Appendix D - 1: Disaster Behavioral Health Concepts

Definition of Disaster Behavioral Health[1]

Disaster behavioral health is a departure from traditional behavioral health practice in many ways. Disaster behavioral health interventions are designed to address incident-specific stress reactions, rather than ongoing or developmental behavioral health needs. Outreach and crisis counseling activities are the core of disaster behavioral health activities. Behavioral health professionals work hand-in-hand with paraprofessionals, volunteers, community leaders, and survivors of the disaster in ways that may differ from their formal clinical training.

Key Concepts of Disaster Behavioral Health[2]

1. NO ONE WHO SEES A DISASTER IS UNTOUCHED BY IT.

In any given disaster, loss and trauma will directly affect many people. In addition, there are many other individuals who are emotionally impacted simply by being part of the affected community.

A disaster is an awesome event. Simply seeing massive destruction and terrible sights may evoke deep feelings. Often residents of disaster-stricken communities report disturbing feelings of grief, sadness anxiety and anger, even when they themselves are not directly impacted. Such strong reactions confuse them when, after all, they were spared any personal loss.

2. THERE ARE TWO TYPES OF DISASTER TRAUMA.

There are two types of disaster trauma that can occur jointly and continuously in most disasters: individual and collective.

Individual trauma is defined 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." Individual trauma manifests itself in the stress and grief reactions which individual survivors experience.

Collective trauma is a "blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of community." Collective trauma can sever the social ties of survivors with each other and with the locale. These may be ties that could provide important psychological support in times of stress. Disaster disrupts nearly all activities of daily living and the connections they entail. People may relocate to temporary housing away from their neighbors and other social supports such as church, clinics, childcare, or recreation programs. Work may be disrupted or lost due to business failure, lack of transportation, loss of tools, or a worker's inability to concentrate due to disaster stress. For children, there may be a loss of friends and school relationships due to relocation. Fatigue and irritability can increase family conflict and undermine family relationships and ties.

3. MOST PEOPLE PULL TOGETHER AND FUNCTION DURING AND AFTER A DISASTER, BUT THEIR EFFECTIVENESS IS DIMINISHED.

There are multitudes of stressors affecting disaster survivors. In the early "heroic" and "honeymoon" phases there is much energy, optimism and altruism. However, there is often a high level of activity with a low level of efficiency. As the implications and meaning of the losses become more real, grief reactions may intensify. As fatigue sets in and frustrations and disillusionment accumulate, more stress symptoms may appear. Diminished cognitive functioning (short-term memory loss, confusion, difficulty setting priorities and making decisions, etc.) may occur because of stress and fatigue. This can impair survivors' ability to make sound decisions and take necessary steps toward recovery and reconstruction.

4. DISASTER STRESS AND GRIEF REACTIONS ARE NORMAL RESPONSES TO ABNORMAL EVENTS.

Most disaster survivors are normal persons who function reasonably well under the responsibilities and stresses of every day life. However, with the added stress of disaster, most individuals usually show some signs of emotional and psychological strain. These reactions are normal reactions to an extraordinary and abnormal situation, and are to be expected under the circumstances. Survivors, residents of the community, and disaster workers alike may experience them. These responses are usually transitory in nature and very rarely imply a serious mental disturbance or mental illness. Contrary to myth, neither post-traumatic stress disorder nor pathological grief reactions are rampant following a disaster.

The post-traumatic stress process is a dynamic one, in which the survivor attempts to integrate traumatic event into his or her self-structure. The process is natural and adaptive. It should not be labeled pathological (i.e. "a disorder") unless it is prolonged, blocked, exceeds a tolerable quality, or interferes with regular functioning to a significant extent.

Grief reactions are a normal part of the recovery from disaster. Not only may individuals lose loved ones, homes and treasured possessions, but hopes, dreams, and assumptions about life and its meaning may be shattered. The grief response to such losses are common and are not pathological (warranting therapy or counseling), unless the grief is an intensification, a prolongation or an inhibition of normal grief.

Relief from stress, the ability to talk about the experience, and the passage of time usually lead to the reestablishment of equilibrium. Public information about normal reactions, education about ways to handle them and early attention to symptoms that are problematic can speed recovery and prevent long-term problems.

5. MANY EMOTIONAL REACTIONS OF DISASTER SURVIVORS STEM FROM PROBLEMS OF LIVING CAUSED BY THE DISASTER.

Because disaster disrupts so many aspects of daily life, many problems for disaster survivors are immediate and practical in nature. People may need help locating missing loved ones; finding temporary housing, clothing, and food; obtaining transportation; applying for financial assistance, unemployment insurance, building permits, income tax assistance; getting medical care, replacement of eyeglasses or medications; obtaining help with demolition, digging out and clean-up.

6. DISASTER RELIEF PROCEDURES HAVE BEEN CALLED "THE SECOND DISASTER".

The process of obtaining temporary housing, replacing belongings, getting permits to rebuild, applying for government assistance, seeking insurance reimbursement and acquiring help from private or voluntary agencies is often fraught with rules, red tape hassles, delays and disappointment. People often establish ties to bureaucracies to get aid they can get nowhere else. However, the organizational style of the aid-giving bureaucracies is often too impersonal for survivors in the emotion-charged aftermath of the disaster. To complicate the matter, disasters and their special circumstances often foul up the bureaucratic procedures even of organizations established to handle disaster. Families are forced to deal with organizations that seem or are impersonal or inefficient.

7. MOST PEOPLE DO NOT SEE THEMSELVES AS NEEDING BEHAVIORAL HEALTH SERVICES FOLLOWING A DISASTER, AND WILL NOT SEEK OUT SUCH SERVICES.

Many people equate "mental health services" with being "crazy." To offer behavioral health assistance to a disaster survivor may seem to add insult to injury – "First I have lost everything and now you think I'm mentally unstable." In addition, most disaster survivors are overwhelmed with the time-consuming activities of putting the concrete aspects of their lives back together. Counseling or support groups may seem esoteric in the face of such pragmatic pressures. Very effective behavioral health assistance can be provided while the worker is helping survivors with concrete tasks.

8. SURVIVORS MAY REJECT DISASTER ASSISTANCE OF ALL TYPES.

People may be too busy cleaning up and dealing with other concrete demands to seek out services and programs that might help them. Initially, people are relieved to be alive and well. They often underestimate the financial impact and implication of their losses, and overestimate their available financial resources. The bottom-line impact of losses is often not evident for many months or, occasionally, for years.

The heroism, altruism, and optimism of the early phases of disaster may make it seem that "others are so much worse off than I am." For most people, there is a strong need to feel self-reliant and in control. Some people equate government relief programs with "welfare." For others, especially recent immigrants who have fled their countries of origin because of war or oppression, government is not to be trusted. Pride may be an issue for some people. They may feel ashamed that help is needed, or may not want help from "outsiders." Tact and sensitivity to these issues are important.

9. DISASTER BEHAVIORAL HEALTH ASSISTANCE IS OFTEN MORE "PRACTICAL" THAN "PSYCHOLOGICAL" IN NATURE.

Most disaster survivors are people who are temporarily disrupted by a severe stress, but can function capably under normal circumstances. Much of the behavioral health work at first will be to give concrete types of help. Behavioral health personnel may assist survivors with problem-solving and decision-making. They can help them to identify specific concerns, set priorities, explore alternatives, seek out resources and choose a plan of action. Behavioral health staff must inform themselves about resources available to survivors, including local organizations and agencies in addition to specialized disaster resources. Behavioral health workers may help directly with some problems, such as providing information for filling out forms, helping cleanup, locating

health care or child care, and finding transportation. They may also make referrals to specific resources such as assistance with loans, housing, employment, permits.

In less frequent cases, individuals may experience more serious psychological responses such as severe depression, disorientation, immobilization, or an exacerbation of prior mental illness diagnosis. These situations will likely require referral for more intensive psychological counseling. The role of the disaster behavioral health worker is not to provide treatment for severely disturbed individuals directly, but to recognize their needs and help link them with an appropriate treatment resource.

10. DISASTER BEHAVIORAL HEALTH SERVICES MUST BE UNIQUELY TAILORED TO THE COMMUNITIES THEY SERVE.

The demographics and characteristics of the communities affected by disaster must be considered when designing a behavioral health program. Urban, suburban and rural areas have different needs, resources, traditions and values about giving and receiving help. It is essential that programs consider the ethnic and cultural groups in the community and provide services that are culturally relevant and in language of the people. Disaster recovery services are best accepted and utilized if they are integrated into existing, trusted community agencies and resources. In addition, programs are most effective if workers are from the community and its various ethnic and cultural groups are integrally involved in service delivery.

11. BEHAVIORAL HEALTH STAFF NEED TO SET ASIDE TRADITIONAL METHODS, AVOID THE USE OF "MENTAL HEALTH" LABELS, AND USE AN ACTIVE OUTREACH APPROACH TO INTERVENE SUCCESSFULLY IN DISASTER.

The traditional, office-based approach is of little use in disaster. Very few people will come to an office or approach a desk labeled "mental health." Most often, the aim will be to provide human services for problems that are accompanied by emotional strain. It is essential not to use words that imply emotional problems, such as counseling, therapy, psychiatric, psychological, neurotic, or psychotic.

Behavioral health staff need to use an active outreach approach. They must go out to community sites where survivors are involved in the activities of their daily lives. Such places include impacted neighborhoods, schools, disaster shelters, Disaster Application Centers, meal sites, hospitals, churches, community centers, and the like.

12. SURVIVORS RESPOND TO ACTIVE INTEREST AND CONCERN.

They will usually be eager to talk about what happened to them when approached with warmth and genuine interest. Behavioral health outreach workers should not hold back from talking with survivors out of fear of "intruding" or invading their privacy.

13. INTERVENTIONS MUST BE APPROPRIATE TO THE PHASE OF THE DISASTER.
It is important that disaster behavioral health workers recognize the different phases of disaster and the varying psychological and emotional reactions of each phase[3]. For example, it will be counterproductive to probe for feelings when shock and denial are shielding the survivor from intense emotion. Once the individual has mobilized internal and external coping resources, he or she is better able to deal with feelings about the situation. During the "heroic" and "honeymoon" phases, people are seeking and discussing the facts about the disaster, trying to piece the reality together and understand what has happened. They may be more invested in discussing their thoughts than talking about feelings. In the "disillusionment" phase, people will likely be expressing feelings of frustration and anger. It is not usually a good time to ask if they can find something "good" that has happened to them through their experience.

Most people are willing and even eager to talk about their experiences in a disaster. However, it is important to respect the times when an individual may not want to talk about how things are going. Talking with a person in crisis does not mean always talking about the crisis. People usually "titrate their dosage" when dealing with pain and sorrow, and periods of normalcy and respite are also important. Talking about ordinary events and laughing at humorous points is also healing. If in doubt, ask the person whether they are in the mood to talk.

14. SUPPORT SYSTEMS ARE CRUCIAL TO RECOVERY.
The most important support group for individuals is the family. Workers should attempt to keep the family together (in shelters and temporary housing, for example). Family members should be involved as much as possible in each others' recovery.

Disaster relocation and the intense activity involved in disaster recovery can disrupt people's interactions with their support systems. Encouraging people to make time for family and friends is important. Emphasizing the importance of "rebuilding relationships" in addition to rebuilding structures can be a helpful analogy.

For people with limited support systems, disaster support groups can be very helpful. Support groups help to counter isolation. People who have been through the same kind of situation feel that can truly understand one another. Groups help to counter the myths of uniqueness and pathology. People find reassurance that they are not "weird" in their reactions. The groups not only provide emotional support, but survivors can share concrete information and recovery tips. In addition to the catharsis of sharing experiences, they can identify with others who are recovering and feel hope for their own situation. Behavioral health staff may involve themselves in setting up self-help support groups for survivors, or may facilitate support groups.

In addition, behavioral health workers may involve themselves in community organization activities. Community organization brings community members together to deal with concrete issues of concern to them. Such issues may include social policy in disaster reconstruction, or disaster preparedness at the neighborhood level. The process can assist survivors with disaster recovery not only by helping with concrete problems, but by reestablishing feelings of control, competence, self-confidence, and effectiveness. Perhaps most important, it can help to reestablish social bonds and support networks that have been fractured by the disaster.

Footnotes

[1]Adapted from: Jackson, G. & Cook, C.G. (1999). Disaster Mental Health: Crisis Counseling Programs for the Rural Community. DHHS Publication No. SMA 99-3378, Washington, D.C.: U.S. Government Printing Office.

[2]Adapted from: Myers, D. (1994). Disaster Response and Recovery: A Handbook for Mental Health Professionals. DHHS Publication No. SMA 94-3010, Washington, D.C.: U.S. Government Printing Office.

[3]See Appendix D-2 for an overview of the phases of a disaster.

Appendix D - 2: Disaster Typologies

As defined under the **Stafford Act**[1], a major disaster is any natural catastrophe (including any hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought), or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which 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.

Geography of a Disaster

A **Local Disaster** is any event real or perceived that threatens the well-being (life or property) of citizens in one municipality. A local disaster is manageable by local officials without a need for outside resources.

A **Regional Disaster** is any event real or perceived that threatens the well-being of multiple communities or contiguous geographic areas of Nebraska.

A **State Disaster** is any event, real and/or perceived, which threatens the well-being of citizens in multiple cities, counties, regions and/or overwhelms a local jurisdiction's ability to respond, or affects a State-owned property or interest. In these situations, the Governor is likely to issue a State Disaster Declaration.

A **Federally Declared Disaster** is any event, real and/or perceived, which threatens the well-being of citizens, overwhelms the local and State ability to respond and/or recover, or the event affects federally owned property or interests. If it appears that a disaster is of a magnitude to warrant a Presidential Disaster Declaration, then steps need to be taken to quantify the extent of needed human services to justify a request to receive federal funding for a Crisis Counseling Program (CCP). There are two types of Federally Declared Disasters: a) federally declared disasters eligible for public assistance and b) federally declared disasters eligible for individual assistance.

Types of Hazards[2]

Natural disasters are of many types and have diverse characteristics. Their onset and duration can be rapid or slow, and the intensity of disruptions caused to people, property and human need vary greatly and are, in part, a product of the degree to which people are prepared, as well as the extent and severity of the event.

Natural disasters include many events such as floods, tornados, earthquakes, forest and bush fires. Natural disasters are often familiar to the survivors, and the affected communities may have developed a lot of experience with these particular hazards. Usually, these disasters are seen as unavoidable. Although early warning systems are developed to various degrees, the impact can be extremely powerful and may cause substantial destruction, social disruption and many secondary stressors, such as loss of both home and income.[3]

Natural hazards identified as potential risks in Nebraska are (in alphabetical order): Drought, Earthquake, Flood/ Flash Flood, Severe Thunderstorm, Tornado, Wildfire, and Winter Storm.

Technological disasters are due to **human failures or accidents**, and are rarely preceded by warnings. Such incidents may have a sudden onset and produce reactions of shock. While the impact is extremely powerful, the destruction is often concentrated and causes little social disintegration. These disasters may result in a sense of loss of control, for which someone or some agency may be seen as responsible. The feeling that someone is to blame may make it more difficult for survivors to cope with the situation.

Technological hazards identified as potential risks in Nebraska are (in alphabetical order): Dam Failure, HAZMAT-Fixed Facility, HAZMAT- Transportation, Power Failure, Radiological - Fixed Facility, Radiological-Transportation, Transportation (Air or Rail Incident), and Urban Fire.

Security-related disasters are caused by **violence, war, and specific acts of human malevolence** (mass shootings, bombings). Chemical, biological and radiological (or nuclear) **terrorism** adds a new dimension to such human-made disasters. The threat may be sudden, focused or unfocused. The intent of such terrorism is, of course, to evoke terror, and the uncertainty and anxiety generated may lead to panic. Physical or physiological responses may be of 'epidemic' proportions, leading to further impact, even in otherwise unaffected populations.[4,5]

Security Hazards (National and State) identified as potential risks in Nebraska are (in alphabetical order): Biological/Chemical Attack, Civil Disorder/ Insurrection, Conventional Attack, Nuclear Attack, Sabotage, and Terrorism.

Many authors have argued that human-caused disasters, both technological and security-related, are phenomenologically and etiologically different from natural disasters. Human-caused disasters seem to be more traumatic to mental health[6]. Their higher **unpredictability**, **uncontrollability** and culpability may partly account for this. Generally, natural and human-caused disasters are differentiated based on distinct qualities of the

stressor (e.g. its **suddenness** and **severity**), mediating factors such as **sense of control** perceived by the victims, or modifying characteristics such as effect on **social support**. Each of these characteristics may theoretically have a differential effect on psychological outcomes.[7]

Psychological Phases of a Disaster[8]

Pre-Disaster Phase

Disasters vary in the amount of warning communities receive before they occur. For example, earthquakes typically hit with no warning; whereas, hurricanes and floods typically arrive within hours to days of warning. When there is no warning, survivors may feel more 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.

When people do not heed warnings and suffer losses as a result, they may experience guilt and self-blame. While they may have specific plans for how they might protect themselves in the future, they can be left with a sense of guilt or responsibility for what has occurred.

Impact Phase
The impact phase of a disaster can vary from the slow, low-threat buildup associated with some types of floods to the violent, dangerous, and destructive outcomes associated with tornadoes and explosions. The greater the scope, community destruction, and personal losses associated with the disaster, the greater the psychosocial effects.

Depending on the characteristics of the incident, people's reactions range from constricted, stunned, shock-like responses to the less common overt expressions of panic or hysteria. Most typically, people respond initially with confusion and disbelief, and focus on the survival and physical well-being of themselves and their loved ones. When families are in different geographic locations during the impact of a disaster (e.g., children at school, adults at work), survivors will experience considerable anxiety until they are reunited.

Heroic Phase
In the immediate aftermath of a disaster event, survival, rescuing others, and promoting safety are priorities. Evacuation to shelters, motels, or other homes may be necessary. For some, post-impact disorientation gives way to adrenaline-induced rescue behavior to save lives and protect property. While activity level may be high, actual productivity is often low. The capacity to assess risk may be impaired and injuries can result. Altruism is prominent among both survivors and emergency responders.

The conditions associated with evacuation and relocation have psychological significance. When there are physical hazards or family separations during the evacuation process, survivors often experience posttrauma reactions. When the family unit is not together due to shelter requirements or other factors, an anxious focus on the welfare of those not present may detract from the attention necessary for immediate problem solving.

Honeymoon Phase
During the week to months following a disaster, formal governmental and volunteer assistance may be readily available. Community bonding occurs as a result of sharing the catastrophic experience and the giving and receiving of community support. Survivors may experience a short-lived sense of optimism that the help they will receive will make them whole again. When disaster mental health workers are visible and perceived as helpful during this phase, they are more readily accepted and have a foundation from which to provide assistance in the difficult phases ahead.

Disillusionment Phase
Over time, survivors go through an inventory process during which they begin to recognize the limits of available disaster assistance. They become physically exhausted due to enormous multiple demands, financial pressures, and the stress of relocation or living in a damaged home. The unrealistic optimism initially experienced can give way to discouragement and fatigue. As disaster assistance agencies and volunteer groups begin to pull out, survivors may feel abandoned and resentful. Survivors calculate the gap between the assistance they have received and what they will require to regain their former living conditions and lifestyle. Stressors abound—family discord, financial losses, bureaucratic hassles, time constraints, home reconstruction, relocation, and lack of recreation or leisure time. Health problems and exacerbations of pre-existing conditions emerge due to ongoing, unrelenting stress and fatigue.

The larger community less impacted by the disaster has often returned to business as usual, which typically is discouraging and alienating for survivors. Ill will and resentment may surface in neighborhoods as survivors

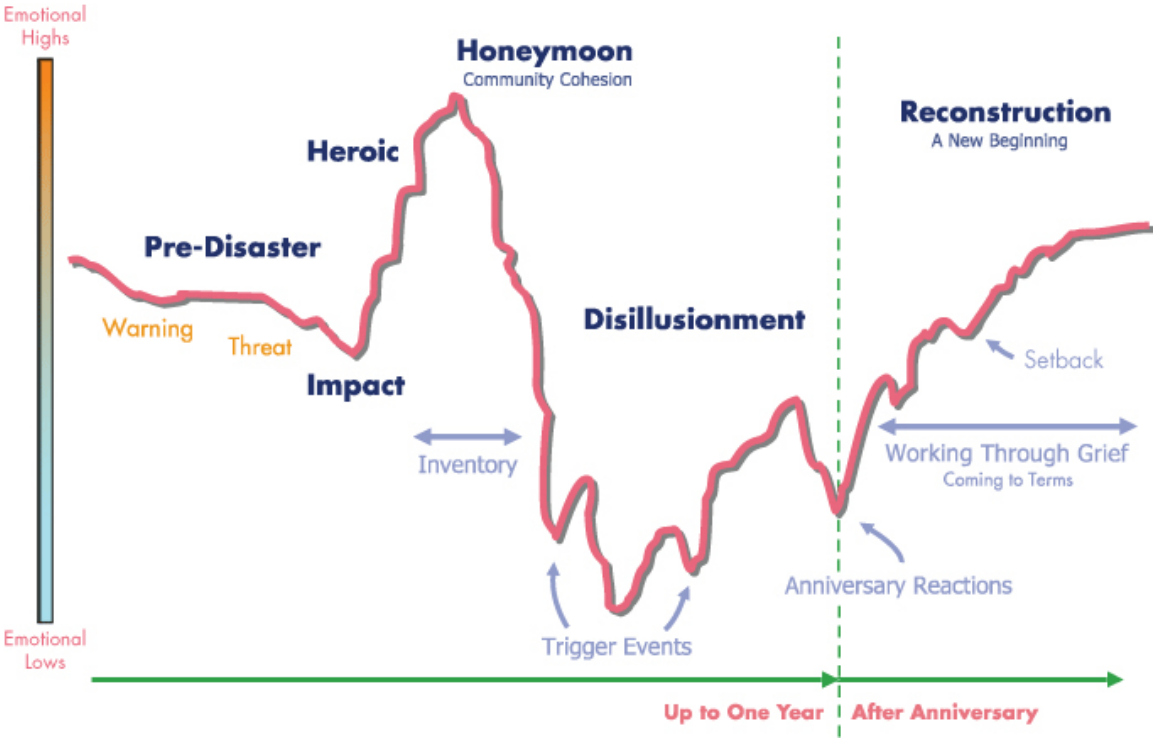
receive unequal monetary amounts for what they perceive to be equal or similar damage. Divisiveness and hostility among neighbors undermine community cohesion and support.

Reconstruction/Recovery Phase
The reconstruction of physical property and recovery of emotional well-being may continue for years following the disaster. Survivors have realized that they will need to solve the problems of rebuilding their own homes, businesses, and lives largely by themselves and have gradually assumed the responsibility for doing so.

With the construction of new residences, buildings, and roads comes another level of recognition of losses. Survivors are faced with the need to readjust to and integrate new surroundings as they continue to grieve losses. Emotional resources within the family may be exhausted, and social support from friends and family may be worn thin.

When people come to see meaning, personal growth, and opportunity from their disaster experience despite their losses and pain, they are well on the road to recovery. While disasters may bring profound life-changing losses, they also bring the opportunity to recognize personal strengths and to reexamine life priorities.

Individuals and communities progress through these phases at different rates, depending on the type of disaster and the degree and nature of disaster exposure. This progression may not be linear or sequential, as each person and community brings unique elements to the recovery process. Individual variables, such as psychological resilience, social support, and financial resources, influence a survivor's capacity to move through the phases. While there is always a risk of aligning expectations too rigidly with a developmental sequence, having an appreciation of the unfolding of psychosocial reactions to disaster is valuable.



Phases of Disaster Response for Organizations

Pre-Disaster/Preparation Phase
The primary goal during this phase is to insure that the behavioral health system continuously improves the capacity to competently respond to a disaster. During the pre-disaster phase, training and planning will occur that will increase the capacity of the system to respond to the needs precipitated by a disaster.

Immediate Response Phase
The primary goal during this phase is to ensure that there is an immediate and appropriate behavioral health response to the needs created by a disaster. During this phase crisis counseling services may be provided, often implementing the existing local capacity of the behavioral health system. If it appears that the behavioral health needs precipitated by the disaster require a response greater than the capacity of local resources, additional resources should be sought.

Long-term Response/Recovery Phase
Recovery services continue beyond the first month of the immediate phase of disaster response services, up to several years depending on the nature of the disaster. Local service providers will often be expected to address the needs of disaster survivors during the recovery phase. In the case of a Presidentially Declared Disaster, federal funding may be available for those who are eligible for individual assistance.

Footnotes

[1]Public Law 93-288
[2]Adapted from: NSW Health. (2000). Disaster Mental Health Response Handbook. New South Wales: NSW Health.
[3]Weisæth, L. (1995). Preventive psychosocial intervention after disaster. In S. E. Hobfoll & M. W. deVries (Eds.), Extreme stress and communities: Impact and intervention. (pp. 401-419). Dordrecht, The Netherlands: Kluwer Academic/Plenum Publishers.
[4]DiGiovanni, C. J. (1999). Domestic terrorism with chemical or biological agents: Psychiatric aspects. American Journal of Psychiatry, 156(10), 1500-1505.
[5]Holloway, H. C., Norwood, A. E., Fullerton, C. S., Engel, C. C., & Ursano, R. J. (1997). The threat of biological weapons. Prophylaxis and mitigation of psychological and social consequences. JAMA, 6, 425-427.
[6]Weisaeth, L. (1994). Psychological and psychiatric aspects of technological disasters. In R. J. Ursano & B. G. McCaughey (Eds.), Individual and community responses to trauma and disaster: The structure of human chaos. (pp. 72-102). New York: Cambridge University Press.
[7]Havenaar, J. M., & van den Brink, W. (1997). Psychological factors affecting health after toxicological disasters. Clinical Psychology Review, 17(4), 359-374.
[8]U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2000). Training manual for mental health and human services workers in major disasters, second edition. Washington, DC. Retrieved 8/25/2011 from: http://www.samhsa.gov/dtac/CCPtoolkit/Phases_of_disaster.htm

Appendix D - 3: Terms and Acronyms

ARC (American Red Cross) - The American Red Cross is a congressionally chartered, humanitarian organization, led by volunteers, that provides relief to victims of disasters and helps people prevent, prepare for, and respond to emergencies

ASD (Acute Stress Disorder) – Acute Stress Disorder, or ASD, is a psychological diagnosis used to explain extreme reactions to stress above what is often expected as a normal response to disaster.

CDC (Centers for Disease Control)

CERT (pronounced 'sert'; **Community Emergency Response Team)** – The Community Emergency Response Team (CERT) is collection of individuals who are trained in basic disaster response skills, such as fire safety, search and rescue, team organization, and disaster medical operations. CERT members can assist others in their neighborhood or workplace following an event when professional responders are not immediately available to help.

CISD (Critical Incident Stress Debriefing) – CISD is a technique that is specifically designed to assist others in dealing with the physical or psychological symptoms that are generally associated with trauma exposure. Debriefing, ideally conducted near the site of the event, allows those involved with the incident to process the event and reflect on its impact. This is a central component of Critical Incident Stress Management. **See CISM**.

CISM (Critical Incident Stress Management) – CISM is an intervention protocol, consisting of several elements, that was developed specifically for dealing with traumatic events. This protocol is a formal, highly structured process for helping those involved in a traumatic event to share their experiences, vent emotions, learn about stress reactions and symptoms and receive referrals for further help if required.

CMHS (Center for Mental Health Services) – The CMHS is a federal agency contained within the Substance Abuse and Mental Health Services Administration and the U.S. Department of Health and Human Services. This organization is mandated to adopt a leadership role in mental health services delivery and policy development. Further, CMHS has a specific interest in Disaster Mental Health and has created a branch specifically for this focus. CMHS disaster mental health programs are conducted by the Emergency Mental Health and Traumatic Stress Services Branch of the Federal Center for Mental Health Services (CMHS). In partnership with the Federal Emergency Management Agency (FEMA), this Branch of CMHS is responsible for assessing, promoting, and enhancing the resilience of Americans in times of crisis. The Branch disseminates mental health information about disasters and traumatic events in print and on the Internet.

CCP (Crisis Counseling Assistance and Training Program) – The Crisis Counseling Training and Assistance Program is funded by the Federal Emergency Management Agency (FEMA) under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. The purpose of the CCP is to support short term interventions with individuals and groups experiencing psychological sequelae to large scale disasters. The CCP is implemented as a supplemental assistance program available to the United States and its Territories, by the Federal Emergency Management Agency (FEMA).

CC (Crisis Counseling) – CC refers to the short term intervention that is focused upon assisting disaster survivors in understanding their current situation and reactions, mitigating additional stress, assisting survivors in reviewing their options, promoting the use of or development of coping strategies, providing emotional support, and encouraging linkages with other individuals and agencies who may help survivors recover to their pre-disaster level of functioning

CSAT (Center for Substance Abuse Treatment) – The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS), was congressionally mandated to expand the availability of effective treatment and recovery services for alcohol and drug problems.

Emergency – As defined by the Stafford Act an "Emergency" means any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States.

DAC (Disaster Application Center)

DFO (Disaster Field Office) – usually staffed by FEMA

DHHS (Department of Health and Human Services)

DHS (Department of Homeland Security)

DMH (Disaster Mental Health)

DTAC (Disaster Technical Assistance Center)

ECC (Emergency Coordination Center) – This usually refers to the State Department of Health and Human Services Command/Coordinator Center.

EMS (Emergency Medical Services)

ESF (Emergency Support Function)

EOC (Emergency Operations Center) – A central location where government at any level can provide interagency coordination and executive decision-making for managing response and recovery

FEMA (Federal Emergency Management Agency) – FEMA is a federal agency affiliated with the Department of Homeland Security (DHS) that reports to the President. FEMA is also the lead federal agency for disaster/emergency management. However, FEMA cannot direct a state or its agencies. **See also NEMA**

Hazard – Any situation with the potential for causing damage to people, property or the environment.

Hazard Mitigation Plan – Hazard mitigation plan means the plan resulting from a systematic evaluation of the nature and extent of vulnerability to the effects of natural hazards present in society and includes the actions needed to minimize future vulnerability to hazards.

HAZMAT (Hazardous Materials) – This refers to substances that are flammable, corrosive, reactive or toxic chemical, infectious biological (etiological) agent, or radioactive material. A hazardous material can be either a material intended for use or a waste intended to be treated or disposed of.

HHS – See DHHS

HRSA (pronounced 'her-sa'; **Health Resources and Services Administration)** – a division of HHS

ICC (Incident Command Center)

ICS (Incident Command System) – An all-hazards, functional incident management system that establishes common standards in organization, terminology, and procedures and further provides a means (unified command) for the establishment of a common set of incident objectives and strategies during multi-agency / multi-jurisdiction operations while maintaining individual agency/jurisdiction authority, responsibility, and accountability. The ICS is a component of the National Interagency Incident Management System (NIIMS).

ICU (Information Coordination Unit)

Immediate Response – Actions taken from the time a disaster/emergency strikes or is imminent to the time which Mental Health Response Teams (MHRT's) and other mental health responders begin leaving the scene and the transition to longer-term, follow-up services begin. **Please see MHRT**

ISP (Immediate Services Program) – This is the initial phase of a Crisis Counseling Program which includes screening techniques, as well as outreach services such as public information and community networking.

Immediate Services Application – The immediate Services Application is an application for funding for Immediate Services Crisis Counseling Program; this must be submitted within 14 days of the Presidentially Declared Disaster and is eligible for individual assistance.

JIC (Joint Information Center)

JOC (Joint Operations Center)

LEDRS (Livestock Emergency Disease Response System) – Veterinarians trained and deployed by the Nebraska Department of Agriculture to investigate suspected livestock disease.

LEOP (pronounced 'lee-op'; **Local Emergency Operations)** – Plan within Nebraska, in which each county's emergency management system maintains their own plan using a template distributed by the state; **Please also see SEOP.**

LMMRS (pronounced 'el-mers'; **Lincoln Metropolitan Medical Response System) – See also MMRS, OMMRS**
Mental Health Needs Assessment – A mental health needs assessment is an assessment conducted by the state or local mental health agencies to determine the approximate size, cost, and length of the proposed mental health program. The assessment also must identify why supplemental grant assistance will be needed. It is the basis for the Immediate Services Application (due 14 days following the Presidentially Declared Disaster) and therefore must be initiated as soon as possible.

MHRT (Mental Health Response Team) – MHRT's are multi-disciplinary teams of mental health professionals and paraprofessionals who provide necessary interventions in the initial phases of disaster/emergency recovery.

MMRS (Metropolitan Medical Response System) – This system is funded through the U.S. Department of Homeland Security and instituted in metropolitan areas of a certain size, including Omaha and Lincoln. The focus of this system is to focus on preparation and coordination of local law enforcement, fire, HAZMAT, EMS, hospital, public health, and other "first response" personnel plan to more effectively respond in the first 48 hours of a public crisis. **See also LMMRS, OMMRS**

MOA or MOU (Memorandum of Agreement OR Memorandum of Understanding)

NCP (National Oil and Hazardous Substances Pollution Contingency Plan) – The federal government's blueprint for responding to both oil spills and hazardous substance releases. This is the result of our country's efforts to develop a national response capability and promote overall coordination among the hierarchy of responders and contingency plans.

NDMS (National Disaster Medical System) – The National Disaster Medical System (NDMS) is a section within the U.S. Department of Homeland Security, Federal Emergency Management Agency, Response Division, Operations Branch, and has the responsibility for managing and coordinating the Federal medical response to major emergencies and Federally declared disasters including: natural disasters, technological disasters, major transportation accidents, and acts of terrorism including weapons of mass destruction events. Working in partnership with the Departments of Health and Human Services (HHS), Defense (DoD), and Veterans Affairs (VA), the NDMS Section serves as the lead Federal agency for medical response.

NDMSOSC (National Disaster Medical System Operations Support Center)

NEMA (pronounced 'nee-ma'; **Nebraska Emergency Management System) – See also FEMA**

NICC (National Interagency Coordination Center)

Non-PDD (Non-Presidentially Declared Disasters) – A Non-PDD is a disaster or emergency of any magnitude, which does not receive a proclamation of Presidentially Declared Disaster.

NPSC (National Processing Service Center)

NVOAD – See VOAD

ODP (Office of Domestic Preparedness)

OMMRS (pronounced 'oh-mers'; **Omaha Metropolitan Medical Response System) – See also MMRS, LMMRS**

POA (Point of Arrival) – The designated location (typically an airport) within or near the disaster-affected area where newly arriving staff, equipment, and supplies are initially directed. Upon arrival, personnel and other resources are dispatched to either the DFO, a mobilization center, a staging area, or directly to a disaster site.

POD (Point of Departure) – The designated location (typically an airport) outside the disaster-affected area from which response personnel and resources will deploy to the disaster area.

PDA (Preliminary Damage Assessment)

PDD (Presidentially Declared Disaster) – A PDD is any natural catastrophe (including any hurricane, tornado, storm, flood, high water, wind driven water, tidal wave, tsunami, volcanic eruption, landslide, mudslide, snowstorm, or drought) or, regardless of cause, any fire, flood, or explosion, which in the determination of the President, causes damage of sufficient severity and magnitude to warrant major disaster assistance under the Federal Disaster Relief Act. The PDD grant is intended to supplement the efforts and available resources of states, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering.

PIO (Public Information Officer)

Presidentially Declared Emergency – A Presidentially Declared Emergency is any occasion or instance for which, in the determination of the President, federal assistance is needed to supplement state and local efforts and capabilities to save lives and to lessen or avert the threat of a catastrophe in any part of the United States.

PTSD (Post-Traumatic Stress Disorder) – Posttraumatic Stress Disorder, or PTSD, is a psychological disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged, and these symptoms can be severe enough and last long enough to significantly impair the person's daily life.

RSP (Regular Services Program) – A Regular Services Program is a continuing portion of a Crisis Counseling Program designed to provide crisis counseling, community outreach, and consultation and education services to people affected by the disaster for the purpose of relieving continued emotional problems caused by the disaster. Funding is available for a period of 9 months beyond the 60 days of an Immediate Service Program for purposes of providing disaster crisis counseling services.

Robert T. Stafford Disaster Relief and Emergency Assistance Act – Public Law 93-288, as amended (P.L. 100-707); an act intended to provide an orderly and continuing means of assistance by the federal government to state and local government in carrying out their responsibilities to alleviate the suffering and damage which results from disaster/emergencies.

SAMHSA (pronounced 'sam-sa'; **Substance Abuse and Mental Health Services Administration)** – an independent agency of the U.S. Department of Health and Human Services (HHS) that was created to focus attention, programs, and funding on improving the lives of people with or at risk for mental and substance abuse disorders. **See also CMHS and CSAT.**

SEOP (pronounced 'see-op'; **State Emergency Operations Plan**) – **See also LEOP**

SITREP (Situation Report)

Stafford Act - See Robert T. Stafford Disaster Relief and Emergency Assistance Act

Terrorism – As defined by the FBI, terrorism is the unlawful use of force against persons or property to intimidate or coerce a government, the civilian population, or any segment thereof, in the furtherance of political or social objectives." This definition includes three elements: terrorist activities are illegal and involve the use of force, the actions are intended to intimidate or coerce, and the actions are committed in support of political or social objectives.

VAL – Department of Homeland Security Voluntary Agency Liaison

VOAD (pronounced 'voh-ad'; **Voluntary Organizations Active in Disasters**) or **NVOAD (National Voluntary Organizations Active in Disasters)** – This is a nation-wide coalition that is compromised of individual member organizations that typically specialize in an aspect of disaster response. Different organizations often have different specialty areas, so that by working in concert, they are able to provide a range of services with little duplication.

WMD (Weapons of Mass Destruction)

Appendix D - 4: Websites

Government Agencies

Administration on Aging: Disaster Assistance Resources http://www.aoa.gov/AoARoot/Preparedness/index.aspx
Links to web-based resources for older persons, their families and caregivers

Assistant Secretary for Preparedness and Response (ASPR) http://www.phe.gov/about/aspr/Pages/default.aspx
The Office of the Assistant Secretary for Preparedness and Response (formerly the Office of Public Health Emergency Preparedness) was created under the Pandemic and All Hazards Preparedness Act in the wake of Katrina to lead the nation in preventing, preparing for, and responding to the adverse health effects of public health emergencies and disasters
Public Health Emergencies – preparedness information http://www.phe.gov/preparedness/pages/default.aspx

Centers for Disease Control – Emergency Preparedness and Response www.bt.cdc.gov
The Center for Disease Control is a governmental organization that is charged with the task of protecting the health of the populace. This includes: agents of bioterrorism, chemical agents, radiation emergencies, mass trauma, natural disasters, outbreaks of disease (i.e. SARS, Influenza, etc.)

Federal Emergency Management Agency (FEMA) http://www.fema.gov/
An agency in Homeland Security, whose mission is to reduce loss of life and property and protect our nation's critical infrastructure from all types of hazards through a comprehensive, risk-based, emergency management program of mitigation, preparedness, response and recovery.

Guide to Citizen Preparedness http://www.citizencorps.gov
Citizen Corps, a component of USA Freedom Corps, was created to help coordinate volunteer activities. It provides opportunities for people to participate in a range of measures to make their families, their homes, and their communities safer from the threats of crime, terrorism, and disasters of all kinds.

National Institute of Mental Health - Information About Coping with Traumatic Events
http://www.nimh.nih.gov/health/topics/coping-with-traumatic-events/index.shtml
The National Institute of Mental Health conducts research not only on a wide range of mental health disorders, but also on the reactions that occur in a time of crisis or terror.

Nebraska Health and Human Services System http://www.hhs.state.ne.us
The Nebraska Health and Human Services System is a governmental agency that seeks to help people live better lives through effective service provision. This agency consists of the: Department of Services (including mental and behavioral health and public health services), Department of regulation and licensure, and Department of Finance and Support.

Disaster Technical Assistance Center (DTAC) http://www.mentalhealth.samhsa.gov/dtac/default.asp
Established by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Disaster Technical Assistance Center (DTAC) helps SAMHSA ensure that our Nation is prepared and able to respond rapidly when events increase the need for trauma-related mental health and substance abuse services.

U.S. Census Bureau http://www.census.gov/
This is a link to the United States Census Bureau that provides a wealth of information regarding people (i.e. income, housing, population estimates), Businesses (i.e. economic census, government, etc.), Geography (Maps, etc.) and Current Events (i.e. recent news releases, etc). This site is often extremely valuable when writing grants and proposals.

U.S. National Library of Medicine http://www.nlm.nih.gov/medlineplus/disasters.html
This MEDLINE Plus site provides links to information on dealing with emergencies and disasters.

U.S. Food and Drug Administration http://www.fda.gov/oca/sthealth.htm
This site lists contact information for each State Health Agency and links to their web sites.

General Information About Psychological Responses to Emergencies

American Psychological Association http://www.apa.org/helpcenter/disaster/index.aspx
Information on managing distress, recovery, and the role of psychologists in disaster recovery.

American Red Cross http://www.redcross.org/

Dart Center for Journalism & Trauma http://dartcenter.org/

Gateway to Post Traumatic Stress Disorder Information http://www.ptsdinfo.org/
This link service is a public Service of the Dart Foundation. It is a gateway to four nonprofit sites that offer PTSD information and resources.

International Society of Traumatic Stress Studies http://www.istss.org/
The International Society for Traumatic Stress Studies provides a forum for the sharing of research, clinical strategies, public policy concerns, and theoretical formulations on trauma.

National Center for Post-Traumatic Stress Disorder http://www.ptsd.va.gov/
The National Center for Post-Traumatic Stress Disorder is involved in multidisciplinary activities in research, education, and training related to PTSD.

National Mental Health Association http://www.nmha.org/reassurance/anniversary/index.cfm
The National Mental Health Association has prepared several fact sheets for adults, seniors, children, individuals with mental illness, employers, and physicians on coping with war-related stress and terrorism. Many are also available in Spanish.

National Rural Behavioral Health Center http://nrbhc.phhp.ufl.edu/disaster/
This is the National Rural Behavioral Health Center rural disaster & trauma page.

National Voluntary Organizations Active In Disaster http://www.nvoad.org/
NVOAD coordinates planning efforts by many voluntary organizations responding to disaster. Member organizations provide more effective and less duplication in service by getting together before disasters strike.

Nebraska Disaster Behavioral Health http://www.disastermh.nebraska.edu/
This link provides information on disaster behavioral health activities in Nebraska.

New South Wales Disaster Mental Health
http://www.churchdisasterhelp.org/files/manuals/Disaster Mental Health Response Handbook.pdf
This is a link to the New South Wales Disaster mental health handbook for professionals.

ReliefWeb http://www.reliefweb.int/w/rwb.nsf
ReliefWeb is an electronic clearinghouse for those needing timely information on humanitarian emergencies and natural disasters – designed specifically to help the humanitarian community improve its response to emergencies.

Sweeney Alliance http://www.sweeneyalliance.org/
The Sweeney Alliance is a nationally recognized non-profit organization that provides help to families and professionals coping with grief and stress.

Resources for Faith Communities

American Academy of Experts in Traumatic Stress www.aaets.org/arts/art82.htm
Discusses roles of funeral, memorials, and spiritual fellowship for communities affected by disaster as well as the effectiveness of pastoral counseling.

National Council of Churches USA www.ncccusa.org/nmu/mce/childrenterrorism.html
Sponsored by the National Council of Churches, this site provides a short list of tips for talking to children about terrorism and also lists religious and secular resources for work with children.

Resources for Families and Educators

After the Disaster: A Children's Mental Health Checklist http://www.fema.gov/kids/tch_mntl.htm
A checklist to assess a child's mental health status, following a disaster or traumatic experience.

Center for Disease Control - National Advisory Committee on Children and Terrorism (NACCT)
http://www.bt.cdc.gov/children/
The National Advisory Committee on Children and Terrorism (NACCT) provides recommendations for the preparedness of the health care system to respond to bioterrorism as it relates to children.

Helping Children After A Disaster http://www.aacap.org/publications/factsfam/disaster.htm
Strategies for parents who are comforting children after a disaster. It explains that children must be allowed to talk about the frightening parts of the disaster and that their experience must not be minimized.

Substance Abuse and Mental Health Services Administration
http://store.samhsa.gov/product/Psychosocial-Issues-for-Children-and-Adolescents-in-Disasters/ADM86-1070R
Psychosocial Issues for Children and Adolescents in Disasters
http://store.samhsa.gov/shin/content/SMA11-DISASTER/SMA11-DISASTER-09.pdf
Tips for Talking to Children and Youth After Traumatic Events: A Guide for Parents and Educators

National Child Traumatic Stress Network http://www.nctsnet.org/
The mission of the National Child Traumatic Stress Network (NCTSN) is to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States.
http://nctsnet.org/resources/audiences/school-personnel
This is a brief overview of child trauma and additional websites provided by the National Center for Child Traumatic Stress about trauma risk, normal reactions, best practices and other resources.

Cultural Competence and Populations of Special Concern

Federal Emergency Management Agency – Spanish Version http://www.fema.gov/spanish/
Agencia Federal para el manajo de emergencias.

National Organization on Disability
http://nod.org/disability_resources/emergency_preparedness_for_persons_with_disabilities/
This page links to a list of information and resources to help individuals with disabilities and their families plan for emergencies or disasters.

Substance Abuse and Mental Health Services Administration (SAMSHA)
http://store.samhsa.gov/product/Developing-Cultural-Competence-in-Disaster-Mental-Health-Programs/SMA03-3828
Developing Cultural Competence in Disaster Mental Health Programs:Guiding Principles and Recommendations was developed to assist States and communities in planning, designing, and implementing culturally competent disaster mental health services for survivors of natural and human-caused disasters.