

Psychosocial Response Workbook

Disaster Stress & Trauma Response Services
(DSTRS)

Ministry of Health



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Disaster Stress & Trauma Response Services Committee (DSTRS)

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- BC Ministry of the Attorney General, *BCERMS Brochure*;
- U.S. Department of Veterans Affairs *A Guidebook for Clinicians and Administrators*;
- American Red Cross *Psychosocial Emergency Response Manual*; and,
- World Health Organization, *Mental Health in Emergencies*.

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Overview of the Workbook

This psychosocial response workbook was prepared for participants of the April 2006 workshop *Disaster Psychosocial Response: What is Our Role?* It introduces disaster psychosocial response to clinicians who are interested in providing psychosocial support before, during and after a large scale emergency event, within the province of British Columbia. The workbook is also intended to be used as a helpful tool when volunteer clinicians are called out to a disaster.

This is the first edition of the workbook and is in many ways a work in progress. It will be expanded and refined over time and will become an integral part of the Ministry of Health's overall provincial disaster psychosocial response planning.

The Disaster Stress & Trauma Response Services (DSTRS) Committee began in May, 2001 to plan for psychosocial response for victims and first responders. This planning was intended as a partnership between the Ministry of Health and a variety of mental health /support organizations and Emergency Social Services.

The DSTRS workshop sub-committee is responsible for the production of this workbook.

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Table of Contents

Acknowledgements.....	i
Overview of the Workbook	ii
Preface: The DSTRS Committee and Network	1
Section 1: Definition and Characteristics of a Disaster	4
Identifying a Disaster Situation	4
Characteristics of a Disaster.....	5
Phases of a Disaster	6
Section 2: BC Emergency Response Management System.....	7
BCERMS Components	8
Four Levels of BCERMS.....	8
BCERMS Organization	9
Section 3: Disaster and Psychosocial Response	11
Objectives and Principles of a Psychosocial Response	11
Phases of a Disaster and the provision of Psychological First Aid.....	13
Global Impacts of a Disaster.....	14
Section 4: Psychological Impacts	16
Client Groups.....	16
Resiliency.....	17
Stress Reaction vs. Post Traumatic Stress Disorder (PTSD).....	18
Psychosocial Impacts - Adults.....	19
Psychosocial Impacts - Children and Adolescents	21
Psychosocial Impacts - Emergency Responders.....	22
Section 5: Managing the Psychosocial Response	25
Phases of the Psychosocial Response	25
Interventions with Client Groups.....	26
Range of Intervention Strategies.....	27
Specific Intervention Strategies	31
Individual Psychological First Aid Sessions.....	32
Additional Psychosocial Response Functions	33
Worker Care Specific Strategies.....	34
Defusing.....	34
Stress Management Strategies	35
Organizational Consulting	36
Dos and Don'ts in Disaster Response	37
Section 6: Surviving the Work.....	38
Self Care Strategies.....	38
Conclusion	40
Section 7: Further Reading	41

Table of Appendices

Appendix 1	Planning Tool
Appendix 2	Description of the Psychosocial Support Role in a Reception Centre
Appendix 3	Basic Principles of Psychological First Aid & Interventions in One-to-one Situations
Appendix 4	Activation Protocols
Appendix 5	Glossary

Preface: The DSTRS Committee and Network

The Disaster Stress & Trauma Response Services (DSTRS) Committee has been active in planning disaster psychosocial response since May 2001, beginning with the idea that professional registered therapists and other clinicians might be willing to volunteer their time in the event of a large scale emergency or disaster. The Ministry of Health is responsible for Health Emergency Management and psychosocial response planning is one of its priorities. Health Emergency Management has assumed the responsibility for the DSTRS network as one of its disaster response resources.

The DSTRS Network is presently comprised of approximately 600 registered clinicians from the B.C. Association of Clinical Counsellors, the B.C. Psychological Association and the B.C. Association of Social Workers. By working with clinicians who are already members of these professional associations, the DSTRS Network is assured that its volunteers have the knowledge and experience required to undertake this work as well as being accountable to their associations' professional codes of ethics. Because all three associations are province-wide, DSTRS can usually count on local, community-based volunteers when the need arises.

Since May 2001 DSTRS has called on volunteer clinicians to assist with the following events:

- September 11, 2001 – Vancouver and Abbotsford Airports
- Forest fires 2003 – Barriere/Louis Creek, Kamloops and Kelowna
- Forest fires 2003 – Canadian Red Cross Call Centre in Vancouver
- Avian influenza 2004 – Farm Crisis Line
- South Asia tsunami, 2005 – British Columbians impacted
- Vancouver's North Shore mudslides, 2005 - evacuees

The DSTRS network has organized many hundreds of volunteer hours over the course of these events; in the Kamloops response alone DSTRS volunteers provided over 500 hours of clinical support. The DSTRS team is proud of its volunteers and grateful for their support.

The psychosocial services that DSTRS can provide include:

- | | |
|-----------------------------------|---|
| • Psychological First Aid | • Development/distribution of materials |
| • Assessment | • Assessment of Community needs |
| • One-to-one support | • Spiritual Care |
| • Crisis counselling | • Worker Care |
| • Crisis line response | • Consultation |
| • Psychoeducational interventions | |
| • Group presentations | |

As the DSTRS Committee and Network evolved, it became clear that volunteers needed training on the difference between disaster work and regular clinical work and how DSTRS responders fit into the larger picture of the response. Disaster response differs greatly from regular clinical practice, although many of the same skills and interventions are required. In addition to standard clinical knowledge, disaster psychosocial responders must possess a number of competencies in addition to their basic clinical skills.

Psychosocial Responder Competencies:

- the ability to function in the midst of chaos and stress;
- knowledge of Emergency Social Services (ESS) (see www.pep.ca/ess);
- cognizance and respect for cultural norms and differences;
- cognizance and respect for evacuee participation in the rescue effort and subsequent rebuilding;
- the ability to handle disaster assignments while demonstrating good self care;
- the ability to work within a diverse team of people; i.e. first responders, Emergency Social Service volunteers, municipal groups, government ministries;
- a strong ability to be flexible and respond to a high-demand, rapidly changing environment;
- the ability to work outside the office setting;
- an understanding of worker care in the context of disaster;
- the ability to adapt special knowledge to the disaster situation (for example, knowledge of child therapy);
- a sense of humour and a warm demeanour.

DSTRS volunteers can be assigned to a number of different settings within a disaster response. Each disaster event is unique; the response to a disaster will vary accordingly. The following are a few examples of response situations to which a volunteer responder might be assigned.

The **Reception Centre** is where Emergency Social Services (ESS), as an umbrella organization, coordinates the provision of food, clothing and lodging, family reunification services, first aid, emotional support to evacuees, information and a variety of other human services. Reception Centres are most often in community centres or school gymnasiums. DSTRS volunteers in the Reception Centre will offer services to both evacuees and emergency social service responders.

The **Respite Centre** is the area in which disaster first responders take their breaks, usually after many long and hard hours of work. Respite Centres provide a place to eat, rest, make personal calls, and receive support and other services. DSTRS volunteers in the Respite Centre provide supportive services to both the first responders on break and the volunteers running the centre.

The **Staging Area** is where the Incident Commander and his/her team are located. It is close to the centre of the disaster situation and may or may not be located in a building, but will be close to "ground zero" where emergency crews are working. DSTRS volunteers at the Staging Area work with the survivors where appropriate and provide consultation as requested.

Emergency Operation Centres (EOCs) are the areas from which officials manage the overall response. This includes a cross section of the various systems impacted by the disaster and their representatives; i.e., police, fire, ambulance, health officials, forest industry, and the coast guard.

The **Staffing Bureau** is where emergency social service responders are processed and receive their assignments. DSTRS volunteers provide support services to volunteers running the Bureau and exit interviews for those volunteers who have completed their assignments and are exiting the response.

The **Canadian Red Cross Call Centre** is where family reunification takes place. Evacuees are registered with the Canadian Red Cross (CRC) so that family and friends can reconnect with those who have been displaced. The Red Cross Call Centre also receives fundraising calls. DSTRS volunteers would provide support services to volunteers and paid employees (including managers) working at the Call Centre.

These situations can be intense and chaotic. A DSTRS volunteer's role is to provide the "calm in the storm", to encourage resilience and to provide support. This requires a willingness to work in non-traditional ways including providing support by pitching in and doing tasks that might not normally be associated with "support" in a traditional clinical practice.

Section 1: Definition and Characteristics of a Disaster

A disaster is defined by the BC Emergency Program Act as "a calamity caused by accident, fire, explosion or technical failure, or by the forces of nature, that has resulted in serious harm to the health, safety, or welfare of people or in widespread damage to property."

An emergency is a present or imminent event that is caused by accident, fire, explosion or technical failure, or by the forces of nature, and requires prompt coordination of action or special regulation of persons or property to protect the health, safety and welfare of people or to limit damage to property.

Emergency Social Services are those services provided on a short-term basis to preserve the emotional and physical well being of evacuees and response workers in emergency situations.

Identifying a Disaster Situation

Here are some signs indicating a disaster situation. When any one of these signs is present, responders should be vigilant.

The **incident** is very unusual and/or extremely dangerous. The incident may involve major scientific or technical unknowns. There may be little or no control over duration.

The **intervention** may require extreme urgency for action, and may involve unusual tasks and procedures. The situation is difficult to control.

Mobilization of several human resources from several fields of expertise may be required. Various government departments and services may have come to the site. Resources available at the site are insufficient.

The **coordination** of more than two government departments may be required. The incident requires sophisticated coordination between

workers and between organizations. Circulation and sharing of information are necessary; decisions are made by authorities.

Communications may be impeded if radio frequencies or telephone lines are overloaded.

Relations with the **media** are complex. Many journalists from both national and international media may be sent to the site.

Consequences are profound. There may be many disaster victims and extensive material damage. The effects of the incident are felt by individuals and by the community as a whole. The consequences (economic, psychosocial, physical health, public health) may be long term, running for months or years.

Characteristics of a Disaster

In a disaster situation, a large number of people are affected:

- people who are dead or injured;
- witnesses and relatives of the disaster victims;
- people who must be or have been evacuated;
- practitioners/responders; and,
- people who are otherwise affected by the incident.

A disaster incident is complex:

- the extent of the incident is large;
- there may be social disorganization;
- there may be danger to the health of the population;
- there may be contradictory information; and
- there may be media coverage.

In a disaster situation, there is an extreme urgency for action. Lives and health are in danger, and needs are urgent. The incident may be continuing. On the psychosocial level, individuals and the entire community will be experiencing acute stress.

Resource investment is vast; for example, there may be 10-20 ambulance attendants, 30-40 firefighters, police, and numerous other emergency responders. In addition, there will be other experts such as city officials, medical health officers, utilities personnel and the psychosocial responders.

The usual intervention framework may be overloaded. There may be little known about the situation. Responders will be working in an environment different from the one they are accustomed to and work schedules will be extended. Responders may be unfamiliar with many of the tasks and will need to learn new working methods. Special precautions will be required to ensure safety, and there will be the need to support persons in a stressful situation.

In a disaster situation, a response structure will be established. This may involve the structures outlined in the section of this workbook dealing with the British Columbia Emergency Response Management System (BCERMS). Mobilization and coordination of human resources will be required. The chain of command must be understood and respected and the same is true for each individual's role.

Phases of a Disaster

In a disaster situation, events unfold in a series of predictable phases. These are:

- the Warning Phase before the disaster event (also known as the Alert Phase);
- the Impact Phase and the Rescue and Inventory Phase, both of which occur during the event; and,
- the Recovery and Reconstruction Phase, after the event.

The phases of a disaster event correspond to different phases for emergency response, as outlined in the table below. It is important to recognize that while the description of disaster phases is helpful from a theoretical perspective, in practice the phases will overlap and it may be difficult to say exactly where one phase begins and another ends.

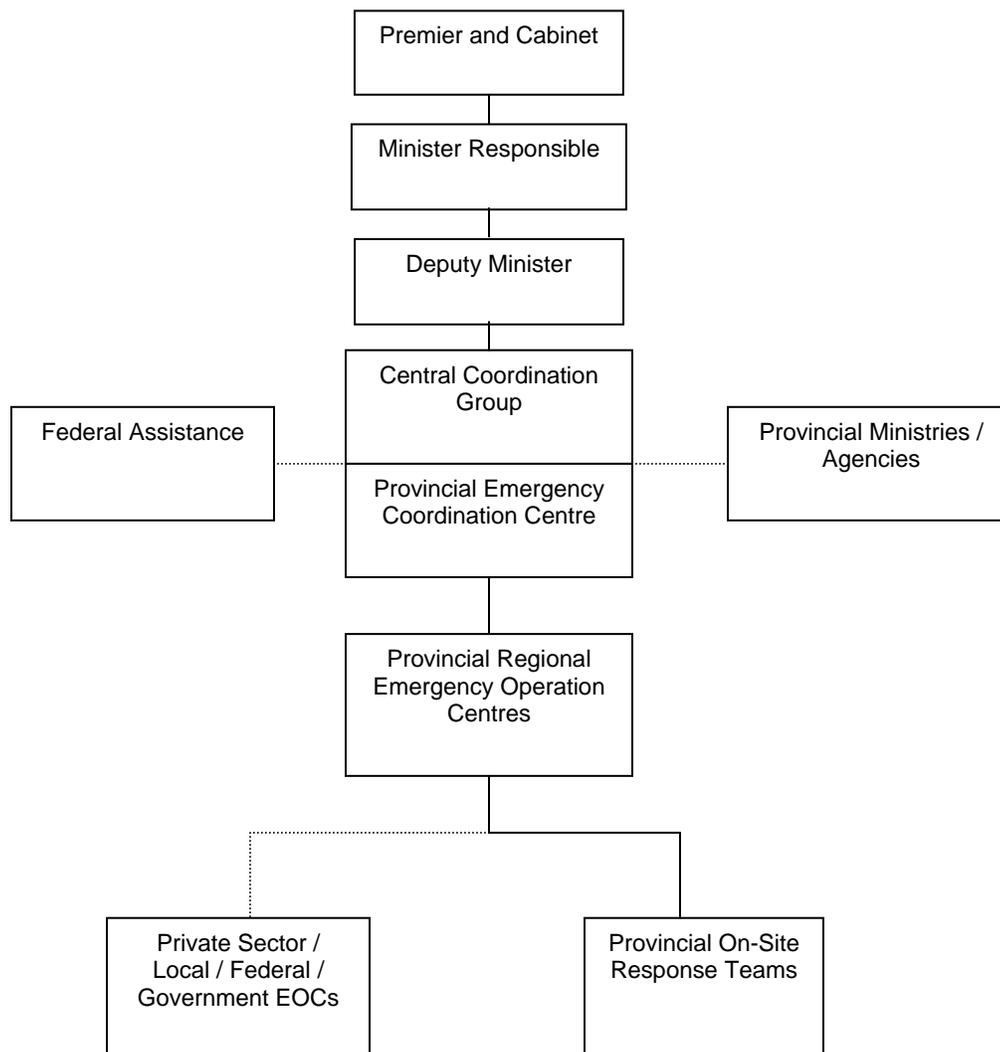
This table outlines the disaster phases and gives examples of some typical emergency response activities during those phases.

	Phases of a Disaster	Examples of Emergency Response Activities
Before	Warning/alert	Evacuation alerts Evacuation Impact mitigation strategies Response planning Activation of emergency operations centres
During	Impact	Mitigation strategies enacted (as possible) Preparation to set up the Reception Centre Activation of emergency operation centres (as needed)
	Rescue and inventory	Search and rescue Damage assessments Set up Reception Centre Set up Respite Centres
After	Recovery and reconstruction	Needs assessment and recovery planning (i.e. involvement of Canadian Red Cross and Recovery B.C.)
		Long-term recovery efforts Reconstruction of homes and community (involving other organizations as appropriate)

Section 2: BC Emergency Response Management System

In order to respond to a major emergency, the Province of British Columbia has created the British Columbia Emergency Response Management System (BCERMS), based on the Incident Command System (ICS). BCERMS is a comprehensive management system designed to ensure a coordinated and organized response to emergency incidents and disasters.

BCERMS Structure



BCERMS supports the following response objectives:

- to provide for the safety and health of all responders;
- to save lives and reduce suffering;
- to protect public health;
- to protect government infrastructure;
- to protect property and the environment; and,
- to reduce economic and social losses.

BCERMS Components

BCERMS is divided into five components. **Operations and Control** has the responsibility of providing organizational structure for the management of personnel, equipment, facilities and resources. It facilitates communication between agencies and coordinates a site response structure. **Qualifications** establish standards for the management of each functional area and level within the larger system. Following the standards established by Qualifications, **Technology** establishes the use of required technologies in support of emergency operations; **Training** mandates appropriate training of personnel, and **Publications** mandates the distribution of forms, reports, and other written material.

Four Levels of BCERMS

1. At the **site level**, BCERMS manages the response through a single or unified command. Responders may represent all levels of government and the private sector.
2. The **site support level** is initiated when off-site support is required. This involves the activation of an Emergency Operations Centre (EOC) to facilitate communications at the site level and to manage multiple-agency support. In addition, EOC will acquire and deploy additional resources obtained locally, from other EOCs or from the provincial regional level.
3. When the site support level (EOC) requires off-site support, the **provincial regional coordination level** is established and activates one or more Provincial Regional Emergency Operations Centres (PREOCs). The PREOC manages the assignment of

multiple-ministry and agency support to individual or multiple site support level locations. The PREOC acquires and deploys resources, provides emergency response services where incidents cross local authority boundaries or where local authorities are not organized to fulfil their role, and coordinates with ministry regional centres when they are established.

4. The **provincial central coordination level** comprises the Provincial Emergency Coordination Centre (PECC) and the Central Coordination Group (CCCG). The function of this level is to manage the overall Provincial government support for the regional levels through:

- seeking direction of senior elected officials;
- obtaining authority of the minister for a declaration of a provincial emergency;
- providing provincial policy guidance and establishing priorities;
- managing provincial emergency public information activities;
- managing the acquisition and deployment of provincial, federal, inter-provincial and international resources; and,
- providing coordination and other support services to provincial ministry or crown corporation operation centres, as well as federal emergency response agencies.

TEAMS

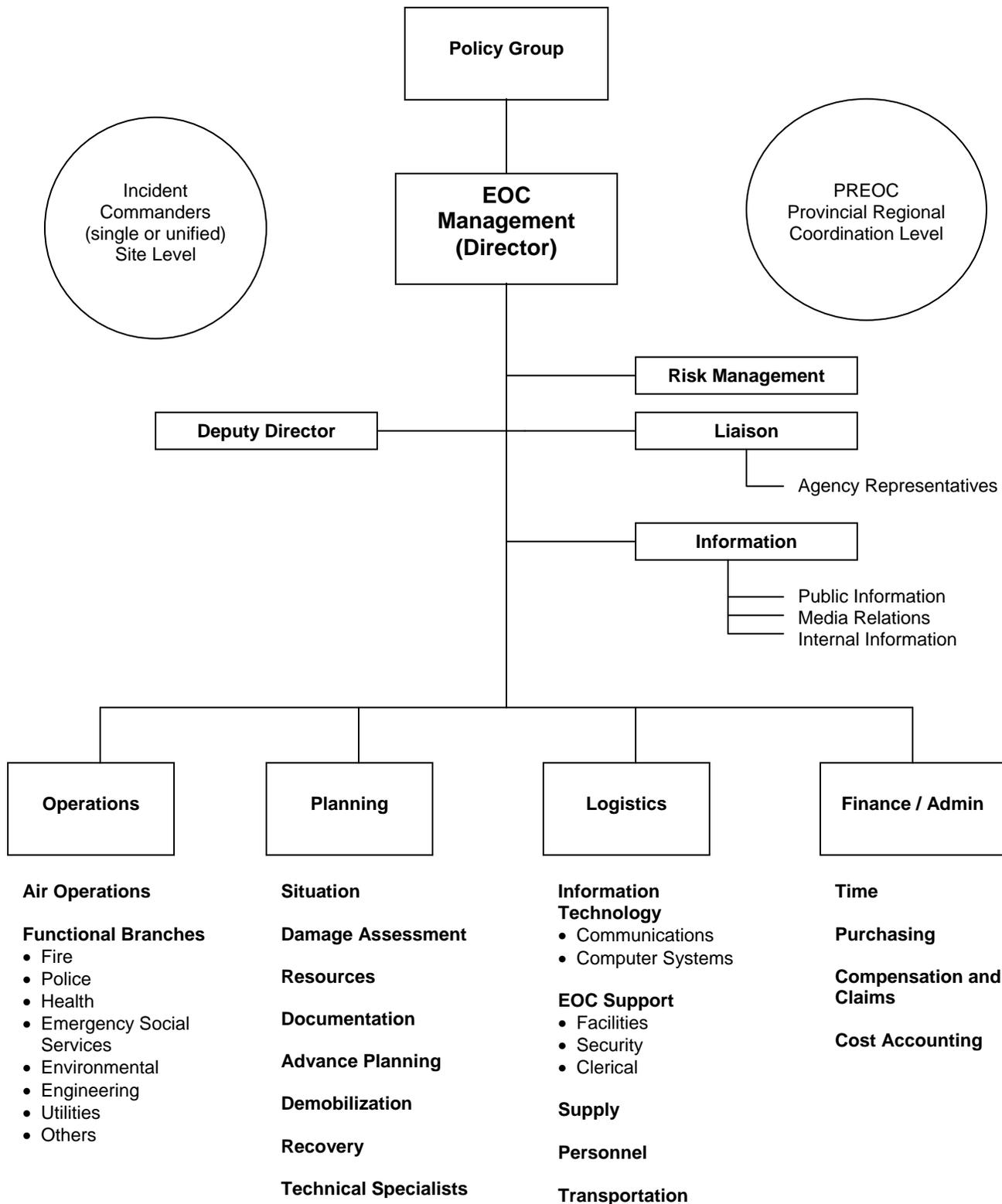
The Temporary Emergency Assignment Management System (TEAMS) is a new concept to improve the province's ability to staff emergency operation centres during an emergency response. Through TEAMS, the province will maintain a province-wide pool of staff, trained and experienced in BCERMS. TEAMS staff will provide on-site support to implement BCERMS throughout British Columbia in emergency response situations.

BCERMS Organization

The diagram on the next page shows a fully functional emergency operations centre, typical of one that might be found in a major operation conducted by a mid- to large-sized municipality.

More detailed information about BCERMS is available in the BCERMS Overview Manual and in the BCERMS Emergency Operations Centre Operational Guidelines. Both publications are available on the Provincial Emergency Program (PEP) Website: www.pep.bc.ca.

Typical Structure of an Emergency Operations Centre



Section 3: Disaster and Psychosocial Response

Throughout this workbook, a variety of terms are used to refer to the people that psychosocial responders support and assist. There is no umbrella term that captures every situation. People affected by a disaster event include the **survivors**, who are sometimes also **evacuees**, their **families and friends**, and the **broader community**. At times, a psychosocial responder works with individual survivors and at other times the work is with the entire community. As well, psychosocial responders attempt to support the variety of other responders to a disaster event, such as the **first responders** (fire, ambulance, police), **emergency social services, non-governmental organizations (NGOs)** such as: Salvation Army, Canadian Red Cross, etc., and a variety of **emergency managers** from municipal, provincial or federal offices. This workbook will employ a variety of terms in referring to the "clients" because there is no term that is appropriate for every situation.

A more detailed discussion of the range of clientele is offered in Section 5.

Objectives and Principles of a Psychosocial Response

The primary objective of a psychosocial response is to **provide an immediate, short-term service** that will help disaster or trauma survivors to *restore* and *increase safety, confidence, competence, and trust*.

Secondary objectives include the following:

- to help people so they can help themselves;
- to enhance individual and collective resiliency;
- to enhance community recovery; and,
- to enhance adaptation through ownership, responsibility and action.

Principles of Disaster Psychosocial Response

1. No one who sees a disaster is untouched by it.

One of the central principles of disaster psychosocial response is the assumption that no one who sees a disaster is untouched by it. Disaster stress, trauma, and loss are experienced at both the individual and the collective levels, and stress and grief reactions are normal responses to crisis and loss. Disaster survivors are usually among

the first to respond in the wake of a disaster, often contributing to early search and rescue. They continue to be active participants and partners in later phases of the disaster response.

2. Those affected by a disaster should be seen as active partners.

Affected people should be seen as active partners not passive victims or service consumers. A consultation model should be adopted in which affected people and communities are seen as the experts in defining needs and providing insight into specific cultural norms and contexts. Development of new social support systems and maintenance of existing ones are crucial to the recovery of the individuals as well as the community. Support of disaster relief workers, including those providing psychosocial support, is also crucial to an effective, long-term response.

3. PSYCHOLOGICAL FIRST AID IS NOT THERAPY.

For psychosocial responders, psychological first aid is the provision of immediate practical support and empathy to those who are most distressed. The goal of psychological first aid is to reduce physiological arousal and to facilitate resilience through education about coping strategies and available resources.

A Psychosocial Responder reviews the range of reactions the survivor has experienced - emotional, physical, and cognitive - both at the time of the event and afterwards. The Psychosocial Responder provides education about trauma and stress as well as information about treatment resources. He or she reviews the survivor's range of support systems, including both formal and informal supports, and assess the need for sustained intervention. The goal is to assist people in taking practical steps towards resuming ordinary life. Psychological first aid should foster accurate expectations and planning about returning to and/or re-establishing normal routines. The focus is concrete and practical, aimed at meeting immediate needs.

An example of a psychological first aid response and intervention reminders in one-to-one situations is included in Appendix 3.

4. Comprehensive and systematic assessments must be conducted throughout the disaster.

In order to best respond to the needs of those affected it is essential to work with affected communities and individuals to assess both existing resources, and short-term and long-term unmet needs. This requires comprehensive and systematic assessment throughout the inventory, recovery and reconstruction phases. Needs and resources will often change over time.

5. Effective psychosocial support is culturally and contextually responsive.

Interventions must always be adapted to the particular needs and cultures of the communities being served and also to the disaster phase. In order to be effective, psychosocial responders must be willing to work in non-traditional ways, including using active outreach, working on multidisciplinary teams, working outside the traditional office setting, and avoiding mental health labels.

Phases of a Disaster and the provision of Psychological First Aid

Just as there are phases for the general psychosocial response to a disaster, there are different phases to the provision of psychological first aid over the course of a disaster. As with the phases of the disaster event, it is important to remember that phases overlap and psychosocial interventions from one phase may be required side by side with those appropriate for another phase.

This table illustrates the connections between the disaster phases and the phases of the DSTRS network response.

	Phases of a Disaster	Examples of DSTRS Response
Before	Warning/alert	DSTRS coordinator/s gather information ¹ Networking with agencies Assessment of need for callout Initial activation of volunteer callout list Ongoing planning
During	Impact	Deployment of volunteers to determined sites Assessment of needs Defusing Preparation of psycho-educational materials
	Rescue and inventory	Assignments to Reception Centres and Staging Areas Psycho-educational presentations Groups Crisis intervention Worker care Outreach
After	Reconstruction and recovery	Ongoing assessment One-to-one sessions Beginning of longer-term planning Support of recovery efforts
		Long-term recovery efforts Return to "normal" Assessment of long-term needs Review of systemic ability for long-term response Determination of resource availability Referrals to long-term care

¹ For activation protocols, see Appendix 4.

Global Impacts of a Disaster

A disaster event will have an effect on individuals and communities across a broad range of domains. Some examples of the range of domains to consider include the following.

The **Economic & Political Environment** may experience effects such as economic and employment disruption, losses and major expenditures during and after the event. There may be a political effect including loss of confidence in elected officials. There may be an effect on the community's values, possibly including such values as the balance between economic development and protection of the quality of life and of life itself. The community may experience uncertainty with regard to the future.

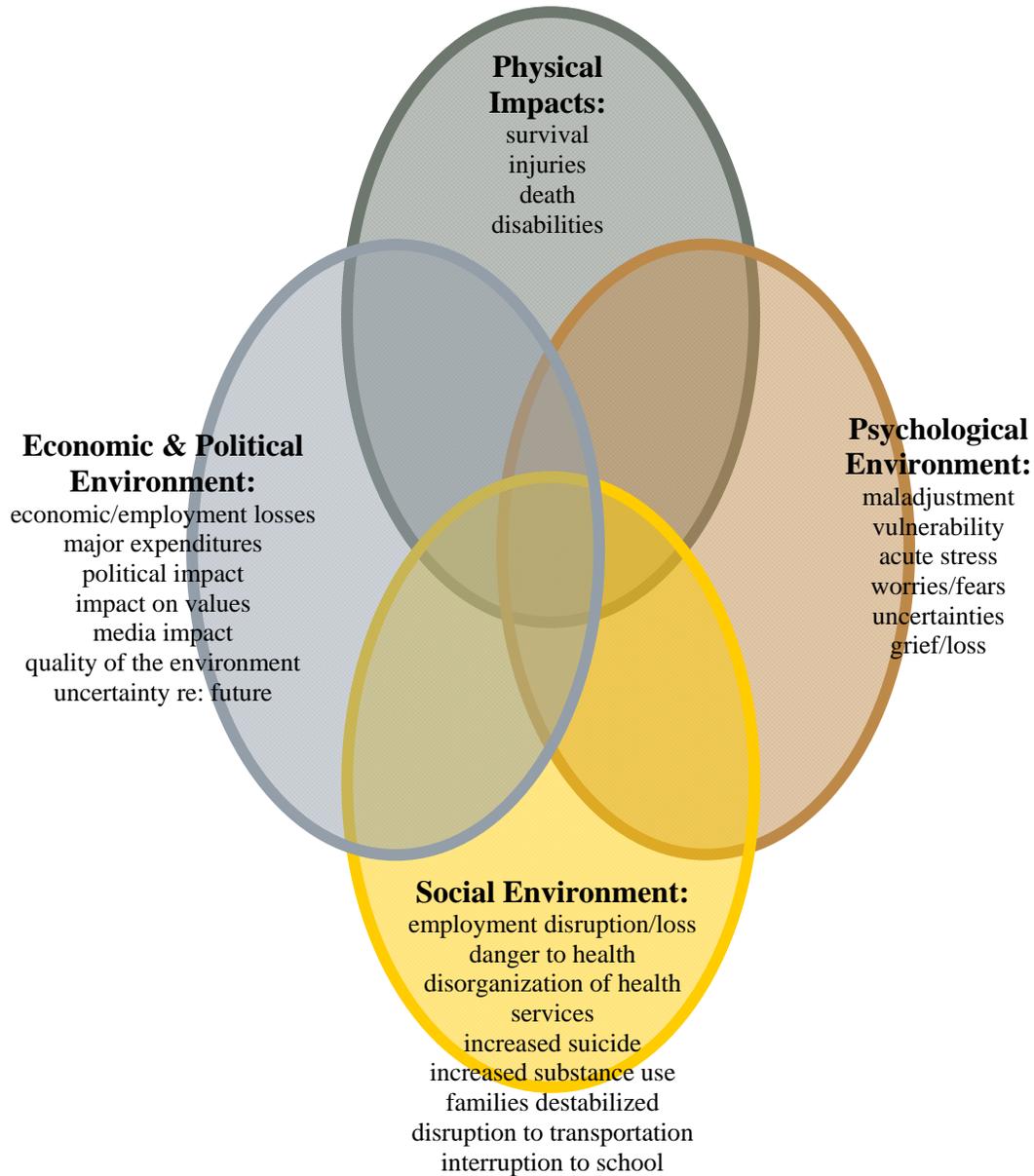
The **Social Environment** may be disrupted. Effects may be felt as work is disrupted and community members experience temporary or permanent loss of employment. There may be an increase in risks and vulnerabilities in the health of the population coupled with disorganization of health services. There may be an increased incidence of suicidality and the use of alcohol and other drugs. Families may be destabilized as their homes are disrupted temporarily or permanently. This may have an impact on family life and there may be an increase in separations, divorces, or violence in relationships. There may also be problems related to schooling, including delinquency. There may be disruptions to transportation and other aspects of social routines and relations.

The **Psychological Environment** may also be affected, resulting in psychological/emotional symptoms. Acute stress, loss and post-trauma responses may arise, as well as short or long-term dislocation and the ongoing challenges of recovery and re-establishment. The vast majority of affected individuals will return in time to pre-disaster levels of mental health; however, there may be an increase in the onset of psychological disorders (e.g., Post Traumatic Stress Disorder, Depression, Anxiety), and existing psychological disorders may be exacerbated. Other psychological impacts may include an increase in vulnerability, high levels of stress, increased worries or fears, and symptoms of grief or loss.

Physical Impacts may include injuries, morbidity, and disabilities and these physical impacts may interact to exacerbate any of the effects in other domains. Hospitals may be overwhelmed. Quarantines may have far ranging effects on individuals, families, and communities. Sequestering of essential services workers may be initiated. Special facilities may have to be created in order to address large scale physical effects on individuals and communities (for example, to contain a flu outbreak during a pandemic).

The following image illustrates the way in which various impacts caused by disasters are interconnected and overlapping.

Dynamic, Interconnected Impacts Caused by Disaster



Section 4: Psychological Impacts

This section deals with the psychological impacts of disaster events on client groups. In Section 5, this workbook will address interventions as they relate to various client groups.

Client Groups

Clients can be usefully grouped into three broad categories, each with differing needs with respect to specific interventions.

Primary clients are those who have directly experienced the disaster either as survivors or as witnesses. Survivors may experience symptoms of distress from mild to severe. The symptoms may be instant, delayed, transient, or chronic. Primary clients may be emotionally, physically, psychologically, or materially affected by the disaster.

Secondary clients are family members, friends, colleagues and anyone else who has a close emotional relationship with one of the primary clients. Secondary clients may be emotionally, physically, psychologically, or materially affected by the disaster.

Tertiary clients are those responding to the disaster. Tertiary clients include first responders (fire, police, ambulance, search and rescue, medical teams, stretcher bearers, hospital personnel, morgue personnel), secondary responders (workers in the Emergency Operations Centres and emergency social service providers), members of the DSTRS team, and other coordinators and leaders including all those within the BCERMS hierarchy.

Others at risk could include:

- particular groups of individuals or communities at greater risk because of a deeper connection or sense of identification with affected communities; for example, ethnic, religious, or professional identification;
- those not directly involved in the response but who are close witnesses, such as journalists; and
- those who may not be directly affected or connected but who identify closely with the victims or with the event and/or are emotionally unstable.

In many of these client groups there may be particular subsets of individuals who are more vulnerable and at greater risk for adverse emotional or psychological reactions; for example, children, seniors, and individuals with pre-existing emotional or mental health concerns.

Resiliency

Resiliency refers to the ability of individuals and communities to take action that will improve their own capacity to respond effectively to stressful circumstances. Resiliency is not a static quality; it is a process that can be developed and strengthened over time.

At the community level, resiliency is closely related to community sustainability. Community resiliency involves the ability to limit the adverse effects and social disruption of disasters and their aftermath. Individual resiliency describes the ability to reduce individual and family risks, to re-establish and sustain self-esteem and to nurture and revitalize individual and collective agency and social networks.

Resiliency theory is built on two basic themes: capacity and active involvement at both the community and individual levels. At the community level, resiliency theory is a strengths-based approach that recognizes the resources that every community has to support itself and respond to emergencies. Resiliency theory sees each individual, no matter how "vulnerable", as having the capacity to be an active partner in the community's recovery. Resiliency theory facilitates community ownership and commitment while building capacity and decreasing dependencies.

With a belief in resiliency, disaster response and recovery is built on existing community strengths, making it more effective and sustainable. The active involvement of community members develops dynamic response systems rather than passive systems that are activated only in emergencies. By focussing on capacity, individuals capitalize on their strengths through ownership and responsible partnerships. The way in which individuals perceive themselves and are treated makes a difference in how they act - as victims or as active partners.

Key questions in the implementation of resiliency principles include:

- How is community capacity defined and utilized as part of the disaster management plan?
- How can community actions enhance resiliency and translate into community responsiveness in emergencies?
- What resources does the survivor have to meet individual needs, family needs, and community needs?
- How can individual capacity be translated into action at each phase of disaster management?

Stress Reaction vs. Post Traumatic Stress Disorder (PTSD)

When dealing with an extraordinary incident, it is normal for people to show various signs and symptoms of acute and chronic stress. Psychosocial responders, who are therapists/clinicians, particularly if they are inexperienced in emergency response, are sometimes too quick to diagnose PTSD, perhaps because they themselves are reacting to the stress of the emergency. It is important, however, to be able to recognize and assess when PTSD is genuinely presenting. If the symptoms become too intense or persist, it is important to seek professional help. The psychosocial responder should offer immediate support and containment and refer the survivor to community resources. The ability to refer includes assessing the actual availability of resources and their accessibility to the survivor. It is important to remember that the psychosocial responder is there to offer immediate, short-term, and often concrete resources, **not** to engage in therapy.

Stress reactions are normal and expected following a disaster event. The following chart indicates some signs and symptoms of acute stress.

Physical Reactions	Emotional Reactions	Cognitive Reactions	Behavioural Reactions
<ul style="list-style-type: none"> • Increase in blood pressure • Fatigue • Muscular Pain • Nausea • Trembling • Perspiration • Increase in heart rate • Hyperventilation • Headache • Shivering • Gastro-intestinal distress • Pain • Indigestion • Disorientation • Decrease in coordination • Chest pains • Sleep disturbance • Appetite disturbance 	<ul style="list-style-type: none"> • Anxiety • Fear • Withdrawal • Resentment • Searching for scapegoat • Guilt • Feeling helpless • Sorrow • Decrease in activity • Anger • Despondency • Despair • Feeling abandoned • Depression 	<ul style="list-style-type: none"> • Inability to perform calculations • Confusion • Memory loss • Difficulty making decisions • Obsession for details • Poor concentration • Difficulty thinking • Memory flashes • Loss of interest in regular activities 	<ul style="list-style-type: none"> • Isolation • Withdrawal • Alcohol increase • Drug increase • Aggressive behaviour

PTSD Diagnostic Criteria

The following are PTSD diagnostic criteria following the DSM IV. There may also be long-term effects, such as sensitivity to smells or sounds, and heightened vigilance that do not fall within the diagnostic criteria of PTSD. When symptoms persist beyond 4-6 weeks a psychosocial responder may consider a diagnosis of PTSD.

A) Exposure to a traumatic event:

- actual or threatened injury
- intense fear, helplessness, or horror

B) Traumatic event persistently re-experienced:

- reoccurring thoughts
- reoccurring dreams
- flashbacks

C) Persistent avoidance of related stimuli:

- avoidant thoughts
- avoiding activities
- limited recall
- feeling of detachment

D) Increased arousal:

- difficulty sleeping
- difficulty concentrating
- hyper-vigilance
- exaggerated startle response
- appetite disturbance
- anxiety
- depression

E) Duration more than one month

F) Clinically significant distress and impairments:

- social
- occupational
- emotional
- sexual

Psychosocial Impacts - Adults

Disaster survivors may suffer a wide range of losses, some visible and others invisible. These losses may include the loss of loved-ones (e.g., family members, friends, companion animals, and co-workers), their health, home, material belongings, the environment to which they belong, and their hopes and dreams. Many of these tangible losses also involve symbolic losses. Objects that have a practical use can also be imbued with memories. Losses may include the loss of significant relationships and networks of support during prolonged evacuations, and may also include loss of a sense of security or faith.

When working with survivors it is important to work to support them in acknowledging the wide range of losses they may have suffered, and their psychological, emotional and physical response to those losses.

Loved ones may include any significant person from the community (e.g., child, parent, partner, friend, neighbour, teacher, daycare worker, minister, nurse, or local store owner). There may be a loss of the sense of being able to protect loved ones or keep them safe. There may also be the loss of a pre-existing support network.

Health may suffer as a result of the disaster environment. There may be smoke, contaminated water or air and other environmental hazards. There may be physical injuries and their consequences such as paralysis, amputation, or impaired functioning. In addition, survivors may have lost the illusion of their own immortality.

Material Belongings often serve as tangible links to the past; for example, inherited items, photos, and other treasured objects. There may also be the loss of material possessions that support day-to-day functioning such a favourite bike, cooking knife, tools, or plants. There may be the loss of a house, representing both a physical structure and a home. There may be other material losses related specifically to the nature of the environmental and/or employment context (for example, fencing and range or arable land, or standing timber).

Animal losses may include companion animals, guide or other aid animals, or animals used in earning one's living, such as farm animals or breeding animals.

Employment losses may include the loss of a place of work, loss of physical, emotional, or cognitive capacity resulting in a reduced ability to return to work. There may also be the loss of someone's own business: the structure, goods, networks, supply or clients.

Environmental losses may include changes to the living environment such as burned trees, lost neighbourhoods, and destroyed landmarks. The community may have lost its community buildings or private or public gathering place such as the seniors' centre, legion hall, community centre, kids' club, or skateboard park. There may have been total devastation of a community or neighbourhood.

Finally, there may be a loss of **dreams** as future plans become uncertain. Survivors may experience the feeling of having to start over again. They may have lost their sense of optimism or of faith.

A survivor may have suffered all or only some of these losses. Regardless, it is important not to define the person only in terms of their losses but also recognize and acknowledge what has been survived and what may, in time, be reclaimed or re-created.

Psychosocial Impacts - Children and Adolescents

The losses caused by a disaster produce various psychosocial effects because they sever or threaten important bonds for those affected. Psychosocial effects can appear at different times: immediately, in the short, medium or long term. Children and adolescents are affected differently from adults, in ways that correspond to their developmental stage as detailed in this chart.

Age	0-6years	7-12 years	13-17 years
Potential Losses	family, friends, home, pets, favourite toys, , daycare or preschool, teachers	family, friends, home, pets, prized possessions, health, sports activities, school, teachers	family, friends, home, pets, prized possessions, health, peer group, sports activities, school, teachers, work
Physical Reactions	headaches vomiting various pains	headaches decrease in appetite trouble sleeping bed-wetting visual or hearing problems	headaches stomach aches decrease in appetite insomnia hypersomnia
Emotional Reactions	anxiety phobias angry outbursts sleeping problems nightmares	fears, worries phobias angry, aggressive behaviour nightmares	worry tension sadness withdrawal suicidal ideation
Cognitive Reactions	loss of interest confusion poor concentration fear of strangers	loss of interest poor concentration, attention	loss of interest poor concentration, attention trouble making decisions
Behavioural Reactions	regression to earlier stages: toilet training thumb sucking clinging	school refusal reluctance to leave parents	apathy agitation, angry outbursts disruptive or absent from school alcohol /drug abuse
Other Elements	<ul style="list-style-type: none"> • routines have been disrupted • family may have been evacuated • parents may be preoccupied by the situation or worried about losses • young children are extremely sensitive to what their parents are going through 	<ul style="list-style-type: none"> • their environment, the school, the places they frequent may have changed • parents may be preoccupied by the situation or worried about losses • older children are impacted by news from friends, teachers, the media in addition to their parents 	<ul style="list-style-type: none"> • regular activities such as sports, social events, school, work may be disrupted. • parents may be preoccupied or worried about losses • older children are impacted by news from friends, teachers, the media in addition to their parents

Psychosocial Impacts - Emergency Responders

The importance of caring for all levels of responders cannot be overstated. Support for their well being is crucial in order to sustain both their health and their operational viability, and in turn the viability of the disaster response. Stress results in decreased efficiency and work performance. Stress interferes with judgment and the ability to make good decisions. Responder stress and trauma can have a ripple effect, resulting in an impact on the team, the organization, the responder's family members and the community.

The role of a Psychosocial Responder with respect to the Emergency Responders is two-fold: (1) to minimize stress, and (2) to assess stress levels and provide consultation to supervisors to ameliorate stress levels.

Sources of Stress

Many emergency responders are involved in some form of care giving in their everyday professional and private lives; for example, they may be ambulance attendants, fire fighters, health care workers, or clinicians. Many are exposed to high levels of stress, crisis events, and/or death and bereavement in the context of their everyday work. This professional background can offer the responder greater resilience and also greater vulnerability in disaster response, depending on the nature of the disaster and the circumstances of the responder's life at the time.

Research shows that disaster responders may be vulnerable to short and long-term stress reactions. The most common long-term stress reactions include **burnout**, **secondary traumatic stress**, and **compassion fatigue**. It is important for responders to pay attention to their own health and well-being. This includes being informed about work-related stress in disaster response, having realistic expectations, and knowing and respecting their own and others' limits.

Pre-event stresses may include poor preparation or briefing, lack of adequate or relevant training, and lack of clarity regarding the job, role, or tasks.

Event-related stresses may include being part of a collective crisis; attending a mass casualty incident with distressing sights, sounds, or smells; prolonged exposure to the event; experiencing uncertain conclusions or ambiguous successes, and experiencing unsafe or unhealthy working conditions.

Occupational stresses may include time pressures; responsibility overload and multitasking; multiple demands or priorities; physical demands requiring strength,

stamina, endurance, long work hours, adverse conditions; the demands of an emotionally charged environment; exposure to trauma stories; cognitive demands such as problem solving, decision making, prioritizing; limited resources; high personal and organizational expectations; moral dilemmas; being detached or distant from support systems such as family and friends; and feeling unsupported. Additional stresses may include the accumulation of work left behind and the impact of that personally and on colleagues.

Organizational stresses may include unclear, inadequate, or inconsistent supervision or leadership; ineffective communication and information dissemination; and unaddressed or acknowledged conflict.

Environmental stresses may include extreme weather conditions; environmental hazards such as poor air and water quality; a devastated natural environment; or challenging working condition.

Reactions to Stress

Emergency Responders may react to stress in a variety of ways, including cognitive, emotional, behavioural, and physical elements.

Cognitive reactions to stress may include problems concentrating, memory loss, difficulty making decisions, confusion, excessive worry, or tunnel vision.

Emotional reactions to stress may include over-identification with survivors; misdirected anger; blaming; overwhelming sadness, depression or moodiness; apathy; feelings of inadequacy, vulnerability, hopelessness, or suicidal thoughts.

Behavioural reactions to stress may include withdrawal from family, friends, or colleagues; excessive or increased use of alcohol or drugs; hyperactivity, constant talking or doing; unexpected or extended periods of crying; changes in sleeping patterns, such as not sleeping or sleeping excessively; exhaustion;

hyper arousal or an increased startle response; and a sense of being "on alert".

Physical reactions to stress may include increased blood pressure and respiration; fatigue; nausea or stomach upset; diarrhoea; excessive sweating or chills; headaches; muscle soreness.

Spiritual reactions to stress may include changes in one's values or beliefs. Belief systems which can be affected include: belief in one's survival and a new or renewed sense of vulnerability; belief in the world as safe; sense of control; trust in the basic goodness of others, sense of lovability and belongingness; self-esteem and self-value; self-actualization and a sense of purpose.

Burnout, Secondary Traumatic Stress and Compassion Fatigue

Burnout is a state of exhaustion resulting from work. Symptoms include fatigue, sleep disruptions, headaches or stomach aches, body aches, or a compromised immune system. Work performance may be affected. Burnout may also result in isolation from friends and colleagues and increased conflict. Emotional and behavioural symptoms are similar to those experienced with secondary trauma stress, but may also include cynicism, isolation and carelessness. Burnout occurs over time. It may begin gradually but can worsen until the individual feels incapable of functioning.

Secondary Traumatic Stress (STS) or **Vicarious Trauma** occurs when those who experience trauma indirectly through caring for or involvement with someone who has been directly traumatized. Symptoms are the same as the symptoms of stress, but may also mirror the symptoms of post traumatic stress disorder (PTSD). Even without a diagnosable disorder, STS can affect the quality of life of workers and those close to them, as well as the quality of the working environment.

Compassion Fatigue is another term commonly used to describe a combination of burnout and STS reactions in caregivers. Compassion fatigue is more likely when support networks and supervision are reduced or absent, when demands on the caregiver are high over an extended period of time; and when successes are ambiguous.

Some stress reactions are to be expected and are considered normal in disaster work. If symptoms persist one may consider seeking professional help and may need to consider lifestyle changes and reducing exposure to disaster work.

Following is a list of common signs of stress among disaster responders. When psychosocial responders see these signs it may be helpful to engage/teach self-care strategies and consult with a supervisor.

Signs of stress in responders

- Loss of spirit, hope
- Grandiose beliefs or ideas in what you can or should do
- Recklessness, ignoring policies & procedures
- Cynicism, despair
- Loss of ideals, not caring
- Self-medicating (with alcohol, tobacco, caffeine, drugs)
- Isolating
- Irritability
- Anger at the organization
- Mistrust of colleagues, supervisors
- Inappropriate behaviour with survivors

Section 5: Managing the Psychosocial Response

Phases of the Psychosocial Response

Section 1 discussed the phases of a disaster event and the relationship between these phases and the activities of the psychosocial responders. In this section more detail is provided regarding those activities. It is important to bear in mind that these phases will overlap to a large extent.

1. Warning/Alert Phase

There may be no warning or threat phase. When there is no warning, people may experience a greater sense of vulnerability, shock, fear, and distress at their inability to protect their loved ones or themselves.

2. Impact Phase

The greater the scope of the destruction, loss of life, and personal losses associated with the disasters the greater the psychosocial effects. Reactions will vary, including shock, disorientation, confusion, disbelief, fear, and anxiety.

3. Rescue Phase

Survival and rescue are the priorities. Some survivors will be disoriented immediately after the disaster, and this disorientation may be replaced by adrenalin-induced rescue behaviours. Judgment may be impaired, increasing the risk of harm and injuries. Survivors may experience post-trauma reactions and concern for loved ones, particularly if they are separated. Individuals and communities may experience a greater sense of connection in having shared and survived the catastrophe.

4. Inventory Phase

At this stage, survivors may feel overwhelmed by the future. They may experience exhaustion, high levels of stress, anger, and despair.

Facing disillusionment

As the rescue phase ends and emergency services begin to demobilize, reality will hit. People may begin to face disillusionment. Survivors and their communities may face high levels of personal and interpersonal stress and conflict, as well as financial hardships. There may be frustration and anger at the bureaucracy involved in disaster aid. They may experience conflict at work or at home, stresses associated with ongoing or permanent relocation, and lack of time or resources to participate in recreational or leisure activities.

Survivors may also experience health problems including exacerbation of pre-existing conditions. They may also experience isolation, alienation, and discouragement as those for whom the impact is less are better able to move on. Conflict and resentment over the distribution of aid and resources may erupt and contribute to divisiveness, hostility and a general erosion of community cohesion and support.

5. Recovery and Reconstruction

This process may take years and is often not a linear progression. By this time, survivors have typically moved to greater self-reliance. Reconstruction, replacement of lost possessions and infrastructure, may trigger a renewed recognition of the losses.

This process involves integration of the experience and the changes that have resulted from it. Emotional resources in the family and from support networks may be depleted. Individual and community progress is idiosyncratic, depending on resilience and the level of resources and support.

Interventions with Client Groups

Section 4 discussed the impacts of a disaster event on various client groups. This section will focus on interventions that are appropriate for each.

Primary Clients

Primary clients are those who have directly experienced the disaster, either as victims or as witnesses. Primary clients should be encouraged to use **natural supports** and to talk with friends, family and co-workers, following their natural inclination with regard to how much and to whom they talk.

If someone wants to speak with a professional in the immediate aftermath period, a helpful response would be to listen actively and supportively but to resist probing for details and emotional responses. Let clients say what they feel comfortable saying without pushing for more. Validate their normal reactions to a stressful event, and their anticipated natural recovery.

Traumatic experiences may stir up memories and/or exacerbate symptoms related to previous traumatic events. Thus some people may feel like this is "opening up old wounds". These symptoms should also be normalized and are likely to abate with time. It may be helpful to ask people what strategies they have successfully used in the past to deal with this, and encourage them to continue to use them.

Individuals who continue for more than three months to experience **severe distress** that interferes with functioning are at higher risk for continued problems. These individuals should be referred for appropriate treatment.

When working with child or adolescent survivors, ensure that interventions are appropriate for the developmental stage of the child.

Secondary Clients

Secondary clients are family members, friends, colleagues and others who have a close emotional relationship with one of the primary clients. It is important to keep family members of the primary clients informed of all relief activities. "Not knowing" is the single most frequently cited stressor and information should be provided even when that information is simply that no concrete answers are yet available. When no official information is available, rumours grow. Attempt to have only one psychosocial responder liaising with family members to reduce confusion and uncertainty.

Psychosocial responders must recognize the fears, anger and anxiety of secondary clients. It is helpful to set up safe, peaceful and private places where survivors and their families can come together. As much as possible, protect all primary and secondary clients from the media.

Tertiary Clients

Tertiary clients are those responding to the disaster. Tertiary clients include first responders (fire, police, ambulance, search and rescue, medical teams, stretcher bearers, hospital personnel, morgue personnel), Secondary responders (workers in the Emergency Operations Centres and emergency social service providers), members of the DSTRS team, and other coordinators and leaders including all those within the BCERMS hierarchy.

Each response group has its own particular culture but rescue and response workers commonly have a high capacity for trust within their own group but tend to be cautious about trusting outsiders. Rescue workers may show great mental and emotional resilience during an operation but have intense emotional reactions afterwards because of their sensitivity to the feelings of survivors and their families.

Range of Intervention Strategies

Section 3 discusses a variety of intervention strategies that may be implemented during a disaster response. The choice of what strategy to use depends on:

- the phase of the response;
- a clinical assessment of the needs of the client or group;
- a clinical decision regarding what is most appropriate under the circumstance; and,
- the constraints and demands of the working environment.

On-scene psychosocial support is delivered primarily through crisis intervention, defusing (or "walk-and-talks"), psycho-educational strategies, consultation, and debriefing. These services may be informal or systematic, and may be conducted individually or with a group in a quiet setting away from the disaster scene. Formal debriefing may not be appropriate in this setting.

The following is a list of the range of roles and responsibilities of a DSTRS network responder. Decisions regarding what response roles and responsibilities are appropriate in a given situation should be made in consultation with DSTRS network coordinators and on-site supervisors.

Roles and Responsibilities of the Psychosocial Responder

- Assist the Coordinator in the facilitation of psychosocial support.
- In consultation with locals, assess the needs and the resources of individuals and the community.
- Provide direct intervention with affected population.
- Be available to provide outreach to the affected population.
- In consultation with local service providers, determine all available resources on site and in the community.
- Set a triage system if needed (with a priority system).
- Train paraprofessionals and volunteers emergency response workers and community members.
- Participate in daily operational staff meetings.
- Provide individual or group exit interviews with volunteers as requested.
- Determine disaster-related mental health needs of the affected population and staff and offer site support or refer as needed.
- Consult with other service providers, eg.: St-John's ambulance, Canadian Red Cross, or other ESS providers.
- Consult with community leaders as needed.
- Supervise psychosocial response service.
- Pass on operational information that may arise in your work schedule to the subsequent team.
- Record operational issues as they arise and forward to supervisor.

Goal of Interventions

With all client groups, the goal of interventions is to support the client's resilience and their natural ability to cope. Careful attention to the particular needs of a given client group will help the responder decide what interventions, if any, are appropriate. For most people the symptoms of traumatic stress, fear, and loss will gradually decrease over time. People should be encouraged, therefore, to use existing coping strategies if they find them effective; such as, connecting and talking with friends, family, and other natural supports. They should follow their natural inclination with regard to how much and to whom they talk. These goals take different forms during the various phases of the disaster.

1. Warning/Alert Phase

Assistance may include supporting evacuees in their decision-making and problem-solving and basic empathic support, combined with practical assistance such as information about shelters, evacuation routes, etc. Local responders may already be activated during this phase.

2. Impact Phase

During the impact phase, the key strategies are to protect, direct, connect, and triage.

Protect

Find ways to protect survivors from further harm and from further exposure to traumatic stimuli. If possible, create a “shelter” or safe haven for survivors, even if it is symbolic. The less traumatic stimuli people see, hear, smell, taste, feel, the better off they will be. Protect survivors from onlookers and the media.

Direct

Direct survivors kindly and firmly. They may be stunned, in shock, or experiencing some degree of dissociation. Direct ambulatory survivors away from the site of destruction, away from severely injured survivors, and away from continuing danger.

Connect

The survivors encountered at the scene have just lost their connection to the world that was familiar to them. A compassionate, verbal or nonverbal exchange between the responder and the survivor may help restore their experience of connection to shared societal values of altruism and goodness. Help survivors connect to loved ones, to accurate information and appropriate resources, and to where they will be able to receive additional support.

Triage

The majority of survivors experience normal stress reactions; however, some may require immediate crisis intervention to help manage intense feelings of panic or grief. Signs of panic include trembling, agitation, rambling speech, and erratic behaviour. Signs of intense grief include loud wailing, rage, or catatonia. In such cases, attempt to quickly establish therapeutic rapport, ensure the survivor’s safety, acknowledge and validate the survivor’s experience, and offer empathy.

3. Rescue Phase

During the rescue phase, continue to protect, direct, connect and triage. Augment these concrete interventions with psycho-educational interventions. Keep information simple and clear. Provide defusing, stress reactions and stress management education. Help survivors cope with “normal” stress reactions by providing unobtrusive, respectful, practical and emotional support. Emotional support, including your physical presence, listening and empathic engagement, enhances recovery. Resilience is enhanced as

soon as a person begins to perform even the smallest act, such as getting coffee or tea. Assess and identify individuals and families who may require more support and/or other mental-health interventions.

By establishing a positive working relationship with survivors the psychosocial responder can help them to establish their own capacity in responding and in accepting assistance. Strategies include supportive listening, problem-solving immediate issues, community meetings, information and referral. Responders may request formal debriefings. Psycho-educational interventions include normalizing stress and trauma responses, acknowledging and fostering resilience, and providing practical tools to enhance resilience and stress management. Responders should anticipate the need for information about ongoing support and concrete resources.

4. Inventory Phase

During the inventory phase, responders should assess the needs, vulnerabilities, and resources of survivors. Specific strategies include:

- supporting survivor participation;
- facilitating support networks;
- initiating community meetings; and,
- networking with existing resources in order to foster community and individual capacity.

In response to disillusionment characteristic of this phase, psychosocial responders can offer:

- promotion of personal and community involvement;
- conflict resolution interventions;
- advocacy;
- community outreach and education;
- case management;
- brief counselling;
- problem-solving, solution-oriented counselling; and,
- information and referral.

5. Recovery and Reconstruction

During the recovery and reconstruction phases, psychosocial response planning should anticipate anniversaries and the potential need for extra support at those times.

Psychosocial response planning should anticipate the exhaustion of natural support networks for individuals, families, and communities. It is important for the various social support systems to be able to identify those individuals and families who continue to experience problems.

Specific Intervention Strategies

Psychosocial response involves a range of interventions, including:

- psychological support
- instrumental support
- education
- advocacy
- problem solving
- referrals
- psychological first aid
- worker care
- organizational consultation

The goal of intervention strategies is to support clients in **regaining a sense of control** and beginning their recovery process. Intervention strategies are used to help **diminish psychological arousal**, to clarify the current situation, and to **improve adaptive coping strategies**.

Intervention strategies include:

- educating people about the most common crisis reactions;
- validating and normalizing stress and grief reactions;
- defusing the emotional overwhelm that arises from the crisis reactions;
- assessing the need for referrals to longer term or other mental health services ;
- supporting and providing cognitive strategies for clients to organize their thinking, to begin 'storying' and to integrate their experience;
- reorienting client to the present (what are they currently experiencing, and what might they experience in the immediate future); and,
- reassuring them that most people cope well.

If someone wants to speak with a professional in this immediate aftermath period, a helpful response will be to:

- listen actively but do not probe for details or emotional response;
- provide an opportunity for clients to tell you about their experience;
- validate and normalize their reactions and experiences; and,
- provide instrumental support, including advocating for better access to services or the provision of additional required resources.

Depending on your involvement and the timing of your interaction you may also want to try the following.

1. Help clients anticipate recovering and coping effectively. Support them in identifying existing coping strategies and provide them with other suggestions as appropriate.
2. Help clients to predict what problems they think they may encounter in the next couple of days or weeks and support clients in problem-solving. If you anticipate other issues they have not identified provide them with concrete information.
3. Help clients anticipate emotional and physical reactions; such as stress or grief reactions in themselves or others.
4. Help clients plan for what is to come by providing information about resources, supporting their decision-making and providing referrals.

These strategies can often be done on the spot, or in the context of a gentle walk (similar to defusing or "walk and talks" with crisis responders), or in a quiet spot in a reception centre.

Individual Psychological First Aid Sessions

You may be asked to provide 1-4 sessions with clients in the aftermath of a disaster. Remember, however, this is not therapy.

Outline of Psychological First Aid Sessions

- 1) Explain to the client the goal of the session:
 - review that this kind of intervention is designed to reduce the likelihood of chronic problems;
 - explain that this 'social support' is free and the DSTRS providers are volunteers;
 - discuss confidentiality and limits of confidentiality;
 - explain that up to 4 sessions will be offered; and
 - ask the client to sign a release of information as appropriate.
- 2) Review emotional, physical and cognitive reactions both at the time of the disaster and since then.
- 3) Provide education about trauma and information about treatment resources.
- 4) Review the person's support system.
- 5) At the last session, assess the need for sustained treatment.
- 6) Help survivors take practical steps to resume ordinary, daily life. Psychological first aid should foster accurate expectations and planning about returning to normal routines.
- 7) Provide support and information to the survivor.
- 8) Be concrete and practical in your support; focus on the survivor's immediate needs.

Additional Psychosocial Response Functions

In addition to clinical activities with disaster survivors, the DSTRS network can take on a variety of other responsibilities, some of which are listed below.

A. Psychoeducational Presentations, Groups, and Training

- 1.) Provide psycho-educational presentations and/or training.
- 2.) Provide training to volunteers on psychological first aid and psychosocial response.
- 3.) Facilitate orientations on aspects of self-care/worker care to other responders.
- 4.) Assist in the provision of local and regional worker-care plans and services.
- 5.) Assist in the provision and awareness of psycho-educational groups with affected communities and groups.

The format of these groups would depend on the need and the specific group. Generally the goal of these groups would be to:

- provide a safe space for emotional expression;
- provide opportunities for cognitive reframing;
- provide information about signs and symptoms of stress and other emotional responses;
- identify and reinforce resiliency and positive coping styles;
- mitigate long term stress reactions; and
- provide an opportunity for the development of community-based networks of support and/or planning.

B. Assessment

Conduct and co-facilitate psychosocial response during needs assessments with all client groups

C. Administrative Support

- 1.) Assist with the accessibility of self-care, community resources for primary, secondary and tertiary clients.
- 2.) Assist with the accessibility of employee assistance, critical incident stress debriefing, and spiritual care as appropriate.
- 3.) Assist in the development of means for workers to stay in touch with key family and friends if on an extended assignment.
- 4.) Provide consultation to, and co-facilitate with disaster services supervisory, managerial, and administrative personnel in worker care related activities such as conflict resolution, team building, informational needs, operational and psychological debriefings, and exit interviews.

Worker Care Specific Strategies

Defusing

Defusing is a technique that allows emergency workers the opportunity to express their thoughts and feelings about the rescue without feeling obligated to do so. Compared to a formal debriefing, defusings are brief (10-30 minutes) and can be offered continuously throughout the operation. The purpose is to allow responders to express and better understand their own reactions while also allowing the DSTRS volunteer to look for indications of long-term stress reactions. DSTRS volunteers must be careful to avoid the appearance of voyeuristic probing. Finding ways to be in the vicinity of workers on breaks, is often a means to conduct informal defusings.

Helpful Questions:

- “Where are you from?”
- “What rescue tasks are you involved with?”
- “What is it about this situation that concerns you the most?”
- “How do you handle what’s going on?”
- “How is this the same or different from other operations you’ve been involved with?”

The range of possible topics that may present themselves for defusing is broad and depends on:

- the nature of the disaster
- proximity to scene of impact
- personal injury/direct losses
- perception of effectiveness of mission
- role ambiguity, perception of control
- managerial styles, effectiveness of communication
- encounter with human remains (particularly of children, mass deaths, close connection with those injured/killed)
- working conditions (weather, length and number of shifts, housing)
- self-expectations
- levels of support/preparedness

Note: Psychological Debriefing (PD) and in particular one-session interventions shortly after a trauma are *not recommended*. Outcome studies of PD overall do not support this intervention. Some studies found that in the long run, a single-session of PD may hinder natural recovery. If survivors do present to clinics or counsellors requesting help, they should be scheduled for 2-3 more visits over 2-6 weeks time.

Stress Management Strategies

Disaster responders have a deep commitment to working long hours without breaks and may quickly dismiss suggestions about using time to relax. The following guidelines are suggested to help psychosocial response professionals establish rapport with disaster workers and to encourage them to consider stress-management strategies.

Guidelines:

1. Inquire about how long they have been on the job and about previous disaster experience.
2. Inquire about coping strategies they have successfully used previously and invite them to use those and consider others.
3. Inquire about major stressors.
4. Inquire about sleeping and eating patterns and level of fatigue.
5. Validate fatigue and its effects. Remind them that relaxation is a tool.
6. Discuss their general vulnerabilities, for example the inability to stop working or thinking about the disaster.
7. Invite them to consider engaging in relaxation strategies, such as, muscle relaxation, conscious breathing, autogenics, visualization, etc. If they are interested, you may have between five and fifteen minutes to demonstrate the value of relaxation. The challenge is to do this quickly and in the midst of chaotic environments. When possible, have handouts available that describe the techniques.

Organizational Consulting

Psychosocial support to emergency responders depends on establishing rapport between the team and the command staff, rescue team managers, and workers. Knowing intervention protocols is not enough to be effective; DSTRS volunteers must be seen as well-organized and professional if they are to be accepted by the disaster responders. Psychosocial responders can also play a role in encouraging first responder organisations to solicit the help of other supportive agencies in identifying sources of worker stress and reducing that stress.

Psychosocial responders can expect rescue workers to resist working with them. Understanding the stressors associated with rescue work and the rescue work culture can make it easier to build trust. An early presence at the site can also help psychosocial responders become integrated into the response team. Assisting in all manner of activities helps to install the psychosocial responder as a full member of the team. Psychosocial responders should be prepared to "roll up their sleeves" and get involved in the work.

Worker Care Suggestions

- Rotate personnel to allow breaks away from the incident area.
- Provide break area, back-up clothing, nutritious food and the time to eat properly.
- Rotate teams and encourage teams to share with one another.
- Phase out workers gradually from high-to medium-to-low stress areas.
- Be available for defusings for all workers as they go off duty or take breaks.
- Provide exit interviews when requested.
- Encourage effective self-care strategies during and after a response.

DSTRS responders can best assist emergency team managers by assuming the role of a low-key observer and advisor role. Responders and team managers will be most likely to accept these suggestions if they see the DSTRS Responder as a supportive helper to their team rather than a detached, professional outsider. In this role the psychosocial responder will be able to provide crisis intervention in the rare cases of severe adverse reactions by responders.

When there are concerns regarding a worker's functioning offer your assessment, but keep in mind the decision to allow a responder to return to the job, be transferred to less distressing tasks, or be released from work must be made by the function supervisor or the safety officer.

Dos and Don'ts in Disaster Response

Do

- Introduce yourself and define your program/service.
- Provide clear information, defining what you can and cannot do as a responder.
- Find the resources available and refer the survivors to them
- Respect and follow the chain of command

Do

- Help survivors focus on short term goals
- Focus on problem-solving and concrete solutions
- Focus on strengths and potentials

Do

- Explain that their feelings and reactions are normal, given this abnormal situation.
- Encourage people to express all their feelings
- Listen to verbal and non-verbal cues and modify efforts accordingly
- Be patient and tolerant
- Be vigilant around the special needs of some groups
- Be aware of your own feelings/ stress
- Understand that each person heals in his/her own way
- It is OK to tell someone that you are touched or sorry about their pain.
- It is OK to say "I don't know." "Let me see what I can do."

Don't

- Don't do therapy.
- Don't use mental health terms or labels.
- Don't insist if people are reluctant to talk about their personal feelings.
- Don't give a religious explanation for their situation.
- Don't ask people how they are feeling in the midst of a disaster event.

Don't

- Don't promise what you cannot deliver.
- Don't try to do everything - you are a part of a team.
- Don't play down the crisis or the magnitude of the situation.
- Don't judge, moralize or accuse.
- Don't comment about the government or the system.

Don't

- Don't project your own feelings.
- Don't talk about your personal situation.
- Don't interrupt.
- Don't take anger personally or respond angrily to people.
- Don't tell people that you fully understand their situation.
- Don't compare situations or survivors reactions.

Section 6: Surviving the Work

Disaster response work is challenging and stressful. It is not suited to everyone, and it is important for prospective volunteers to consider carefully the list of competencies offered on page 2 of this workbook. This section addresses techniques that are available to responders for maintaining their own equilibrium through self care.

Self Care Strategies

Preparation

As for all disaster responders, prior preparation is essential for DSTRS responders. Regardless of one's professional capacity to meet the suffering of others and cope with stress, disaster response is out of the normal routine of one's work life and therefore can present new and sometimes overwhelming challenges. Every responder must build personal and team resilience to increase one's capacity to adapt and respond effectively.

Preparation for disaster response should include developing a personal care plan.

Some elements of a Self-Care Plan

- Get up-to-date disaster-specific training, education and practice.
- Develop dynamic support networks of other individuals involved in psychosocial response.
- Ensure organizational support for participation in disaster response, or (for private practice) make a plan for current clients.
- Develop awareness and Emotional IQ (EQ).
- Engage in routine activities that support mental, physical and emotional health.
- Identify what specific things you find stressful in your work and life.
- Identify what stress relief and management practices you have successfully engaged in the past that have helped you cope with the stress of care-giving.

On-assignment

While on assignment, the work environment and tasks may present significant challenges. The environment in which you work may be foreign, may not include the comforts, or at times even the necessities which are familiar and assumed at home. The hours are often longer than normal, and the work atmosphere is often characterized by a sense of urgency, uncertainty, role ambiguity, high levels of stress throughout the organization, and at times may involve ongoing threat. As a result, engaging in effective self-care strategies while on assignment is essential. It also models for other workers a healthy and sustainable approach to disaster response.

Self Care Strategies can include:

- Identify major stressors.
- Be assertive.
- Practice existing relaxation strategies.
- Pace yourself.
- Learn new relaxation strategies
- Seek out support (before, during, after).
- Talk it out with friends, colleagues, support workers.
- Listen and support others.
- Avoid excess and self-medication.
- Acknowledge how you are feeling and allow yourself to feel.
- Develop realistic expectation of yourself and others.
- Exercise (includes stretching on the job, taking a short walk on a break, getting a cardiovascular workout each day).
- Take care of yourself physically by resting, taking breaks, eating healthy, drinking lots of water.
- Maintain contact with your support network (friends at home, family).
- Seek support and counselling.
- Acknowledge that none of us is a superhero.

Being a member of a supportive, well functioning team enhances resilience and effectiveness for members of the team; it reduces stress while increasing trust, and the sense of being supported. Regular conversations about how the team is doing and how the work is going create an atmosphere of support and mutuality. Regular attention to defusing activities and open, respectful dialogue create an atmosphere open to conflict resolution. All of these activities contribute to the effectiveness of the team, and the success of the work.

Re-entry

One of the challenges upon return from a disaster assignment may be a sense of isolation and a lack of colleagues/friends with whom to process your experiences. Finding others who have shared your experience or who have some other disaster experience can be helpful. While many or most psychosocial responders may already actively incorporate effective self-care strategies into their personal and professional lives, some of the following may be helpful reminders of how to support healthy and successful processing of one's disaster experiences:

- contemplation and purposeful processing of the event;
- seeking social support, particularly with those that 'get it';
- engaging in cognitive behavioural activities that provide comfort (e.g., listening to music, writing about the event) or that provide an outlet for sharing the experiences (e.g., giving presentation);
- engaging in physical activity, hobbies, relaxation;
- reconnecting with spiritual communities and/or practices; and,
- ensuring healthy eating.

We encourage all DSTRS network responders to commit to enact self-care strategies, and to a continual process of self-evaluation of individual stress levels and the responder's ability to respond to that stress. This includes a self-assessment of one's readiness at any given time to participate in a disaster response.

Conclusion

This workbook was prepared for use in conjunction with a two-day workshop for clinicians who are interested in volunteering their time with the DSTRS network. Its purpose is to provide an overview of psychosocial emergency response and to offer clinicians some tools for use in the field.

We hope that the workshop and workbook will whet your appetite for participating in disaster response while providing a realistic sense of this difficult and rewarding work. Our goal, for those of you who choose to volunteer your time in this way, is to help you better equip yourself for the challenges so that you can enjoy the rewards.

Good luck!

Members of the DSTRS Workshop and Workbook Planning Group

Section 7: Further Reading

And now what? A helping hand for children who have suffered a loss
www.crisis.org/document.htm

A guide to managing stress in Crises Response Profession
www.samhsa.gov

Developing Cultural Competence in Disaster Mental Health Programs
www.mentalhealth.samhsa.gov/publications/allpubs/SMA03-3828/default.asp

Disaster Counselling Fact Sheet
www.mentalhealth.samhsa.gov/publications/allpubs/KEN-01-0096/default.asp

Field Manual for Mental Health and Human Services Workers in a Major Disaster
www.mentalhealth.samhsa.gov/publications/allpubs/ADM90-537/Default.asp
americanprofessional.com/insight.htm

Breslau, Naomi. (1990). Stressors: Continuous and discontinuous. *Journal of Applied Social Psychology, 20*(20), 1666-1673.

Bryant, R.A. (2000). Acute Stress Disorder. *PTSD Research Quarterly, 11*(2), 1-7.

Bryant, R.A. & Harvey, A.G. (1997). Acute Stress Disorder: A critical review of diagnostic issues. *Clinical Psychology Review, 17*, 757-773.

Kessler, R.C., Sonnega, A., Bromet, E.J., Hughes, M., & Nelson, C.B. (1995). Posttraumatic Stress Disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*(12), 1048-1060.

Koopman, C., Classen, C.C., Cardena, E., & Spiegel, D. (1995). When disaster strikes, Acute Stress Disorder may follow. *Journal of Traumatic Stress, 8*(1), 29-46.

Kulka, R.A., Schlenger, W.E., Fairbank, J.A., Hough, R.L., Jordan, B.K., Marmar, C.R., et al. (1990). *Trauma and the Vietnam War generation: Report of findings from the National Vietnam Veterans Readjustment Study*. New York: Brunner/Mazel.

NSW Institute of Psychiatry and Centre for Mental Health. (2000). *Disaster Mental Health Response Handbook*. North Sydney: NSW Health.

Ursano, R.J., Grieger, T.A., & McCarroll, J.E. (1996). Prevention of posttraumatic stress: Consultation, training, and early treatment. In B. A. Van der Kolk, A.C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 441-462). New York: Guilford Press.

APA Help Centre offers material to the public on managing traumatic stress after Hurricane Katrina www.APAHelpCentre.org

APA has posted news about its involvement in hurricane relief efforts on the www.apapractice.org and www.apa.org websites. In addition, APA has posted a new fact sheet entitled "Managing Traumatic Stress: After Hurricane Katrina" on the front page of its online consumer help centre, www.APAHelpCenter.org

The Department of Health and Human Services has established a website

<https://volunteer.hhs.gov>

<https://volunteer.hhs.gov>

and

toll-free number (1-866-KAT MEDI) to help identify health care professionals and relief personnel to assist in Hurricane Katrina relief efforts.

http://www.ncptsd.org/topics/disaster_handout_pdfs/Psychosocial_Treatment.pdf

http://www.ncptsd.org/topics/disaster_handout_pdfs/suicide.pdf
(PDF)

http://www.ncptsd.org/topics/disaster_handout_pdfs/Reactions_Survivors.pdf

http://www.ncptsd.org/topics/disaster_handout_pdfs/EFFECTS_hurricanes_Norris.pdf

http://www.ncptsd.org/facts/disasters/fs_helping_survivors.html

Phases of Traumatic Stress Reactions in a Disaster:

http://www.ncptsd.org/facts/disasters/fs_phases_disaster.html

Disaster Rescue and Response Workers:

http://www.ncptsd.org/facts/disasters/fs_rescue_workers.html

Working with Trauma Survivors:

http://www.ncptsd.org/facts/disasters/fs_working_disaster.html

Understanding Disaster Trauma: Effects of Traumatic Stress in a Disaster Situation

http://www.ncptsd.org/facts/disasters/fs_effects_disaster.html

Mental-Health Intervention for Disasters:

http://www.ncptsd.org/facts/disasters/fs_treatment_disaster.html

Anger and Trauma:

http://www.ncptsd.va.gov/facts/specific/fs_anger.html

Grief and Death: Casualty and Death Notification

http://www.ncptsd.org/facts/disasters/fs_death_notification.html

Managing Grief after Disaster:

http://www.ncptsd.org/facts/disasters/fs_grief_disaster.html

Early Intervention for Trauma: Current Status and Future Directions

http://www.ncptsd.org/facts/disasters/fs_earlyint_disaster.html

Recommendations for Pharmacologic Treatment of Acute Stress Reactions:
http://www.ncptsd.org/facts/disasters/fs_medication_disaster.html

Treating Survivors in the Acute Aftermath of Traumatic Events:
http://www.ncptsd.org/facts/disasters/fs_shalev.html

Cautions on Mental Health Interventions Provided Within a Month of Trauma:
http://www.ncptsd.org/facts/disasters/fs_cautions.html

<http://www.apa.org/practice/practitionerhelp.html>
<http://www.crisisinfo.org/documents.htm>

Appendix 1: Planning Tool

When responding to the psychosocial needs of those affected by a disaster, there are several phases. During any of these phases it is important to clearly plan for who one is assisting, what assistance is needed, and what can be provided. The following provides a general outline of the various stages of planning required.

Stage 1

Describe the incident: Global Environment, Living Environment, Individual Environment.

Stage 2

Identify the clientele.

Stage 3

Estimate the psychosocial impacts.

Stage 4

Identify the perceived needs.

Stage 5

Assess the resources available.

Stage 6

Prepare your intervention strategies.

Stage 7

Analyze your capacity to respond to the needs of the identified clients.

Stage 8

Assess the activities and reassess the needs.

Appendix 2: Psychosocial Responder Role in Reception Centre



DISASTER STRESS & TRAUMA RESPONSE SERVICE “DSTRS” Committee

Reception Centre (RC)

Local Emergency Social Services (ESS) groups set up Reception Centres (RC) in communities during emergencies, supported by the provincial ESS program. Reception Centres provide food, clothing and lodging to evacuees during a disaster. Many agencies are involved to provide additional services such as the Salvation Army (personal services), Canadian Red Cross (family reunification), St. John’s Ambulance (first aid), and any additional groups the situation demands.

The volunteer counsellor/psychologist’s role falls under the responsibility of Health Services Branch within the Operations Section of the local Reception Centre’s management system.

Ministry of Health, DSTRS Committee and its representatives from the various professional associations will activate the volunteer therapist/clinician fan-out list in the event of an emergency. Therapists/clinicians will be contacted by their respective associations and asked if they are willing to assist, what time they have available and ultimately scheduled for shifts at the designated Reception Centre. At that time they will also be given information on where to report upon arrival.

Upon arrival at the Reception Centre

- Sign in at the volunteer services table (for WCB through provincial emergency program)
- You will be scheduled to attend a situational briefing.
- Report to the Personal Services Supervisor or the Emotional Support Supervisor.
- Wear identifying nametags only; include your role as ‘support person’ on it.
- Bring your professional identification.

Roles and Responsibilities

Therapists/Clinicians are responsible for providing support and, intervention if needed. This role at a Reception Centre is unique, as is each disaster, in that the work of the therapist/clinician requires flexibility. Please review the following:

Introduction

- Introduce yourself to the ESS volunteers and supervisors at the Reception Centre and begin to build relationships. They will seek you out later or refer evacuees to you once your role has been identified.
- Gather information on local demographics, social, community and cultural contexts and any other information of significance that may have implications for service needs.
- Determine all available resources on site and know what’s available. Cautionary note: be sure to consult with appropriate resources within the Reception Centre, don’t make assumptions on their services.

Contact

- Talk with the evacuees waiting to be seen and build a relationship. Evacuees spend many hours at a Reception Centre; you will be identified as a person to go to for support or help.
- Consult with, and connect evacuees with Reception Centre services (i.e. connect with the primary services such as food, clothing and lodging, spiritual care).
- Identify evacuees who should be seen immediately.
- Provide self-care and stress reduction information to evacuees and volunteers.
- Participate in daily operations section staff meetings to both learn the complexities of a RC and also provide educational information.
- Provide exit interviews/debriefing with volunteers as requested.

Clinical/Medical

- Determine disaster-related mental health needs of evacuees and staff, and offer on-site support or refer as needed to off-site resources.
- If mental illness is suspected, ask evacuee if they are prescribed any medication. If the medication is for mental illness ask if they are connected to a mental health team, which one and who is their worker. There may be a Community Mental Health Worker on site; refer the evacuee to them; otherwise refer them to their team for further follow up if needed. (Be tentative in your diagnosis and consult with others as appropriate.)
- People with severe and persistent mental illness may require further resources than a Reception Centre can offer. When the RC does not have a Community Mental Health Worker on site refer them to an appropriate service or to hospital if it is an emergency.
- Determine “disaster-aggravated mental health” needs (for example, mental illness) of evacuees and offer support, provide information and make referrals where appropriate.

Operational

- Identify issues or stressors as they arise within the Reception Centre and write it down for future reference. The goal is to ease evacuee or volunteer discomfort.
- Pass on operational information that may arise in your work or from the exit interview/debriefing that may be causing stress in volunteers; for example, through a suggestion box.
- Consult with other service providers such as St. John’s Ambulance regarding medical questions or the Canadian Red Cross regarding family reunification.
- Consult with community resources and leaders as needed.
- Ensure that the activity log or other documentation is completed by shift’s end in order to pass on the information to the next shift.
- Record operational issues as they arise and forward to the supervisor.

Working in a disaster situation can be a challenge for all concerned. A sense of chaos will likely increase the difficulty of the work and the challenge is how we deal with this. Although our role is providing support to volunteers/responders and evacuees or victims, it is important to pay attention to how we respond, what our needs may be and what level of coping skills we have for that environment. It will be important to talk with each other and with your association’s representative when situations arise that you have concerns about.

Your work is important to the efforts of a disaster response and your well-being is a priority for us, please remember to use your self-care techniques.

Thank you for offering your time and energy!

Appendix 3: The DSTRS Committee



DISASTER STRESS & TRAUMA RESPONSE SERVICE “DSTRS” Committee

BASIC PRINCIPLES OF PSYCHOLOGICAL FIRST AID Intervention Reminders for One-to-One Situations

1. Psychological first aid is not therapy.
2. All sessions are confidential.
3. Explain to the client the goal of the sessions:
 - a) Explain that there is no cost for this social support and the DSTRS counsellors and psychologists are volunteering their services.
 - b) 3-4 sessions will be offered.
 - c) Ask the client to sign the release of information if/when a referral is made.
4. Review emotional, physical and cognitive reactions:
 - a) At the time of the disaster
 - b) Since then
5. Provide education about trauma and information about treatment resources
6. Review the person's support system, both formal supports and community supports.
7. Assess the need for sustained treatment (last session)
8. Help survivors take practical steps to resume ordinary, daily life. Psychological first aid should foster accurate expectations and planning about returning to normal routines.
9. Provide support and information to the survivor
10. Be concrete and practical in your support; focus on the survivors' immediate needs.
11. A complication to psychological first aid may be when there is a threat to personal safety or freedom.
12. You are bound by the ethical principles and code of ethics of your professional organization while volunteering.

Appendix 4: Activation Protocols



DISASTER STRESS & TRAUMA RESPONSE SERVICE (DSTRS) Committee

DSTRS Network Callout Protocols

Coordinator activation responsibilities

1. Receive request for DSTRS network services from:
 - Emergency Operation Centres (EOC);
 - Reception Centres;
 - Non Governmental Organizations (NGO) e.g.: Red Cross, Salvation Army; and,
 - An agency involved in a disaster; e.g.: Immigration Canada.
2. Receive first contact from one of the four DSTRS coordinators, starting from the top down:
 - Heleen Sandvik
 - Robin Cox
 - Bev Abbey
 - Nicole Aube
3. Coordinator gathers and documents as much information about the disaster situation as possible, including deaths and losses. Logistical information:
 - Who is requesting, contact information?
 - Who will support be provided to?
 - Who will they report to?
 - Past and present situation of those involved.
 - Location of response site.
 - Scheduling – how many people, how many shifts, hours of shift.
 - Determine and inform the caller who will be the ongoing coordinator for this response; yourself or one of the other 3 coordinators.
 - All volunteers will be activated under the provincial emergency program act, lodging, food and transportation will be covered where appropriate.
4. Coordinator contacts the representatives for British Columbia Association of Clinical Counsellors (BCACC), British Columbia Psychological Association (BCPA) & British Columbia Association of Social Workers (BCASW) to request

- they activate their callout protocol. Provide the above information (#3) to them in order to pass on to the volunteer therapists.
5. When therapists are willing to assist, provide them with the information from #3. Volunteers contact their respective representatives as needed and as the situation unfolds, unless otherwise informed. If it is a brief, small callout it may be more efficient to contact the coordinator rather than their association representative. Document everything.
 6. The coordinator will inform the person who requested support of available therapists coming to their site: when, how many, who will be their ongoing contact.
 7. The coordinator will also inform other related agencies of DSTRS activation: for example, the Ministry of Health contact, and the impacted health authority. Emergency Operation Centres (EOC) that are activated.
 8. Worker Care: coordinators are responsible for ensuring that volunteers receive the support they require, including a description of their role and the responsibilities of their assignment, clearly defined scheduling and who they report to on site. Support to volunteers to be provided through their respective associations, the coordinator, and a buddy system.
 9. Assemble and distribute psychoeducational materials for affected populations and volunteers.
 10. Provide consultation to emergency managers upon request.
 11. Media work will be arranged through the provincial government public relations office. (Arrangements with them will be initiated in 2006.)

Appendix 5: Glossary

ARC	American Red Cross
BCACC	British Columbia Association of Clinical Counsellors
BCASW	British Columbia Association of Social Workers
BCERMS	British Columbia Emergency Response Management System
BCPA	British Columbia Psychological Association
CISM	Critical Incident Stress Management
CRC	Canadian Red Cross
DSTRS	Disaster Stress & Trauma Response Services
EMB	Emergency Management Branch
EOC	Emergency Operation Center
ESS	Emergency Social Services
ICS	Incident Command System
MCFD	Ministry of Child and Family Development
MOH	Ministry of Health
NGO	Non Governmental Organization
PD	Psychological Debriefing
PEP	Provincial Emergency Program
PREOC	Provincial Regional Operation Center
PS	Psychosocial
WHO	World Health Organization