Program Development

Coordination of Mental Health and Community Agencies in Disaster Response

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ABSTRACT: *Within the past 10 years, the American Red Cross has responded to dramatic disasters and terrorist events that have resulted in significant loss of life and traumatic stress responses. These disasters have included events as diverse as earthquakes, explosions, and aviation accidents [International Journal of Emergency Mental Health, 2000, 2(3), 159-165].*

KEY WORDS: American Red Cross; CISM; disaster services, crisis intervention; debriefing

Mass casualty disasters exemplify both the problems and successes of trying to deliver quality services to all those in need, in the most effective and timely manner possible, using the most appropriate resources. This paper introduces the reader to the need for coordination of crisis intervention and mental health services in disaster response. There are four definitive phases of disaster response: The heroic phase, occurring in the days following a disaster when initial search and recovery efforts are being performed; the honeymoon phase, when the community pulls together and outside resources are brought in; the disillusionment phase when the reality of the impact of the event takes hold; and finally the recovery phase, when the individual and community begin to return to their pre-disaster state.

Disasters with a large loss of life and high drama bring out not only professional emergency responders, including fire, police and emergency medical services but also volunteers from the surrounding area who may have witnessed the event or have family members involved.

During the heroic phase, volunteers come forward to the Red Cross and other organizations with offers to assist in any way possible. Most of them have no prior life experience to help them understand these tragedies or to place them in perspective.

The honeymoon phase brings even more volunteers, as well as donations of food, clothing, money, and thousands of letters and cards of support from around the country. Even as the immediate disaster area is cordoned off by the police, people will begin to come from near and far to start their journey of grief coming to makeshift memorials to mourn the dead and say prayers for the living. We often see flowers, stuffed animals, personal letters, and other items left around disaster sites. Rather than focusing on the horror of the event, the community and country watch as rescuers sift through rubble focusing their hopes and prayers on those efforts, all the while knowing the potential of finding survivors is slim to none. Rescue workers and others involved in the event may become heroes to the community who needs something positive to believe in after these senseless tragedies.

Approximately three weeks after these events, the rescue and recovery efforts end, and the relief operation begins to wind down. This decision usually coincides with the community beginning the normal transition into the disillusionment phase. Increased anger becomes more evident as survivors, families of those who died, and everyone involved in the event begin to look for answers. As the various programs set up by relief agencies, mental health specialty groups, and Critical Incident Stress Management teams to provide information and immediate emotional support begin winding down or closing, many of the national and international media depart leaving the community to begin addressing the long term issues related to the disaster.

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Addressing the Emotional Needs

The emotional needs of the community can be overwhelming. Like a stone thrown into a pond that causes ripples to spread outward, so do the mental health needs of the community expand. Mass casualty disasters have the broadest impact of all; they reach not only the entire community but across the country and the world.

Potential mental health clients may be extremely varied in their exposure and response to the disaster but may include emergency responders, search and rescue personnel, mortuary teams, fire, police, and EMS agencies, witnesses, families of those killed, missing, and injured, friends and coworkers of the aforementioned, churches, schools, businesses in the affected area whether damaged or not, residents of the community and state, hospital staff, national guard, clean up crews, volunteers for the many agencies responding, politicians, funeral directors, clergy, civic groups and organizations, and mental health workers.

When a disaster is large enough to overwhelm the local community agency's resources, i.e., State or County Department of Mental Health, a request is made through governmental channels to the office of the governor who requests the Federal Coordinating Officer to recommend that grants be made available to the local community for the provision of mental health services. Before grant monies can be allocated, a needs assessment must be completed and a budget developed for how the funds will be used. The needs assessment should include all potential clients, including ages, racial and cultural background, the elderly, disabled, and any others with special needs so that programs can be developed and staff hired that are best qualified to meet the diverse needs. This task alone is both labor and time intensive. Consequently, these agencies may be overwhelmed and unable to provide the wide-scale services necessary during the early stages of a disaster response.

If the local mental health agency is unable to effectively lead a response and no pre-existing agreements or relationships have been developed establishing clearly defined agency roles and responsibilities, the initial response can be one of extreme chaos. With no one agency immediately ready to take the lead, many of the volunteers that will appear on site may be either unqualified, unprepared, or inappropriate. If there is no advanced planning and coordination between agencies about who should respond and when, it is not unusual for mental health workers to outnumber clients and actually fight over who has access them, or who will be the ones to give the waiting family members the news of the death of their relatives! Some of the mental health workers and clergy who respond during the first week after these disasters appear to have ulterior and not totally altruistic motives for assisting.

These motives vary from a desire to say they have been part of the response, to wishing to write articles, to being undercover for the media, to being able to hand out business cards in the hopes of adding to their client base.

Since the local governmental mental health organization may not be heavily involved in the initial response, who can respond and coordinate the mental health program? Because of their proven ability to respond quickly, assess needs, and recruit appropriate professionals to meet the disaster related needs, The Red Cross is usually the first agency to begin coordinating the mental health programs for families, survivors, and the community. Services are provided to an impacted community in the immediate days to weeks after a disaster until the local community resources are able to step in to meet the emotional needs of the residents. Depending upon needs, the Red Cross will coordinate community volunteers such as mental health professionals from Veterans and other hospitals, private practitioners, Critical Incident Stress Management (CISM) teams, professional organizations, and the clergy.

The Red Cross cooperates closely with affected communities after a disaster by sharing information about the number and type of anticipated clients and the number of clients currently being seen by Red Cross counselors. Information is provided to the local Department of Mental Health but may not be acted upon; thus their needs assessment can fall far short of the actual needs of the community for both immediate and long term counseling. During this period, objectivity is frequently lost as the stresses of attempting to provide needed services take their toll. While community mental health providers may recognize the need for outside help, they may experience ambivalence or suspicion of those who they perceive as wishing to "meddle" in their disaster. Outside responders can be met with a paradoxical mixture of gratitude and resentment. Crisis counseling services offered by groups such as Association of Traumatic Stress Specialists (ATSS), International Critical Incident Stress Foundation (ICISF), National Association of Social Workers (NASW), American Counseling Association (ACA), and others may be turned away, and

the resources they offer may go unused. The American Red Cross, coordinating many of these professionals, can serve fill to the gap and thus may become a major provider of crisis counseling for an extended period of time.

What does this mean to you as mental health and CISM professionals? The agency that gets the money has the power. The funded agency, which is usually governmental, has the authority to decide what programs will be implemented and who will get to assist in service delivery. They will decide how to use volunteers, what training will be offered, and what credentials will be accepted. Thus the agencies ability to be objective about its ability to respond or willingness to accept outside support will affect how effective its programs will be.

Without coordination between various agencies, groups, and organizations, there would be no way to monitor the level and quality of care, assess skills and credentials of those wishing to help, or share information about the many needs and areas where services could best be provided without getting into territorial or political battles, or duplicating efforts.

In order to resolve the problems that will inevitably occur during the immediate response period, it is vital to identify the various key agencies, programs, and services that are available within the community as well as other programs that might be called upon to assist in a wide-scale disaster.

These include the local governmental agency charged with the responsibility for meeting the mental health needs of a given community, CISM and EAP programs, VA and university staff, religious leaders, professional organizations, and the Red Cross.

Key representatives of these agencies and organizations should have their first planning meeting within 24 hours of any large incident to identify needs, resources, and responsibilities. Territorial issues must be put aside for the greater good of the community so that mental health needs can be addressed in a timely and appropriate manner.

Schools may be heavily impacted by mass casualty disasters as many students may lose a family member, teacher, friend, or sibling. Not only are the children affected, so are teachers, administrators, and others who may also have lost a friend, relative or student. Programs must be initiated immediately to train school counselors and teachers how best to deal with the effects on the entire school population as well as to give teachers and others an opportunity to debrief.

Now that we have discussed the importance of a collaborative community based response, let's discuss the issues related to using volunteer crisis counselors in disasters. After any disaster with a high emotional impact and heavy media attention, mental health professionals and Critical Incident Stress Management teams from near and far will attempt to volunteer their services. It is often difficult to educate these well-meaning volunteers that the best way to assist is through an established agency or organization. Even those who are accepted by these groups must meet certain criteria prior to being assigned in order to minimize the potential damage which may occur by providing inappropriate services, or by becoming secondary victims themselves. All agencies or groups that wish to provide services through or with volunteer staff should plan to implement a screening and training program for prospective staff prior to being assigned to the disaster. Screening programs that meet a minimum standard for all agencies should be implemented as rapidly as possible to ensure appropriate quality service delivery and to keep out those who may do more harm than good. If possible, volunteers from the clergy should be screened by a panel representing leaders of the local ministerial alliance. Volunteers should complete a volunteer application form indicating the name, address, and phone number of the applicant, represented agency or organization, special skills, and availability. Volunteers from within the disaster area should be screened and assigned to work in areas that best suit their skills and backgrounds, and only when the needs and skills exceed the local resources should additional support be accepted from outside the affected area.

Furthermore, only volunteers with proof of licensure, credential, or clerical identification should be accepted. As quickly as possible, this volunteer roster should be computerized to assure a manageable method of maintaining information about each volunteer. Such information should include volunteer's license or credentials, special skills or training, areas of assignment, and shifts. Volunteer staff should be available for key areas 24 hours a day. Outside groups coming into the area should be available for at least a one week period. When volunteers come to assist for only a day or two or even less, the time required to train, orient, and debrief them significantly reduces the amount of time they are able to actually provide services and unnecessarily taxes the volunteer coordinator's efforts. Whenever possible, a separate site should be set up to handle the influx of

volunteers, and no one should be allowed access to any service delivery site without preregistering at the volunteer center and receiving an appropriate ID.

A frequent problem on disasters are the influx of volunteers who choose to "freelance." These volunteers are usually well intentioned and simply do not understand the organizational structure of a disaster response. Those who choose to work outside of an organizational structure can cause confusion among the various disaster response organizations who may assume that they are part of an official local response. This can result in conflict if an independent group of volunteers establishes itself as a service provider for a survivor group that is the responsibility of the local mental health jurisdiction. Those with no prior experience or training may engage in activities which are ethically questionable as well as potentially damaging to those they are attempting to assist.

Volunteers should be assigned based on need and skill, which can be attained through continual open lines of communication between various service providers including mental health agencies, CISM teams, and Red Cross. Also, by keeping a centralized list of volunteers, each agency can easily be made aware of "problem" volunteers who may wander from site to site attempting to volunteer for other agencies after being fired.

Skills most needed for mass casualty disaster work include training and experience in PTSD, trauma, bereavement, CISM, debriefing, crisis intervention, and Red Cross Disaster Mental Health training.

Ideally, responsibilities can be defined prior to an incident, so each agency knows what type of volunteers will be needed, and where they will be assigned.

Assignment sites in the community include mental health hot lines, disaster sites, perimeter areas, clean up areas, feeding areas, CISM teams, hospitals, churches, work sites, and schools.

Red Cross assignment settings include shelters, Family Support Centers, service centers, headquarters, outreach teams, mass care warehouses, and any other site deemed necessary and upon request by or approval of the community mental health agency.

Staff are assigned to the above suggested areas based on the skills, knowledge, and training identified during the initial volunteer interview. Those with skills in grief and bereavement will usually be assigned to assist with the notification and home visit teams, follow up and community outreach to churches, and schools.

Volunteers with skills in crisis intervention and PTSD are best assisting those injured as well as witnesses and community volunteers who assisted with the initial rescue attempts. They can also be a vital support to those too overwhelmed to come in for counseling services, who are fearful about the health and welfare of those still missing by providing support to crisis hot lines set up in the immediate aftermath of such disasters.

Workers with backgrounds and experience in family counseling are often best suited to support those waiting for information about missing family members, staffing the perimeter area where mourners are frequently drawn, and working in shelters and service centers. These individuals can also be used to help screen and assign potential volunteers for the many sites in need of services.

Those with training and experience in CISM can be used in a variety of settings, debriefing or defusing emergency agency personnel, volunteers at the site, those working in the Family Support Centers, temporary morgues, hospitals, churches and schools.

Clergy should be teamed with a mental health professional on notification teams, and trained in setting up support programs for family members and friends. They can provide assistance at shelters and other sites if approved and accepted by community leaders and if their interventions are appropriate to the needs of the survivors.

Be aware that most groups organizing responses do not appreciate volunteers who are there for only a few hours. The stresses associated with organizing a response in any area are high enough without having to deal with individuals who "want to play" or "get some experience." Most leaders of the various response programs want volunteers who will commit for several days, for specific shifts, in specific areas. They are liable for any problems that arise due to the inappropriate actions of these individuals and know that volunteers who have been pre-screened and assigned to specific shifts are usually more effective and reliable to the benefit of the entire program.

Family Assistance Centers

Based on the type of disaster and the population affected, the Red Cross may set up a Family Assistance Center as well as shelters if homes were also damaged or destroyed causing families to be displaced. These areas are set up not only to

provide shelter if needed for evacuees but also as safe and secure areas for family members waiting for information and/or to meet with representatives of the medical examiners office. These secure facilities allow families begin to develop a mutual support network where both good news and bad is shared by all. Mental health professionals are assigned to each arriving family to provide comfort and support. They help to verify information which assists in suppressing a number of rumors as well as protect families from overly intrusive members of the media, victims rights groups, and the legal community.

In order to control the number of mental health volunteers having access to the victims and decrease the potential for an increase in stress levels due to too many intrusive "helpers," a tag or ID system should be developed. Each family can be given a tag which denotes that they are already assigned to a mental health team. Mental health workers should be on site 24 hours a day and turn over their client(s) to another team member at the end of their shifts. When a client is asked to come to the "Notification Room" where identification and notifications are done, the assigned team member should go along as an escort to provide continuing support as needed. If the disaster is an aviation accident, the mental health staff will work in tandem with the affected airline's family assistance staff to ensure that families are "tagged" and identified to the mental health staff so support can be offered.

A day care area may need to be set up for children whose families are awaiting news about loved ones. Volunteers whose specialty is pediatric counseling should be assigned to this area to assist the children with their own emotional recovery. Play therapy and individual counseling may be offered to these youngest victims. The ARC has an agreement with Church of The Brethren to provide child care if a Family Support Center is opened.

A team may be assigned to support family members once information has been received verifying the death of their loved one. This team is usually comprised of a representative of the Medical Examiner's Office who does the formal notification, a representative of the clergy, and a mental health professional with a specialty in bereavement and loss or trauma. The notification area should be isolated from the rest of the building to ensure privacy for family members as they receive the news and begin the grief process. Entry and exit to the notification area should be secured by law enforcement to prevent intrusion by the media and to protect the client's privacy.

The final team should be assigned the task of defusing and debriefing each of the teams at the end of their shifts. Debriefings should also be offered for all workers assigned from the various agencies on site. Initially, few may take advantage of the services but as time goes on and the number of notifications increases, the demand also increases to the point that sessions may need to be held frequently during the day and evening.

The Red Cross also works to help both the injured and their family members from throughout the country. Hospital bedside visits are made by a team representing Disaster Health Services and Mental Health. In addition, needs for assistance are evaluated, cases are opened as required, psychological support is offered, and family members are flown into the area on request to assist those hospitalized or injured.

Mental health workers comfort family members and workers assigned to the Red Cross Service Centers if and when they open to assist with education about the grief process, defuse a variety of intense emotions that may be experienced by both clients and workers, and provide continual support and referrals as needed. For those families who have lost a relative or who are too emotionally impacted to come into a Red Cross Service Center for assistance, a team can be developed to assess their disaster-caused needs and provide assistance on an individual basis. These teams are usually comprised of a Disaster Health Services Nurse, Family Service Caseworker, and Mental Health Caseworker. Phone contact can be made to each identified family, and based on need or request, a mental health worker would accompany both the caseworker and nurse to provide emotional support.

Once the local or state Department of Mental Health has developed its response plan and staffed it accordingly, it is expected that they will work closely with the ARC, local CISM teams, and other groups who may have been involved with initiating the response. Again, close collaboration is vital to ensure that those impacted by the event are identified and that a plan for outreach and follow up by the appropriate community providers is in place.

In order to be effectively used in any disaster situation, it is important to identify community groups that have a role in disaster response prior to a disaster. Attempting to respond after a disaster occurs may lead to the daunting task of trying to identify and locate the leader of the group or agency with

whom volunteers are most interested in working. Becoming affiliated with a group with national ties before a disaster occurs will help establish interest and credibility as a provider so that volunteer services will be welcomed after disaster strikes. To this end, it is imperative that involvement with local CISM teams, local mental health crisis lines, mental health organizations, national EAP associations or Red Cross units is established prior to a crisis situation.

Be politically sensitive when entering into this scene by giving appreciation to those who began the response. Making an effort to ask how assistance can be given rather than telling those already involved that one is going to help will more readily ensure acceptance. It is important not to jump in but to learn about and respect the local agency and their desire for authority, control, and self-determination. Going through channels within agencies, even if it is sometimes frustrating, will pay off in the long run, and volunteers will eventually find a role to play. It may not be the role hoped for, but help will be needed wherever one ends up. For example, several ATSS members attempting to provide debriefings for emergency workers without going through all the political and necessary hoops were, consequently, denied the opportunity to provide those services as planned. By connecting with the Red Cross, we were able to use their considerable expertise as debriefers for our death notification teams.

Recognize that the local community may very well be able to handle the initial response and that by coming into an area uninvited, volunteers may find themselves unwelcome and unappreciated. Too often volunteers descend upon a disaster area without a plan for where they will stay, eat, or work. These well-meaning volunteers usually increase chaos in an already chaotic situation. Understand that mental health needs will increase with time and that during the initial response period, most workers and survivors are either numb or just trying to meet the basic needs of survival. Therefore, counseling at that time will not be effective or well received. By waiting a week or more before descending on the affected community, volunteers will actually be more welcome and will have a larger role to play. Local mental health providers typically burn out and need to return to their pre-disaster activities within about two to three weeks. Local CISD teams will have worn out their own staff, as well as those from surrounding states, and will be more open to teams coming in from farther away. As the rescue and response activities wind down, the media interest will wane, yet this is the period when psychological needs will begin to be felt throughout the community. Survivors will begin the grieving process, rescue and emergency workers will attempt to return to a more normal routine, and all will begin to realize how difficult the recovery process will be and thus will be more open and accepting of mental health services. For example, the Oklahoma CISM team was actually trying to find volunteer teams to come in to assist from mid-June on when demands for services were increasing, and volunteer interest had dropped. At that time, any legitimate team probably would have been welcomed and even had their expenses paid; however, most offers for team assistance were made during the highly dramatic early response phase and as a result, were not appreciated or welcome.

In choosing to volunteer without a preagreement or invitation from a local group or organization, be prepared to finance travel and all associated expenses including hotel accommodations. Such preparation may be necessary as the media, governmental agencies, Red Cross, invited professionals, consultants, and others fill all available hotel rooms within a widespread area. For example, the Red Cross volunteers were housed in hotels at least a half hour from the work site because every place closer was filled.

Volunteering with the Red Cross

The Red Cross has a policy that only Red Cross trained mental health volunteers will be recruited to assist in any disaster response. We essentially guarantee any state or community in need of our mental health services fully trained, qualified, and experienced volunteers who are covered by our liability insurance and under most state's reciprocal laws thus allowing licensed mental health professionals to assist in times of disaster.

If the disaster is large enough to overwhelm the community agency and the local Red Cross, the Red Cross will coordinate the volunteer response, using local mental health and clergy who have not yet had Red Cross training. These volunteers will be assigned to positions under the supervision of a trained Red Cross mental health worker and must follow Red Cross guidelines in the provision of counseling services. The Red Cross typically does not pay for hotels or other expenses for volunteers from outside the impacted area unless they are already trained and recruited through our national disaster services human resource system.

If volunteers choose to affiliate with the Red Cross after

they have completed the 2-day training in Disaster Mental Health, they may be requested to assist in disaster operations within their own unit or anywhere in the United States and its territories. Assignments are for a minimum of 7 days outside your unit but within the state, or 10 days outside the state.

It is evident that there are many players involved in any disaster response. By understanding the role of each agency, you can identify where you and your skills would best fit in.