, Laotian, and Vietnamese languages and distributed them to churches serving large numbers of Asian immigrants. The crisis counseling project also employed interpreters, a strategy that was viewed as highly effective in disseminating information to these groups. Finally, the project provided screening and information services to Asian adolescents in a church group.

Alabama Final Report, 1999

Program managers must be cautious in selecting bilingual staff members and interpreters. Those who are bilingual also must understand nonverbal and cultural patterns to communicate effectively. Bilingual staff members should demonstrate bilingual proficiency and undergo cultural competence training (DHHS, 2000a).

Dissemination of Educational Information

Written information should be translated[3] into multiple languages, as appropriate for the community to be served. The literacy level of the target population must be considered when developing written materials. Any written materials should be supplemented with other forms of information (DHHS, 2000a). For example, messages may be conveyed by radio or through announcements at churches and other community centers. Most localities now have television stations that broadcast in the languages of various cultural groups. Although these communications media should be used, it is important to note that some people do not have access to television and may depend on radio broadcasts for information.

Crisis support programs should establish relationships with multicultural television stations, radio stations, and newspapers before a disaster occurs. In addition, program staff should invite television and radio station personnel to participate in the development of a disaster communications plan.

The information needs of people who are deaf or hard of hearing also must be considered. Closed-captioned television, for example, is a critical communication tool for this population. The Federal Communications Commission requires that all emergency information presented on television be accessible to persons who are deaf or hard of hearing.

Language and Sign-Language Interpretation

Language interpretation may be used when the language barrier is so great that communication between mental health workers and survivors is not possible or when no bilingual staff can be hired. Sign-language interpretation also must be considered when developing communication strategies.

Although language interpreters may be the only viable option in some situations, hiring bilingual staff members remains the preferred solution. Van der Veer (1995) notes that an interpreter's behavior may evoke certain feelings in the disaster survivor. Factors such as the interpreter's gender, age, or level of acculturation may affect the survivor's willingness to speak openly. Disaster survivors may be ashamed of mental health problems that are considered a sign of madness or a cause for contempt in their cultures. They also may distrust interpreters who are from the same country and speak the same language, but who have different political or religious backgrounds (Van der Veer, 1995).

Interpreters should be trained to accurately convey the tone, level, and meaning of the information presented in the original language. Without adequate training, interpreters may interpret information inaccurately or incompletely. The most common problems include changing open-ended questions into leading questions, altering the content of questions, and adding comments. Problems in interpreting answers include leaving out part of the answer, adding something to the answer, and making mistakes because of limited understanding of English (Van der Veer, 1995).

When working with refugees, mental health workers should be aware that interpreters might have experienced traumatic events similar to those experienced by the refugees. In such situations, the interpreter may want to avoid reliving unhappy or traumatic memories. Thus, the interpreter may present information inaccurately, evade certain topics, change the subject, or tell the mental health worker that the interview is too stressful for the disaster survivor (Westermeyer, 1989). Table 2-5 provides useful guidelines for using interpreters.

[3] Interpretation is the oral restating in one language of what has been said in another language. Translation typically refers to the conversion of written materials from one language to another (Goode et al., 2001).

TABLE 2-5

Guidelines for Using Interpreters

The following guidelines should be considered when using language interpreters (Bamford, 1991; Gaw, 1993; Paniagua, 1998; Westermeyer, 1989):

- Before hiring interpreters, attempt to identify mental health workers who speak the language spoken by survivors and who identify with the survivors' culture.
- Hire certified, qualified interpreters who share the survivor's racial and ethnic background.
- Determine the survivor's dialect before asking for an interpreter.
- Compare the level of acculturation of the interpreter with that of the survivor. If it is not similar, effective communication may not be possible because Western values may be reflected in the interpreter's comments.
- Introduce the interpreter to the disaster survivor, and allow time for them to build trust through informal conversation.
- Take time for translation. Use a sequential mode of interpretation—that is, the disaster survivor speaks, the interpreter interprets what has been said into English, the disaster mental health worker speaks, and the interpreter speaks again.
- Do not use survivors' friends and relatives, including their children, as interpreters. The survivor may not feel comfortable expressing concerns of a personal nature to relatives and friends. Using children can reverse the hierarchical role of parents and place burdens on children. Moreover, such responsibility may require skills beyond the child's current stage of development and be too stressful for the child (DHHS, 2000c).

PRINCIPLE 9: ASSESS AND EVALUATE THE PROGRAM'S LEVEL OF CULTURAL COMPETENCE

Self-assessment and process evaluation are keys to ensuring that disaster mental health services are as effective as possible and to making maximum use of resources. Self-assessment helps programs identify organizational problems that may impede the delivery of culturally competent services. The self-assessment tool presented in Table 2-6 may be used in conjunction with the Cultural Competence Checklist for Disaster Crisis Counseling Programs, presented in Appendix F. The Cultural Competence Continuum (Figure 1-1) is another useful tool for assessing a program's level of cultural competence.

Process evaluation helps ensure that the disaster mental health program stays on course. It also can identify problems or gaps in providing culturally competent services. Involving representatives from as many cultural groups as possible in process evaluation ensures that diverse cultural groups or group perspectives are heard and understood.

The program can use a variety of techniques for collecting information for process evaluations. For example, staff might create an evaluation task force or advisory group or a discussion or focus group that includes representatives of different cultural groups. A group that includes a disaster survivor perspective, as well as

TABLE 2-6

A Cultural Competence Self-Assessment for Disaster Crisis Counseling Programs

Six elements are needed to ensure cultural competence of mental health agencies (Bernard, 1998). Programs can use these elements to assess their level of cultural competence as well.

Leadership

- Are the leaders of the program committed to cultural competence?
- Does the project manager hold staff accountable for knowledge of the provision of appropriate services to all disaster survivors?

Understanding of cultural competence

- Has the program staff developed a common understanding of cultural competence and do they clearly and frequently communicate that understanding to others?

Organizational culture

- Does the crisis counseling program promote and encourage cultural competence?
- Is the program administered by an organization with a strong commitment to and history of working toward cultural competence?
- Are policies, procedures, and systems in place for delivering interpretation, bilingual, or translation services?

Training

- Have all crisis counseling staff members been trained in cultural competence, and are they familiar with the diverse cultural and ethnic groups in the community?
- Are training programs ongoing?
- Are regular meetings convened and educational opportunities offered for staff members to discuss cultural competence issues and concerns, build cross-cultural skills, and develop strategies?

Cultural competence plan

- Has the program identified goals designed to address the mental health needs of the community in a culturally competent manner?
- Has the program explored various methods of working with disaster survivors in a way that respects and is sensitive to the needs of all groups in the community?
- Has the program established partnerships with community-based agencies that serve cultural and ethnic groups for input on needs assessment, program planning, and evaluation?
- Has the program developed a mechanism to acquire knowledge about the customs, values, and beliefs of special populations?

Managing the plan

- Has a person or group been identified to evaluate the success of the program in addressing cultural competency issues?
- Have methods been instituted to recognize innovations in serving culturally distinct groups and implement those innovations project-wide?

representatives of partner agencies, can provide qualitative information and innovative ideas that can help the crisis counseling program more effectively address the community's cultural needs. Evaluation methods should be consistent with the cultural norms of the groups being served. Evaluators should be sensitive to the culture and familiar with the culture whenever possible and practical (DHHS, 2001).

Program staff should regularly communicate process evaluation findings to key informants and cultural groups engaged in the project and in the evaluation in order to ensure their ongoing support.

Developing a culturally competent disaster crisis counseling program requires commitment and diligence. The rewards of such dedication are at the heart of the program—effective and appropriate services to help disaster survivors recover and heal.

REPORT

Bilingual and Bicultural Staff Assist in Assuring Cultural Competence

Late winter storms in California in 1995 affected several ethnic groups in Fresno County. The county crisis counseling project sought to deliver services in a bilingual, bicultural manner. Staff members were assigned to match the ethnic and cultural attributes of each community; for example, Spanish-English speakers primarily concentrated in one area of the county, while Hmong-English speakers were deployed to another area. Brochures and other forms of written information were translated into both Hmong and Spanish. Interpreters were used to reach persons who spoke Punjabi, Armenian, and Chinese. The project also arranged to provide oral translations of handouts for those who were illiterate.

California Final Report, 1995

REPORT

Information Dissemination for Deaf and Hard-of-Hearing Populations Improved

In September 1999, Hurricane Floyd arrived in North Carolina, causing the most devastating flooding the State had ever experienced. Outreach efforts organized through the "Hope After Floyd" program helped thousands of residents to deal with the hurricane's aftermath.

Outreach workers reported particular success in providing crisis counseling services to individuals who were deaf and hard of hearing, many of whom experienced fear and stress associated with the lack of access to information provided through television or radio. Following the disaster, project staff provided in-service training and consultation to emergency management agency officials on the needs of the deaf and hard-of-hearing populations, and worked to ensure that the Federal Communications Commission required broadcast stations to provide closed-captioned emergency information.

North Carolina Site Visit Report, 2000

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CRISIS COUNSELING PROGRAM REPORTS

The Emergency Mental Health and Traumatic Stress Services Branch reviews reports from States that have received funding under the Robert T. Stafford Disaster Relief and Emergency Assistance Act. The following reports were reviewed for this publication:

Alabama, Hurricane George, 1998
FEMA-1250-DR

Alaska, Storms and Floods, 1994
FEMA-1039-DR

California, Civil Unrest, 1994
FEMA-942-DR

California, Northridge Earthquake, 1994
FEMA-1008-DR

California, Late Winter Storms, 1995
FEMA-1046-DR

California, Flooding, 1998
FEMA-1203-DR

California, El Nino Storms, 1998
FEMA-1203-DR

Florida, Severe Storms, 1999
FEMA-1204-DR

Guam, Super Typhoon, 1997
FEMA-1193-DR

Minnesota, Storms and Floods, 1993
FEMA-995-DR

North Carolina, Hurricane Floyd, 1999
FEMA-1292-DR

Oklahoma, Oklahoma City Bombing, 1995
FEMA-1048-DR

Puerto Rico, Hurricane Hortense, 1997
FEMA-1136-DR

South Dakota, Severe Storms, 1997
FEMA-1156-DR

Appendices

Appendix A:

Cultural Competence Resources and Tools

- American Psychological Association (1990). *APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations.* Washington, DC: American Psychological Association.

  Offers recommendations on working with ethnic and culturally diverse populations to providers of psychological services.

- Child Welfare League of America (1993). *Cultural Competence Self-assessment Instrument.* Washington, DC: Child Welfare League of America.

  A tool designed to help organizations providing family services identify, improve, and enhance cultural competence in staff relations and client service functions. The instrument, which has been field-tested, provides a practical, easy-to-use approach to addressing the major issues associated with delivering culturally competent services.

- Cohen, R. (1992). Training mental health professionals to work with families in diverse cultural contexts. *Responding to Disaster: A Guide for Mental Health Professionals.* Washington, DC: American Psychiatric Press, Inc.

  Explores cultural considerations for mental health workers and disaster survivors in the immediate and longer-term aftermath of a disaster. Examines issues of loss, mourning, separation, coping, and adaptation as they relate to disaster survivors from various cultures.

- Cross, T. L. (1989). *Towards a Culturally Competent System of Care. Vol. I: A Monograph of Effective Services for Minority Children who are Severely Emotionally Disturbed.* Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.

  One of the first documents to provide practical information on operationalizing cultural competence. Provides definitions for competence, introduces the concept of a cultural competence continuum, and provides information that can be used at individual and organizational levels.

- Giger, J., and Davidhizar, R. (1999). *Transcultural Nursing: Assessment and Intervention.* St. Louis, MO: Mosby, Inc.

  Provides tools that can be used to evaluate cultures' perceptions and needs related to communication, space, social organization, time, environmental control, and biological variations. Giger and Davidhizar were among the first to develop the concept of cultural competence in the nursing profession. Now in its third printing, the publication is used by a number of other disciplines.

- Goode, T. D. (1999). *Getting Started: Planning, Implementing and Evaluating Culturally Competent Service Delivery Systems in Primary Health Care Settings, Implications for Policy Makers and Administrators.* Washington, DC: Georgetown University, National Center for Cultural Competence.

  A checklist that can assist programs and organizations in initiating strategic development of policies, structures, procedures, and practices that support cultural and linguistic competence.

- Health Resources and Services Administration (1998). *Health Care Rx: Access for All.* Washington, DC: Health Resources and Services Administration.

  A chart book that provides a picture of the health of racial and ethnic minority Americans and the cascade of factors that limit access to health care, hamper workforce diversity, and limit culturally competent services.

- Hernandez, M., and Isaacs, M. (1998). *Promoting Cultural Competence in Children's Mental Health Services.* Baltimore, MD: Paul H. Brookes Publishing.

  Provides an excellent framework for developing a culturally competent mental health system. Focuses on the need to develop organizational infrastructures that support and further cultural competence and the need to ensure that programs are meaningful at the community and neighborhood levels. Also addresses special issues related to serving culturally diverse populations. Designed for planners, program

managers, policy makers, practitioners, parents, teachers, researchers, and others who are interested in improving mental health services for families.

- Hicks, Noboa-Rios (1998). *Cultural Competence in Mental Health: A Study of Nine Mental Health Programs in Ohio.* Columbus, OH: Outcomes Management Group, Ltd.

  Provides an assessment of nine culturally competent programs that were funded to encourage the provision of cultural sensitivity training to the mental health community and to develop nontraditional, culturally sensitive methods of delivering services to persons of color. Prepared for the Multi-Ethnic Behavioral Consortium of the Ohio Department of Mental Health.

- Nader, K., Dubrow, N., and Stamm, H. (1999). *Honoring Differences: Cultural Issues in the Treatment of Trauma and Loss.* Ann Arbor, MI: Brunner/Mazel.

  Discusses the treatment of trauma and loss while recognizing the importance of understanding the cultural context in which the mental health professional provides assistance.

- Perkins, J., Simon, H., Cheng, F., et al. (1998). *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities.* Los Angeles, CA: National Health Law Program.

  An informative discussion on linguistic issues that can impede effective service delivery. Covers the importance of language access, use of community volunteers, limitations of interpretation, linguistic barriers in mental health, and effective use of written materials.

- Substance Abuse and Mental Health Services Administration (2000). *Cultural Competence Standards in Managed Mental Health Care for Underserved/Underrepresented Racial/Ethnic Groups.* Washington, DC: Western Interstate Commission for Higher Education and Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

  Provides information on cultural competence guidelines, performance indicators, and potential outcomes in the areas of triage and assessment, care planning, treatment plans, treatment services, communication styles, and cross-cultural linguistic and communication support.

- Substance Abuse and Mental Health Services Administration (2000). Cultural strengths and challenges in implementing a system of care model in American Indian communities. *Systems of Care: Promising Practices in Children's Mental Health* (2000 Series, Vol. 1). Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

  Examines promising practices of five American Indian children's mental health projects that integrate traditional American Indian helping and healing methods with the systems of care model.

- U.S. Department of Health and Human Services (1992-1999). *Cultural Competence Series.*

  Monograph series sponsored by Bureau of Primary Health Care, Health Resources and Services Administration; Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration; and Office of Minority Health.

- Van der Veer, G. (1995). *Psychotherapeutic Work with Refugees.* New York: Plenum Press.

  Suggests that the trauma that a refugee experiences in a disaster may not be an isolated incident, but part of a series of ongoing traumatic events. Stresses that overcoming cultural difference is essential in working with traumatized refugees and that such work requires creatively adjusting a variety of existing techniques.

Appendix B:

Disaster Mental Health Resources from the Center for Mental Health Services (CMHS)

The following publications and videos on disaster response and recovery planning for special populations were developed by the Emergency Mental Health and Traumatic Stress Services Branch of CMHS. To download these documents or order copies, please visit the Substance Abuse and Mental Health Services Administration (SAMHSA) Web site at www.samhsa.gov.

PUBLICATIONS

ADM 86-1070R *Psychosocial Issues for Children and Adolescents in Disasters*

ADM 90-538 *Training Manual for Mental Health and Human Service Workers in Major Disasters, Second Edition*

SMA 94-3010R *Disaster Mental Health Response and Recovery: A Strategic Guide (May not be available; revised edition in press)*

SMA 95-3022 *Psychosocial Issues for Children and Families: A Guide for the Primary Care Physician*

SMA 96-3077 *Responding to the Needs of People with Serious and Persistent Mental Illness in Times of Major Disaster*

SMA 99-3323 *Psychosocial Issues for Older Adults in Disasters*

SMA 99-3378 *Crisis Counseling Programs for the Rural Community*

VIDEOS

ESDRB-2 Children and Trauma: The School's Response

OM 00-4070 Voices of Wisdom: Seniors Cope with Disaster

OM 00-4070S Voices of Wisdom: Seniors Cope with Disaster (Spanish Version)

OM 00-4071 Hurricane Andrew: The Fellowship House Experience

GENERAL MATERIALS

CMHS Program Guidance Series

Appendix C:

Sources of Demographic and Statistical Information

The following World Wide Web resources offer demographic and statistical information useful for developing disaster mental health community profiles:

STATISTICS ABOUT IMMIGRATION PATTERNS

Immigration and Naturalization Service,
U.S. Department of Justice:

http://uscis.gov/graphics/shared/aboutus/statistics/index.htm

NATIONAL, STATE, AND COUNTY STATISTICS AND DEMOGRAPHIC DATA BY AGE, RACIAL, ETHNIC, AND LINGUISTIC SUBGROUPS

U.S. Bureau of the Census:

www.census.gov/population/www/index.html

UNEMPLOYMENT INFORMATION BY GENDER, RACE, AND AGE

Bureau of Labor Statistics:

http://stats.bls.gov/

DEMOGRAPHIC INFORMATION BY ZIP CODE

PeopleSpot:

http://peoplespot.com/statistics/demographics.htm

GENERAL INFORMATION

Government Information Sharing Project,
Oregon State University:

http://govinfo.kerr.orst.edu/index.html

National Center for Health Statistics,
Centers for Disease Control and Prevention:

www.cdc.gov/nchs/

Federal Healthfinder®:

www.healthfinder.gov/

Appendix D:

Sources of Assistance and Information

FEDERAL GOVERNMENT ORGANIZATIONS AND RESOURCES

Federal Emergency Management Agency (FEMA)

FEMA coordinates with other State and Federal agencies to respond to presidentially declared disasters. It provides disaster assistance for individuals, businesses (through the Small Business Administration), and communities (through the Robert T. Stafford Disaster Relief and Emergency Assistance Act).

Federal Emergency Management Agency
Human Services Division
500 C Street, SW
Washington, DC 20472
Phone: 202-566-1600
www.fema.gov

Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA)

Through an interagency agreement with FEMA, CMHS provides consultation and technical assistance for the Crisis Counseling Assistance and Training Program. Publications and videotapes on disaster human response are available through SAMHSA's National Mental Health Information Center.

Center for Mental Health Services
Emergency Mental Health and Traumatic Stress Services Branch
5600 Fishers Lane
Room 17C-20
Rockville, MD 20857
Phone: 301-443-4735
Fax: 301-443-8040
www.samhsa.gov

SAMHSA's National Mental Health Information Center
P.O. Box 42557
Washington, DC 20015
Phone: 1-800-789-2647
Fax: 301-984-8796
TDD: 1-866-889-2647
www.mentalhealth.samhsa.gov/

Federal Communications Commission (FCC)

445 12th Street, SW
Washington, DC 20554
Phone: 202-418-1771 or 1-888-225-5322
TTY: 202-418-2520 or 1-888-835-5322
Fax: 202-418-0710 or 1-866-418-0232
www.fcc.gov

Health Resources and Services Administration (HRSA)

Office of Minority Health
5600 Fishers Lane
Room 14-48
Rockville, MD 20857
Phone: 301-443-3376 or 1-888-275-4772
www.hrsa.gov

Indian Health Service (IHS)

Office of Public Health
The Reyes Building
801 Thompson Avenue
Suite 400
Rockville, MD 20852-1627
Phone: 301-443-3024
www.ihs.gov

National Institute on Deafness and Other Communication Disorders (NIDCD)

31 Center Drive
MSC 2320
Bethesda, MD 20892
Phone: 301-496-7243
www.nidcd.nih.gov

NIDCD Information Clearinghouse

1 Communication Avenue
Bethesda, MD 20892
Phone: 1-800-241-1044
TTY: 1-800-241-1055
www.nidcd.nih.gov

Office for Civil Rights

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F
Hubert H. Humphrey Building
Washington, DC 20201
Phone: 202-619-0257 or 1-877-696-6775
www.hhs.gov/ocr

Office of Public Health and Science
U.S. Office of Minority Health Resource Center

U.S. Department of Health and Human Services
P.O. Box 37337
Washington, DC 20013-7337
Phone: 301-443-5084 or 1-800-444-6472
Fax: 301-251-2160
www.omhrc.gov

Rural Information Center Health Service

National Agricultural Library
10301 Baltimore Avenue
Room 304
Beltsville, MD 20705-2351
Phone: 301-504-5547 or 1-800-633-7701
Fax: 301-504-5181
TDD/TTY: 301-504-6856
www.nal.usda.gov/ric

NATIONAL ORGANIZATIONS

American Red Cross (ARC)

ARC has chapters in most large cities and a State chapter in each capital city. Every local Red Cross chapter is charged with readiness and response responsibilities in collaboration with its disaster partners. Disaster services include preparedness training, community education, mitigation, and response. ARC chapters help families with immediate basic needs (food, clothing, and shelter) and provide supportive services and longer-term interventions. Contact the local chapter for assistance or the chapter in your State capital.

American Red Cross National Headquarters
2025 E Street, NW
Washington, DC 20006
Phone: 202-737-8300 General Information
Phone: 202-303-4498 Public Inquiry
Phone: 703-206-7460 Disaster Services
www.redcross.org

PROFESSIONAL PRIVATE-SECTOR ORGANIZATIONS AND RESOURCES

African American Mental Health Research Center
Institute for Social Research

University of Michigan
426 Thompson
Room 5118
Ann Arbor, MI 48106
Phone: 734-763-0045
Fax: 734-763-0044
http://rcgd.isr.umich.edu/prba

American Psychological Association

750 First Street, NE
Washington, DC 20002-4242
Phone: 202-336-5510 or 1-800-374-2721
TDD/TTY: 202-336-6123
www.apa.org

Cross Cultural Health Care Program

270 S. Hanford Street
Suite 100
Seattle, WA 98134
Phone: 206-860-0329
Fax: 206-860-0334
www.xculture.org

National Alliance for Hispanic Health

1501 16th Street, NW
Washington, DC 20036
Phone: 202-387-5000
www.hispanichealth.org

National Asian American and Pacific Islander Mental Health Association

1215 19th Street
Suite A
Denver, CO 80202
Phone: 303-298-7910
Fax: 303-298-8180
www.naapimha.org

National Association for Rural Mental Health

3700 W. Division Street
Suite 105
St. Cloud, MN 56301
Phone: 320-202-1820
Fax: 320-202-1833
www.narmh.org

National Association of Social Workers

750 First Street, NE
Suite 700
Washington, DC 20002-4241
Phone: 202-408-8600 or 1-800-638-8799
www.naswdc.org

National Center for American Indian and Alaska Native Mental Health Research

University of Colorado Health Sciences Center
Department of Psychiatry, North Pavilion
4455 E. 12th Avenue
Campus Box A011-13
Denver, CO 80220
Phone: 303-724-1414
Fax: 303-724-1474
www.uchsc.edu/sm/ncaianmhr

National Center for Cultural Competence

Georgetown University Center for
Child and Human Development
3307 M Street, NW
Suite 401
Washington, DC 20007-3935
Phone: 202-687-8635 or 1-800-788-2066
Fax: 202-687-8899
TTY: 202-687-5503
http://gucchd.georgetown.edu

National Indian Health Board

101 Constitution Avenue, NW
Suite 8-B09
Washington, DC 20001
Phone: 202-742-4262
Fax: 202-742-4285
www.nihb.org

National MultiCultural Institute

3000 Connecticut Avenue, NW
Suite 438
Washington, DC 20008-2556
Phone: 202-483-0700
Fax: 202-483-5233
www.nmci.org

National Rural Health Association

One West Armour Boulevard
Suite 203
Kansas City, MO 64111-2087
Phone: 816-756-3140
www.nrharural.org

STATE AND LOCAL GOVERNMENT AGENCIES

Departments of Mental Health

Contact the State agency responsible for mental health services. A State disaster mental health coordinator may be designated to manage the Crisis Counseling Program. The main office will be located in your State's capital city.

Emergency Services

The emergency services agency is the lead agency delegated by the State's governor to carry out day-to-day emergency management responsibilities. Contact the Office of Emergency Services in your capital city.

UNIVERSITY AND MEDICAL UNIVERSITIES

Academic practitioners with general training in stress, coping, and counseling often express interest in offering assistance to communities that have experienced a disaster. Undergraduate and graduate students are usually very interested in serving as crisis counselors. Caution is advised to ensure that survivors are treated appropriately and not enlisted into research studies or given treatments designed for traditional psychiatric disorders. Contact your local university's departments of psychiatry, psychology, or social work.

RELIGIOUS ORGANIZATIONS

Churches, synagogues, other faith-based organizations, and interfaith organizations are valuable resources for identifying and serving disaster survivors. Often, they are the most productive and rapid responders for immediate basic needs. Most denominations have some kind of disaster relief program. Contact the district office for major denominations in your area.

MEDIA

Television, radio, and newspapers can provide a list of resources and supports in major disasters.

VOLUNTARY ORGANIZATIONS

The National Voluntary Organizations Active in Disasters (NVOAD) has made disaster response a priority. Member organizations provide effective services and avoid service duplication by coordinating response efforts. Member organizations include:

- Adventist Community Services (ACS)
- American Red Cross (ARC)
- American Relay League, Inc. (ARL)
- AMURT (Ananda Marga Universal Relief Team)
- Catholic Charities USA (CC)
- Christian Disaster Response, AECCGC
- Christian Reformed World Relief Committee (CRWRC)
- Church of the Brethren (CB)
- Church World Service (CWS)
- The Episcopal Church (EC)
- Friends Disaster Service (FDS)
- Inter-Lutheran Disaster Response (ILDR)
- Mennonite Disaster Service (MDS)
- Nazarene Disaster Response (NDR)
- The Phoenix Society (PS)
- The Points of Light Foundation (PLF)
- Presbyterian Church, USA (PC)
- REACT International, Inc. (REACT)
- The Salvation Army (SA)
- Second Harvest National Network of Food Banks (SHNNFB)
- Society of St. Vincent de Paul (SSVP)
- Southern Baptist Convention (SBC)
- United Methodist Church Committee of Relief (UMCOR)
- Volunteers of America (VOA)
- World Vision (WV)

ADDITIONAL RESOURCES

Building Cultural Competence: A Blueprint for Action

Washington State Department of Health
Maternal and Child Health Community and Family Health
New Market Industrial Campus, Building #7
P.O. Box 47880
Olympia, WA 98504-7880
Phone: 360-236-3504 or 206-389-3052
Fax: 360-586-7868

The Diversity Journal

Harvard Pilgrim Health Care
Office of Diversity
Brookline, MA 02146-7229
Phone: 617-730-7710
Fax: 617-730-4695

A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations

The Technical Assistance Center for the Evaluation of Children's Mental Health System
Judge Baker Children's Center
295 Longwood Avenue
Boston, MA 02115
Phone: 617-232-8390
Fax: 617-232-4125

Appendix E:

Glossary

This glossary defines terms often used in the disaster mental health response field and terms that may be useful in understanding cultural competence. The definitions for cultural competence terms are based on standards used by the Federal Government and by national and community-based systems of care.

Acculturation

The process by which an individual or group adopts the identity, customs, and values of another culture.

Center for Mental Health Services (CMHS)

A center within the Substance Abuse and Mental Health Services Administration (SAMHSA). CMHS advises the Federal Emergency Management Agency (FEMA) on disaster mental health issues. SAMHSA is part of the U.S. Department of Health and Human Services (DHHS).

Competence

The capacity to function effectively.

Crisis Counseling Assistance and Training Program
(commonly referred to as the Crisis Counseling Program)

A program funded by the Federal Emergency Management Agency through the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Public Law 93-288 as amended by Public Law 100-707). The Crisis Counseling Program supports the provision of crisis counseling to individuals and groups who have been affected by a major disaster or its aftermath, educational activities and public information on disaster mental health issues, and disaster mental health consultation and training.

Crisis Counselor (Outreach Worker)

An individual who provides crisis counseling services and ideally is from the community, cultural, or ethnic group that is to receive those services. Crisis counselors are members of, familiar to, and recognized by their own communities. They may be spouses of community leaders, natural leaders in their own right, or individuals who have a nurturing role in their communities. Crisis counselors may include retired persons, students, and community volunteers. They may or may not have formal training in counseling or related professions, and they may be paraprofessionals or professionals.

Cultural Competence

A set of values, behaviors, attitudes, and practices that enables an organization or individual to work effectively across cultures; the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services as well as of staff who are providing such services.

Culture

The shared attributes of a group of people; a common heritage or learned set of beliefs, norms, and values.

Emergency Mental Health and Traumatic Stress Services Branch

The branch within the Division of Program Development, Special Populations and Projects, CMHS, that provides disaster mental health technical assistance to FEMA and the State Mental Health Authority on the Crisis Counseling Assistance and Training Program.

Ethnicity

The common heritage of a particular group of people; includes shared history, language, rituals, and preferences for music and foods.

Federal Emergency Management Agency

The lead Federal agency in disaster response and recovery; provides funding for crisis counseling grants to State mental health authorities following presidentially declared disasters.

Formative Evaluation

Data-based description of the trends of the program over time.

Healers

Persons who have cultural knowledge and training to relieve people of their physical and emotional afflictions according to their cultural beliefs. Healers may use physical approaches, spirituality, herbs, and other techniques.

Interpretation

The oral restating in one language of information that has been stated in another language (Goode et al., 2001). An interpretation should convey the tone, level, and meaning of the information on which it is based.

Key Stakeholder

One who has a primary interest in the success of the program.

Linguistic Competence

The capacity of an organization or individual to communicate effectively with persons of limited English proficiency, those who are illiterate or have low literacy skills, and individuals who are deaf or hard of hearing.

Major Disaster

According to Section 102 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, "any natural catastrophe (including any hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought) that in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under this Act to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby."

National Voluntary Organizations Active in Disaster (NVOAD)

A group of voluntary organizations that have made disaster response a priority. State VOADs perform a similar function at the State level by directing local organizations and governments to area resources.

Outreach

A method for delivering crisis counseling services to disaster survivors; consists primarily of direct contact with survivors in their natural environments.

Paraprofessional

A person who works as a crisis counselor and has a bachelor's degree or less in a specialty that may or may not be related to counseling. Paraprofessionals have strong intuitive skills, know how to relate well to others, possess good judgment and common sense, and are good listeners. They may or may not be indigenous workers. In times of disaster, they provide outreach, counseling, education, information, and referral services. They work with individuals, families, and groups. Effective crisis counseling programs train paraprofessionals in how to work with people who are experiencing the psychological sequelae of disasters.

Process Evaluation

Changes in the program based on findings/reports from program date.

Professional

A person who has an advanced degree (master's level or higher) in psychology, social work, counseling, or a related profession. Professionals have experience in the mental health or counseling fields as well as the expertise needed to provide clinical supervision and training to crisis counselors. Typically, a professional coordinates and supervises the local outreach team associated with a crisis counseling program. He or she may provide crisis services directly or offer consultation and support to crisis counselors. Professionals clinically evaluate clients to determine whether their needs exceed the scope of the crisis counseling program. They may work directly with individuals, families, and groups whose problems are unusually challenging or complex.

Professionals often need training on the ways in which crisis counseling for disaster survivors differs from traditional mental health or counseling practice.

Race

A category describing people according to a set of characteristics that are socially important but that are not necessarily defined by visible physical features (DHHS, 2001).

Racial and Ethnic Minority Group

A collective, heterogeneous group of people who identify as African American, American Indian and Alaska Native, Asian American and Pacific Islander, or Hispanic American (DHHS, 2001, p. 5).

Refugee

A person who, because of fear of being persecuted for reasons of race, religion, nationality, or political opinion, is residing outside the country of his or her nationality and is unable or unwilling to avail himself or herself of the protection of that country; also, a person who, not having a nationality and being outside the country of his or her former habitual residence, is unable or unwilling to return to that country.

Special Population

A targeted group in a disaster-impacted community or area with needs that require specific attention by the crisis counseling program. Special populations include children, adolescents, older adults, elderly persons, members of ethnic and cultural groups, migrant workers, disaster relief workers, persons who are severely mentally ill, persons with disabilities, and homeless persons. Other special populations may be unique to the area being served by the crisis counseling program.

Stafford Act (Robert T. Stafford Disaster Relief and Emergency Assistance Act)

The legislation (Public Law 93-288 as amended by Public Law 100-707) that enables Federal emergency response and services to be provided following a disaster. Section 416 authorizes the President to provide crisis counseling assistance and training for disaster survivors following presidentially declared disasters.

State Mental Health Authority (SMHA)

The lead State government organization for providing mental health services. Because this organization may be a department, division, or branch, depending on the State government system, CMHS and FEMA use the abbreviation "SMHA" to denote the lead mental health organization.

Substance Abuse and Mental Health Services Administration

A component of DHHS. SAMHSA comprises three centers: CMHS, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment. CMHS provides technical assistance to FEMA for the Crisis Counseling Assistance and Training Program.

Translation

Written conversion of written materials from one language to another (Goode et al., 2001).

Appendix F:

Cultural Competence Checklist for Disaster Crisis Counseling Programs

Cultural competence should be integrated into a community emergency mental health management plan before a disaster actually occurs. When disaster strikes, certain principles must be followed to ensure a culturally competent disaster crisis counseling program. The following checklist can assist in developing cultural competence in disaster crisis counseling programs. You also can use this checklist as an informal program assessment tool. For this purpose, use the check boxes to insert a numerical ranking from 1 to 3, with 1 reflecting the cultural pre-competence stage of development (good intentions, no actions yet); 2 representing the cultural competence stage (importance recognized, some actions underway); and 3 denoting the cultural proficiency stage (effective program in place). The terminology used to describe these phases was drawn from the Cultural Competence Continuum developed by Cross and colleagues (1989).

Recognize the importance of culture and respect diversity.

- ☐ Complete a self-assessment to determine your own beliefs about culture.
- ☐ Encourage staff to complete self-assessments in order to understand their own cultures and worldviews; examine their own attitudes, values, and beliefs about culture; and acknowledge cultural differences.
- ☐ Assess capabilities of the counselors to understand and respect the values, customs, beliefs, language, and interpersonal style of the disaster survivor.
- ☐ Seek evidence that you/staff respect the importance of verbal and nonverbal communication, space, social organization, time, and environment control within various cultures.

Maintain a current profile of the cultural composition of the community.

- ☐ Develop and periodically update a community profile that describes the community's composition in terms of race and ethnicity, age, gender, religion, refugee and immigrant status, housing status, income and poverty levels, percentage of residents living in rural versus urban areas, unemployment rate, language and dialects, literacy level, and number of schools and businesses.
- ☐ Include in the profile information about the values, beliefs, social and family norms, traditions, practices, and politics of local cultural groups, and historical racial relations or ethnic issues.
- ☐ Gather information in consultation with community cultural leaders who represent and understand local cultural groups.

Recruit disaster workers who are representative of the community or service area.

- ☐ Review the community profile when recruiting disaster crisis counseling workers and attempt to recruit workers from the ethnic and cultural groups included among the survivors.
- ☐ If workers from the community or service area are not available, recruit others with backgrounds and language skills similar to those of local residents.
- ☐ Assess disaster workers' personal attributes, knowledge, and skills as they relate to cultural competence.

Provide ongoing cultural competence training to disaster mental health staff.

- ☐ Offer ongoing cultural competence training (e.g., in-service training and regularly scheduled meetings) to service providers, administrators and managers, language and sign interpreters, and temporary staff.
- ☐ Involve community-based groups with expertise in cultural competence or in the needs of specific cultures.
- ☐ Allot time for training participants to examine and assess their values, attitudes, and beliefs about their own and other cultures.

Ensure that services are accessible, appropriate, and equitable.

- ☐ Identify and take steps to overcome reluctance of ethnic groups to use services because of mistrust of the system or previous inequitable treatment.
- ☐ Identify and take steps to eliminate service barriers that occur as a result of racial and ethnic discrimination, language barriers, transportation issues, and the stigma associated with counseling services.

- [ ] Involve representatives of diverse cultural groups in program committees, planning boards, and policy-setting bodies and in decision making.
- [ ] Identify and use strategies to address specific concerns of refugees who had negative experiences that make them suspicious of government intervention.

Recognize the role of help-seeking behaviors, customs and traditions, and natural support networks. Identify and use strategies to:

- [ ] Identify cultural patterns that may influence help-seeking behaviors.
- [ ] Build trusting relationships and rapport with disaster survivors.
- [ ] Recognize that survivors may find traditional relief procedures confusing or difficult.
- [ ] Recognize individual cultures' customs and traditions related to healing, trauma, and loss, and identify how these customs and traditions influence an individual's receptivity to and need for assistance.
- [ ] Acknowledge cultural beliefs about healing and recognize their importance to some disaster survivors.
- [ ] Help survivors reestablish rituals; organize culturally appropriate anniversary activities and commemorations.
- [ ] Recognize that outreach efforts focused only on the individual may not be effective for people whose cultures are centered around family and community.
- [ ] Determine who is significant in survivors' families and social spheres by listening to their descriptions of the home, family, and community.

Involve community leaders and organizations representing diverse cultural groups as cultural brokers.

- [ ] Collaborate with trusted leaders (e.g., spiritual leaders, clergy members, and teachers) who know the community.
- [ ] Invite organizations representing cultural groups and other special interest groups in the community to participate in disaster mental health program planning and service delivery.
- [ ] Collaborate with community-based organizations to communicate with the cultural groups they represent.
- [ ] Identify effective ways to work with informal culture-specific groups.
- [ ] Coordinate with other public and private agencies in responding to the disaster.

Ensure that services and information are culturally and linguistically competent.

- [ ] Identify indigenous workers who speak the language of the survivors; use interpreters only when necessary.
- [ ] Identify trained interpreters who share the disaster survivors' cultural backgrounds.
- [ ] Determine the dialect of the disaster survivor before asking for an interpreter.
- [ ] Assess the level of acculturation of the interpreter in relation to that of the disaster survivors.
- [ ] Establish a plan for providing written materials in languages other than English and at the literacy level of the target population.
- [ ] Provide means to reach people who are deaf or hard of hearing.
- [ ] Consult with cultural groups in the community to determine the most effective outreach activities.
- [ ] Use existing community resources (e.g., multicultural television and radio stations) to enhance outreach efforts.

Assess and evaluate the program's level of cultural competence.

- [ ] Continuously assess the program to identify and correct problems that may impede the delivery of culturally competent services.
- [ ] Incorporate process evaluation into the crisis counseling program.
- [ ] Involve representatives of various cultural groups in process evaluation.
- [ ] Communicate process evaluation findings to key informants and cultural groups engaged in the program.

Appendix F- 1

Tips For Survivors of a Traumatic Event
Managing Your Stress

Tips for Survivors of a Traumatic Event

Managing Your Stress

Know When to Get Help

Sometimes things become so overwhelming that you need help from a mental health or substance abuse professional. If you or someone you know threatens to hurt or kill him/herself or another person; looks for ways to kill him/herself; talks or writes about death, dying, or suicide; feels rage, uncontrolled anger, or desires revenge; or shows signs of stress (listed on this page) for several days or weeks, GET HELP by calling one of the hotlines listed on the next page.

What You Should Know

When you are exposed to traumatic events, such as natural disaster, mass violence, or terrorism, be aware of how these events can affect you personally. Most people show signs of stress after the event. These signs are normal. Over time, as your life gets back to normal, they should decrease. After a stressful event, monitor your own physical and mental health. Know the signs of stress in yourself and your loved ones. Know how to relieve stress. And know when to get help.

Know the Signs of Stress

Your Behavior:

- An increase or decrease in your energy and activity levels.
- An increase in your alcohol, tobacco use, or use of illegal drugs.
- An increase in irritability, with outbursts of anger and frequent arguing.
- Having trouble relaxing or sleeping.
- Crying frequently.
- Worrying excessively.
- Wanting to be alone most of the time.
- Blaming other people for everything.
- **Having difficulty communicating** or listening.
- **Having difficulty giving or** accepting help.
- Inability to feel pleasure or have fun.

Your Body:

- Having stomach aches or diarrhea.
- Having headaches and other pains.
- Losing your appetite or eating too much.
- Sweating or having chills.
- Getting tremors or muscle twitches.
- Being easily startled.

Your Emotions:

- Being anxious or fearful.
- Feeling depressed.
- Feeling guilty.
- Feeling angry.
- Feeling heroic, euphoric, or invulnerable.
- Not caring about anything.
- Feeling overwhelmed by sadness.

Your Thinking:

- Having trouble remembering things.
- Feeling confused.
- Having trouble thinking clearly and concentrating.
- **Having difficulty making decisions.**

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

Helpful Resources

National Mental Health Information Center
Toll-Free: 1-800-789-2647 (English and Español)
TDD: 1-866-889-2647
Web Site: www.mentalhealth.samhsa.gov

National Clearinghouse for Alcohol and Drug Information
Toll-Free: 1-800-729-6686 (English and Español)
TDD: 1-800-487-4889
Web Site: www.ncadi.samhsa.gov

Treatment Locators

Mental Health Services Locator
Toll-Free: 1-800-789-2647 (English and Español)
TDD: 1-866-889-2647
Web Site: www.mentalhealth.samhsa.gov/databases

Substance Abuse Treatment Facility Locator
Toll-Free: 1-800-662-HELP (4357) (24/7 English and Español)
TDD: 1-800-487-4889
Web Site: www.findtreatment.samhsa.gov

Hotlines

National Suicide Prevention Lifeline
Toll-Free: 1-800-273-TALK (8255)
TTY: 1-800-799-4TTY (4889)
Web Site: www.suicidepreventionlifeline.org

Workplace Helpline
Toll-Free: 1-800-WORKPLACE (967-5752)
Web Site: http://dwp.samhsa.gov/helpline/helpline.aspx

Office for Victims of Crime
Toll-Free: 1-800-851-3420
TTY: 1-877-712-9279
Web Site: www.ojp.usdoj.gov/ovc/ovcres/welcome.html

Note: Inclusion of a resource in this fact sheet does not imply endorsement by the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration, or the U.S. Department of Health and Human Services.

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Know How To Relieve Stress

You can manage and alleviate your stress by taking time to take care of yourself.

Keep Yourself Healthy:

- Eat healthy foods, and drink water.
- Avoid excessive amounts of caffeine and alcohol.
- Do not use tobacco or illegal drugs.
- Get enough sleep and rest.
- Get physical exercise.

Use Practical Ways To Relax:

- Relax your body often by things that work for you—take deep breaths, stretch, meditate, wash your face and hands, or engage in pleasurable hobbies.
- Pace yourself between stressful activities, and do a fun thing after a hard task.
- Use time off to relax—eat a good meal, read, listen to music, take a bath, or talk to family.
- Talk about your feelings to loved ones and friends often.

Pay Attention to Your Body, Feelings, and Spirit:

- Recognize and heed early warning signs of stress.
- Recognize how your own past experiences affect your way of handling this event, and think of how you handled past events.
- Know that feeling stressed, depressed, guilty, or angry is common after a traumatic event.
- Connect with other survivors of traumatic events or violent crime, many of whom may experience similar difficulties.
- Take time to renew your spirit through meditation, prayer, or helping others in need.

Have a Plan To Manage Your Tasks:

Do the important things first. If necessary, find a safe place to stay. Tell family where you are and how they can contact you. Get water and food. If needed, get papers for your property, insurance, bank, medical records, and job qualifications from agencies if you lost them in the traumatic event. It may take time to feel like you've regained control over your life. Be patient with yourself and others.

A Life In the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Appendix H-1

County Mental Health Administrators List

NEW JERSEY ASSOCIATION OF COUNTY MENTAL HEALTH ADMINISTRATORS

COUNTY (Region)	NAME	ADDRESS	TELEPHONE/FAX E-Mail
Atlantic (South)	Sally Williams	MH Administrator 101 South Shore Road Northfield, NJ 08225	(609) 645-7700 x4307 Fax (609) 645-5809 williams_sally@aclink.org
Bergen (North)	Sue Boggia	Mental Health Administrator Division of Mental Health 327 E. Ridgewood Avenue Paramus, NJ 07652-4895	(201) 634-2751/2753 Fax (201) 702-7070 sboggia@co.bergen.nj.us
Burlington (South)	Elda Goss	Mental Health Planner 795 Woodland Road P.O. Box 6000 Mt. Holly, NJ 08060	(609) 265-5386 Fax (609) 265-5382 Egoss@co.burlington.nj.us
Camden (South)	Charles Steinmetz	Mental Health Coordinator CPAC/HSC 6981 N. Park Drive E. #309-10 Pennsauken, NJ 08109-4212	(856) 663-3998 Fax (856) 663-7182 Chuck.steinmetz@us.army.mil
Cape May (South)	Pat Devaney	Cape May Court House #4 Moore Road DN 907 Cape May, NJ 08210	(609) 465-1055 Fax (609) 465-2012 Devaneyp@co.cape-may.nj.us
Cumberland (South)	Ethan Aronoff	County Administration Bldg. Department of Health 590 Shiloh Pike Bridgeton, NJ 08302	(856) 453-7804 Fax (856) 453-8419 EthanAr@co.cumberland.nj.us
Essex (North)	Joe Scarpelli,D.C.	Mental Health Administrator Essex County Dept. of Health 125 Fairview Ave., Bldg.37 Cedar Grove, NJ 07009	(973) 228-8021 Fax (973) 395-2305 JPSDC@aol.com
Glouchester (South)	Kathy Spinosi	Mental Health Administrator Budd Boulevard Complex Route 45 and Budd Boulevard P.O. Box 337 Woodbury, NJ 08096	(856) 384-6870 Fax (856) 384-0207 Kspinosi@co.gloucester.nj.us
Hudson (North)	Jim Gallagher	Mental Health Administrator Department of Human Services C/O Meadowview Hospital 595 County Avenue Building 2 Secaucus, NJ 07094	(201) 271-4344 Fax (201) 271-4365 jjgall_hcdhhs@yahoo.com
Hunterdon (Central)	Pamela Pontrelli (Cathy Zahn-MH Planner)	Hunterdon County Department of Human Services P.O. Box 2900 Flemington, NJ 08822-2900	(908) 788-1253 Fax (908) 806-4204 Czahn@co.hunterdon.nj.us
Mercer (Central)	Marc A. Celentana, Ph.D.	Mental Health Administrator Mercer Cty. Div. Of Mental Health 640 South Broad Street P.O. Box 8068 Trenton, NJ 08650	(609) 989-6574/6575 Fax (609) 989-6032 Mcelentana@mercercounty.org

Psychosocial Considerations – Appendix 7

COUNTY (Region)	NAME	ADDRESS	TELEPHONE/FAX E-Mail
Middlesex (Central)	Lori Dillon (Wanda Dillon Children's Coord)	Mental Health Administrator Department of Human Services JFK Square, 5th Floor New Brunswick, NJ 08901	(732) 745-4518 Fax (732) 296-7971 Lori.dillon@co.middlesex.nj.us wanda.dillon@co.middlesex.nj.us
Monmouth (Central)	Charles D. Brown III	Mental Health Administrator P.O. Box 3000 Kozloski Road Freehold, NJ 07758-1255	(732) 431-7200 Fax (732) 308-3700 cbrown@co.monmouth.nj.us
Morris (North)	Laurie Becker	Mental Health Administrator Department of Human Services P.O. Box 900 Morristown, NJ 07963-0900	(973) 285-6852 Fax (973) 285-6713 lbecker@co.morris.nj.us
Ocean (Central) NJAC Contact	Jill Perez Asst. Mental Health Administrator	Department of Human Services 1027 Hooper Ave., Bldg. 2 P.O. Box 2191 Toms River, NJ 08754-2191	(732) 506-5319 Fax (732) 341-4539 jperez@co.ocean.nj.us
Passaic (North)	Francine Vince	Mental Health Department County Administration Bldg. 317 Pennsylvania Avenue Paterson, NJ 07503	(973) 225-3700 Fax (973) 357-0159 francinev@passaiccountynj.org
Salem (South)	Issac A. Young,Ed.D.	Mental Health Administrator Salem County MHB 98 Market Street Salem, NJ 08079	(856) 339-8618 Fax (856) 935-1234 Isaac.young@salemcountynj.gov
Somerset (Central)	Pam Mastro	Mental Health Administrator Somerset County DHS P.O. Box 3000 Somerville, NJ 08876-1262	(908) 704-6302 Fax (908) 704-1629 Mastro@co.somerset.nj.us
Sussex (North)	Cindy Armstrong	Sussex County Administrative Center One Spring Street, 2nd floor Newton, NJ 07860	973-579-0570 ext 1212 Fax (973) 579-0571 carmstrong@sussex.nj.us
Union (Central)	Tom Graham	Mental Health Administrator Union County Admin. Bldg. Elizabethtown Plaza Elizabethtown, NJ 07207	(908) 527-4846 Fax (908) 558-2562 tgraham@ucnj.org
Warren (Central)	Shannon Brennan	Mental Health Administrator Warren County DHS Cummins Building 202 Mansfield Street Belvidere, NJ 07823	(908) 475-6331 Fax (908) 475-6206 Sbrennan@co.warren.nj.us

Appendix J- 1

Coping With Grief and Loss

How to Deal With Grief

What is grief?

Grief is the normal response of sorrow, emotion, and confusion that comes from losing someone or something important to you. It is a natural part of life. Grief is a typical reaction to death, divorce, job loss, a move away from friends anf family, or loss of good health due to illness.

How does grief feel?

Just after a death or loss, you may feel empty and numb, as if you are in shock. You may notice physical changes such as trembling, nausea, trouble breathing, muscle weakness, dry mouth, or trouble sleeping and eating.

You may become angry - at a situation, a particular person, or just angry in general. Almost everyone in grief also experiences guilt. Guilt is often expressed as "I could have, I should have, and I wish I would have" statements.

People in grief may have strange dreams or nightmares, be absent-minded, withdraw socially, or lack the desire to return to work. While these feelings and behaviors are normal during grief, they will pass.

How long does grief last?

Grief lasts as long as it takes you to accept and learn to live with your loss. For some people, grief lasts a few months. For others, grieving may take years.

The length of time spent grieving is different for each person. There are many reasons for the differences, including personality, health, coping style, culture, family background, and life experiences. The time spent grieving also depends on your relationship with the person lost and how prepared you were for the loss.

How will I know when I'm done grieving?

Every person who experiences a death or other loss must complete a four-step grieving process:

(1) Accept the loss;
(2) Work through and feel the physical and emotional pain of grief;
(3) Adjust to living in a world without the person or item lost; and
(4) Move on with life.

The grieving process is over only when a person completes the four steps.

How does grief differ from depression?

Depression is more than a feeling of grief after losing someone or something you love. Clinical depression is a whole body disorder. It can take over the way you think and feel. Symptoms of depression include:

- A sad, anxious, or "empty" mood that won't go away;

- Loss of interest in what you used to enjoy;
- Low energy, fatigue, feeling "slowed down;"
- Changes in sleep patterns;
- Loss of appetite, weight loss, or weight gain;
- Trouble concentrating, remembering, or making decisions;
- Feeling hopeless or gloomy;
- Feeling guilty, worthless, or helpless;
- Thoughts of death or suicide or a suicide attempt; and
- Recurring aches and pains that don't respond to treatment.

If you recently experienced a death or other loss, these feelings may be part of a normal grief reaction. But if these feelings persist with no lifting mood, ask for help.

KEN-01-0104

Appendix J-2

PTSD Checklist

PTSD Checklist (PCL)

This information was excerpted from Norris, F. H., & Hamblen, J. L. (2003). Standardized self-report measures of civilian trauma and PTSD. In J. Wilson & T. Keane (Eds.), *Assessing Psychological Trauma and PTSD: A Practitioner's Handbook* (2nd Ed.), New York: Guilford.

The PTSD Checklist, Civilian Version (PCL-C) was developed by Frank Weathers and his colleagues at the National Center for PTSD (1993). The scale consists of 17 questions that now correspond to DSM-IV. Respondents are asked how often they have been bothered by each symptom is the past month on a 5-point severity scale. According to the authors, the questions may be worded generically to refer to "stressful experiences in the past" (PCL-C) or to describe reactions to a specific event (PCL-S). Initial psychometric data was derived by using a military version of the PCL (PCL-M) in a sample of Vietnam veterans, in which the prevalence of PTSD was high. Internal consistency coefficients were very high for the total scale (.97) and for each subscale (.92 - .93). Test-retest reliability over 2 – 3 days was .96. The PCL-M correlated highly with the Mississippi Scale for Combat Related PTSD (.93), the PK Scale of the MMPI (.77), and the Impact of Event Scale (.90). In this sample, the PCL-M was quite predictive of PTSD caseness as assessed with the SCID; a cutoff score of 50 had a sensitivity of .82, a specificity of .83, and a kappa of .64. (The reader should note that cutoff scores may vary depending upon the prevalence of disorder in a sample.)

Other researchers have also presented evidence supporting the reliability and validity of the PCL-C or PCL-S. In a sample of 40 motor vehicle accident and sexual assault victims (of whom 18 had PTSD on the Clinician Administered PTSD Scale (CAPS), Blanchard, Alexander, Buckley, and Forneris (1996) found an alpha of .94 and an overall correlation between total PCL-S and CAPS scores of .93. They found that a score of 44 (rather than 50) maximized diagnostic efficiency (sensitivity of .94, specificity of .86, overall efficiency of .90). In a sample of individuals in France who had experienced a variety of events, Ventureya, Yao, Cottraux, Note, and Guillard (2002) reported excellent internal consistency (.86) and test-retest reliability (.80) for the total PCL-S score. Using the cutpoint of 44 recommended by Blanchard et al. (1996), the PCL-S showed a sensitivity of .97, a specificity of .87, and an overall diagnostic efficacy of .94.

The PCL appears to have much to recommend it. Because it was developed by the National Center for PTSD, it is in the public domain. It is reliable, and the M and S versions map directly onto DSM criteria. The M and S versions have been shown to correlate highly with clinician-administered measures. Less information is available about version C, the civilian version that does not identify a specific event, and the reader should be cautious about generalizing psychometric findings from one version of the scale to another. Also, the published cutpoints should be used with caution as they were derived from samples with high prevalence rates of current PTSD and may not be appropriate for samples with lower rates.

PCL-S

e event you experienced was _____ on _____.
(event) (date)

INSTRUCTIONS: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated, disturbing *memories, thoughts,* or *images* of the stressful experience?	1	2	3	4	5
2.	Repeated, disturbing *dreams* of the stressful experience?	1	2	3	4	5
3.	Suddenly *acting* or *feeling* as if the stressful experience *were happening again* (as if you were reliving it)?	1	2	3	4	5
4.	Feeling *very upset* when *something reminded you* of the stressful experience?	1	2	3	4	5
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of the stressful experience?	1	2	3	4	5
6.	Avoiding *thinking about* or *talking about* the stressful experience or avoiding *having feelings* related to it?	1	2	3	4	5
7.	Avoiding *activities* or *situations* because *they reminded you* of the stressful experience?	1	2	3	4	5
8.	Trouble *remembering important parts* of the stressful experience?	1	2	3	4	5
9.	*Loss of interest* in activities that you used to enjoy?	1	2	3	4	5
10.	Feeling *distant* or *cut off* from other people?	1	2	3	4	5
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	1	2	3	4	5
12.	Feeling as if your *future* will somehow be *cut short*?	1	2	3	4	5
13.	Trouble *falling* or *staying asleep*?	1	2	3	4	5
14.	Feeling *irritable* or having *angry outbursts*?	1	2	3	4	5
5.	Having *difficulty concentrating*?	1	2	3	4	5
16.	Being *"super-alert"* or watchful or on guard?	1	2	3	4	5
17.	Feeling *jumpy* or easily startled?	1	2	3	4	5

PCL-C

INSTRUCTIONS: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience from the past?	1	2	3	4	5
2. Repeated, disturbing *dreams* of a stressful experience from the past?	1	2	3	4	5
3. Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?	1	2	3	4	5
4. Feeling *very upset* when *something reminded you* of a stressful experience from the past?	1	2	3	4	5
5. Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful experience from the past?	1	2	3	4	5
6. Avoiding *thinking about* or *talking about* a stressful experience from the past or avoiding *having feelings* related to it?	1	2	3	4	5
7. Avoiding *activities* or *situations* because *they reminded you* of a stressful experience from the past?	1	2	3	4	5
8. Trouble *remembering important parts* of a stressful experience from the past?	1	2	3	4	5
9. *Loss of interest* in activities that you used to enjoy?	1	2	3	4	5
10. Feeling *distant* or *cut off* from other people?	1	2	3	4	5
11. Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your *future* will somehow be *cut short*?	1	2	3	4	5
13. Trouble *falling* or *staying asleep*?	1	2	3	4	5
14. Feeling *irritable* or having *angry outbursts*?	1	2	3	4	5
15. Having *difficulty concentrating*?	1	2	3	4	5
16. Being *"super-alert"* or watchful or on guard?	1	2	3	4	5
17. Feeling *jumpy* or easily startled?	1	2	3	4	5

PCL-M

STRUCTIONS: Below is a list of problems and complaints that veterans sometimes have in response to stressful military experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated, disturbing *memories, thoughts,* or *images* of a stressful military experience?	1	2	3	4	5
2.	Repeated, disturbing *dreams* of a stressful military experience?	1	2	3	4	5
3.	Suddenly *acting* or *feeling* as if a stressful military experience *were happening again* (as if you were reliving it)?	1	2	3	4	5
4.	Feeling *very upset* when *something reminded you* of a stressful military experience?	1	2	3	4	5
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful military experience?	1	2	3	4	5
6.	Avoiding *thinking about* or *talking about* a stressful military experience or avoiding *having feelings* related to it?	1	2	3	4	5
7.	Avoiding *activities* or *situations* because *they reminded you* of a stressful military experience?	1	2	3	4	5
8.	Trouble *remembering important parts* of a stressful military experience?	1	2	3	4	5
9.	*Loss of interest* in activities that you used to enjoy?	1	2	3	4	5
10.	Feeling *distant* or *cut off* from other people?	1	2	3	4	5
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	1	2	3	4	5
12.	Feeling as if your *future* will somehow be *cut short*?	1	2	3	4	5
13.	Trouble *falling* or *staying asleep*?	1	2	3	4	5
14.	Feeling *irritable* or having *angry outbursts*?	1	2	3	4	5
15.	Having *difficulty concentrating*?	1	2	3	4	5
16.	Being *"super-alert"* or watchful or on guard?	1	2	3	4	5
17.	Feeling *jumpy* or easily startled?	1	2	3	4	5

PCL Scoring

There are several ways in which to score the **PTSD Checklist (PCL).** Perhaps the easiest way to score the PCL is to add up all the items for a total severity score. A total score of 44 is considered to be PTSD positive for the general population while a total score of 50 is considered to be PTSD positive in military populations. A second way to score the PCL is to treat "moderately" or above (responses 3 through 5) as symptomatic and anything below "moderately" (1 and 2) as non-symptomatic. Then use the DSM scoring rules to make a diagnosis. That is:

- You need an endorsement of at least 1 B item (question #s 1-5)
- You need an endorsement of at least 3 C items (question #s 6-12)
- You need an endorsement of at least 2 D items (question #s 13-17)

However, please note that it is then possible to get a PTSD diagnosis with a total score of 18, which would be very low. It may therefore be best to use a combination of the two approaches. That is, the requisite number of items within each cluster are met at a 3 or above AND the total score is above the specified cut point.

Appendix K- 1

Parent Tips to Help Children Cope After Disasters

Parent Tips for Helping Infants and Toddlers after Disasters		
IF YOUR CHILD. .	**UNDERSTAND**	**WAYS TO HELP**
. . has problems sleeping, doesn't want to go to bed, won't sleep alone, wakes up at night screaming.	►When children are scared they want to be with people who help them feel safe, and they worry when you are not together. ►If you were separated during the disaster, going to bed alone may remind your child of that separation. ►Bedtime is a time for remembering because we are not busy doing other things. People often dream about things they fear and can be scared of going to sleep.	►If you want, let your child sleep with you. Let him know this is just for now. ►Have a bedtime routine: a story, a prayer, cuddle time. Tell him the routine (every day), so he knows what to expect. ►Hold him and tell him that he is safe; that you are there and will not leave. Understand that he is not being difficult on purpose. This may take time, but when he feels safer, he will sleep better.
. . worries something bad will happen to you. (You may also have worries like this.)	►It is natural to have fears like this after being in danger. ►These fears may be even stronger if your child was separated from loved ones during the disaster.	►Remind your child and yourself that right now you are safe. ►If you are not safe, talk about how you are working to keep her safe. ►Make a plan for who would care for your child if something did happen to you. This may help you worry less. ►Do positive things together to help her think about other things.
. . cries or complains whenever you leave him, even when you go to the bathroom. . . can't stand to be away from you.	►Children who cannot yet speak or say how they feel may show their fear by clinging or crying. ►Goodbyes may remind your child of any separation you had related to the disaster. ►Children's bodies react to separations (stomach sinks, heart beats faster). Something inside says, "Oh no, I can't lose her." ►Your child is not trying to manipulate or control you. He is scared. ►He may also get scared when other people (not just you) leave. Goodbyes make him scared.	►Try to stay with your child and avoid separations right now. ►For brief separations (store, bathroom) help your child by naming his feelings and linking them to what he has been through. Let him know you love him and that this goodbye is different, you'll be back soon. "You're so scared. You don't want me to go because last time we weren't together you didn't know where I was. This is different, and I'll be right back." ►For longer separations have him stay with familiar people, tell him where you are going, why, and when you will come back. Let him know you will think about him. Leave a photo or something of yours and call if you can. When you come back, tell him you missed him, thought about him, and did come back. You will need to say this over and over.
. . has problems eating, eats too much or refuses food.	►Stress affects your child in different ways, including her appetite. ►Eating healthy is important but focusing too much on eating can cause stress and tension in your relationship.	►Relax. Usually, as your child's level of stress goes down, her eating habits will return to normal. Don't force your child to eat. ►Eat together and make meal times fun and relaxing. ►Keep healthy snacks around. Young children often eat on the go. ►If you are worried, or if your child loses a significant amount of weight, consult a pediatrician.
. . is not able to do things he used to do (like use the potty) . . does not talk like he used to	►Often when young children are stressed or scared, they temporarily lose abilities or skills they recently learned. ►This is the way young children tell us that they are not okay and need our help. ►Losing an ability after children have gained it (like starting to wet the bed again) can make them feel ashamed or embarrassed. Caregivers should be understanding and supportive. ►Your child is not doing this on purpose.	►Avoid criticism. It makes him worried that he'll never learn. ►Do not force your child. It creates a power struggle. ►Instead of focusing on the ability (like not using the potty), help your child feel understood, accepted, loved and supported. ►As your child feels safer, he will recover the ability he lost.
. . is reckless, does dangerous things.	►It may seem strange, but when children feel unsafe, they often behave in unsafe ways. ►It is one way of saying, "I need you. Show me I'm important by keeping me safe.	►Keep her safe. Calmly go and get her and hold her if necessary. ►Let her know that what she is doing is unsafe, that she is important, and you wouldn't want anything to happen to her. ►Show her other more positive ways that she can have your attention.

National Child Traumatic Stress Network and National Center for PTSD *Psychological First Aid: Field Operations Guide*, 2nd Edition, July 2006. Available on www.nctsn.org and www.ncptad.va.gov.

Parent Tips for Helping Infants and Toddlers after Disasters		
IF YOUR CHILD. .	**UNDERSTAND**	**WAYS TO HELP**
. . is scared by things that did not scare her before	►Young children believe their parents are all-powerful and can protect them from anything. This belief helps them feel safe. ►Because of what happened, this belief has been damaged, and without it, the world is a scarier place. ►Many things may remind your child of the disaster (rain, aftershocks, ambulances, people yelling, a scared look on your face), and will scare her. ►It is not your fault – it was the disaster.	►When your child is scared, talk to her about how you will keep her safe. ►If things remind your child of the disaster and cause her to worry that it is happening again, help her understand how what is happening now (like rain or aftershocks) is different from the disaster. ►If she talks about monsters, join her in chasing them out. "Go away monster. Don't bother my baby. I'm going to tell the monster boo, and it will get scared and go away. Boo, boo." ►Your child is too young to understand and recognize how you did protect her, but remind yourself of the good things you did.
. . seems "hyper," can't sit still, and doesn't pay attention to anything.	►Fear can create nervous energy that stays in our bodies. ►Adults sometimes pace when we are worried. Young children run, jump, and fidget. ►When our minds are stuck on bad things, it is hard to pay attention to other things. ►Some children are naturally active.	►Help you child to recognize his feelings (fear, worry) and reassure your child that he is safe. ►Help your child get rid of nervous energy: stretching, running, sports, breathing deep and slow. ►Sit with him and do an activity you both enjoy: throw a ball, read books, play, draw. Even if he doesn't stop running around, this helps him. ►If your child is naturally active, focus on the positive. Think of all the energy he has to get things done, and find activities that fit his needs.
. . plays in a violent way. . . keeps talking about the disaster and the bad things he saw.	►Young children often talk through play. Violent play can be their way of telling us how crazy things were or are, and how they feel inside. ►When your child talks about what happened, strong feelings may come up both for you and your child (fear, sadness, anger)	►If you can tolerate it, listen to your child when he "talks." ►As your child plays, notice the feelings he has and help him by naming feelings and being there to support him (hold him, soothe him). ►If he gets overly upset, spaces out, or he plays out the same upsetting scene, help him calm down, help him feel safe, and consider getting professional help.
. .is now very demanding and controlling. . . seems "stubborn" insisting that things be done her way.	►Between the age of 18 months to 3 years, young children often seem "controlling." ►It can be annoying, but it is a normal part of growing up and helps them learn that they are important and can make things happen. ►When children feel unsafe, they may become more controlling than usual. This is one way of dealing with fears. They are saying "things are so crazy I need control over <u>something</u>."	►Remember your child is not controlling or bad. This is normal, but may be worse right now because she feels unsafe. ►Let your child have control over small things. Give her choices over what she wears or eats, games you play, stories you read. If she has control over small things, it can make her feel better. Balance giving her choices and control with giving her structure and routines. She will feel unsafe if she "runs the show." ►Cheer her on as she tries new things. She can also feel more in control when she can put her shoes on, put a puzzle together, pour juice.
. . tantrums and is cranky. . .yells a lot – more than usual.	►Even before the disaster, your child may have had tantrums. They are a normal part of being little. It's frustrating when you can't do things and when you don't have the words to say what you want or need. ►Now, your child has a lot to be upset about (just like you) and may really need to cry and yell.	►Let him know you understand how hard this is for him. "Thing are really bad right now. It's been so scary. We don't have your toys or T.V., and you're mad." ►Tolerate tantrums more than you usually would, and respond with love rather than discipline. You might not normally do this, but things are not normal. If he cries or yells, stay with him and let him know you are there for him. Reasonable limits should be set if tantrums become frequent or are extreme.
. . hits you.	►For children, hitting is a way of expressing anger. ►When children can hit adults they feel unsafe. It's scary to be able to hit someone who's supposed to protect you. ►Hitting can also come from seeing other people hit each other.	►Each time your child hits, let her know that this is not ok. Hold her hands, so she can't hit, have her sit down. Say something like "It's not OK to hit, it's not safe. When you hit, you are going to need to sit down." ►If she is old enough, give her the words to use or tell her what she needs to do. Tell her "Use your words. Say I want that toy." ►Help her express anger in other ways: play, talk, draw. ►If you are having conflict

Parent Tips for Helping Infants and Toddlers after Disasters		
IF YOUR CHILD. .	**UNDERSTAND**	**WAYS TO HELP**
		with other adults, try to work it out in private, away from where your child can see or hear you. If needed, talk with a friend or professional about your feelings.
. . says go away, I hate you! . . says this is all your fault.	►The real problem is the disaster and everything that followed, but your child is too little to fully understand that. ►When things go wrong, young children often get mad at their parents because they believe they should have stopped it from happening. ►You are not to blame, but now is not the time to defend yourself. Your child needs you.	►Remember what your child has been through. He doesn't mean everything he is saying; he's angry and dealing with so many difficult feelings. ►Support your child's feeling of anger, but gently redirect the anger towards the disaster. "You are really mad. Lots of bad things have happened. I'm mad too. I really wish it didn't happen, but even mommies can't make hurricanes not happen. It's so hard for both of us.".
. .doesn't want to play or do anything. . . seems to not really have any feelings (happy or sad).	► Your child needs you. So much has happened and he may be feeling sad and overwhelmed. ► When children are stressed, some yell and others shut down. Both need their loved ones.	►Sit by your child and keep him close. Let him know you care. ►If you can, give words to his feelings. Let him know it's OK to feel sad, mad, or worried. "It seems like you don't want to do anything. I wonder if you are sad. It's OK to be sad. I will stay with you." ►Try to do things with your child, anything he might like: read a book, sing, play together.
. . . cries a lot.	► Your family may have experienced difficult changes because of the disaster, and it is natural that your child is sad. ►When you let your child feel sad and provide her with comfort, you help your child even if she remains sad. ► If you have strong feelings of sadness, it may be good for you to get support. Your child's well-being is connected to your well-being.	► Allow your child to express feelings of sadness. ►Help your child name her feelings and understand why she may feel that way. "I think you're sad. A lot of hard things have happened, like . . ." ►Support your child by sitting with her and giving her extra attention. Spend special time together. ►Help your child feel hopeful about the future. It will be important to think and talk about how your lives will continue and the good things you will do, like go for a walk, go to the park or zoo, play with friends. ► Take care of yourself.
. . . misses people you are no longer able to see after the disaster.	► Even though young children do not always express how they feel, be aware that it is difficult for them when they lose contact with important people. ►If someone close to your child died, your child may show stronger reactions to the disaster. If the reactions appear to be strong and to last longer than two weeks, it may be helpful to seek help from a professional. ►Young children do not understand death, and may think that the person can come back.	► For those that have moved away, help your child say in touch in some way (for example, sending pictures or cards, calling) ►Help your child talk about these important people. Even when we are apart from people, we can still have positive feelings about them by remembering and talking about them. ►Acknowledge how hard it is to not be able to see people we care for. It is sad. ►Where someone has died, answer your child's questions simply and honestly.
. . misses things you have lost because of the disaster.	►When a disaster brings so much loss to a family and community, it is easy to lose sight of how much the loss of a toy or other important item (blanket) can mean to a child. ►Grieving for a toy is also your child's way of grieving for all you had before the disaster.	►Allow your child to express feelings of sadness. It is sad that your child lost her toy or blanket. ►If possible, try to find something that would replace the toy or blanket that would be acceptable and satisfying to your child. ►Distract your child with other activities.

Parent Tips for Helping Preschool-Age Children after Disasters		
Reactions/Behavior	**Responses**	**Examples of things to do and say**
Helplessness and Passivity: Young children know they can't protect themselves. In a disaster they feel even more helpless. They want to know their parents will keep them safe. They might express this by being unusually quiet or agitated.	►Provide comfort, rest, food, water, and opportunities for play and drawing. ►Provide ways to turn spontaneous drawing or playing from traumatic events to include something that would make them feel safer or better. ► Reassure your child that you and other grownups will protect them.	►Give your child more hugs, hand holding, or time in your lap. ►Make sure there is a special safe area for your child to play with proper supervision. ►In play, a four year old keeps having the blocks knocked down by hurricane winds. Asked, "Can you make it safe from the winds?" the child quickly builds a double block thick wall and says, "Winds won't get us now." A parent might respond with, "That wall sure is strong" and explain, "We're doing a lot of things to keep us safe."
General Fearfulness: Young children may become more afraid of being alone, being in the bathroom, going to sleep, or otherwise separated from parents. Children want to believe that their parents can protect them in all situations and that other grownups, such as teachers or police officers, are there to help them.	►Be as calm as you can with your child. Try not to voice your own fears in front of your child. ►Help children regain confidence that you aren't leaving them and that you can protect them. ►Remind them that there are people working to keep families safe, and that your family can get more help if you need to. ►If you leave, reassure your children you will be back. Tell them a realistic time in words they understand, and be back on time. ►Give your child ways to communicate their fears to you.	► Be aware when you are on the phone or talking to others, that your child does not overhear you expressing fear. ►Say things such as, "We are safe from the hurricane now, and people are working hard to make sure we are okay." ►Say, "If you start feeling more scared, come and take my hand. Then I'll know you need to tell me something."
Confusion about the danger being over: Young children can overhear things from adults and older children, or see things on TV or just imagine that it is happening all over again. They believe the danger is closer to home, even if it happened further away.	►Give simple, repeated explanations as needed, even every day. Make sure they understand the words you are using. ►Find out what other words or explanations they have heard and clarify inaccuracies. ►If you are at some distance from the danger, it is important to tell your child that the danger is not near you.	►Continue to explain to your child that the hurricane has passed and that you are away from the flooded area ►Draw, or show on a map, how far away you are from the disaster area, and that where you are is safe. "See? The hurricane was way over there, and we're way over here in this safe place."

Parent Tips for Helping Preschool-Age Children after Disasters		
Reactions/Behavior	**Responses**	**Examples of things to do and say**
Not talking: Being silent or having difficulty saying what is bothering them.	►Put common feelings of children into words, such as anger, sadness, and worry about the safety of parents, friends and siblings. ►Do not force them to talk, but let them know they can talk to you any time.	►Draw simple "happy faces" for different feelings on paper plates. Tell a brief story about each one, such as, "Remember when the water came into the house and had a worried face like this?" ►Say something like, "Children can feel really sad when their home is damaged." ► Provide art or play materials to help them express themselves. Then use feeling words to check out how they felt. "This is a really scary picture. Were you scared when you saw the water?"
Fears the disaster will return: When having reminders--seeing, hearing, or otherwise sensing something that reminds them of the disaster.	►Explain the difference between the event and reminders of the event. ►Protect children from things that will remind them as best you can.	► "Even though it's raining, that doesn't mean the hurricane is happening again. A rainstorm is smaller and can't wreck stuff like a hurricane can." ► Keep your child from seeing television, radio, and computer images of the disaster that can trigger fears of it happening again."
Sleep problems: fear of being alone at night, sleeping alone, waking up afraid, having bad dreams.	►Reassure your child that s/he is safe. Spend extra quiet time together at bedtime. ►Let the child sleep with a dim light on, or sleep with you for a limited time. ►Some might understand an explanation of the difference between dreams and real life.	►Provide calming activities before bedtime. Tell a favorite story with a comforting theme. ►At bedtime say, "You can sleep with us tonight, but tomorrow you'll sleep in your own bed." ► "Bad dreams come from our thoughts inside about being scared, not from real things happening."
Returning to earlier behaviors: Thumb sucking, bedwetting, baby-talk, needing to be in your lap	►Remain neutral or matter-of-fact, as best you can, as these may continue a while after the disaster.	►If your child starts bedwetting, change her clothes and linens without comment. Don't let anyone criticize or shame the child by saying, "You're such a baby."
Not understanding about death: Preschool age children don't understand that death is not reversible. They have "magical thinking" and might believe their thoughts caused the death. The loss of a pet may be very hard on a child.	►Give age-appropriate consistent explanation--that does not give false hopes--about the reality of death. ►Don't minimize their feelings over a loss of a pet or a special toy. ►Take cues from what your child seems to want to know. Answer simply and ask if he has any more questions.	►Allow children to participate in cultural and religious grieving rituals. ►Help them find their own way to say goodbye by drawing a happy memory or lighting a candle or saying a prayer for them. ► "No, Pepper won't be back, but we can think about him and talk about him and remember what a silly doggy he was." ► "The firefighter said no one could save Pepper and it wasn't your fault. I know you miss him very much."

Appendix E: Handouts

Parent Tips for Helping School-Age Children after Disasters		
Reactions	**Responses**	**Examples of things to do and say**
Confusion about what happened	►Give clear explanations of what happened whenever your child asks. Avoid details that would scare your child. Correct any information that your child is unclear or confused about regarding if there is a present danger. ►Remind children that there are people working to keep families safe and that your family can get more help if needed. ►Let your children know what they can expect to happen next.	► "I know other kids said that more hurricanes are coming, but we are now in a place that is safer from hurricanes." ►Continue to answer questions your children have (without getting irritable) and to reassure them the family is safe. ►Tell them what's happening, especially about issues regarding school and where they will be living.
Feelings of being responsible: School-age children may have concerns that they were somehow at fault, or should have been able to change what happened. They may hesitate to voice their concerns in front of others.	►Provide opportunities for children to voice their concerns to you. ►Offer reassurance and tell them why it was not their fault.	►Take your child aside. Explain that, "After a disaster like this, lots of kids—and parents too—keep thinking 'What could I have done differently?' or 'I should have been able to do something.' That doesn't mean they were at fault." ► "Remember? The firefighter said no one could save Pepper and it wasn't your fault."
Fears of recurrence of the event and reactions to reminders	►Help child to identify reminders (people, places, sounds, smells, feelings, time of day) and to clarify the difference between the event and the reminders that occur after it. ►Reassure them, as often as they need, that they are safe. ►Protect children from seeing media coverage of the event as it can trigger fears of the disaster happening again.	►When they recognize that they are being reminded, say, "Try to think to yourself, 'I am upset because I am being reminded of the hurricane because it is raining, but now there is no hurricane and I am safe." ► "I think we need to take a break from the TV right now."
Retelling the event or playing out the event over and over	►Permit the child to talk and act out these reactions. Let them know that this is normal. ►Encourage positive problem-solving in play or drawing.	► "I notice you're drawing a lot of pictures of what happened. Did you know that many children do that?" ► "It might help to draw about how you would like your school to be rebuilt to make it safer."

Parent Tips for Helping School-Age Children after Disasters		
Reactions/Behavior	**Responses**	**Examples of things to do and say**
Fear of being overwhelmed by their feelings	►Provide a safe place for them to express their fears, anger, sadness, etc. Allow children to cry or be sad; don't expect them to be brave or tough.	► "When scary things happen, people have strong feelings, like being mad at everyone or being very sad. Would you like to sit here with a blanket until you're feeling better?"
Sleep problems, including bad dreams, fear of sleeping alone, demanding to sleep with parents.	►Let your child tell you about the bad dream. Explain that bad dreams are normal and they will go away. Do not ask the child to go into too many details of the bad dream. ►Temporary sleeping arrangements are okay; make a plan with your child to return to normal sleeping habits.	► "That was a scary dream. Let's think about some good things you can dream about and I'll rub your back until you fall asleep." ► "You can stay in our bedroom for the next couple of nights. Then we will spend more time with you in your bed before you go to sleep. If you get scared again, we can talk about it."
Concerns about the safety of themselves and others.	►Help them to share their worries and give them realistic information.	►Create a "worry box" where children can write out their worries and place them in the box. Set a time to look these over, problem-solve, and come up with answers to the worries.
Altered behavior: Unusually aggressive or restless behavior.	►Encourage the child to engage in recreational activities and exercise as an outlet for feelings and frustration.	► "I know you didn't mean to slam that door. It must be hard to feel so angry." ► "How about if we take a walk? Sometimes getting our bodies moving helps with strong feelings."
Somatic complaints: Headaches, stomachaches, muscle aches for which there seem to be no reason.	►Find out if there is a medical reason. If not, provide comfort and assurance that this is normal. ►Be matter-of-fact with your child; giving these non-medical complaints too much attention may increase them.	►Make sure the child gets enough sleep, eats well, drinks plenty of water, and gets enough exercise. ► "How about sitting over there? When you feel better, let me know and we can play cards."
Closely watching a parent's responses and recovery: not wanting to disturb parent with their own worries.	►Give children opportunities to talk about their feelings as well as your own. ►Remain as calm as you can, so as not to increase your child's worries.	►"Yes, my ankle is broken, but it feels better since the paramedics wrapped it. I bet it was scary seeing me hurt, wasn't it?"
Concern for other victims and families.	►Encourage constructive activities on behalf of others, but do not burden with undo responsibility.	►Help children identify projects that are age-appropriate and meaningful (e.g., clearing rubble from school grounds, collecting money or supplies for those in need).

Appendix E: Handouts

Parent Tips for Helping Adolescents after Disasters		
Reactions	**Responses**	**Examples of things to do and say**
Detachment, shame, and guilt	►Provide a safe time to discuss with your teen the events and their feelings. ►Emphasize that these feelings are common, and correct excessive self-blame with realistic explanations of what actually could have been done.	► "Many kids—and adults—feel like you do, angry and blaming themselves that they couldn't do more. You're not at fault—remember; even the firefighters said there was nothing more we could have done."
Self-consciousness about their fears, sense of vulnerability, fear of being labeled abnormal	►Help teens understand that these feelings are common. ►Encourage relationships with family and peers for needed support during the recovery period.	► "I was feeling the same thing. Scared and helpless. Most people feel like this when a disaster happens, even if they look calm on the outside." ► "My cell phone is working again, why don't you see if you can get a hold of Pete to see how he's doing."► "And thanks for playing the game with your little sister. She's much better now."
Acting out behavior; using alcohol and drugs, sexual acting out, accident-prone behavior.	►Help teens understand that acting out behavior is a dangerous way to express strong feelings (like anger) over what happened. ►Limit access to alcohol and drugs. ►Talk about the danger of high-risk sexual activity. ►On a time-limited basis, have them let you know where they are going and what they're planning to do.	► "Many teens—and some adults—feel out of control and angry after a disaster like this. They think drinking or taking drugs will help somehow. It's very normal to feel that way—but it's not a good idea to act on it." ► "It's important during these times that I know where you are and how to contact you." Assure them that this extra checking-in is temporary, just until things have stabilized.
Fears of recurrence and reactions to reminders	►Help to identify different reminders (people, places, sounds, smells, feelings, time of day) and to clarify the difference between the event and the reminders that occur after it. ►Explain to teens that media coverage of the disaster can trigger fears of it happening again.	► "When you're reminded, you might try saying to yourself, 'I am upset now because I am being reminded, but it is different now because there is no hurricane and I am safe.'" ►Suggest "Watching the news reports could make it worse, because they are playing the same images over and over. How about turning it off now?"

Parent Tips for Helping Adolescents after Disasters		
Reactions	**Responses**	**Examples of things to do and say**
Abrupt shifts in interpersonal relationships: Teens may pull away from parents, family, and even from peers; they may respond strongly to parent's reactions in the crisis.	►Explain that the strain on relationships is expectable. Emphasize that we need family and friends for support during the recovery period. ►Encourage tolerance for different family member's courses to recovery. ►Accept responsibility for your own feelings.	►Spend more time talking as a family about how everyone is doing. Say, "You know, the fact that we're crabby with each other is completely normal, given what we've been through. I think we're handling things amazingly. It's a good thing we have each other." ►You might say, "I appreciate your being calm when your brother was screaming last night. I know he woke you up too." ►"I want to apologize for being irritable with you yesterday. I am going to work harder to stay calm myself."
Radical changes in attitude	►Explain that changes in people's attitudes after a disaster are common, but will return back to normal over time.	► "We are all under great stress. When people's lives are disrupted this way, we all feel more scared, angry—even full of revenge. It might not seem like it, but we all will feel better when we get back to a more structured routine."
Wanting premature entrance into adulthood: (e.g., wanting to leave school, get married)	►Encourage postponing major life decisions. Find other ways to make the adolescent feel more in control over things.	► "I know you're thinking about quitting school and getting a job to help out. But it's important not to make big decisions right now. A crisis time is not a great time to make major changes."
Concern for other victims and families	►Encourage constructive activities on behalf of others, but do not burden with undo responsibility.	►Help teens to identify projects that are age-appropriate and meaningful (e.g., clearing rubble from school grounds, collecting money or supplies for those in need).

Appendix L-1

SAMHSA
Guide to Older Adults

A Guide For Older Adults

Senior citizens today are a sturdy, reliable generation. We have proven time and again our ability to survive everything from the Great Depression to world wars and the threat of nuclear holocaust. We are proud, tough and resilient.

However, when disaster strikes, we may find that we suddenly feel terrified...alone...and overwhelmingly vulnerable. These feelings of helplessness may frighten us even more.

Coping with personal trauma is a process that each person moves through differently. It helps to know that what we are feeling and the way we are behaving is quite normal under the circumstances. As we learn to understand what is happening to us, we can regain power over our lives and begin to heal.

- Physical reactions to a disaster are normal.
- Acknowledging our feelings helps us recover.
- Asking for what we need can help heal us.
- Focusing on our strengths and abilities will help.
- Accepting help from community programs is healthy.
- We each heal at our own pace.
- We each have different needs and different ways to cope.

It is important for older adults recovering from a disaster to talk about their feelings. Sharing their experiences with other disaster victims can help them to understand they are not alone. Also, becoming involved in the disaster recovery process and helping others to heal can be beneficial to the older adults own recovery. Older adults should be encouraged to ask for any type of help needed, such as financial, emotional, and medi-cal assistance. Seeking assistance is a step toward recovery and indepen-dence. Older adults are a generation of survivors and with the proper support will become even stronger and more capable of facing future challenges.

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