

DISASTER

Mental Health Intervention Field Guide

INDIANA

Contacts

The Indiana Division of Mental Health and Addiction Director designated a State Mental Health Disaster Mental Health Program Coordinator and one backup person to respond to the mental health needs of the citizens of the State of Indiana in the event of a disaster. Both positions are located in the Indiana Division of Mental Health and Addiction Office.

The State Mental Health Disaster Program Coordinator will take the lead in the event of a disaster. Back up personnel have been designated to assist or take the lead in the event that either or both of the state coordinators cannot act in that capacity.

For immediate assistance with any urgent disaster related information or request, call the following numbers as necessary or appropriate:

State Mental Health Disaster Coordinator

Andrew Klatte

Office Phone 317-232-7935

Cell Phone (work) 317-431-7464

Cell Phone (personal) 812-216-7560

Fax 317-233-3472

Andrew.Klatte@fssa.in.gov

Backup State Mental Health Disaster Coordinator

Stephanie Stscherban

Office Phone 317-232-7864

Cell Phone (work) 317-431-7461

Fax 317-233-3472

Stephanie.Stscherban@fssa.in.gov

Deputy Director, Office of Addiction, Prevention and Emergency Preparedness

John Viernes

Office Phone 317-232-7913

Fax 317-233-3472

John.Viernes@fssa.in.gov

Table of Contents

I	Key Concepts	4
II	Psychological First Aid	5
III	Disaster Intervention Skills.....	7
IV	When to Refer	8
V	Reaction/Intervention Suggestion Tables	9
VI	Communicating in Crisis	15
VII	Population Exposure Model Hierarchy	16
VIII	Immediate Trauma Responses	17
IX	Delayed Trauma Responses.....	19
X	Behaviors to Monitor	21
XI	At-Risk Populations	22
XII	Spiritual Perspective	23
XIII	Community Response Phases	24
XIV	Definitions	25

I. Key Concepts

- No one who sees a disaster is untouched by it.
- Disaster stress and grief reactions are normal responses to an abnormal situation.
- Many emotional reactions of disaster survivors stem from new and/or existing problems of everyday living brought about or exacerbated by the disaster.
- Following a disaster, most people do not see the need for and will not seek mental health 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 uniquely tailored to the communities they serve.
- Mental health workers need to set aside traditional methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully after a 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.
- Self-care for responders is essential.

II. Psychological First Aid

Objectives

- Establish a connection with survivors in a non-intrusive, compassionate manner.
- Provide physical and emotional support.
- Address immediate needs.
- Answer pressing questions and current concerns.
- Gather additional information.
- Offer practical assistance and information.
- Connect survivors to social support.
- Support and acknowledge coping efforts and strengths.
- Encourage survivors to take an active role in their own recovery.

Core Actions

- Contact and engagement
- Safety and comfort
- Stabilization
- Information gathering: needs/concerns
- Practical assistance
- Connections and social supports
- Information on coping
- Linkage with collaborative services

Psychological First Aid *Continued...*

Guidelines

- Be present...respect person's privacy...give alone time if needed.
- Listen to survivor's story...not the story you want to hear or think they are going to tell.
- Be sensitive to culture and diversity.
- Be aware of your own values and biases and how these may coincide or differ with those of the community served.
- Be aware of possible mistrust, stigma, fear and lack of knowledge about relief services.
- Do not make assumptions about what a person is experiencing or assume that everyone exposed will be "traumatized".
- Do not assume that everyone needs to talk with you.
- Allow individuals to "tell their stories", but do not follow a traditional debriefing model.
- Look for threat of harm to self or others.
- Be aware if you need to connect person with someone else.
- Help move individual from "victim to survivor".
- Speak to adolescents in an adult-like manner, so not to sound condescending.

Remember Disaster/Trauma Can:

- Reduce ability to concentrate
- Disrupt attention span
- Disrupt cognitive skills
- Lead to regression in individuals & to less effective ways of coping
- Result in anger issues

III. Disaster Intervention Skills

Key Skills

- Listen
- Offer acceptance of what is said
- Be accessible

Active Listening

- Allow silence
- Attend non verbally
- Paraphrase
- Reflect feelings
- Allow expression of emotions
- Clarify what is said to you

Problem-Solving

Workers can guide survivors through the problem-solving steps to assist with prioritizing and focusing action.

1. **Identify and define the problem.** “Describe the problems/challenges she/he faces right now.”
2. **Assess the survivor’s functioning and coping.** “How has s/he coped with stressful life events in the past? How is she/he doing now?”
3. **Evaluate available resources.** “Who might be able to help with this problem? What resources/options might help?”
4. **Develop and implement a plan.** “What steps will she/he take to address the problem?”

IV. When to Refer

The following reactions, behaviors, and symptoms signal a need for the responder to consult with the appropriate professional, and in most cases, to sensitively refer the survivor for further assistance.

- Disorientation
- Significant Depression
- Anxiety
- Mental Illness
- Inability to care for self
- Suicidal or homicidal thoughts or plans
- Problematic use of alcohol or drugs
- Domestic violence, child abuse or elder abuse

V. Disaster Reaction/Intervention Suggestion Tables

Ages 1 through 5

Behavioral Symptoms

- Resumption of bed-wetting, thumb sucking, clinging to parents
- Fears of the dark
- Avoidance of sleeping alone
- Increased crying

Physical Symptoms

- Loss of appetite
- Stomachaches
- Nausea
- Sleep problems, nightmares
- Speech difficulties
- Tics

Emotional Symptoms

- Anxiety
- Fear
- Irritability
- Angry outbursts
- Sadness
- Withdrawal

Intervention Suggestions

- Give verbal assurance and physical comfort
- Provide comforting bedtime routines
- Permit the child to sleep in parents' room temporarily
- Encourage expression regarding losses (i.e. deaths, pets, toys)
- Monitor media exposure to disaster trauma
- Encourage expression through play activities

V. Disaster Reaction/Intervention Suggestion Tables *Continued...*

Ages 6 through 11

Behavioral Symptoms

- Decline in school performance
- Aggressive behavior at home and/or school
- Hyperactivity or silly behavior
- Whining, clinging, acting like a younger child
- Increased competition with younger siblings for parents' attention

Physical Symptoms

- Change in appetite
- Headaches
- Stomachaches
- Sleep disturbances, nightmares

Emotional Symptoms

- School avoidance
- Withdrawal from friends, familiar activities
- Angry outburst
- Obsessive preoccupation with disaster, safety

Intervention Suggestions

- Give attention and consideration
- Relax expectations of performance at home/school temporarily
- Set gentle/firm limits on acting out
- Provide structured but undemanding home chores and rehabilitation activities
- Encourage expression (verbal and play) of thoughts and feelings
- Listen to the child's repeated retelling of a disaster event
- Involve the child in preparation of family emergency kit, home drills ~Rehearse safety measures
- Coordinate school disaster program; peer support, expressive activities, disaster education and planning, identify at-risk children

V. Disaster Reaction/Intervention Suggestion Tables *Continued...*

Ages 12 through 18

Behavioral Symptoms

- Decline in academic performance
- Rebellion at home and/or school
- Decline in previous responsible behavior
- Agitation or decrease in energy level, apathy
- Delinquent behavior
- Social withdrawal

Physical Symptoms

- Appetite changes
- Headaches
- Gastrointestinal problems
- Skin eruptions
- Complaints of vague aches and pains
- Sleep disorders

Emotional Symptoms

- Loss of interest in peer social activities, hobbies, recreation
- Sadness or depression
- Resistance to authority
- Feelings of inadequacy and helplessness

Intervention Suggestions

- Give attention and consideration
- Relax expectations of performance at home/school temporarily
- Encourage discussion of disaster with peers, significant adults
- Avoid insistence on discussion of feelings with parents
- Encourage physical activity
- Rehearse safety measures
- Encourage resumption of social activities, athletics, clubs, etc.
- Encourage participation in community rehabilitation and reclamation work
- Coordinate school disaster program; peer support, expressive activities, disaster education and planning, identify at-risk children

V. Disaster Reaction/Intervention Suggestion Tables *Continued...*

Adults

Behavioral Symptoms

- Sleep problems
- Avoidance of reminders
- Excessive activity level
- Crying easily
- Increased conflicts with family
- Hypervigilance
- Isolation, withdrawal

Physical Symptoms

- Fatigue, exhaustion
- Gastrointestinal distress
- Appetite changes
- Somatic complaints
- Worsening of chronic conditions

Emotional Symptoms

- Depression, sadness
- Irritability, anger
- Anxiety, fear
- Despair, hopelessness
- Guilt, self doubt
- Mood swings

Intervention Suggestions

- Provide supportive listening and opportunity to talk in detail about disaster experience
- Assist with prioritizing and problem solving
- Offer assistance for family members to facilitate communication and effective functioning
- Assess and refer when indicated
- Provide information on disaster stress and coping, children's reactions and families
- Provide information on referral resources

V. Disaster Reaction/Intervention Suggestion Tables *Continued...*

Older Adults

Behavioral Symptoms

- Withdrawal and isolation
- Reluctance to leave home
- Mobility limitations
- Relocation adjustment problems
- Symptoms resulting from loss of medications

Physical Symptoms

- Worsening of chronic conditions
- Sleep disorders
- Memory problems
- More susceptible to hypo/hyperthermia
- Physical and sensory limitations (sight, hearing) interfere with recovery
- Symptoms resulting from loss of medications

Emotional Symptoms

- Depression
- Despair about losses
- Apathy
- Confusion, disorientation
- Suspicion
- Agitation, anger
- Anxiety with unfamiliar surroundings
- Embarrassment about receiving "handouts"
- Symptoms resulting from loss of medications

Intervention Suggestions

- Provide strong and persistent verbal reassurance
- Provide orienting information
- Use multiple assessment methods as problems may be under reported - especially medications
- Assist with possession recovery
- Obtain medical/financial assistance
- Reestablish family/social contacts
- Pay attention to suitable residential relocation
- Encourage discussion of disaster losses and expression of emotions
- Provide and facilitate referrals for disaster assistance
- Engage service providers of transportation, meals, home chore, health and visits as needed

VI. Communicating in Crisis

ALWAYS refer media to the Public Information Officer (PIO) FIRST.

When making a statement to the public or press, build trust and credibility with these guidelines:

Introduction

A statement of:

- personal concern
- organizational commitment/intent
- what crisis response team is doing

Key Messages

- A maximum of three talking points
- Information to support the key messages

Conclusion

- A summarizing statement

TIPS

- Do no harm. Your words have consequences – select them carefully.
- Use empathy and care — focus more on informing than impressing them. Use everyday language.
- Do not over-reassure.
- Say only those things you would be comfortable reading on the front page.
- Don't use "No Comment." It will look like you have something to hide.
- Don't get angry. When you argue with the media, you always lose...publicly.
- Acknowledge people's fears.
- Don't speculate, guess or assume. If you don't know something, say so.
- Advise survivors on media interaction.

VII. Population Exposure Model Hierarchy

Level I

- Seriously injured victims
- Bereaved family members

Level II

- Victims with high exposure to trauma
- Victims evacuated from disaster zone

Level III.

- Bereaved extended family members and friends
- Rescue and recovery workers with prolonged exposure
- Medical examiner's office staff
- Service providers directly involved with death notification and bereaved families

Level IV.

- People who lost their homes, jobs, pets, valued possessions
- Mental health providers
- Clergy, chaplains, spiritual leaders
- Emergency health care providers
- School personnel involved with survivors, families or victims
- Media personnel

Level V.

- Government officials
- Groups that identify with target victim group
- Businesses with financial impacts

Level VI.

- Community-at-large

VIII. Immediate Trauma Responses

Cognitive

- Memory impairment
- Slowed thought process
- Difficulty:
 - making decisions
 - solving problems
 - concentrating
 - calculating
- Limited attention span
- Surreal
- Recurring/intrusive images or dreams

Behavioral

- Changes in behavior:
 - Withdrawal
 - Silence or talkativeness
 - Under/over eating
 - Under/over sleeping
 - Improper Humor
- Lack of interest in usual satisfying activities
- Over interest in anything that distracts
- Relapse in chemically dependent person

Emotional

- Flood of emotions – anxiety, fear, joy, loneliness, anger, confusion, guilt
- Irritability
- Depression
 - Helplessness
 - Hopelessness
 - Haplessness
- Overwhelmed...numb

Immediate Trauma Responses *Continued...*

Physical

- Fatigue that sleep does not alleviate
- Flare-ups of old medical problems
- Headaches
- Muscle and/or joint discomfort
- Digestive problems
- Sleep disturbances
- Hyperventilation

Spiritual

- Changes in relationships with:
 - Family members
 - Friends
 - Co-workers
 - Self
 - Higher Power
- Questioning beliefs and values
- Re-evaluation of life structure

IX. Delayed Trauma Responses

Cognitive

- Slowed thought processes
- Disorientation
- Cynicism
- “They” syndrome
- Hallucinations – escapism and/or flashbacks

Behavioral

- Change in behavior
 - Withdrawal
 - Silence / talkativeness
 - Under/over eating
 - Under/over sleeping
- Lack of interest in usual satisfying activities
- Over interest in anything that distracts
- Drug and/or alcohol abuse – possible relapse of previous addiction
- Sexual acting out

Emotional

- Denial
- Derogatory labels
- Excessive use of jargon
- Division of life areas
- Poor school/work performance...absences
- Sick or “carried away” humor
- Sense of “omnipotence”
- Unacceptable behavior
- Intellectualization
- Excessive use of excuses
- Emotional abuse of others

Delayed Trauma Responses *Continued...*

Physical

- Chronic low energy
- Stress related to medical problems
- Migraines
- Muscle and/or joint problems
- Frequent injuries
- Ulcers, colitis, high blood pressure, high cholesterol, heart irregularities

Spiritual

- Changes in relationships
 - Promiscuity
 - Sudden separation, divorce, marriage, co-habitation
- Social withdrawal, isolation
- Fantastic view of life
- Little or no view of own future
- No clear sense of own wants or needs

X. Behaviors to Monitor

Immediate

- Denial or inability to acknowledge the situation occurred
- Shock...numbness
- Dissociate behavior...appearing dazed, apathetic
- Confusion
- Very emotional
- Disorganized
- Difficulty making decisions

Delayed (weeks or months)

- Increased
 - Fears or anxiety
 - Aggression and oppositional behavior
 - Irritability and emotional lability
- Decreased
 - Work or school performance
 - Concentration
 - Frustration tolerance
- Regression in behavior
- Depressive feelings
- Denial
- Sleep or appetite changes
- Withdrawal...social isolation
- Attention-seeking behavior
- Risk-taking behavior
- Physical problems
- Peer...work...family problems
- Unwanted, intrusive recollections...dreams
- Loss of interest in activities once enjoyed

XI. At-Risk Populations

- Children
- Elderly
- All responders
- Immigrants / Aliens
- Ethnic minorities
- Poor
- Displaced or alienated individuals
- Persons living alone
- Single parents
- Developmentally / Physically challenged
- Special populations
- Individuals with:
 - Limited social support network
 - Previous disaster or trauma exposure (PTSD survivors)
 - History of poor coping skills
 - Pre-existing psychopathology or emotional concerns
 - Pre-existing physical health concerns (including addictions)

XII. Spiritual Perspective

Traumatic events challenge assumptions about:

- Relationships among people and with God
- Life, death and the afterlife
- How people and the world should be
- How everyday life should be lived

Faith — As a result of trauma or disaster:

- Faith is reinforced
- Faith is challenged
- Faith is rejected
- Faith is transformed

When responding to spiritual issues:

- **Don't** try to explain or ignore answers to spiritual questions
- **Don't** try to impose a spiritual answers on survivors
- **Don't** validate or affirm a spiritual belief or interpretation – even if asked to do so
- **Don't** give a spiritual response that you think the victim is looking for
- **Do** affirm the right to question God...normalize their search for spiritual answers
- **Do** assist in connecting survivors with their spiritual advisors and base

XIII. Community Response Phases

Pre-Event

- Pre-impact phase
- Warning
- Threat

Event

- Impact

Post-Event

- Inventory
- Rescue
- Heroic
- Honeymoon — community cohesion
- Disillusionment
- Reconstruction...Remedy...Mitigation
- Adjustment
- Anniversaries and trigger events

XIV. Definitions

- CIRR – Critical Incidence Report Request
- COOP – Continuity of Operations Plan
- DHS – Department of Homeland Security
- DNR – Department of Natural Resources
- DMHA – Department of Mental Health & Addiction
- EAP – Employee Assistance Program
- EMAC – Emergency Management Assistance Compact
- EMS – Emergency Medical Services
- EOC – Emergency Operations Center
- ESF – Emergency Support Function
- FEMA – Federal Emergency Management Administration
- FSSA – Family & Social Services Administration
- IAP – Incident Action Plans
- ICS – Incident Command System
- IDA – Indiana Department of Agriculture
- IDHS – Indiana Department of Homeland Security
- IDEM – Indiana Department of Environmental Management
- IDOT – Indiana Department of Transportation
- IEDC – Indiana Economic Development Corporation
- IIFC – Indiana Intelligence Fusion Center
- ISDH – Indiana State Department of Health
- IBOAH – Indiana Board of Animal Health
- IPA – Indiana Project Aftermath
- ISDA – Indiana State Department of Administration
- ISP – Indiana State Police
- IURC – Indiana Utility Regulatory Committee
- LHD – Local Health Department
- LEMA – Local Emergency Management Agency
- MDI – Military Department of Indiana

Definitions *Continued...*

NIMS – National Incident Management System

PIO – Public Information Officer

PPE – Personal Protective Equipment

SAMHSA – Substance Abuse and Mental Health Services Administration

SOP – Standard Operating Procedures

SRP – State Response Plan

TSA – Transportation Security Administration

VOA – Volunteers of America

References

Psychological First Aid: Field Operations Guide (Terrorism Branch of the National Child Traumatic Stress Network... National Center for Post Traumatic Stress Disorder, 2005

Field Manual for Mental Health and Human Service Workers in Major Disasters, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Publication (ADM) 90-537, 2000, 2002

Communicating in a Crisis: Risk Communication Guidelines for Public Officials, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Document 02-3641, 2002, 2003

Public Health Emergency Response Guide for State, Local, and Tribal Health Directors, Department of Health and Human Services, Centers for Disease Control and Prevention, Version 1.0

Disaster Mental Health Intervention Training Manual, State of Indiana, Family & Social Services Administration, Division of Mental Health & Addictions, Office of Emergency Preparedness & Response, Summer 2006



Mitchell E. Daniels, Jr., Governor
State of Indiana

Family & Social Services Administration
Division of Mental Health and Addiction
402 W. Washington Street, Room W353
Indianapolis, Indiana 46204-2739
317-232-7800 • FAX: 317-233-3472

E. Mitchell Roob Jr., Secretary

NN 151 (10-06)
Job #4655