CCP Participant Workbook

Core Content Training

Crisis Counseling Assistance and Training Program

Module 1

resilience
community
hope
recovery
partnership
outreach

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

FEMA

Crisis Counseling Assistance and Training Program (CCP)
Participant Workbook

Core Content Training

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Revised 2/2013

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Course Agenda

Core Content—2½ Days					
DAY 1		**DAY 2**		**DAY 3**	
8:30 a.m.	Welcome and Introductions	8:30 a.m.	Opening—Review and Preview	8:30 a.m.	Opening—Review and Preview
	Course Objectives, Agenda, Norms	8:45 a.m.	Survivor Reactions	8:45 a.m.	Data Collection and Evaluation*
9:00 a.m.	Disaster Response Overview	10:00 a.m.	Break	10:00 a.m.	Break
10:00 a.m.	Break	10:15 a.m.	Survivor Reactions (cont.)	10:15 a.m.	Stress Management
10:15 a.m.	CCP and Services	10:45 a.m.	Special Populations	11:30 a.m.	Applying Your Learning, Course Evaluation
12:15 p.m.	Lunch	12:15 p.m.	Lunch	Noon	Adjourn
1:15 p.m.	CCP and Services (cont.)	1:15 p.m.	Interventions and Skills	**Optional Half-Day Session for Program Managers**	
3:00 p.m.	Break	3:15 p.m.	Break	1:00 p.m.	Needs Assessment, Outreach, Staffing Plan
3:15 p.m.	Cultural Awareness	3:30 p.m.	Survivor Tools	2:00 p.m.	Field Deployment and Supervision
4:45 p.m.	Journal Reflection	4:45 p.m.	Journal Reflection	2:30 p.m.	Break
5:00 p.m.	Adjourn	5:00 p.m.	Adjourn	2:45 p.m.	Communications and Media Plan
				4:00 p.m.	Training, Stress Management, Fiscal Management
				4:30 p.m.	Data Collection and Evaluation, Reporting, Quality Assurance
				5:00 p.m.	Adjourn

*Revised 11/2012. May be shortened if CCP staff are using online training for data forms.

Core Content—2 Days					
DAY 1		**DAY 2**		**DAY 3**	
8:30 a.m.	Welcome and Introductions	8:30 a.m.	Opening—Review and Preview	**Optional Half-Day Session for Program Managers**	
	Course Objectives, Agenda, Norms	8:45 a.m.	Survivor Reactions (cont.)	8:30 a.m.	Objectives and Agenda
9:00 a.m.	Disaster Response Overview	10:15 a.m.	Break	8:45 a.m.	Needs Assessment, Outreach, Staffing Plan
10:00 a.m.	Break	10:30 a.m.	At-Risk Populations	9:45 a.m.	Field Deployment and Supervision
10:15 a.m.	CCP and Services	11:30 a.m.	Interventions and Skills	10:00 a.m.	Break
Noon	Lunch	Noon	Lunch	10:15 a.m.	Communications and Media Plan
1:00 p.m.	CCP and Services (cont.)	1:00 p.m.	Interventions and Skills (cont.)	11:30 a.m.	Training, Stress Management, Fiscal Management
3:00 p.m.	Break	2:00 p.m.	Survivor Tools	Noon	Data Collection and Evaluation, Reporting, Quality Assurance
3:15 p.m.	Cultural Awareness	3:00 p.m.	Break	12:30 p.m.	Adjourn
4:15 p.m.	Survivor Reactions	3:15 p.m.	Data Collection and Evaluation		
4:50 p.m.	Journal Reflection	3:45 p.m.	Stress Management		
5:00 p.m.	Adjourn	4:45 p.m.	Applying Your Learning, Course Evaluation		
		5:00 p.m.	Adjourn		

Course Objectives

After training, participants will be able to do the following:

- Describe the range of crisis counseling services.
- Identify typical disaster reactions.
- Demonstrate basic crisis counseling skills.
- Explain the importance of data collection and how to use it.
- Apply techniques for managing stress.

Guidelines for Working Together

- Keep time (start on time; return from breaks on time; end on time).
- Switch mobile phones off or to “vibrate.”
- Participate fully.
- Ask questions freely.
- Balance talking and listening.
- Respect each other’s point of view.

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SECTION 1: Disaster Response Overview

Definitions of Disaster

A disaster is a natural or human-caused occurrence (e.g., hurricane, tornado, flood, tsunami, earthquake, explosion, hazardous materials accident, mass criminal victimization incident, war, transportation accident, fire, terrorist attack, famine, epidemic) that causes human suffering. A disaster creates a collective need that overwhelms local resources and requires additional assistance.

Adapted from the Center for Mental Health Services (CMHS), 2000.

A disaster is any natural catastrophe (e.g., tornado, hurricane, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, drought) or, regardless of cause, any fire, flood, or explosion in any part of the United States that, in the determination of the President, causes sufficient severity and magnitude to warrant major disaster assistance under the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1974 (Stafford Act).

Robert T. Stafford Disaster Relief and Emergency Assistance Act, 1974.

Notes:

Natural v. Human-Caused Disasters

Natural	Human-Caused
Earthquakes, fires, floods, tornadoes	Airplane crashes, chemical leaks, mass violence, terrorism
No one to blame	People, governments, or businesses to blame
Beyond human control	Seen as preventable and a betrayal by fellow humans
Advance warning is possible	No advance warning
Post-disaster distress is high and felt mainly by survivors	Post-disaster distress is often more intense than the distress experienced by people after natural disasters, and it is felt by more people not directly affected by the disaster

Characteristics of This Disaster Worksheet

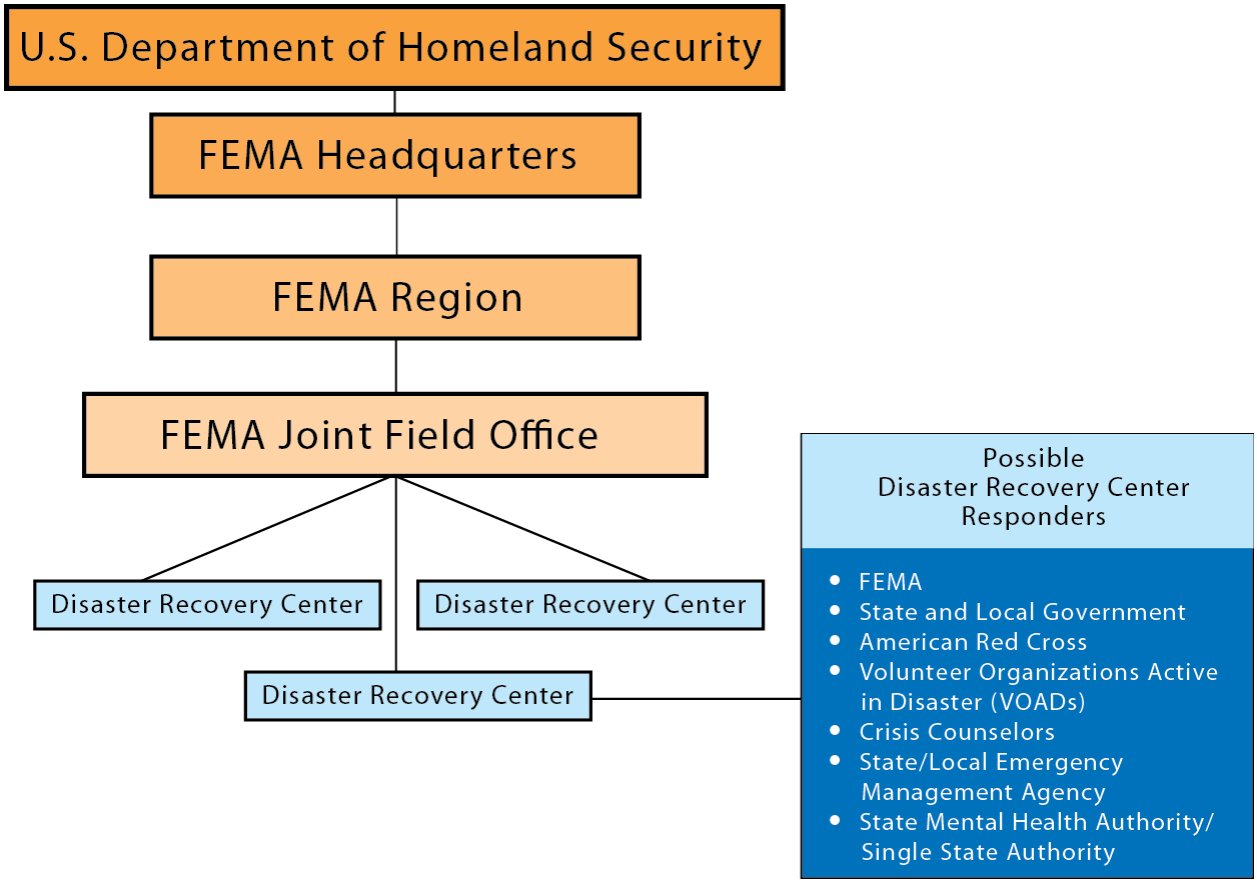
Cause:

Size:

Scope:

Impact on survivors:

FEMA Disaster Operations Structure



This chart reflects a typical disaster response structure in the immediate aftermath of large, usually natural, disasters.

In a typical disaster, it is the responsibility of the FEMA region where the disaster occurred to carry out the initial response, do damage assessments, set up a joint field office, and deploy staff.

Immediately after the declaration, FEMA disaster workers arrive and set up a central field office to coordinate the recovery effort. A toll-free telephone number is available for use by affected residents and business owners in registering for assistance (1-800-621-FEMA [3362] or TTY 1-800-462-7585 for people with speech or hearing needs). Disaster recovery centers are open for disaster survivors to meet with program representatives and obtain information about available aid and the recovery process.

Types of Assistance Available From FEMA

The Presidential disaster declaration will specify the types of assistance for which a state is eligible.

Hazard Mitigation—Disaster survivors and public entities are encouraged to avoid the life and property risks of future disasters. Examples include the elevation or relocation of chronically flood-damaged homes away from flood hazard areas, retrofitting buildings to make them resistant to earthquakes or strong winds, and adoption and enforcement of adequate codes and standards by local, state, and federal governments.

Public Assistance—Aid to state or local governments to pay part of the costs of rebuilding a community's damaged infrastructure. Generally, public assistance programs pay for 75 percent of the approved project costs. Public assistance may include debris removal, emergency protective measures and public services, repair of damaged public property, loans needed by communities for essential government functions, and grants for public schools.

Individual Assistance—Includes FEMA CCPs and is covered in detail in this section.

Notes:

Overview of CCP

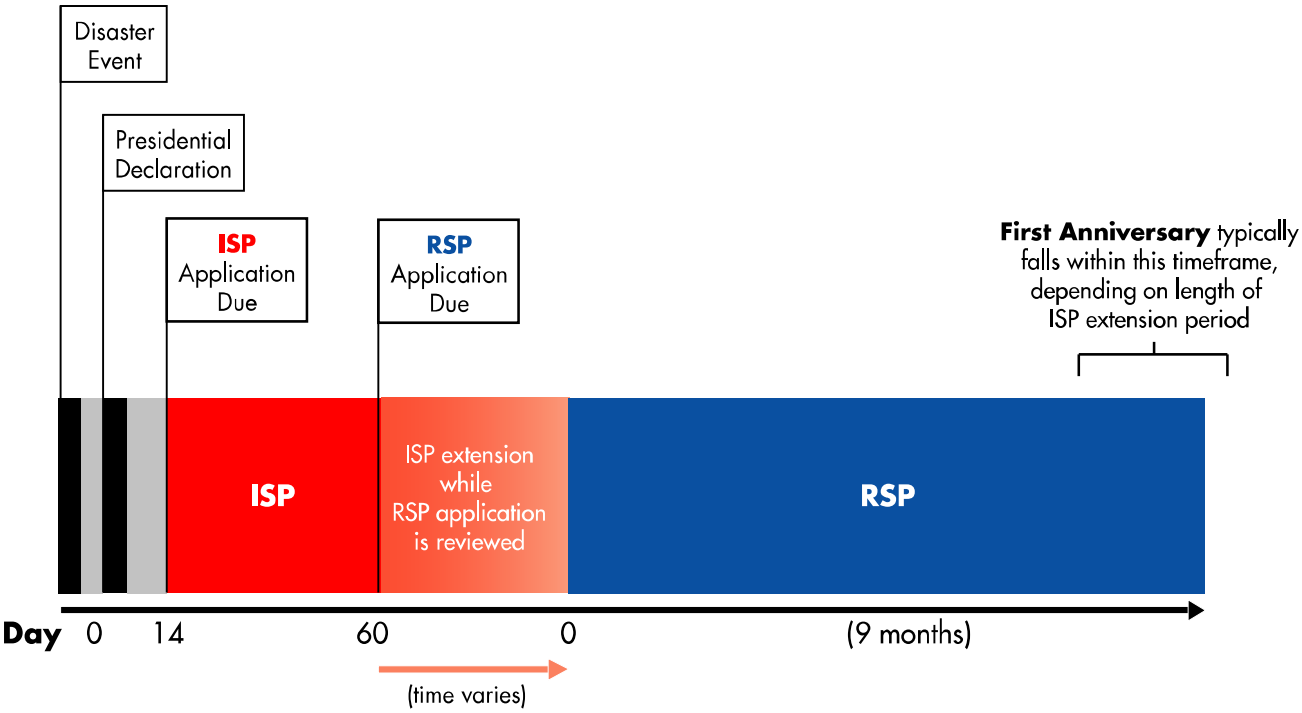
Entities eligible to apply for and receive CCP funding:

- States
- U.S. territories
- Federally recognized tribes and tribal organizations

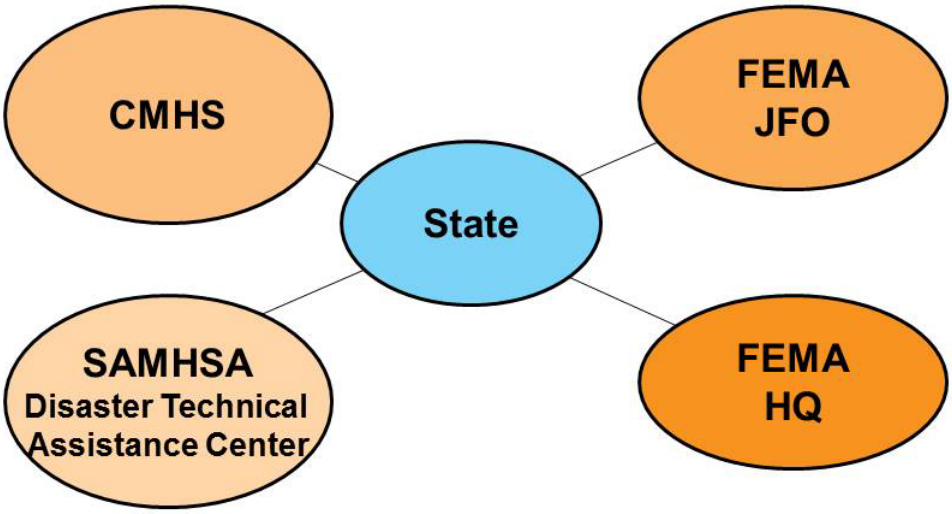
The CCP consists of two grant types:

- Immediate Services Program (ISP): 60 days
- Regular Services Program (RSP): up to 9 months

CCP Typical Timeline



ISP Organizational Roles and Responsibilities



The FEMA JFO Program Specialist

- Works with the CMHS Project Officer, the state, and the CCP to ensure the quality, consistency, and fiscal management of the program.
- Provides information to the state about FEMA requirements and regulations related to the CCP.

The CMHS Project Officer

- Works with the state and the CCP staff to ensure that the program runs consistently and efficiently.
- Provides ongoing technical assistance (TA) to the state and FEMA on programmatic, behavioral health, and budgetary issues.
- Works with the CCP leadership to ensure ongoing services are relevant and fiscally consistent.

FEMA Headquarters

- Works with the CMHS Project Officer, the state, and the CCP to ensure the quality, consistency, and fiscal management of the program.
- Confers with the FEMA JFO Program Specialist and the CMHS Project Officer as needed.

State Disaster Behavioral Health Coordinator

- Works with the CMHS Project Officer, FEMA, and the CCP to ensure the quality, consistency, and fiscal management of the program.
- Is responsible for CCP reporting.
- Manages the CCP including oversight in hiring and training of CCP staff.

The Substance Abuse and Mental Health Services Administration (SAMHSA) Disaster Technical Assistance Center (DTAC)

- Provides TA to the CMHS Project Officer, FEMA, and the CCP.
- Is a resource for materials and trainings.

Notes:

SECTION 2: Crisis Counseling Program and Services

The CCP model is . . .

Strengths based—While CCP workers may assess significant adverse reactions and refer people accordingly, program services assume natural resilience in individuals and communities.

Anonymous—People should not be classified, labeled, or diagnosed. Each person should be seen as unique in his or her needs and recovery. Therefore, there are no case files, records, or diagnoses for users of CCP services.

Outreach oriented—Crisis counselors take services into the community rather than waiting for survivors to seek services.

Culturally aware—Throughout the project, staff should strive to understand and respect the community and the cultures within the community.

Conducted in nontraditional settings—Crisis counseling is community based and occurs primarily in homes, community centers, disaster shelters, and settings other than traditional mental health clinics or hospitals.

Designed to strengthen existing community support systems—The CCP supports but does not supplant natural community support systems. Likewise, the crisis counselor supports community recovery activities but does not organize or manage them.

Based on an assumption of natural resilience and competence—Most people will recover and move on with their lives after a disaster, even without assistance. Promote independence rather than dependence on the CCP, other people, or other organizations and assume competence in recovery. A key step in recovery is regaining a sense of mastery and control.

Traditional Treatment v. Crisis Counseling

Traditional Treatment	Crisis Counseling
• Is office based	• Is home and community based
• Diagnoses and treats mental illnesses	• Assesses strengths and coping skills
• Focuses on personality and functioning	• Counsels on disaster-related issues
• Examines content	• Accepts content at face value
• Explores past experiences and their influence on current problems	• Validates common reactions and experiences
• Has a psycho-therapeutic focus	• Has a psycho-educational focus
• Keeps records, charts, case files, etc.	• Does not collect identifying information

Notes:

Overview of CCP Services

Individual crisis counseling—Assists disaster survivors in understanding their current situations and reactions, reviewing their options, and linking them with other individuals and agencies that may assist them. During individual services, crisis counseling staff are active listeners who provide emotional support. Individual crisis counseling also includes working with the family as a unit. This service is more than 15 minutes in duration.

Brief educational or supportive contact—The number of brief contacts with individuals, or groups of individuals, that did not result in indepth discussion or interaction of an educational or crisis counseling nature. This service is 15 minutes or less in duration.

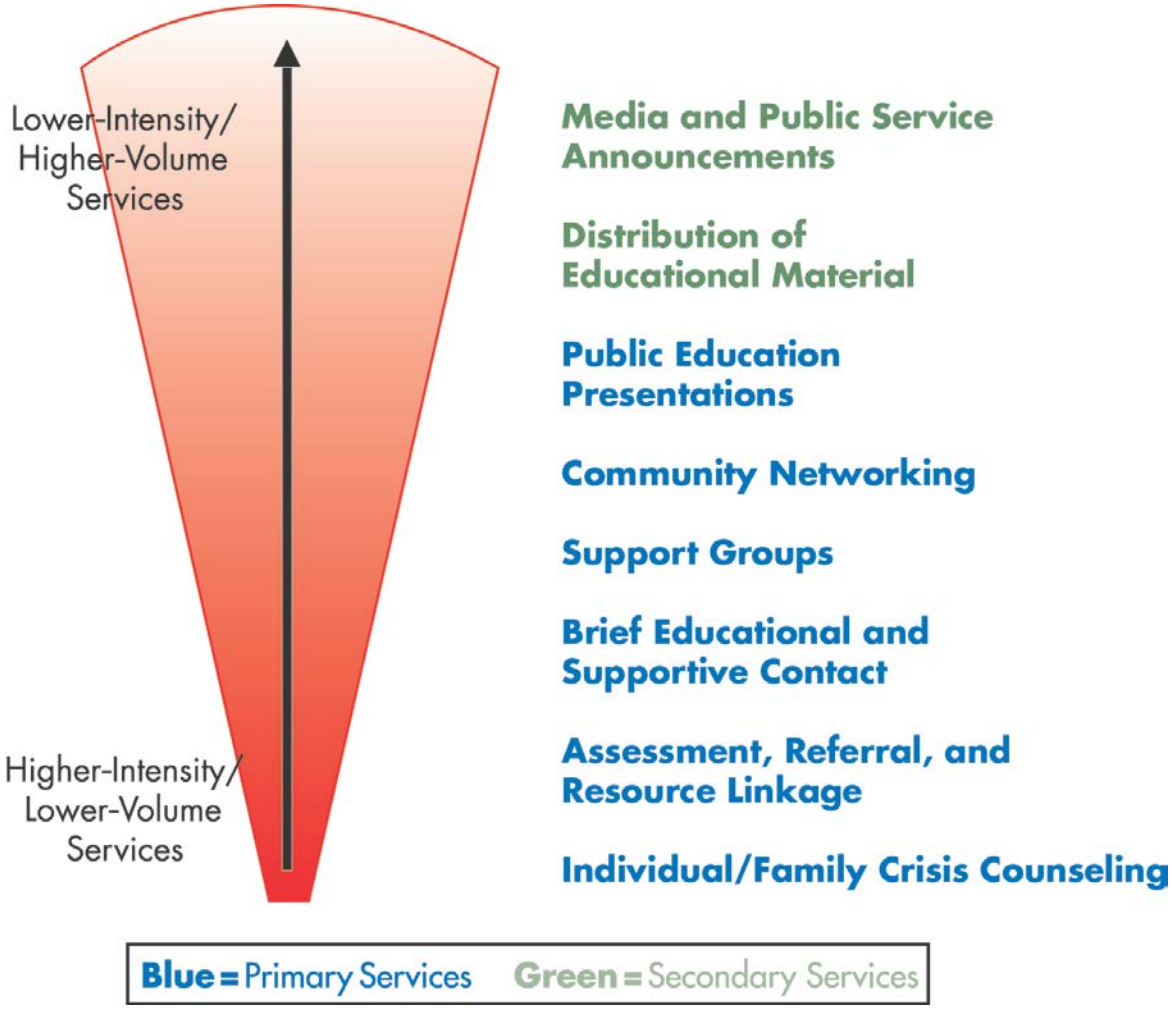
Group crisis counseling—Involves providing and facilitating support or education to a group to help members cope with their situations and reactions.

Public education—Involves the distribution of educational information on CCP or crisis counseling-related topics. Educational information may be provided via public presentations, brochures, flyers, mailings, and training to human services personnel. The media are often partners in providing information through public service announcements, newspaper articles, and advertisements.

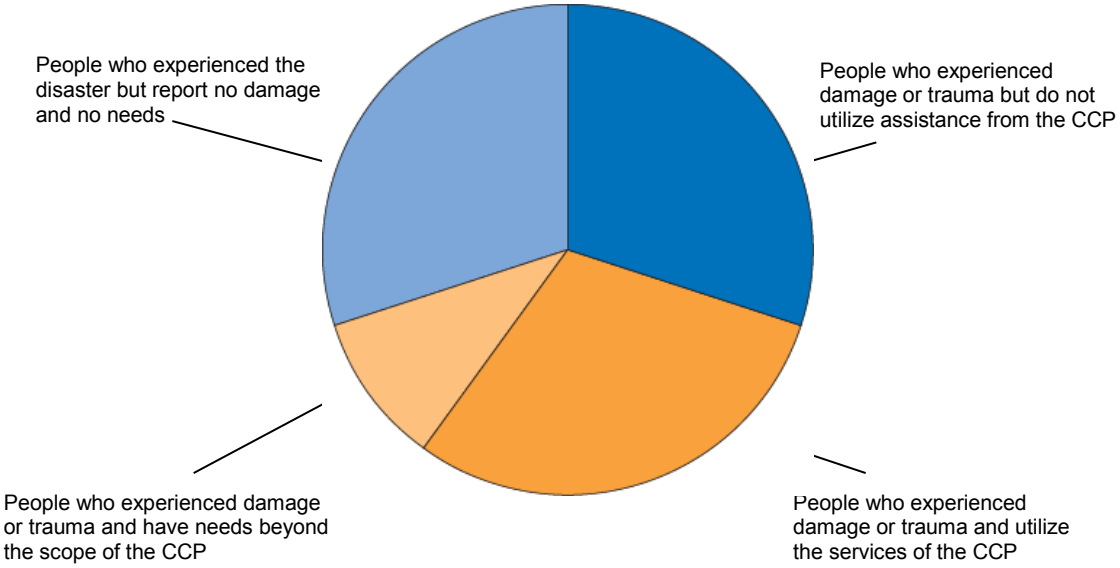
Assessment, referral, and resource linkage—Assessment determines the need for referral. Referrals can link survivors experiencing severe reactions with formal mental health and substance abuse treatment. Referrals also can direct survivors to other disaster relief resources in their community to meet physical, structural, or economic needs.

Community support and networking—Supports every other service delivered by the CCP. CCP staff participate in, but do not initiate or lead, community support activities (e.g., being present at remembrance events). Crisis counselors can provide a "compassionate presence" and be available to provide crisis counseling services, should the need arise.

Reach of Services



Typical Scope of CCP Services Provision



These segments are estimated proportions and do not represent statistical values.

Identify the geographic areas affected in the disaster.

Who are the special population groups?

What are the priority needs in the affected communities (e.g., rebuilding/repairing homes, clothing, treatment)?

Resource Identification Worksheet

For the priority needs selected, identify the community resources that would be needed to meet those needs (e.g., community organizations such as faith-based organizations, disaster assistance organizations, schools).

Outreach Strategy Worksheet

What are the key actions this program should take to conduct successful outreach to survivors?

What key actions can you take to conduct outreach to organizations that have resources available for survivors?

Individual/ Family Crisis Counseling

Encounter Characteristics

- This service consists of encounters or visits with adults and children.
- It can last 15 minutes or longer.
- It typically ranges from one to five visits.
- The number of visits provided should be determined through discussions with supervisors and teams.
- Multiple visits may indicate a need for referral to longer-term services and should be discussed with supervisors.
- Each visit should stand alone. Crisis counselors should reinforce prior successful coping skills in addition to helping survivors develop new ones.

Goals and Objectives

- **Engage**—Through outreach, make contact with affected individuals to provide crisis counseling services.
- **Identify immediate needs**—Assist survivors in assessing their current needs.
- **Gather information**—Use reframing, reflecting, paraphrasing, and opening skills to gather information to assess the survivor's needs.
- **Prioritize needs**—Disaster survivors often have safety and physical needs that need to be met first.
- **Provide practical assistance**—Provide referrals and linkage to additional services including disaster assistance, clothing, food, and shelter.
- **Provide education**—Teach survivors about common reactions, stress management techniques, and coping skills.
- **Provide emotional support**—Normalize the survivor's reactions, and provide reassurance.
- **Determine next steps and follow up**—Assist the survivor in developing a plan and creating action steps.

Brief Educational or Supportive Contact

- This service is less than 15 minutes long.
- It provides reassurance, other support, and information.
- Activities, such as brief interactions, telephone calls, and handing out brochures, are examples of brief educational or supportive contact.

Group Crisis Counseling

Encounter Characteristics

- Group crisis counseling refers to services that help group members understand their current situations and reactions to the disaster, help them review or discuss their options, provide emotional support or referral services, and provide skills to cope with their current situations and reactions. In group counseling, participants do most of the talking.
- Group counseling encounters last 15 minutes or longer.
- The CCP focuses on two types of groups: support and education groups, and self-help groups.
- Group counseling may vary from less structured, purely educational groups to more structured support groups. All groups are likely to share some elements of support and education.
- Groups can be led by a licensed mental health professional, co-facilitated with a mental health professional and a paraprofessional, or led by survivors themselves.
- When members of social support networks are struggling with the disaster's aftermath, counseling groups may augment overloaded support systems.
- It is important to ensure that group members have had similar levels of exposure to the disaster event. People with low exposure should not be exposed to the stories of those whose exposure was significantly higher.

Support and Educational Groups

- Increase the social support network.
- Facilitate exchange of information on life situations.
- Help develop new ways of adapting and coping.
- Provide tools to obtain and process new information.
- Provide practical and concrete assistance.
- Use handouts and factual information relevant to the group's discussion.
- Use speakers relevant to content area and group members' needs.

Tips for Starting and Facilitating Support and Educational Groups

- In a support group, it is acceptable to allow members to begin the dialogue. Keep track of time, and facilitate discussion.
- It may be helpful to have homogeneous membership (e.g., bereaved parents, neighbors, occupational groups, women, children).
- The format and content of the group and educational materials presented should be tailored to meet the developmental and cultural needs of group members. Consider accessing written resources in various languages and

materials geared toward people with disabilities and targeted toward children's developmental stages.

- Speakers may include mental health and substance abuse professionals, public health workers, faith-based leaders, community leaders, and disaster survivors.
- People need to be emotionally ready to participate in group crisis counseling. Bringing people together too early can be detrimental. Use caution in deciding when to begin group crisis counseling.

Self-Help Groups

- Are initially facilitated by a crisis counselor.
- Can be co-facilitated by a group member to encourage transition to a member-facilitated process.
- Are no longer a CCP service once the group has transitioned to a member-facilitated process.

Practical Concerns in Group Crisis Counseling

- Counselors should assess their own skills and knowledge about the group's content to set clear boundaries on how to approach the group process. Group members may inquire about symptoms on which counselors are not authorized to give advice. Counselors can, however, provide concrete information and make appropriate referrals to mental health professionals.
- Be aware of personal biases related to religion, spirituality, culture, ethnicity, and gender. It is common and healthy to recognize these qualities for personal reflection, but it is detrimental if these qualities disrupt the group process.
- Respect and maintain confidentiality. A group should be in a safe place in which people, families, and communities can freely share their feelings without worrying about other people knowing their personal business.
- Facilitate the group by making sure that each member has a chance to talk and that no one person is dominating the conversation. Ask a member who has not spoken if he or she would like to talk; however, respect his or her right to just sit back and listen.
- Ask for feedback. Some groups may warrant more structure than others will; however, it can be empowering for group members to become actively engaged in the process of deciding what they would like to achieve in group sessions.

Assessment and Referral

- Assessment is the process of reviewing, identifying, and evaluating survivors' needs.
- The CCP screens for the following:
  - Practical or tangible needs of survivors
  - Substance abuse and mental health needs
- Crisis counselors also identify resources in the community that match the needs of survivors.
- The CCP Adult Assessment and Referral Tool may be used to assist crisis counselors in making decisions regarding the need for referral.
- Crisis counselors provide information on available resources to meet tangible needs.
  - Crisis counselors help survivors meet unmet needs through resource linkage.
  - Services are provided regardless of level of functioning.
  - Resource linkage empowers survivors to advocate for themselves.
  - Crisis counselors assist survivors in prioritizing and accessing services.
  - Relationships with survivors are short term.

Assessment and Referral Considerations

- **Amount of time since the event**—Some reactions are very common in the first few weeks and, by themselves, do not necessitate referral. Poor functioning, avoidance of situations, and sleeping problems are common at first.
- **Degree to which the symptoms are interfering with daily life functioning**—This includes how well the individual is managing his or her symptoms, and how strong his or her support systems are.

Emergency Treatment Referral

- Alert the team leader if you notice any of the following:
  - There is intent or means to harm self or others.
  - A person exhibits severe paranoia, delusions, or hallucinations.
  - Functioning is so poor that a person's (or dependent's) safety is in danger.
  - Excessive substance use is placing a person or others at risk.
  - A child's safety or health is at risk.

- When in doubt, call 911, or refer for immediate psychiatric or medical intervention.

Nonemergency Treatment Referral

- Reduce perceived stigma:
  - Demystify mental health or substance abuse treatment by letting people know that counseling and treatment are methods of support, information, education, problem solving, and coping.
  - Explore referral options, and give choices.
- Increase compliance:
  - Explore obstacles to accepting services.
  - Encourage the person to call for the appointment while the counselor is there.
  - Accompany the person to the first appointment, if necessary and appropriate.
- Sometimes it is acceptable to guide survivors through the referral process. Some strategies include the following:
  - Provide referral options.
  - Assist them in making appointments.
  - Remind them to attend appointments.
  - Follow up to see if they attended.
- Facilitating the survivor's connection with the external provider can increase future follow-through with treatment.

Community Support and Networking

Through community support and networking, the CCP engages in the following activities:

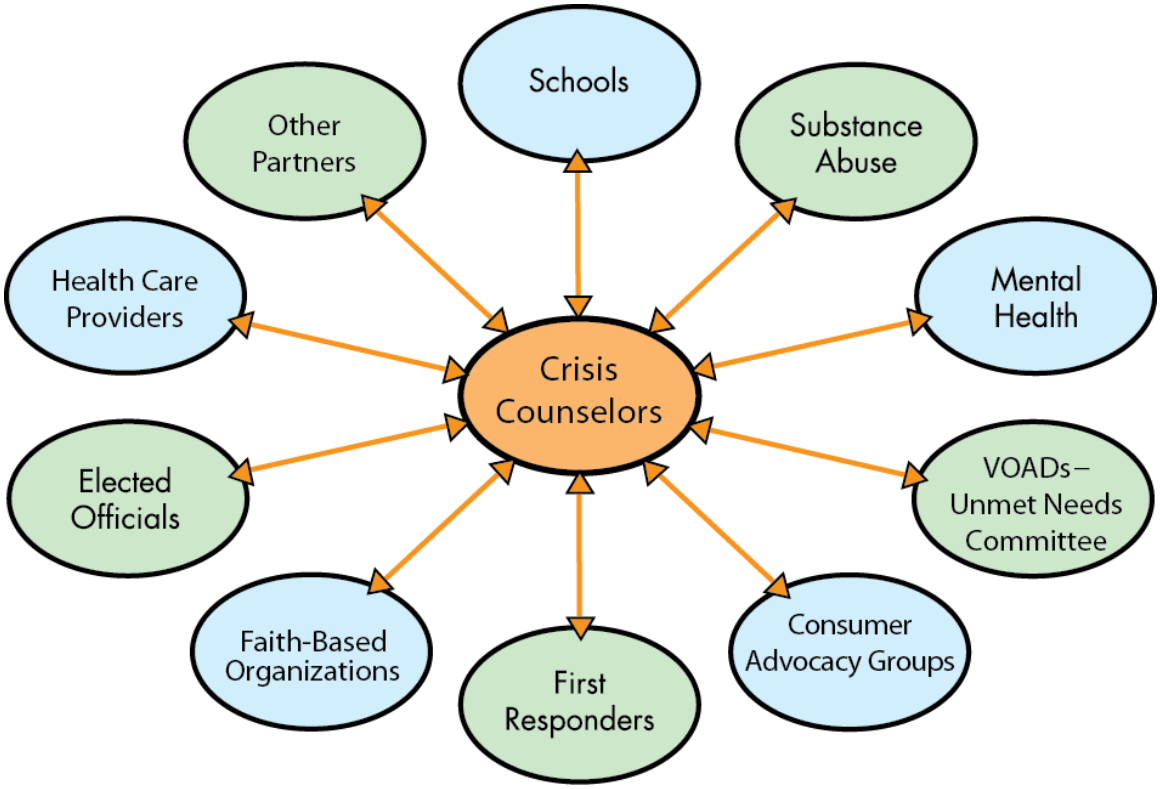
- Partners with community support systems
- Participates in community gatherings and rituals
- Reaches out to community groups and leaders
- Maintains a compassionate presence
- Bolsters, but does not replace, systems in place

The CCP has the following goals for its community support and networking work:

- Foster community resilience through improved connectivity.
- Promote familiarity with disaster relief resources.
- Create a seamless system for referral.
- Create opportunities for shared resources and training.
- Make referrals to organizations and agencies, and do not limit referrals to those for mental health and substance abuse treatment. Referrals can be made for other disaster relief services as well.
- Share training resources, as appropriate, with other disaster relief organizations.
- Use networking to help identify needs, referral sources, and sources of in-kind donations.

Community support and networking activities are captured on the Weekly Tally Sheet.

Typical Community Partners



Other potential partners:

- Emergency management
- Law enforcement
- Substance abuse prevention community
- Office for Victims of Crime
- Community-based cultural organizations
- American Indian and Alaska Native tribal community leaders
- Refugee organizations
- Suicide prevention organizations
- Mental health and substance abuse consumer groups

Public Education

- Includes distribution of information and educational materials
- Is likely to increase during the course of the CCP
- Is designed to do the following:
  - Build resilience
  - Promote constructive coping skills
  - Educate about disaster reactions
  - Help people access support and services
  - Leave a legacy of knowledge, skills, and community resources

Distribution of educational materials:

- This includes flyers, brochures, tip sheets, guidance, and website content.
- It covers the following topics:
  - Basic disaster information
  - Key concepts of disaster behavioral health
  - Disaster reactions
  - Coping skills
  - Individual and community resilience
- Contact SAMHSA DTAC for help in accessing educational materials.
- Culturally appropriate materials address special populations, are available in multiple languages, and consider varying educational levels of survivors.
- Distribution of educational materials is captured on the Weekly Tally Sheet.

Media Messaging and Risk Communication

- Media messaging and risk communication are important parts of a comprehensive disaster behavioral health plan and any CCP. An effective plan for engaging the media will get the word out about CCP resources and the message of resilience.
- The CCP reaches large numbers of disaster survivors through media campaigns.
- Media messaging accomplishes the following:
  - Increases education and awareness for survivors
  - Promotes a shared understanding of the CCP message
  - Delivers a clear message regarding the CCP
  - Promotes the services of the CCP, such as the helpline, ongoing crisis counseling, and referral
  - Shares information on common reactions and important talking points
- The SAMHSA publication *Communicating in a Crisis: Risk Communication Guidelines for Public Officials* is a good resource for planning communication and dealing with the media. It is available online at http://store.samhsa.gov/product/Risk-Communication-Guidelines-for-Public-Officials/SMA02-3641.

Developing a CCP media plan helps to do the following things:

- Identify spokespeople with expertise in the field of disaster behavioral health and experience in dealing with the media.
- Develop simple talking points that reflect the goals and services of the CCP.
- Develop a press kit with information on the CCP and its services.

There are several important points to consider when developing talking points:

- The CCP emphasizes resilience and hope.
- Help is available through a variety of services provided by the CCP.
- The CCP provides education on common reactions and teaches effective coping skills.
- Cultural diversity is respected in providing assistance.
- People often find stories of people like them interesting and compelling. If appropriate, and while maintaining confidentiality, highlight stories of people who have been helped by the CCP.

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SECTION 3: Cultural Awareness

Definition of Cultural Awareness

- Awareness of your own culture as a set of values, behaviors, attitudes, and practices, and the understanding that other cultures may be different from your own
- Respect for the beliefs, language, and behaviors of others
- A quality that develops over time, usually involving increasing sensitivity and long-term commitment

Notes:

Principles of Programmatic Cultural Awareness

- Recruit crisis counselors who represent the various cultural groups affected by the disaster.
- Provide ongoing cultural awareness training to staff.
- Identify the various cultural groups or populations in need of services.
- Ensure that services are accessible, appropriate, and equitable.
- Allow time to gain acceptance in a community.
- Involve cultural brokers and community leaders in a meaningful way.
- Ensure that program materials are sensitive to and reflect the languages of the cultural groups served.
- Develop mechanisms, use team meetings, and use quality assurance processes to ensure the program is moving toward cultural awareness.

Notes:

Principles of Individual Cultural Awareness

- Recognize the importance of culture, respect diversity, and take a nonjudgmental approach.
- Recognize differences in the expression of help-seeking customs, traditions, and support networks.
- Learn local norms from community leaders.
- Recognize beliefs about healing, trauma, and loss.

Notes:

Key Questions for Culturally Aware Programming

Community Demographic Characteristics

- Who are the most vulnerable persons in the community? Where do they live?
- What is the range of family composition (e.g., single-parent households)?
- How could individuals be identified and reached in a disaster?

Cultural Groups

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

Socioeconomic Factors

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

Mental Health Resources

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

Cultural Awareness Worksheet

What are you doing in your program to address cultural awareness? What are some specific examples?

Who are the cultural brokers with whom you're working?

Whom else could you be working with—individuals, groups?

What more could you do to increase the cultural awareness of the staff? Generate three specific recommendations.

1.

2.

3.

Journal Reflection—Sections 1 Through 3

What are two things about federal disaster response operations—particularly FEMA and the CCP—that you want to remember?

What key messages are you taking away about the range of CCP services and how services work together to promote individual and community resilience?

What are some ways you can increase your cultural awareness and the cultural sensitivity of the services you're providing?

How well are your training needs and expectations being met so far in this course? What topics or issues do you suggest we focus on during tomorrow's sessions?

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SECTION 4: Survivor Reactions

Key Concepts

- Everyone who experiences a disaster is affected by it in some way.
- People pull together during and after a disaster.
- Stress and grief are common reactions to uncommon situations.
- People's natural resilience will support individual and collective recovery.

Vulnerability Factors

- Poverty
- Race
- Age
- Ethnicity
- Unemployment
- Gender

Risk Factors Model

The risk factors model helps identify potential populations who are most at risk for adverse reactions and potentially in need of crisis counseling services.

Highest Risk	A. Injured survivors, bereaved family members
	B. Survivors with high exposure to disaster trauma, or evacuated from disaster zones
	C. Bereaved extended family and friends, first responders
Lower Risk	D. People who lost homes, jobs, and possessions; people with preexisting trauma and dysfunction; special groups; other disaster responders
	E. Affected people from the larger community

Survivor Reactions Worksheet

For the type of reaction assigned to your table, discuss the following:

What specific reactions have you seen in this category—either in response to this disaster, or in previous experiences?

What differences in reactions have you seen—or could you imagine—across age groups?

Summary of Survivor Reactions

Physical Reactions

- Gastrointestinal problems
- Headaches, aches, and pains
- Weight change
- Sweating or chills
- Tremors or muscle twitching
- Clumsiness, increased accidents
- Increased reactivity to stimuli such as sound and light (being easily startled)
- Chronic fatigue or sleep disturbances
- Immune system disorders
- Sexual dysfunction

Positive responses can include alertness.

Emotional Reactions

- Feelings of heroism, euphoria, or invulnerability
- Denial
- Anxiety or fear
- Depression
- Guilt
- Apathy
- Grief

Positive responses can include feeling challenged, involved, and pressured to act.

Cognitive Reactions

- Disorientation and confusion
- Poor concentration
- Difficulty setting priorities or making decisions
- Loss of objectivity
- Recurring dreams, nightmares, or flashbacks
- Preoccupation with disaster

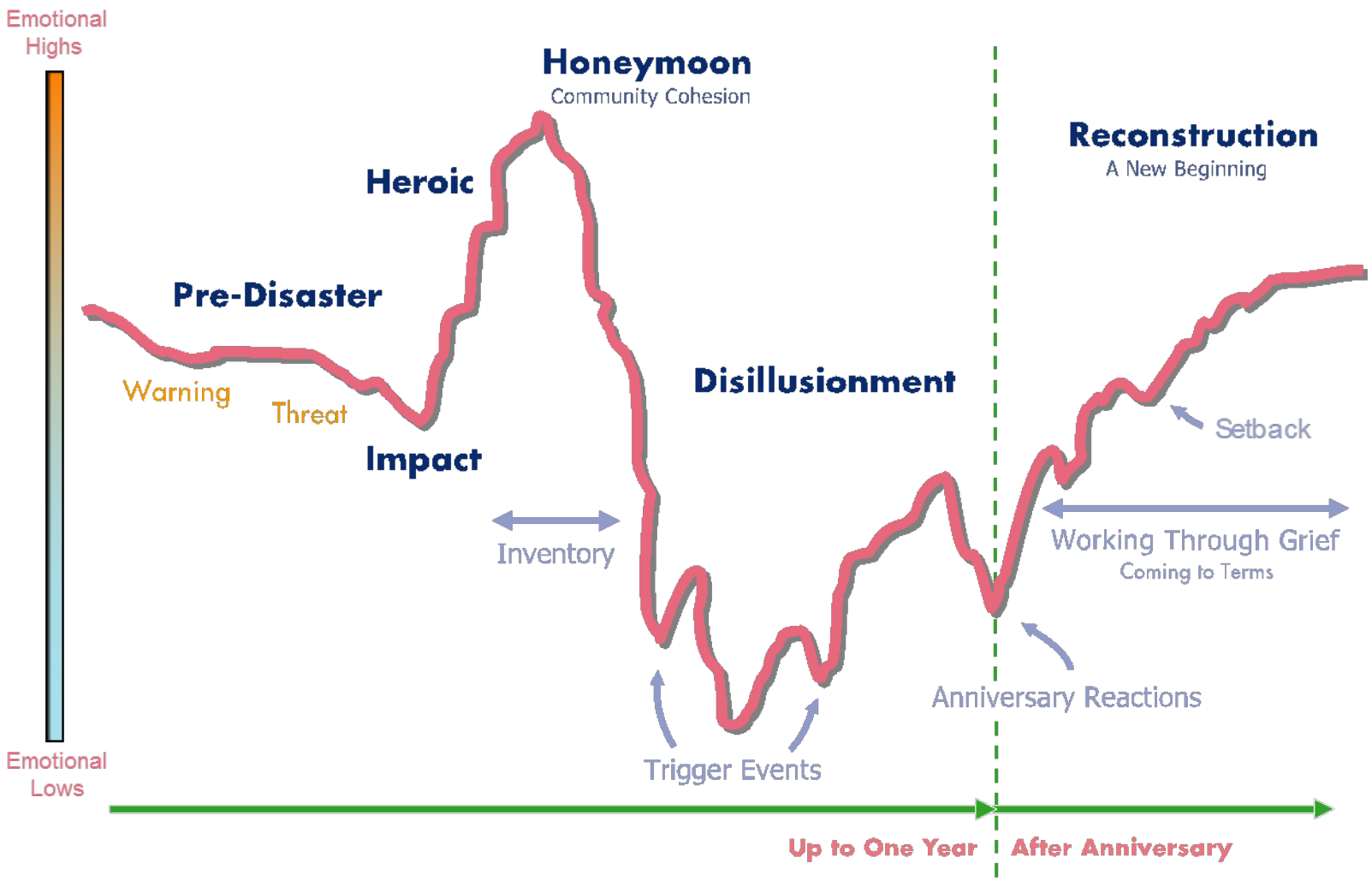
Positive responses can include group identification and sharpened perception.

Behavioral Reactions

- Change in activity level
- Alcohol and drug use or abuse
- Increased use of over-the-counter medications
- Difficulty communicating or listening
- Irritability, anger, or frequent arguments
- Declining job performance
- Frequent crying
- Difficulty sleeping
- Avoidance of triggering places or activities

Positive responses can include unselfish and helping behavior.

Phases of Disaster



Source: Zunin/Meyers, as cited in U.S. Department of Health and Human Services. (2000). Training *manual for mental health and human service workers in major disasters* (DHHS Publication 90–538). Washington, DC: Substance Abuse and Mental Health Services Administration Center for Mental Health Services.

Pre-Disaster Phase

- Disasters with no warning can cause feelings of vulnerability and lack of security; fears of the future and of unpredicted tragedies; a sense of loss of control; and the sense of being unable to protect oneself and one's family.
- Disasters with warning can cause guilt or self-blame for failure to heed warnings.

Impact Phase

- Reactions can range from shock to overt panic.
- Initial confusion and disbelief are followed by focus on self-preservation and family protection.
- Slow, low-threat disasters and rapid, dangerous disasters have different psychological effects.
- Great destruction and loss lead to great psychosocial effects.
- Family separation during impact causes considerable anxiety.

Heroic Phase

- Many exhibit adrenaline-induced rescue behavior and have high activity with low productivity.
- Risk assessment may be impaired.
- There is a sense of altruism.
- Evacuation and relocation have psychological significance—effect of physical hazards and repercussions of family separation.

Honeymoon Phase

- Disaster assistance is readily available.
- Community bonding occurs.
- Optimism exists that everything quickly will return to normal.
- CCP staff can establish program identity, gain entrée to affected people, and build relationships with stakeholders.

Disillusionment Phase

- Stress and fatigue take a toll.
- Optimism turns into discouragement.
- There may be an increased need for substance abuse services.
- The larger community returns to business as usual.
- The CCP may have an increased demand for services, as individuals and communities become ready to accept support.
- Reality of losses sets in.
- Diminishing assistance leads to feelings of abandonment.

Reconstruction Phase

- Individuals and communities begin to assume responsibility for rebuilding their lives.
- People begin to adjust to new circumstances.
- There is recognition of growth and opportunity.
- The reconstruction process may continue for years.
- People adjust to a new "normal," while continuing to grieve losses.

Resilience Worksheet

How do you define resilience?

What helps foster the resilience of individuals?

What helps foster the resilience of communities?

What factors decrease resilience?

SECTION 5: Special Populations

Special Populations Worksheet

Which populations are most affected by this disaster?

How well served are they?

How have the services they rely on been affected?

Prioritize the populations according to how much they have been affected.

Children and Youth

For children and youth, their age and development determine their capacity to understand what is occurring around them and to regulate their emotional reactions.

Children are considered at risk for psychological problems following a disaster for a number of reasons:

- Less developed cognitive skills may limit the ways children understand and process events.
- Limited experience coping with adversity may result in a lack of coping skills for managing stress.
- Limited verbal skills may impede the processing of events and expressions of reactions.
- Dependence on adults for resources and psychological support may result in limited independence and self-reliance.
- Most importantly, children's development is at risk if they are unable to proceed with the normal activities and developmental tasks of childhood.

Risk Factors

- Risk factors for children and youth include these:
  - Separation from family
  - Evacuation and relocation
  - Loss of a family member or a close friend
  - High levels of parental distress
  - Family members at risk (such as first responders)
- Children's reactions depend on how much destruction they have experienced. The death of family or close friends is most traumatic for children; followed by loss of home, school, or pets; and extensive damage to the community.
- Reactions also are influenced by the destruction children experience secondhand through television and other media.
- The strongest predictor of children's distress is parental distress.
- The caregiver is the role model for children, in terms of disaster reactions, coping, and recovery.
- Family support and stability are positively correlated with children's well-being.
- Preexisting adjustment or learning difficulties may be exacerbated.
- Most children will recover without professional intervention. Most simply need time to experience their world as a secure place again and their parents as nurturing caregivers who are again in charge.

- Each element of a child's world—family, school, friends, pets, and social clubs—are important in the recovery process.
- Children are more vulnerable to difficulty when they have experienced other life stressors in the past year (e.g., divorce, moving, death of a loved one).
- Children who have secure relationships with nurturing caregivers are the most resilient in reconciling the disruption and recovering from traumatic events.
- Stability and security of home life affect how a child reacts to trauma.

Special Considerations

- Parents or caregivers often deny help for themselves but accept it for their children.
- Parents or caregivers often see disaster stress in their children before seeing it in themselves.
- Parents or caregivers sometimes overlook the disaster stress in their children.
- Parents are sometimes unaware of how their own stress affects their children.
- It is mandatory to involve parents and caregivers when working with children.
- Consideration should be given to the needs of single parents or caregivers, especially single women.
- Sometimes the simple presence of a crisis counselor in discussion is enough to facilitate communication within the family.
- Often parents and caregivers will deny the need for disaster mental health information for themselves but will gladly participate in programs or gatherings in which this type of information is provided as support for their children.
- Parents and caregivers often will recognize stress reactions in their children before they recognize them in themselves. The crisis counselor helps all members of the family unit by sensitizing parents to the signs of stress in their children and suggesting strategies for helping their children.
- The caregiver is the child's role model, in terms of disaster reactions, coping, and recovery.
- Single parents or caregivers may be under added stress and may need specialized referral.

How Adults Can Support Children

- **Model calm behaviors**—Be a role model. Children will take cues of how to handle situations from their parents. Modeling calm behaviors will be important during chaotic times.
- **Maintain routines**—Even in the midst of chaos and change, children feel safer and more secure with structure and routine (e.g., mealtimes, bedtime).
- **Engage in fun activities**—Should be age appropriate. This can include coloring, board games, and other family activities.

- **Limit media exposure**—It is important for parents to protect their children from overexposure to sights and images of the event, including those in newspapers, on the Internet, or on television.

- **Repeat instructions often**—Be patient. Children may need added reminders or extra help with chores or homework once school is in session, as they may be more distracted.

- **Provide support at bedtime**—Children may become anxious when they separate from their parents, particularly at bedtime. Try to spend more time with the child at bedtime with activities such as reading a book. It is okay to make temporary arrangements for young children to sleep in bed with their parents, with the understanding that they will go back to normal sleeping arrangements at a set future date.

Notes:

Older Adults

Risk Factors

- **Physical limitations**—In older adults these limitations include sensory deficits, limited mobility, decreased cognitive ability, or chronic illness. Older adults' experience of the disaster is often influenced by their physical needs.
- **Previous losses**—Recent losses and cumulative unresolved trauma leave older adults at risk for difficulty in coping with disaster aftermath. However, successful coping in the past may create a reservoir of skills that increase resilience and the ability to adapt to disaster aftermath.
- **Relocation trauma**—Relocation from nursing homes and other residential facilities can cause distress and disorientation. Sudden evacuations sometimes precipitate a decline in health and functioning.
- **Dependence on medications**—A disaster may cause interruption of prescribed medications that are difficult to replace quickly after the effects of the disaster. Improper use of multiple medications (both prescribed and over-the-counter medications) can pose a risk for abuse or severe side effects.
- **Disaster-related health risks**—Older adults are at risk for hyperthermia or hypothermia in disasters in which heating or air conditioning is interrupted.
- **Lack of social supports**—Many may not have family or close friends.

People with Prior Trauma History

- Prior trauma history includes physical, sexual, or emotional abuse, as well as combat veteran status or survival from prior disasters.
- In some cases, individuals may have flashbacks or other dissociative experiences. Disaster events may trigger preexisting posttraumatic stress disorder (PTSD) or place individuals with prior trauma at increased risk for developing PTSD.
- However, people with prior trauma history often have more resilience, experience, skills, and knowledge about how to cope with trauma. They can help others by sharing their coping skills and techniques.

Risk Factors

- Feelings of increased vulnerability and decreased trust
- Increased likelihood of experiencing a trauma similar to the original one
- Increased risk for developing PTSD
- Increased risk of clinical depression or anxiety

People with Serious Mental Illnesses

- The needs of most survivors with serious mental illnesses will be the same as the needs of the larger community—physical, cognitive, behavioral, and emotional. Some may rise to the occasion in the immediate aftermath of disaster and function at a higher level than they usually do. For others, disaster stress can disrupt their tenuous balance and worsen their condition.
- The mere presence of serious mental illnesses does not necessarily indicate higher risk for disaster-related severe reactions. The type of mental illness, trauma history, and the level of stability before the disaster must be taken into consideration.
- When people with serious mental illnesses are able to maintain their regular mental health services or medications, many can cope with the additional stress presented by the disaster.
- If not stable prior to the disaster, they may require additional support, medication adjustment, or brief hospitalization.
- For those who had previously been diagnosed with PTSD, the disaster stimuli can trigger memories, can cause them to re-experience the trauma, or can worsen their symptoms.
- People with serious mental illnesses may have used social support systems in the past and, therefore, may be more open to receiving services.

Risk Factors

- Inability to maintain medication regimens and other essential services
- Tenuous stability prior to disaster
- Vulnerability to sudden changes in environment and routines
- Trauma or other symptoms that may be triggered or worsened by disaster stimuli

People with a History of Substance Abuse

- Substance use increases after a disaster due to new use, increased use, or relapse.
- Increased substance use may create additional demands on treatment systems.
- Risk factors for substance abuse:
  - Current users are at greatest risk for increased use and abuse.
  - Stress and PTSD are known risk factors for substance abuse.
  - Alcohol and drug users may experience an increase in use. Some may cross the line into addiction.
  - People with current addictions may worsen; those in recovery (even for a long time) may relapse.
- The CCP does not fund substance abuse treatment, but staff should be prepared within the program in the following ways to work with people with substance use and abuse issues:
  - Be trained to screen for substance abuse issues and make referrals
  - Be educated about the effect of substance abuse on individuals, families, and communities
  - Develop partnerships with treatment providers and the prevention community
- Substance abuse prevention strategies can play an important role in strengthening individual and community resilience. Public education and outreach to people affected by a disaster can include general prevention information, in addition to links to emergency substance abuse services and resources. Such public education can begin immediately and continue well into the recovery process.
- **Methadone patients**—If a methadone clinic is closed due to a disaster, patients will need referrals to other methadone clinics for “guest dosing.”

People with Disabilities

- The disability community is not a homogeneous group. Therefore, people's risk factors vary.
- Partnerships with state and local disability organizations are essential in providing thoughtful and appropriate services for people with disabilities.
- The state emergency management agency (SEMA) often maintains a list of individuals with disabilities and their locations within the community.

Risk Factors

- Evacuation can be more difficult.
- Service animals need to be considered.
- Shelters may not be wheelchair accessible.
- Access to medication or therapy may be disrupted.
- Educational materials may not be available in accessible formats.

Low-Income Groups

- Stress that disaster risks are not limited to people in lower socioeconomic groups.
- Low-income groups often lack material support from family and friends and have no insurance or savings. This makes recovery longer, harder, and sometimes impossible. They lose a larger part of their material assets and suffer more lasting negative effects.
- Low-income housing often is more vulnerable to damage.
- There often are negative perceptions from experiences that occurred prior to the disaster, a lack of familiarity with sources of community support, a lack of transportation to obtain services, and an unwillingness to disclose immigration status.
- Many must relocate due to unaffordable rent increases after repairs, often moving several times to undesirable housing in locations far from social support and jobs. These people usually stay in mass-care shelters the longest.

Risk Factors

- Have fewer resources
- Have greater preexisting vulnerability
- May have weaker support systems
- May be unable to relocate
- May have to spend more time in shelters

Public Safety Workers (PSWs)

- The CCP needs to understand the distinction between traditional PSWs (e.g., police, firefighters, emergency medical technicians) and nontraditional PSWs (e.g., construction staff, electricians, sewer or gas workers).
- The term “first responder” may carry emotional weight (e.g., people may disagree about who “deserves” the title). The CCP attempts to avoid this issue by taking a very broad definition of a PSW.
- Many traditional first responder organizations have excellent support systems already in place. Assess needs so that the CCP does not duplicate services.
- Risk factors include these:
  - Exposure to the disaster event
  - Threat of injury or harm
  - Separation from family
  - View of oneself as a helper, not as a person who needs help
  - Demanding work schedule

Additional Special Populations

- Recent immigrants
- Refugees
- Undocumented workers
- Non-English speakers
- People with preexisting medical conditions

Notes:

Intervention Strategies for Special Adults

- Be aware of unique needs.
- Canvass communities to locate isolated survivors.
- Educate community providers who work with special populations on disaster reactions.
- Collaborate with community leaders and cultural brokers.
- Partner with organizations that serve special populations.
- Consider cultural factors.
- Reconnect individuals to prior treatment services (i.e., substance abuse, mental health, medical).
- Ensure that services and materials are appropriate and accessible.

Notes:

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SECTION 6: Skills and Interventions

Engagement

- Engagement is a means of reaching affected individuals to provide crisis counseling services.
- It is also a method of creating a safe and comfortable environment.
- Engagement is done in partnership with other organizations to plan and execute events.
- Examples of engagement strategies include these:
  - Creative arts
  - Social networking opportunities
  - Community information fairs
  - Anniversary events
- When developing engagement approaches, the primary focus always should be on crisis counseling services.
- Teenagers are especially vulnerable. Using writing projects, such as journal writing, can be a helpful way to engage this population and identify their needs and coping skills.

Crisis Counseling Skills

- Establishing rapport
- Calming
- Screening/assessment
- Empathy
- Reflecting feelings
- Validating feelings
- Paraphrasing
- Normalizing
- Active listening (nonverbal attending)
- Closing

Notes:

Establishing Rapport

- **Introduce yourself**—Identify who you are; give your name and the name of the CCP.

- **Use door openers**—A door opener is generally a positive, nonjudgmental response made during the initial phase of contact. Examples include "You seem sad; do you want to talk about it?" "What's on your mind?" "Can you say more about that?" "What would you like to talk about today?"

- **Use minimal encouragers**—These interactions are brief, supportive statements that convey attention and understanding. Such phrases reinforce talking on the part of the person and are often accompanied by an approving nod of the head. Examples include "I see," "Yes," "Right," "Okay," "I hear you."

- **Listen**—Pay close attention to what the survivor is saying. Listen with understanding and empathy. Do not interrupt or talk over the person.

Notes:

Calming Skills

These are measures that may be taken if the individual is too upset, agitated, or disoriented to talk, or is showing extreme fear or panic.

- **Address the primary concern**—Rather than encouraging the person to calm down or feel safe, attempt to help the person focus.
- **Provide a supportive presence**—Remain nearby, showing that you are available, if needed. Offer something tangible such as a blanket or drink.
- **Enlist support**—If family or friends are nearby, engage their help in providing emotional support. If a child or adolescent is with parents, see how the adults are coping, and work to empower the adults rather than undermine their role.
- **Help provide focus**—Offer support that helps the person focus on specific manageable feelings, thoughts, or goals.

Notes:

Active Listening (Nonverbal Attending Skills)

Crisis counselors use specific nonverbal behaviors to communicate listening, attention, openness, and safety:

- **Eye contact**—Use a moderate amount of eye contact to communicate attention. A fixed stare can be disconcerting and should be broken intermittently if the person becomes uncomfortable. It may be best to try to mirror the survivor's use of eye contact.
- **Body position**—A relaxed yet attentive posture puts a person at ease.
- **Attentive silence**—Brief periods of silence give the survivor moments for reflection and may prompt the survivor to open up more and fill the gap in the conversation.
- **Facial expressions and gestures**—Try to be moderately reactive to the person's words and feelings with your gestures. Occasional head nodding for encouragement, a facial expression that indicates concern and interest, and encouraging movements of the hands that are not distracting can be helpful.
- **Physical distance**—Personal space varies from culture to culture and from person to person. For most Americans, about 3 feet is a comfortable distance for personal interaction. Avoid physical barriers, such as desks, because they increase distance and add a feeling of formality.

Note: Nonverbal cues will vary depending on cultural expectations and situational factors.

Normalizing

- Educate the survivor about disaster reactions.
- Reassure the survivor that his or her reactions are common.

Notes:

Empathy

- Is an awareness of and sensitivity to the survivor's experience
- Demonstrates that you are trying to understand how the survivor is experiencing the disaster

Reflecting Feelings

- Lets the survivor know you are aware of how he or she is feeling
- Can encourage emotional expression
- Should include only what you hear clearly stated
- Does not include probing, interpreting, or speculating

Paraphrasing

- Involves rephrasing or rewording what the survivor says
- Does not change, modify, or add to the message
- Demonstrates that you have accurately heard what has been said
- Allows the survivor to either confirm that you are correct or provide additional clarification

Validating Feelings

- Reassures survivors that their reactions are typical
- Lets survivors know that others have felt the way they feel

Notes:

Some Do's and Don'ts for Empathy and Paraphrasing:

Do:

- Find an uninterrupted time and place to talk.
- Show interest, attention, and care.
- Show respect for individuals' reactions and ways of coping.
- Talk about reactions to disasters that are to be expected and about healthy coping.
- Be free of expectations or judgments.
- Acknowledge that this type of stress can take time to resolve.
- Help brainstorm positive ways to deal with their reactions.
- Believe that they are capable of recovery.
- Offer to talk or spend time together as many times as is needed.

Don't:

- Rush to tell them they will be okay or they should just "get over it."
- Daydream about or discuss your own personal experiences instead of listening to them.
- Avoid talking about what is bothering them because you don't know how to handle it.
- Judge them to be weak or exaggerating because they aren't coping as well as you or others are.
- Give advice instead of asking them what works for them.
- Refrain from asking for help from a professional if you feel you can't help them enough.
- Probe for details or insist that others must talk.

Source: National Child Traumatic Stress Network (NCTSN), & National Center for Posttraumatic Stress Disorder (NCPTSD). (2006, July). *Psychological First Aid: Field operations guide, second edition.* Retrieved from http://www.nctsn.org

Screening

- Listen and observe for cues of functioning.
- Recognize when to consult a supervisor.
- Identify and prioritize issues with the survivor.
- Check in with the survivor to clarify what you're hearing and observing.
- Use the assessment and referral tools.
- Ask questions:
  - **Closed questions**—These questions ask for specific information and usually require a short, factual response. Closed questions are necessary when it is important to get the facts straight or to clear up confusion in your understanding of the story.
  - **Open questions**—These questions allow for more freedom of expression. They open general topics, rather than requesting specific information. Examples include "Can you tell me what's been happening at school?" and "You say you're experiencing [x]; what do you mean by that?"

Notes:

What Is Psychological First Aid (PFA)?

- PFA is an approach to help survivors in the immediate aftermath of disaster and terrorism.
- It is designed to reduce the distress caused by traumatic events and to foster coping.
- It is consistent with the CCP model.
- It is an evidence-informed approach.

Where Does PFA Fit?

After a disaster occurs, PFA fits into several parts of the response:

- **Immediate aftermath**—State- or provider-trained staff respond to evacuation sites or shelters and provide PFA.
- **If no Presidential disaster declaration**—State or provider staff continue to provide PFA.
- **If there is a Presidential disaster declaration**—The state applies for and delivers CCP services, which include PFA core actions.

PFA Core Actions

- **Contact and engagement**—To respond to contacts initiated by survivors, or to initiate contacts in a non-intrusive, compassionate, and helpful manner
- **Safety and comfort**—To enhance immediate and ongoing safety, and provide physical and emotional comfort
- **Stabilization**—To calm and orient emotionally overwhelmed or disoriented survivors
- **Information gathering** (current needs and concerns)—To identify immediate needs and concerns, gather additional information, and tailor PFA interventions
- **Practical assistance**—To offer practical help to survivors in addressing immediate needs and concerns
- **Connection with social supports**—To help establish brief or ongoing contacts with primary support persons and other sources of support, including family members, friends, and community helping resources
- **Information on coping**—To provide information about stress reactions and coping to reduce distress and promote adaptive functioning
- **Linkage with collaborative services**—To link survivors with available services needed at the time or in the future

Simulation Exercise Case 1—Craig

You are meeting with Craig, one of the evacuees who suffered significant damage to his house and minimal damage to the convenience store he owns. During your meeting, Craig conveys sadness about the loss of his property, as well as anxiety about when he will be able to return home, but he expresses relief that neither he nor his family members were hurt. He tells you that he's not sure how to access financial help and requests your assistance in linking him to the appropriate resources.

Preparation Worksheet

As you prepare for your encounter with Craig, answer the following questions:

How will you start the conversation with Craig? What are some specific questions you want to ask him?

What skills do you want to be sure to use during the encounter? How will you use them?

How will you provide information, education, and reassurance during the encounter?

Simulation Exercise Case 2—James

James, a 43-year-old man in recovery for 10 years from cocaine addiction, suffered injuries as he and his family took shelter from the disaster that devastated their home and community. Three months later, he is unemployed and stressed, but still a proud man as he tries to care for his family. You and your teammate have visited with James at his home once before.. He tells you he is proud of his time in recovery, yet jokes that he's not doing too badly because of the "pain pills" a doctor prescribed him for his injuries. You notice that he is more withdrawn this visit, that during the last time you met with him. In your last meeting with him, he disclosed that he had a few drinks, but that it is not a big deal because he has "never had a problem with alcohol before."

Preparation Worksheet

As you prepare for your encounter with James, answer the following questions:

How will you start the conversation with James? What are some specific questions you want to ask him?

What skills do you want to be sure to use during the encounter? How will you use them?

How will you provide information, education, and reassurance during the encounter?

Simulation Exercise Case 3—Rachel

Rachel, a local business owner, lost her home in the disaster. Her mother, who lived with her, died in the disaster. Your first encounter with Rachel is to discuss arrangements for shelter and financial assistance; however, during your conversation, Rachel begins to cry and confides that she has not been sleeping or eating much, and she can't stop thinking about her mother dying. She does not feel that she will ever be able to move on.

Preparation Worksheet

As you prepare for your encounter with Rachel, answer the following questions:

How will you start the conversation with Rachel? What are some specific questions you want to ask her?

What skills do you want to be sure to use during the encounter? How will you use them?

How will you provide information, education, and reassurance during the encounter?

Simulation Exercise Observer Worksheet

What skills did you see the crisis counselor use?

What did he or she do well?

What suggestions do you have for improvement?

Survivor Tools

Adapted from NCTSN, & NCPTSD. (2006, July). Psychological First Aid: Field operations guide, second edition. Retrieved from http://www.nctsn.org

Goal-Setting Tools

Crisis counselors assist individuals in doing the following to set goals:

- Identifying their needs
- Prioritizing their needs and identifying the most pressing ones
- Developing a plan of action to address the needs
- Following through with the plan
- Remaining solution focused

Social Support Tools

Crisis counselors assist individuals in doing the following to access social support:

- Identifying primary or familial supports
- Identifying which of these supports is/are readily available
- Reaching out to use immediately available supports
- Identifying options to use when support is not working

Supports vary by the individual and might include family, friends, significant others, religious groups, support groups, or mental health or substance abuse services providers. In addition to identifying supports, discussing support-seeking and giving strategies also may prove helpful.

Coping Tools

To teach better coping, crisis counselors assist individuals in doing the following:

- Identifying and addressing their primary concerns
- Seeing the crisis counselor as a supportive presence
- Allowing family or friends to provide support
- Focusing on manageable feelings, thoughts, or goals
- Exploring the options for spiritual support
- Practicing grounding exercises such as deep breathing
- Understanding common stress reactions

Suggested coping actions:

- Talking to another person for support
- Getting needed information
- Getting adequate rest, nutrition, exercise
- Engaging in positive distracting activities (sports, hobbies, reading)
- Trying to maintain a normal schedule to the extent possible
- Telling yourself that it is natural to be upset for some period of time
- Scheduling pleasant activities
- Eating healthful meals

- Taking breaks
- Spending time with others
- Participating in a support group
- Using relaxation methods
- Using calming self-talk
- Exercising in moderation
- Seeking counseling
- Keeping a journal
- Focusing on something practical you can do right now to manage the situation better
- Using coping methods that have been successful for you in the past

Other coping tools:

- **Positive activity scheduling**—One explanation for feeling sad or being withdrawn is that it results from, and is maintained by, having more negative experiences than positive ones. In order to improve your mood, you need to increase positive experiences and decrease negative ones. One way of achieving this is for the survivor to identify some enjoyable or pleasurable activities he or she could do in the following week.
- **Relaxation techniques and self-calming**—People who have been exposed to extreme stress and fear as a result of disaster have bodies that are often on alert, ready for danger. In the absence of real danger, this anxiety is unnecessary and may have bad effects on one's health. Relaxation and self-calming can include breathing and muscle relaxation techniques.
- **Stress management**—For more information on stress management, refer to Section 8 of Core Content Training.

Helping survivors improve or learn coping skills is a way of fostering resilience.

Notes:

Typical Visits or Encounters

Phase of Visit	Intervention/Skills	Tools for Survivors
Opening	Establishing rapport Calming Screening/assessment Information gathering	Self-calming
Middle	Information and education Active listening Normalizing reactions Empathy Reflecting feelings Paraphrasing Screening/assessment Practical assistance Linking to resources Validating feelings	Prioritizing needs Goal setting Social support Coping skills Relaxation techniques Stress management Positive activity scheduling Problem solving
Closing	Screening/assessment Referral, if needed Followup, if needed	Next steps

Each visit should be a standalone encounter in the event that the person is unavailable or not interested in additional encounters.

Crisis counselors should remain solution focused, provide reassurance, and instill hope.

Opening

- Opening skills
  - Ask about disaster damage—"Can you tell me what happened?" "Did your home sustain any damage?" "Did you have to evacuate?" "Did you have any warning?" "When did you return home?"
  - Ask about the person—"What was it like for you?" "Where were you?" "How did you react?" "How are you doing now?"
- Calming (if needed)
  - "We notice you are very upset, having to catch your breath, having trouble sitting still, etc.; I can do a quick and easy exercise with you to help you feel calmer. You can even use this technique on your own."
  - Teach calming techniques.

- Screening—
  - Observe behavior, emotional state, ability to think clearly; ask questions about daily functioning, maintenance of daily routines, eating, sleeping, working, caring for children, household activities, etc.
- Gathering information—
  - Ask survivors to tell you about their most pressing concerns; safety issues; access to food, clothing, water; issues surrounding children and substance use or abuse.

Middle

- Prioritizing needs—Ask survivors to tell you what they need right now.
- Goal setting—Assist the survivor in setting attainable goals; use the intervention skills to teach the survivors the tools they need to promote their own recovery.

Closing

Encourage the survivor to use the tools he or she learned during the encounter. This ensures that the survivor leaves the encounter with a set of next steps he or she can carry out to achieve the goals identified in the middle of the encounter.

Notes:

Survivor Tools Practice Scenario

Paula is a retired 64-year-old African-American woman who was born and raised in a place where she continued to live until it was affected by a disaster. She lived alone in the house where she grew up until she was forced to evacuate during the disaster. Paula's house sustained extensive damage, and she has decided to sell the house rather than repair it.

You first met Paula just after the disaster. She told you how upsetting it was to leave her childhood home and how she can't understand why God would put her through this trial. On her second visit to the crisis center, Paula talked about how lonely she feels now that she lives in a neighboring town, and she said that the people in her apartment building are not friendly. On her third visit to the center, she continued to talk about her loneliness but commented that she thinks the disaster may have been God's way of telling her she is getting too old to handle the upkeep of a house alone. She also admitted that she is beginning to like her apartment.

How will you apply your assigned tool during your next encounter with Paula?

Maintain Confidentiality

Crisis counseling services provided through the CCP are anonymous and confidential.

Crisis counselors should not share individual or group encounter experiences with anyone outside of the contact or group, with the exception of the following people:

- Their supervisor, for supervision purposes
- Other crisis counselors with a legitimate need to know the information to provide services
- Public safety personnel, if the individual or another human being is in imminent risk or danger

Crisis counselors should not keep formal records; there is not clinical charting in the CCP. However, it is appropriate to maintain basic contact information for the purpose of following up with individuals.

Be sure to get permission for release of information from individuals before sharing any personal information for referrals or any other reason.

Follow the state and local regulations on mandatory reporting for child or elder abuse and neglect.

Immediately discuss any allegations or cases of suspected child abuse with your supervisor.

Follow state and local reporting regulations in cases of suicidal or homicidal intent.

Safeguard the interests and rights of individuals who lack decision making abilities—e.g., children, people with developmental disabilities, people with severe mental illness, or people with cognitive impairments.

Additional Ethical Guidelines

- Do no harm.
- Participation is voluntary.
- Consider reactions in relation to the disaster phase and context.
- Individual coping styles should be respected.
- Immediate interventions are supportive.
- Talking with a person in crisis does not always mean talking about the crisis.
- Be aware of the situational and cultural contexts of the survivor and the intervention itself.

Journal Reflection—Sections 4 through 6

What were your key lessons learned from the practice sessions on using crisis counseling skills and survivor tools effectively?

What did you learn today about the range of individual and collective reactions to disaster that will be helpful to you as a crisis counselor?

What do you want to remember about the unique needs of and intervention strategies for special populations?

How well are your training needs and expectations being met so far in this course? What suggestions do you have of topics or issues to focus on during tomorrow's sessions?

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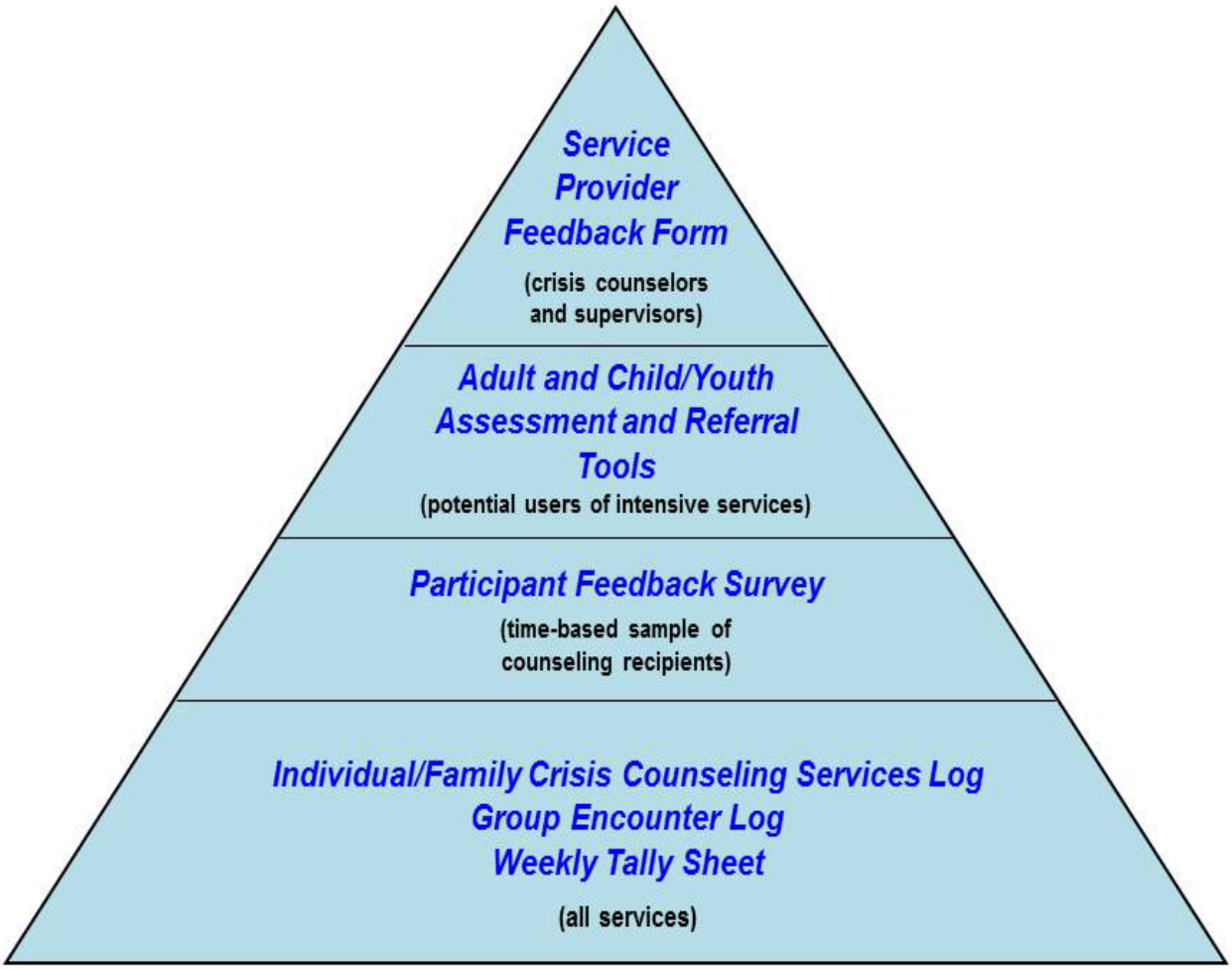
SECTION 7: Data Collection and Program Evaluation

- Data collection is a process of tracking the services provided, including these details of the services:
  - How many
  - What kind
  - To whom
  - Where provided
- Program evaluation is a systematic effort to collect, analyze, and interpret data/information.
- We collect data and evaluate programs to understand and improve services based on observable and verifiable data.



In most cases, a separate training session will be offered to learn details of CCP data collection:

- How the information is gathered
- How the encounter and contacts should be documented
- How the data are entered (for data entry staff)
- How the data are analyzed (for program staff)

Brief Overview of the Data Collection Forms

- The CCP data collection forms are cleared by the federal Office of Management and Budget (OMB) and have an official OMB number. They may not be altered.
- Included with each form is a page of detailed instructions for your reference.
- Every CCP is required to utilize and complete the following forms, as appropriate:
    - Individual/Family Crisis Counseling Services Encounter Log
    - Group Encounter Log
    - Weekly Tally Sheet
    - Adult Assessment and Referral Tool
    - Child/Youth Assessment and Referral Tool
    - Provider Feedback Forms and Participant Feedback Surveys are also required at 6 and 12 months after the disaster.

Encounter Logs and Weekly Tally Sheets

- Are used to document all services delivered
- Ensure that services are counted in a standardized way in all areas
- Should always be completed by the crisis counselor in a timely manner, so that information is not lost.

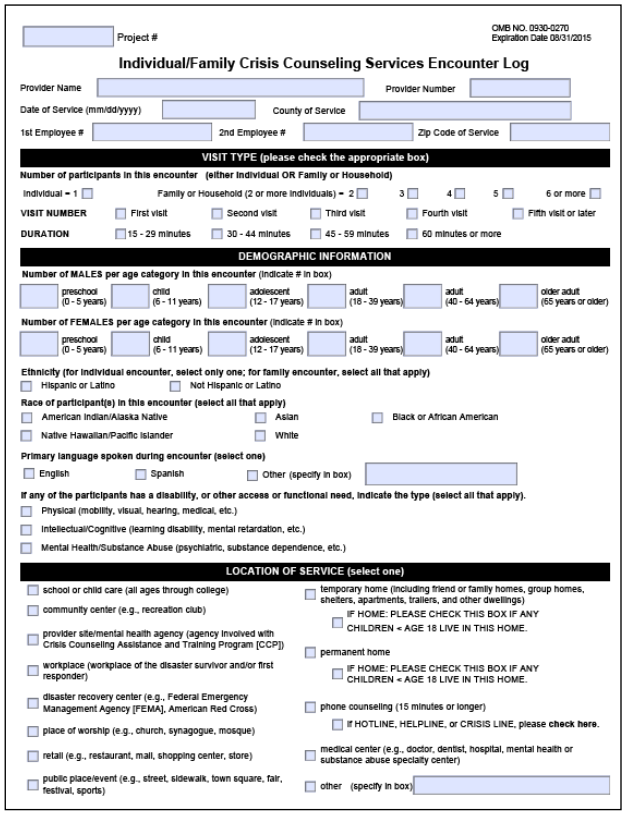
Individual/Family Crisis Counseling Services Encounter Logs

- Document interactions of 15 minutes or longer with individuals or families
- Involve participant disclosure
- Capture information gathered by a team of crisis counselors on one form, rather than two separate forms

– **Parts of the form:**

- First page captures visit type, demographic information, number of people in the encounter, and location of service.
- Second page (back of form) captures risk categories, event reactions, focus of encounter, materials, and referrals.
    - Event reactions—Behavioral, emotional, physical, or cognitive reactions that are being experienced at the time of the service encounter
    - Focus of encounter—Information, skills, coping tips, or support provided to the individual(s) participating in the encounter
    - Materials—Printed educational materials made available and left with the survivor(s), so in most cases, this should be "yes"
    - Referrals—List of names and contact information for commonly used resources and referrals provided when necessary

A copy of this form can be found at the end of this workbook.



Project #

OMB NO. 0930-0270
Expiration Date 08/31/2015

Individual/Family Crisis Counseling Services Encounter Log

Provider Name | Provider Number
Date of Service (mm/dd/yyyy) | County of Service
1st Employee # | 2nd Employee # | Zip Code of Service

VISIT TYPE (please check the appropriate box)

Number of participants in this encounter (either individual OR family or household)
Individual = 1 ☐ Family or Household (2 or more individuals) = 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more ☐

VISIT NUMBER ☐ First visit ☐ Second visit ☐ Third visit ☐ Fourth visit ☐ Fifth visit or later

DURATION ☐ 15 - 29 minutes ☐ 30 - 44 minutes ☐ 45 - 59 minutes ☐ 60 minutes or more

DEMOGRAPHIC INFORMATION

Number of MALES per age category in this encounter (indicate # in box)
☐ preschool (0 - 5 years) ☐ child (6 - 11 years) ☐ adolescent (12 - 17 years) ☐ adult (18 - 39 years) ☐ adult (40 - 64 years) ☐ older adult (65 years or older)

Number of FEMALES per age category in this encounter (indicate # in box)
☐ preschool (0 - 5 years) ☐ child (6 - 11 years) ☐ adolescent (12 - 17 years) ☐ adult (18 - 39 years) ☐ adult (40 - 64 years) ☐ older adult (65 years or older)

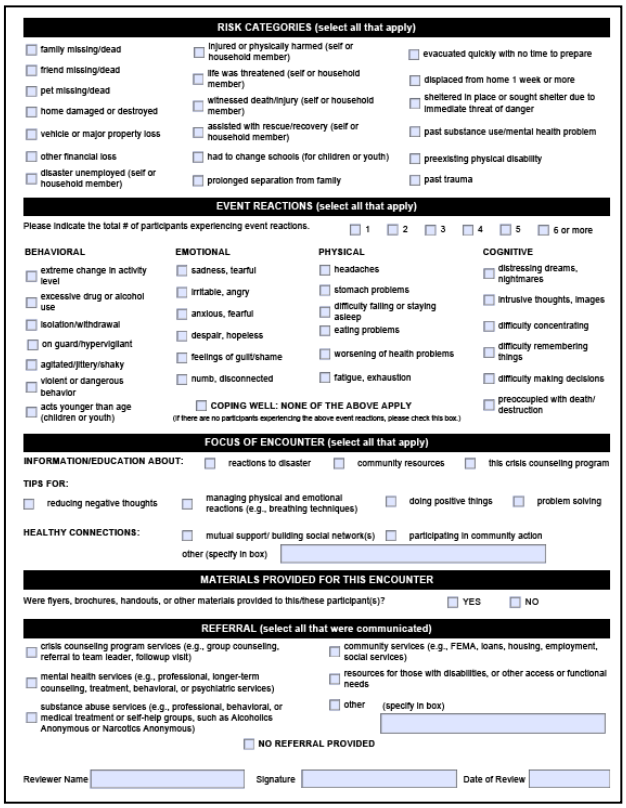
Ethnicity (for individual encounter, select only one; for family encounter, select all that apply)
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race of participant(s) in this encounter (select all that apply)
☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian/Pacific Islander ☐ White

Primary language spoken during encounter (select one)
☐ English ☐ Spanish ☐ Other (specify in box)

If any of the participants has a disability, or other access or functional need, indicate the type (select all that apply).
☐ Physical (mobility, visual, hearing, medical, etc.)
☐ Intellectual/Cognitive (learning disability, mental retardation, etc.)
☐ Mental Health/Substance Abuse (psychiatric, substance dependence, etc.)

LOCATION OF SERVICE (select one)
☐ school or child care (all ages through college)
☐ community center (e.g., recreation club)
☐ provider site/mental health agency (agency involved with Crisis Counseling Assistance and Training Program [CCP])
☐ workplace (workplace of the disaster survivor and/or first responder)
☐ disaster recovery center (e.g., Federal Emergency Management Agency [FEMA], American Red Cross)
☐ place of worship (e.g., church, synagogue, mosque)
☐ retail (e.g., restaurant, mall, shopping center, store)
☐ public place/event (e.g., street, sidewalk, town square, fair, festival, sports)
☐ temporary home (including friend or family homes, group homes, shelters, apartments, trailers, and other dwellings)
☐ IF HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN < AGE 18 LIVE IN THIS HOME.
☐ permanent home
☐ IF HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN < AGE 18 LIVE IN THIS HOME.
☐ phone counseling (15 minutes or longer)
☐ if HOTLINE, HELPLINE, or CRISIS LINE, please check here.
☐ medical center (e.g., doctor, dentist, hospital, mental health or substance abuse specialty center)
☐ other (specify in box)



RISK CATEGORIES (select all that apply)
☐ family missing/dead
☐ friend missing/dead
☐ pet missing/dead
☐ home damaged or destroyed
☐ vehicle or major property loss
☐ other financial loss
☐ disaster unemployed (self or household member)
☐ injured or physically harmed (self or household member)
☐ life was threatened (self or household member)
☐ witnessed death/injury (self or household member)
☐ assisted with rescue/recovery (self or household member)
☐ had to change schools (for children or youth)
☐ prolonged separation from family
☐ evacuated quickly with no time to prepare
☐ displaced from home 1 week or more
☐ sheltered in place or sought shelter due to immediate threat of danger
☐ past substance use/mental health problem
☐ preexisting physical disability
☐ past trauma

EVENT REACTIONS (select all that apply)
Please indicate the total # of participants experiencing event reactions. ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more

BEHAVIORAL
☐ extreme change in activity level
☐ excessive drug or alcohol use
☐ isolation/withdrawal
☐ on guard/hypervigilant
☐ agitated/jittery/shaky
☐ violent or dangerous behavior
☐ acts younger than age (children or youth)

EMOTIONAL
☐ sadness, tearful
☐ irritable, angry
☐ anxious, fearful
☐ despair, hopeless
☐ feelings of guilt/shame
☐ numb, disconnected

PHYSICAL
☐ headaches
☐ stomach problems
☐ difficulty falling or staying asleep
☐ eating problems
☐ worsening of health problems
☐ fatigue, exhaustion

COGNITIVE
☐ distressing dreams, nightmares
☐ intrusive thoughts, images
☐ difficulty concentrating
☐ difficulty remembering things
☐ difficulty making decisions
☐ preoccupied with death/destruction

☐ **COPING WELL: NONE OF THE ABOVE APPLY**
(If there are no participants experiencing the above event reactions, please check this box.)

FOCUS OF ENCOUNTER (select all that apply)
INFORMATION/EDUCATION ABOUT: ☐ reactions to disaster ☐ community resources ☐ this crisis counseling program
TIPS FOR:
☐ reducing negative thoughts ☐ managing physical and emotional reactions (e.g., breathing techniques) ☐ doing positive things ☐ problem solving
HEALTHY CONNECTIONS: ☐ mutual support/ building social network(s) ☐ participating in community action
other (specify in box)

MATERIALS PROVIDED FOR THIS ENCOUNTER
Were flyers, brochures, handouts, or other materials provided to this/these participant(s)? ☐ YES ☐ NO

REFERRAL (select all that were communicated)
☐ crisis counseling program services (e.g., group counseling, referral to team leader, followup visit)
☐ mental health services (e.g., professional, longer-term counseling, treatment, behavioral, or psychiatric services)
☐ substance abuse services (e.g., professional, behavioral, or medical treatment or self-help groups, such as Alcoholics Anonymous or Narcotics Anonymous)
☐ community services (e.g., FEMA, loans, housing, employment, social services)
☐ resources for those with disabilities, or other access or functional needs
☐ other (specify in box)
☐ **NO REFERRAL PROVIDED**

Reviewer Name | Signature | Date of Review

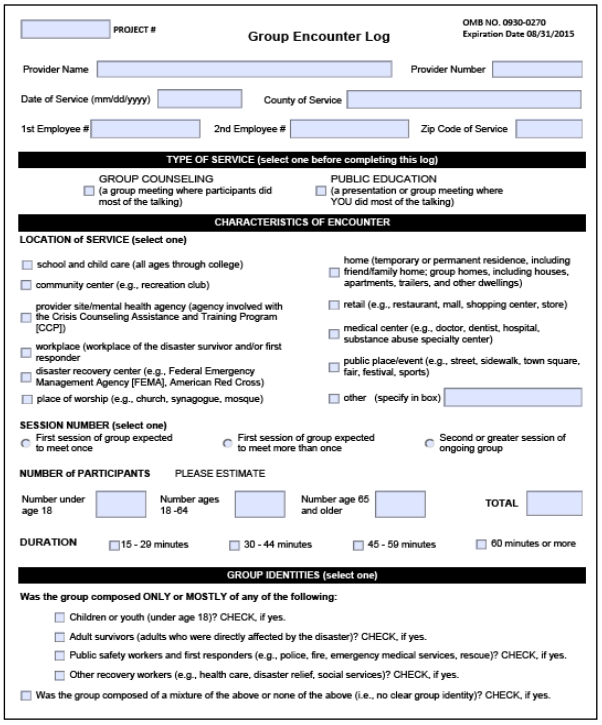
Group Encounter Logs

- Document group crisis counseling (in which participants do most of the talking) and public education (in which the counselor does most of the talking)
- Measure encounter characteristics, group identities, and focus
- Capture information gathered by a team of crisis counselors on one form, rather than two separate forms

– **Parts of the form:**

- First page captures type of service, characteristics of encounter, and group identities.
- Second page (back of form) captures demographics, focus of group session, and materials provided.
    - Focus of encounter—This includes the information, skills, coping tips, or support that is provided to the individual(s) participating in the encounter.
    - Materials—Printed educational materials should be made available and left with the survivor(s), so in most cases, this should be "yes."
    - Referrals—List of names and contact information for commonly used resources and referrals should also be provided, when necessary.

A copy of this form can be found at the end of this workbook.



PROJECT #

Group Encounter Log

OMB NO. 0930-0270
Expiration Date 08/31/2015

Provider Name | Provider Number

Date of Service (mm/dd/yyyy) | County of Service

1st Employee # | 2nd Employee # | Zip Code of Service

TYPE OF SERVICE (select one before completing this log)

GROUP COUNSELING (a group meeting where participants did most of the talking)

PUBLIC EDUCATION (a presentation or group meeting where YOU did most of the talking)

CHARACTERISTICS OF ENCOUNTER

LOCATION of SERVICE (select one)

- school and child care (all ages through college)
- community center (e.g., recreation club)
- provider site/mental health agency (agency involved with the Crisis Counseling Assistance and Training Program [CCP])
- workplace (workplace of the disaster survivor and/or first responder
- disaster recovery center (e.g., Federal Emergency Management Agency [FEMA], American Red Cross)
- place of worship (e.g., church, synagogue, mosque)
- home (temporary or permanent residence, including friend/family home; group homes, including houses, apartments, trailers, and other dwellings)
- retail (e.g., restaurant, mall, shopping center, store)
- medical center (e.g., doctor, dentist, hospital, substance abuse specialty center)
- public place/event (e.g., street, sidewalk, town square, fair, festival, sports)
- other (specify in box)

SESSION NUMBER (select one)

First session of group expected to meet once | First session of group expected to meet more than once | Second or greater session of ongoing group

NUMBER of PARTICIPANTS PLEASE ESTIMATE

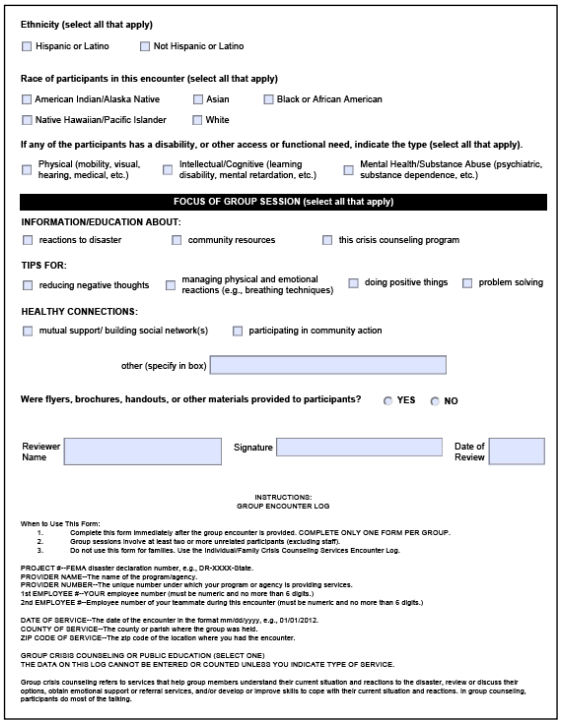
Number under age 18 | Number ages 18 -64 | Number age 65 and older | TOTAL

DURATION 15 - 29 minutes | 30 - 44 minutes | 45 - 59 minutes | 60 minutes or more

GROUP IDENTITIES (select one)

Was the group composed ONLY or MOSTLY of any of the following:

- Children or youth (under age 18)? CHECK, if yes.
- Adult survivors (adults who were directly affected by the disaster)? CHECK, if yes.
- Public safety workers and first responders (e.g., police, fire, emergency medical services, rescue)? CHECK, if yes.
- Other recovery workers (e.g., health care, disaster relief, social services)? CHECK, if yes.
- Was the group composed of a mixture of the above or none of the above (i.e., no clear group identity)? CHECK, if yes.



Ethnicity (select all that apply)

Hispanic or Latino | Not Hispanic or Latino

Race of participants in this encounter (select all that apply)

American Indian/Alaska Native | Asian | Black or African American

Native Hawaiian/Pacific Islander | White

If any of the participants has a disability, or other access or functional need, indicate the type (select all that apply).

Physical (mobility, visual, hearing, medical, etc.) | Intellectual/Cognitive (learning disability, mental retardation, etc.) | Mental Health/Substance Abuse (psychiatric, substance dependence, etc.)

FOCUS OF GROUP SESSION (select all that apply)

INFORMATION/EDUCATION ABOUT:

reactions to disaster | community resources | this crisis counseling program

TIPS FOR:

reducing negative thoughts | managing physical and emotional reactions (e.g., breathing techniques) | doing positive things | problem solving

HEALTHY CONNECTIONS:

mutual support/ building social network(s) | participating in community action

other (specify in box)

Were flyers, brochures, handouts, or other materials provided to participants? YES | NO

Reviewer Name | Signature | Date of Review

INSTRUCTIONS:
GROUP ENCOUNTER LOG

When to Use This Form:
1. Complete this form immediately after the group encounter is provided. COMPLETE ONLY ONE FORM PER GROUP.
2. Group sessions involve at least two or more unrelated participants (excluding staff).
3. Do not use this form for families. Use the Individual/Family Crisis Counseling Services Encounter Log.

PROJECT #–FEMA disaster declaration number, e.g., DR-XXXX-State.
PROVIDER NAME–The name of the program/agency.
PROVIDER NUMBER–The unique number under which your program or agency is providing services.
1st EMPLOYEE #–YOUR employee number (must be numeric and no more than 6 digits.)
2nd EMPLOYEE #–Employee number of your teammate during this encounter (must be numeric and no more than 6 digits.)

DATE OF SERVICE–The date of the encounter in the format mm/dd/yyyy, e.g., 01/01/2012.
COUNTY OF SERVICE–The county or parish where the group was held.
ZIP CODE OF SERVICE–The zip code of the location where you had the encounter.

GROUP CRISIS COUNSELING OR PUBLIC EDUCATION (SELECT ONE)
THE DATA ON THIS LOG CANNOT BE ENTERED OR COUNTED UNLESS YOU INDICATE TYPE OF SERVICE.

Group crisis counseling refers to services that help group members understand their current situation and reactions to the disaster, review or discuss their options, obtain emotional support or referral services, and/or develop or improve skills to cope with their current situation and reactions. In group counseling, participants do most of the talking.

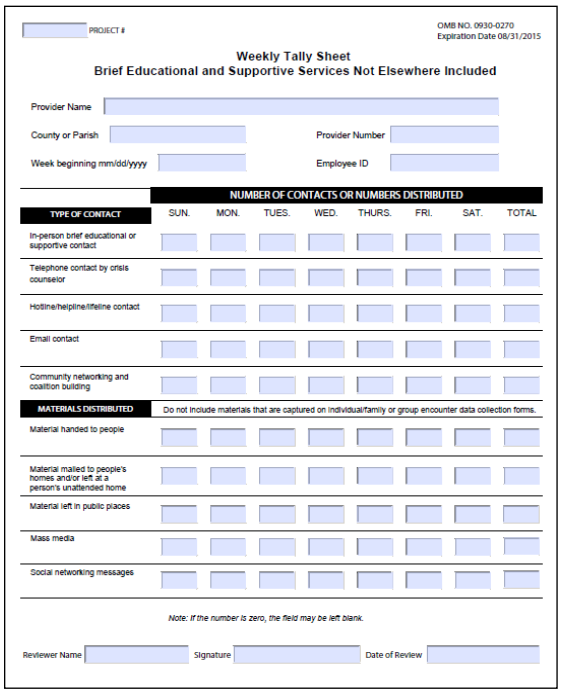
Weekly Tally Sheets

- Document brief educational and supportive contacts (less than 15 minutes), telephone calls, e-mails, and material distribution
- Include information for 1 week (beginning Sunday)
- Tally services at the county level, using three-digit county codes
- Should be completed by crisis counselors for each county in which they work (one tally per crisis counselor for each county)
- May be partly completed (the social networking and mass media sections) by administrative staff

– **Parts of the form:**

- Captures number of contacts made through brief in-person contacts, telephone contacts by crisis counselors, hotline/helpline/lifeline contacts, e-mails, and community networking
- Captures materials distributed that are not otherwise captured on the Individual/Family Crisis Counseling Services Encounter Log or Group Encounter Log
    - When packets of materials are handed to people, mailed, or left at someone's house, the number of packets is counted (not individual pieces within the packet).
    - When mass media messages and social networking announcements are posted, count the number of messages you post (not the number of viewers/listeners, and not the number that "like," "re-tweet," or share your message).

A copy of this form can be found at the end of this workbook.



PROJECT #

OMB NO. 0930-0270
Expiration Date 08/31/2015

Weekly Tally Sheet
Brief Educational and Supportive Services Not Elsewhere Included

Provider Name

County or Parish | Provider Number

Week beginning mm/dd/yyyy | Employee ID

	NUMBER OF CONTACTS OR NUMBERS DISTRIBUTED							
TYPE OF CONTACT	SUN.	MON.	TUES.	WED.	THURS.	FRI.	SAT.	TOTAL
In-person brief educational or supportive contact								
Telephone contact by crisis counselor								
Hotline/helpline/lifeline contact								
Email contact								
Community networking and coalition building								
MATERIALS DISTRIBUTED	Do not include materials that are captured on individual/family or group encounter data collection forms.							
Material handed to people								
Material mailed to people's homes and/or left at a person's unattended home								
Material left in public places								
Mass media								
Social networking messages								

Note: If the number is zero, the field may be left blank.

Reviewer Name | Signature | Date of Review

Assessment and Referral Tools

- Your employer should have protocols or procedures in place for how to respond if serious reactions are indicated and should provide training on how to use these tools and when to make a referral for more intensive services.

- All of the following are true of the Child/Youth Assessment and Referral Tool and the Adult Assessment and Referral Tool:

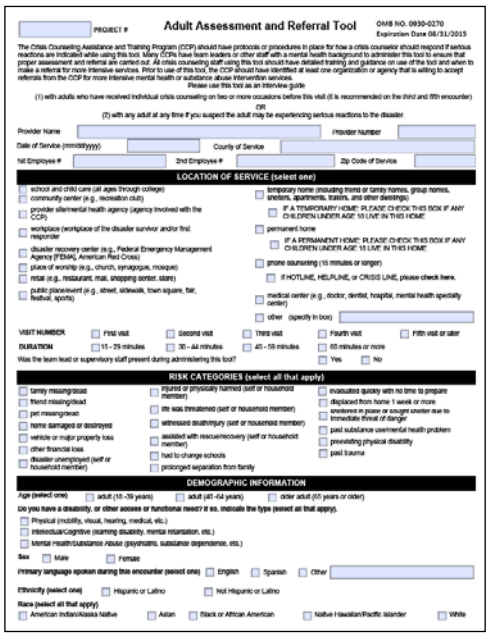
    - They are used to facilitate referrals to more intensive behavioral health services.

    - They can be used at any time if you suspect the individual may be experiencing serious reactions.

    - They should always be used at the third individual/family crisis counseling encounter.

    - They measure risk categories and event reactions using a structured interview approach.

For adults:



PROJECT #

Adult Assessment and Referral Tool

OMB NO. 0930-0270
Expiration Date 08/31/2015

The Crisis Counseling Assistance and Training Program (CCP) should have protocols or procedures in place for how a crisis counselor should respond if serious reactions are indicated while using this tool. Many CCPs have team leaders or other staff with a mental health background to administer this tool to ensure that proper assessment and referral are carried out. All crisis counseling staff using this tool should have detailed training and guidance on use of the tool and when to make a referral for more intensive services. Prior to use of this tool, the CCP should have identified at least one organization or agency that is willing to accept referrals from the CCP for more intensive mental health or substance abuse intervention services.

Please use this tool as an interview guide

(1) with adults who have received individual crisis counseling on two or more occasions before this visit (it is recommended on the third and fifth encounter)

OR

(2) with any adult at any time if you suspect the adult may be experiencing serious reactions to the disaster.

Provider Name | Provider Number

Date of Service (mm/dd/yyyy) | County of Service

1st Employee # | 2nd Employee # | Zip Code of Service

LOCATION OF SERVICE (select one)

- school and child care (all ages through college)
- community center (e.g., recreation club)
- provider site/mental health agency (agency involved with the CCP)
- workplace (workplace of the disaster survivor and/or first responder
- disaster recovery center (e.g., Federal Emergency Management Agency (FEMA), American Red Cross)
- place of worship (e.g., church, synagogue, mosque)
- retail (e.g., restaurant, mall, shopping center, store)
- public place/event (e.g., street, sidewalk, town square, fair, festival, sports)
- temporary home (including friend or family homes, group homes, shelters, apartments, trailers, and other dwellings)
  - IF A TEMPORARY HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN UNDER AGE 18 LIVE IN THIS HOME
- permanent home
  - IF A PERMANENT HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN UNDER AGE 18 LIVE IN THIS HOME
- phone counseling (15 minutes or longer)
  - IF HOTLINE, HELPLINE, or CRISIS LINE, please check here.
- medical center (e.g., doctor, dentist, hospital, mental health specialty center)
- other (specify in box)

VISIT NUMBER: First visit | Second visit | Third visit | Fourth visit | Fifth visit or later

DURATION: 15 – 29 minutes | 30 – 44 minutes | 45 – 59 minutes | 60 minutes or more

Was the team lead or supervisory staff present during administering this tool? Yes | No

RISK CATEGORIES (select all that apply)

- family missing/dead
- friend missing/dead
- pet missing/dead
- home damaged or destroyed
- vehicle or major property loss
- other financial loss
- disaster unemployed (self or household member)
- injured or physically harmed (self or household member)
- life was threatened (self or household member)
- witnessed death/injury (self or household member)
- assisted with rescue/recovery (self or household member)
- had to change schools
- prolonged separation from family
- evacuated quickly with no time to prepare
- displaced from home 1 week or more
- sheltered in place or sought shelter due to immediate threat of danger
- past substance use/mental health problem
- preexisting physical disability
- past trauma

DEMOGRAPHIC INFORMATION

Age (select one): adult (18 –39 years) | adult (40 –64 years) | older adult (65 years or older)

Do you have a disability, or other access or functional need? If so, indicate the type (select all that apply).

- Physical (mobility, visual, hearing, medical, etc.)
- Intellectual/Cognitive (learning disability, mental retardation, etc.)
- Mental Health/Substance Abuse (psychiatric, substance dependence, etc.)

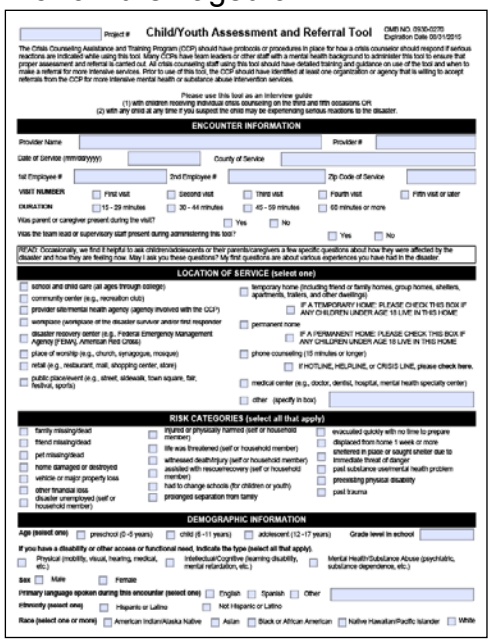
Sex: Male | Female

Primary language spoken during this encounter (select one): English | Spanish | Other

Ethnicity (select one): Hispanic or Latino | Not Hispanic or Latino

Race (select all that apply): American Indian/Alaska Native | Asian | Black or African American | Native Hawaiian/Pacific Islander | White

For children aged 0–17:



Project #

Child/Youth Assessment and Referral Tool

OMB NO. 0930-0270
Expiration Date 08/31/2015

The Crisis Counseling Assistance and Training Program (CCP) should have protocols or procedures in place for how a crisis counselor should respond if serious reactions are indicated while using this tool. Many CCPs have team leaders or other staff with a mental health background to administer this tool to ensure that proper assessment and referral are carried out. All crisis counseling staff using this tool should have detailed training and guidance on use of the tool and when to make a referral for more intensive services. Prior to use of this tool, the CCP should have identified at least one organization or agency that is willing to accept referrals from the CCP for more intensive mental health or substance abuse intervention services.

Please use this tool as an interview guide

(1) with children receiving individual crisis counseling on the third and fifth occasions OR

(2) with any child at any time if you suspect the child may be experiencing serious reactions to the disaster.

ENCOUNTER INFORMATION

Provider Name | Provider #

Date of Service (mm/dd/yyyy) | County of Service

1st Employee # | 2nd Employee # | Zip Code of Service

VISIT NUMBER: First visit | Second visit | Third visit | Fourth visit | Fifth visit or later

DURATION: 15 – 29 minutes | 30 – 44 minutes | 45 – 59 minutes | 60 minutes or more

Was parent or caregiver present during the visit? Yes | No

Was the team lead or supervisory staff present during administering this tool? Yes | No

READ: Occasionally, we find it helpful to ask children/adolescents or their parents/caregivers a few specific questions about how they were affected by the disaster and how they are feeling now. May I ask you these questions? My first questions are about various experiences you have had in the disaster.

LOCATION OF SERVICE (select one)

- school and child care (all ages through college)
- community center (e.g., recreation club)
- provider site/mental health agency (agency involved with the CCP)
- workplace (workplace of the disaster survivor and/or first responder
- disaster recovery center (e.g., Federal Emergency Management Agency (FEMA), American Red Cross)
- place of worship (e.g., church, synagogue, mosque)
- retail (e.g., restaurant, mall, shopping center, store)
- public place/event (e.g., street, sidewalk, town square, fair, festival, sports)
- temporary home (including friend or family homes, group homes, shelters, apartments, trailers, and other dwellings)
  - IF A TEMPORARY HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN UNDER AGE 18 LIVE IN THIS HOME
- permanent home
  - IF A PERMANENT HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN UNDER AGE 18 LIVE IN THIS HOME
- phone counseling (15 minutes or longer)
  - IF HOTLINE, HELPLINE, or CRISIS LINE, please check here.
- medical center (e.g., doctor, dentist, hospital, mental health specialty center)
- other (specify in box)

RISK CATEGORIES (select all that apply)

- family missing/dead
- friend missing/dead
- pet missing/dead
- home damaged or destroyed
- vehicle or major property loss
- other financial loss
- disaster unemployed (self or household member)
- injured or physically harmed (self or household member)
- life was threatened (self or household member)
- witnessed death/injury (self or household member)
- assisted with rescue/recovery (self or household member)
- had to change schools (for children or youth)
- prolonged separation from family
- evacuated quickly with no time to prepare
- displaced from home 1 week or more
- sheltered in place or sought shelter due to immediate threat of danger
- past substance use/mental health problem
- preexisting physical disability
- past trauma

DEMOGRAPHIC INFORMATION

Age (select one): preschool (0 –5 years) | child (6 –11 years) | adolescent (12 –17 years) | Grade level in school

If you have a disability or other access or functional need, indicate the type (select all that apply).

- Physical (mobility, visual, hearing, medical, etc.)
- Intellectual/Cognitive (learning disability, mental retardation, etc.)
- Mental Health/Substance Abuse (psychiatric, substance dependence, etc.)

Sex: Male | Female

Primary language spoken during this encounter (select one): English | Spanish | Other

Ethnicity (select one): Hispanic or Latino | Not Hispanic or Latino

Race (select one or more): American Indian/Alaska Native | Asian | Black or African American | Native Hawaiian/Pacific Islander | White

- Assessment and referral tools are used in ISP and RSP, as needed.

- At the end of the form, you should review the responses that are indicated with a “4” or “5,” and be prepared to offer the respondent a referral for more intensive services.

- You should also have a plan in place (that adheres to your employer's protocol) for what to do if the individual says "yes" to the question "Is there any possibility that you might hurt or kill yourself?"

Quality Assurance and Management

- Each form has a reviewer signature area at the bottom.
- A supervisor (team leader) in the field should approve and sign the form before sending it to data entry staff.
- Any recurring errors in completed forms should prompt followup training for crisis counselors.
- Data entry staff should review forms at the time of data entry.
- Data entered by one staff member should be checked by another to increase accuracy and minimize errors.
- Data and evaluation staff should be providing regular reports of the data (at least every 2 weeks) and working with program staff to determine the impact of the analysis.

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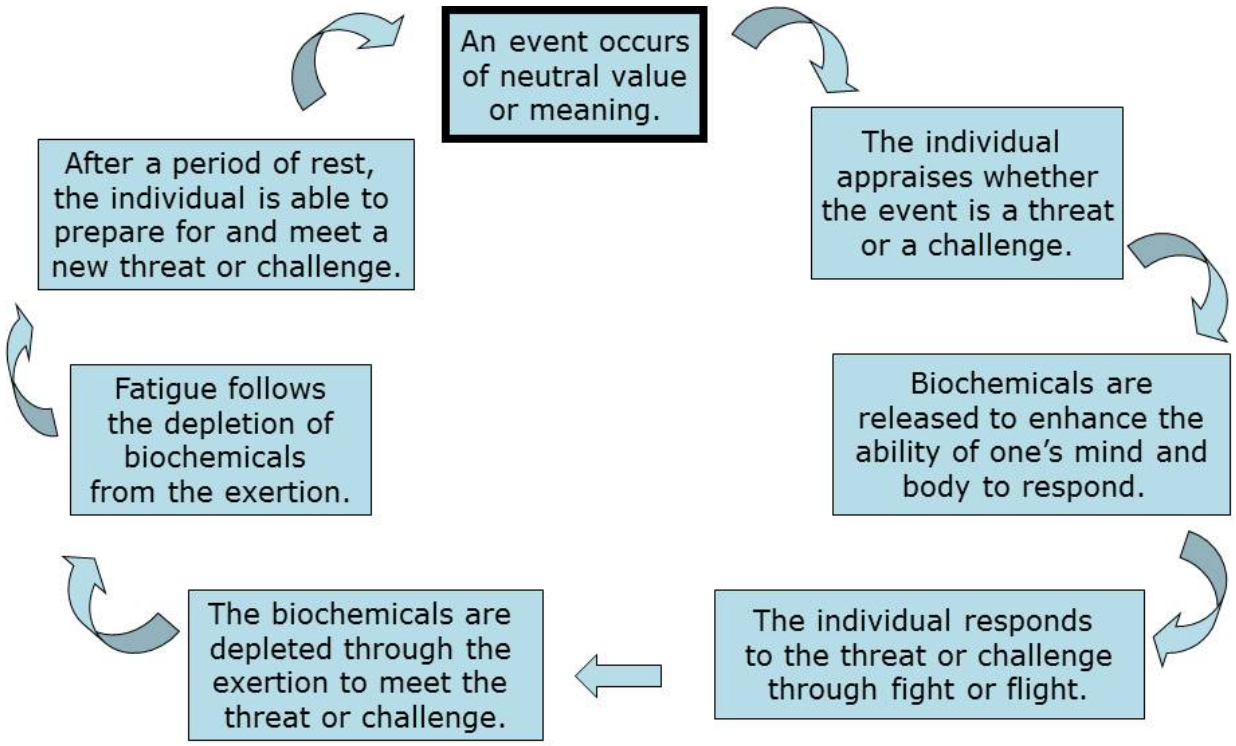
SECTION 8: Stress Management

Definition of Stress

- Stress is a response to a challenge or a threat.
- Stress is tension, strain, or pressure that requires people to use, adapt, or develop new coping skills.
- Stress can be positive or negative.
- Perception plays a key role in interpreting stressful situations.
- An optimum level can act as a motivational force.

The Stress Cycle



Notes:

Typical Stressors for Crisis Counselors

- At the core of a CCP are its staff—the program's success is directly dependent on staff's ability to regulate their own stress.
- Particular care needs to be taken to address and process the effects this exposure can have on the crisis counselor. Individual supervision and process sessions following deployment shifts are two main venues for this type of support.

My Top Three Stressors

1.

2.

3.

Warning Signs of Excessive Stress

- You cannot shake distressing images from your mind.
- Work consumes you at the expense of family and friends.
- You experience increased substance use or abuse.
- You are excessively irritable and impatient.
- You exhibit other serious or severe reactions.

What To Do

Disaster workers commonly experience many reactions that have limited impact on performance. However, when a number of reactions are experienced simultaneously and intensely, functioning is likely to be impaired. Under these circumstances, the worker should take a break from the disaster assignment for a few hours at first, and then, longer, if necessary. If normal functioning does not return, the person needs to discontinue the assignment.

Notes:

Individual Approaches to Stress Management

- Self-awareness
- Management of workload
- Balanced lifestyle
- Stress-reduction techniques
- Effective supervision and training

Inventory of Stress Management Techniques

This list of ways to manage stress can be used by crisis counselors themselves and recommended to individuals seeking crisis counseling services.

- Acupuncture—Insertion of needles at certain spots under the skin for the purpose of attaining a balance of the body's energy
- Aromatherapy—Therapy through the sense of smell, using essential oils, claimed to produce a sense of well-being
- Asking for help and advice from family and friends
- Art therapy—Creating something, which allows free expression and results in feelings of achievement and mood change
- Behavioral therapy—A variety of psychotherapies based on changing ourselves by retraining
- Biofeedback—Monitoring rates of body functions and using results to increase relaxation
- Breathing for relaxation—Stylized breathing techniques to control blood pressure and stress levels
- Dance movement therapy—Freedom of expression through movement
- Eating a balanced diet
- Exercising at least three times a week
- Hobbies—Doing something just for the fun of it
- Getting enough sleep
- Going for a walk
- Guided imagery—Creating a mental picture of what is desired (creative imagery, visualization)
- Homeopathy—Small doses of plant, animal, or mineral substances to stimulate the body's natural healing
- Learning to say no—Not taking on more than you can reasonably do
- Laughter—Not taking yourself too seriously
- Listening to your favorite music
- Massage—Use of touch or deep tissue manipulation to soothe
- Meditation—Deep, relaxed, focused concentration on a single word, object, or sound
- Psychotherapy—Talk-based therapy with a mental health professional to get to the root of a conflict and modify behavior and disruptive negative thought patterns

- Reducing caffeine intake
- Quitting smoking
- T’ai chi ch'uan—System of slow, continuous exercises based on rhythm and equilibrium
- Taking a break
- Yoga—A system of exercises combining certain positions with deep breathing and meditation

Individual Stress Management Plan Worksheet

1. What do you value most about doing disaster mental health work?

2. What are—or do you expect to be—the most stressful and most rewarding aspects of disaster work?

   Stressful

   Rewarding

3. How do you know when you are stressed?

4. What can others do for you when you are stressed?

5. How can you let them know that?

6. What can you do for yourself in each of the following areas:

   Management of workload

   Balanced lifestyle

   Stress-reduction techniques

Applying Your Learning

Review your journal reflections for Sections 1–6, and reflect on your lessons learned from Sections 7 and 8—Data Collection and Stress Management.

Summarize what you have learned and what you plan to do back at work by answering the following questions.

What are the most important things you have learned as a result of this course?

What are three things you plan to do in the next 2 weeks to apply in your work setting what you have learned here?

What are the skills you feel will continue to be the most difficult for you, and what can you do to overcome those difficulties?

How can you continue to get feedback on your crisis counseling skills? Who can help you, and how will you approach these people?

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Crisis Counseling Assistance and Training Program (CCP)

Training Feedback Form for Participants

CCP Name/Disaster Number:_____

1. The goals and objectives of the training were clearly stated.

Strongly Disagree				Strongly Agree
1	2	3	4	5

2. The training content, handouts, and activities were effective in meeting the stated objectives.

Strongly Disagree				Strongly Agree
1	2	3	4	5

3. The content of the training module was well organized.

Strongly Disagree				Strongly Agree
1	2	3	4	5

4. The information was clearly presented.

Strongly Disagree				Strongly Agree
1	2	3	4	5

5. The trainer demonstrated thorough knowledge of the subject matter.

Strongly Disagree				Strongly Agree
1	2	3	4	5

6. The trainer facilitated the session effectively (e.g., exercises were appropriate and well executed, and the training was on schedule).

Strongly Disagree				Strongly Agree
1	2	3	4	5

7. The length of the training was appropriate for the amount of material covered.

Strongly Disagree				Strongly Agree
1	2	3	4	5

8. The training environment was physically comfortable (e.g. temperature, room size, setup).

Strongly Disagree				Strongly Agree
1	2	3	4	5

9. What elements of this training session will most assist you in effectively performing your job duties?

10. How do you think the module content or the training session could be improved?

Thank you for your valued feedback. Please return this form to your trainer. Copies will be mailed to SAMHSA DTAC at:

SAMHSA DTAC
9300 Lee Highway
Fairfax, VA 22301

Additional Resources

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Disaster Behavioral Health Acronyms

A

ACF	Administration for Children and Families
ADA	Americans with Disabilities Act of 1990
ADP	Automated Data Processing
ANH	Average Number of People per Household
APA	American Psychological Association
APHA	American Public Health Association
APHIS	Animal and Plant Health Inspection Service
ARC	American Red Cross
ASL	American Sign Language
ASPR	Office of the Assistant Secretary for Preparedness and Response
ASTHO	Association of State and Territorial Health Officials
ATF	Bureau of Alcohol, Tobacco, Firearms, and Explosives (also BATF)

B

BH	Behavioral Health
BIA	Bureau of Indian Affairs
BNICE	Biological, Nuclear, Incendiary, or Explosive

C

CARD	Center for Asbestos-Related Disease (Libby, MT)
CARD	Collaborating Agencies Responding to Disasters
CBRN	Chemical, Biological, Radiological, or Nuclear
CCP	Crisis Counseling Assistance and Training Program (grant program)
CDC	Centers for Disease Control and Prevention
CERT	Community Emergency Response Team
CFR	Code of Federal Regulations
CIO	Chief Information Officer
CISD	Critical Incident Stress Debriefing
CISM	Critical Incident Stress Management
CMHC	Community Mental Health Center
CMHS	Center for Mental Health Services
COOP	Continuity of Operations
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment

D

DFO	Disaster Field Office (FEMA)
DHS	Department of Homeland Security
DIRM	Division of Information Resource Management
DMAT	Disaster Medical Assistance Team
DMH	Disaster Mental Health
DMHC	Disaster Mental Health Coordinator
DMORT	Disaster Mortuary Operational Response Team
DOD	Department of Defense
DOJ	Department of Justice
DPO	Disaster Psychiatry Outreach
DRC	Disaster Recovery Center (FEMA)
DTAC	Disaster Technical Assistance Center
DUNS	Data Universal Numbering System

E

EAP	Employee Assistance Program
EAS	Emergency Alert System (formerly Emergency Broadcast System)
ED	Department of Education
EMA	Emergency Management Agency (local)
EMAC	Emergency Management Assistance Compact
EMHTSSB	Emergency Mental Health and Traumatic Stress Services Branch (formerly ESDRB)
EMS	Emergency Medical Services
EOC	Emergency Operations Center
ESAR–VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function

F

FAD	Foreign Animal Disease
FAQ	Frequently Asked Questions
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
FMD	Foot and Mouth Disease
FTE	Full-Time Equivalent

G

GAR	Governor's Authorized Representative
GPO	Government Printing Office
GPRA	Government Performance and Results Act

GPS	Global Positioning System

H

HAZMAT	Hazardous Materials
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development

I

ICISF	International Critical Incident Stress Foundation
ICS	Incident Command System
ICU	Incident Crisis Unit
IHS	Indian Health Service
ISP	Immediate Services Program (CCP)
IT	Information Technology

J

JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JFO	Joint Field Office (FEMA)

M

MH	Mental Health
MHT	Mental Health Team
MIS	Management of Information Systems
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
MRDD	Mental Retardation and Developmental Disabilities

N

NACCHO	National Association of County and City Health Officials
NAMI	National Alliance for the Mentally Ill
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NASMHPD	National Association of State Mental Health Program Directors
NBC	Nuclear, Biological, and Chemical
NCADI	National Clearinghouse for Alcohol and Drug Information
NCID	National Center for Infectious Diseases
NCPTSD	National Center for Posttraumatic Stress Disorder
NCTSS	National Center for Child Traumatic Stress
NCTSI	National Child Traumatic Stress Initiative
NCTSN	National Child Traumatic Stress Network
NCVC	National Center for Victims of Crime
NDMS	National Disaster Medical System
NGA	National Governor's Association
NGO	Nongovernmental Organization

NIAAA	National Institute of Alcoholism and Alcohol Abuse
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NIIMS	National Interagency Incident Management System
NIMH	National Institute of Mental Health
NIMS	National Incident Management System
NMHA	National Mental Health Association
NMHIC	National Mental Health Information Center
NOVA	National Organization for Victim Assistance
NVOAD	National Voluntary Organizations Active in Disaster

O

OC	Office of Communications
OMB	Office of Management and Budget
OVC	Office for Victims of Crime

P

PH	Public Health
PIO	Public Information Officer
PO	Project Officer
PSA	Public Service Announcement
PSW	Public Safety Worker
PTSD	Posttraumatic Stress Disorder

R

RSP	Regular Services Program (CCP)

S

SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SCE	State Capacity Expansion
SEMA	State Emergency Management Agency
SERG	SAMHSA Emergency Response Grant (grant program)
SERT	State Emergency Response Team
SF	Standard Form
SHIN	SAMHSA Health Information Network
SMHA	State Mental Health Authority
SMHC	State Mental Health Commissioner
SMTD	Slow Motion Technological Disaster

SOP	Standard Operating Procedure
SSA	Single State Authority

T

TA	Technical Assistance
TDD	Telecommunications Device for the Deaf
TOT	Training of Trainers
TTX	Tabletop Exercise

U

USAMRIID	U.S. Army Medical Research Institute of Infectious Diseases
USPHS	U.S. Public Health Service
USUHS	Uniformed Services University of the Health Sciences

V

VA	Veteran's Administration
VOAD	Voluntary Organizations Active in Disaster
VOLAG	Voluntary Agency

W

WHO	World Health Organization
WMD	Weapons of Mass Destruction

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Disaster Reactions and Interventions					
Age Group	**Behavioral Reactions**	**Physical Reactions**	**Emotional Reactions**	**Cognitive Reactions**	**Intervention Options**
Preschool (1–5)	- Clinging to parents or familiar adults - Helplessness and passive behavior - Resumption of bed-wetting or thumb-sucking - Fears of the dark - Avoidance of sleeping alone - Increased crying	- Loss of appetite - Stomachaches - Nausea - Sleep problems or nightmares - Speech difficulties - Tics	- Anxiety - Generalized fear - Irritability - Angry outbursts - Sadness - Withdrawal	- Preoccupation with disaster - Poor concentration - Recurring dreams or nightmares	- Give verbal reassurance and physical comfort - Clarify misconceptions repeatedly - Provide comforting bedtime routines - Help with labels for emotions - Avoid unnecessary separations - Permit child to sleep in parents' room temporarily - Demystify reminders - Encourage expression regarding losses (deaths, pets, toys) - Monitor media exposure - Encourage expression through play activities

Disaster Reactions and Interventions					
Age Group	**Behavioral Reactions**	**Physical Reactions**	**Emotional Reactions**	**Cognitive Reactions**	**Intervention Options**
Childhood (6–11)	- Decline in school performance - School avoidance - Aggressive behavior at home or school - Hyperactive or silly behavior - Whining, clinging, or acting like a younger child - Increased competition with younger siblings for parents' attention - Traumatic play and reenactments	- Change in appetite - Headaches - Stomachaches - Sleep disturbances or nightmares - Somatic complaints	- Fear of feelings - Withdrawal from friends or familiar activities - Reminders triggering fears - Angry outbursts - Preoccupation with crime, criminals, safety, and death - Self-blame - Guilt	- Preoccupation with disaster - Poor concentration - Recurring dreams or nightmares - Disorientation or confusion - Flashbacks - Questioning of spiritual beliefs	- Give additional attention and consideration - Relax expectations of performance at home and at school temporarily - Set gentle but firm limits for acting out - Provide structured but undemanding home chores and rehabilitation activities - Encourage verbal and play expression of thoughts and feelings - Listen to child's repeated retelling of traumatic event - Clarify child's distortions and misconceptions - Identify and assist with reminders - Develop school program for peer support, expressive activities, education on trauma and crime, preparedness planning, and identifying special children

Disaster Reactions and Interventions					
Age Group	**Behavioral Reactions**	**Physical Reactions**	**Emotional Reactions**	**Cognitive Reactions**	**Intervention Options**
Pre-Adolescence and Adolescence (12–18)	- Decline in academic performance - Rebellion at home or school - Decline in responsible behavior - Agitation or decrease in energy level, or apathy - Delinquent behavior - Risk-taking behavior - Social withdrawal - Abrupt shift in relationships	- Appetite changes - Headaches - Gastrointestinal problems - Skin eruptions - Complaints of vague aches and pains - Sleep disorders	- Loss of interest in peer social activities, hobbies, or recreation - Sadness or depression - Anxiety and fearfulness about safety - Resistance to authority - Feelings of inadequacy and helplessness - Guilt, self-blame, shame, and self-consciousness - Desire for revenge	- Preoccupation with disaster - Poor concentration - Recurring dreams, nightmares, or flashbacks - Disorientation or confusion - Questioning of spiritual beliefs - Difficulty setting priorities - Difficulty making decisions - Loss of objectivity	- Give additional attention and consideration - Relax expectations of performance at home and school temporarily - Encourage discussion of experience of trauma with peers and significant adults - Avoid insistence on discussion of feelings with parents - Address impulse to recklessness - Link behavior and feelings to event - Encourage physical activities - Encourage resumption of social activities, athletics, clubs, etc. - Encourage participation in community activities and school events - Develop school programs for peer support and debriefing, special student support groups, telephone hotlines, drop-in centers, and identification of special teens

Disaster Reactions and Interventions					
Age Group	**Behavioral Reactions**	**Physical Reactions**	**Emotional Reactions**	**Cognitive Reactions**	**Intervention Options**
Adults	- Sleep problems - Avoidance of reminders - Excessive activity level - Protectiveness toward loved ones - Crying easily - Angry outbursts - Increased conflicts with family - Hypervigilance - Isolation, withdrawal, or shutting down	- Nausea - Headaches - Fatigue or exhaustion - Gastrointestinal distress - Appetite change - Somatic complaints - Worsening of chronic conditions	- Shock, disorientation, and numbness - Depression or sadness - Grief - Irritability or anger - Anxiety or fear - Despair or hopelessness - Guilt or self-doubt - Mood swings	- Preoccupation with disaster - Poor concentration - Recurring dreams, nightmares, or flashbacks - Disorientation or confusion - Questioning of spiritual beliefs - Difficulty setting priorities - Difficulty making decisions - Loss of objectivity	- Protect, direct, and connect - Ensure access to emergency medical services - Provide supportive listening and opportunity to talk about experience and losses - Provide frequent rescue and recovery updates and resources for questions - Assist with prioritizing and problem solving - Help family to facilitate communication and effective functioning - Provide information on traumatic stress and coping, children's reactions, and tips for families - Provide information on criminal justice procedures and roles of primary responder groups - Provide crime victim services - Assess and refer, when indicated - Provide information on referral resources - Provide information on substance abuse self-help (for self, family, friends)

Disaster Reactions and Interventions					
Age Group	**Behavioral Reactions**	**Physical Reactions**	**Emotional Reactions**	**Cognitive Reactions**	**Intervention Options**
Older Adults	- Withdrawal and isolation - Reluctance to leave home - Mobility limitations - Relocation adjustment problems	- Worsening of chronic illnesses - Sleep disorders - Memory problems - Somatic symptoms - More susceptibility to hypothermia and hyperthermia - Physical and sensory limitations (sight, hearing) that interfere with recovery	- Depression - Despair about losses - Apathy - Suspicion - Agitation or anger - Fears of institutionalization - Anxiety about unfamiliar surroundings - Embarrassment about receiving "handouts"	- Preoccupation with disaster - Poor concentration - Recurring dreams, nightmares, or flashbacks - Disorientation or confusion - Questioning of spiritual beliefs - Difficulty setting priorities - Difficulty making decisions - Loss of objectivity	- Provide strong and persistent verbal reassurance - Provide orienting information - Ensure physical needs are addressed (water, food, warmth) - Use multiple assessment methods, as problems may be underreported - Assist with reconnecting with family and support systems - Assist in obtaining medical and financial assistance - Encourage discussion of traumatic experience and losses, and expression of emotions - Provide crime victim assistance - Same as adults for substance abuse services

Adapted from U.S. Department of Health and Human Services. (2000). *Training manual for mental health and human service workers in major disasters* (DHHS Publication 90–538). Washington, DC: Substance Abuse and Mental Health Services Administration Center for Mental Health Services.

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Recognizing Severe Reactions to Disaster and Common Psychiatric Disorders

Introduction

When meeting with disaster survivors, crisis counselors may come into contact with people experiencing severe reactions to the disaster. Because treatment is not part of the Crisis Counseling Assistance and Training Program (CCP), the goal of crisis counseling is to recognize these reactions and know when to alert a team leader or program manager to any concerns. If unresolved, severe reactions, such as social isolation, paranoia, and suicidal behavior, may begin to interfere with daily functioning and develop into psychiatric disorders. The psychiatric disorders most often associated with a traumatic event include depressive disorders, substance abuse, acute stress disorder, anxiety disorders, posttraumatic stress disorder (PTSD), and dissociative disorders.

Crisis counselors may also encounter survivors who have preexisting psychiatric disorders and have become disconnected from treatment, or who may be experiencing an aggravation of their symptoms. These disorders include those described above, as well as bipolar disorder, borderline personality disorder, eating disorders, obsessive-compulsive disorder (OCD), panic disorder, schizoaffective disorder, schizophrenia, and co-occurring mental illness and substance abuse. Crisis counselors need to be able to recognize the possible symptoms of common psychiatric disorders so they know when to request assistance from their team leaders or other professionals in the program.

Since the CCP is not a treatment program, the role of team leaders or other mental health professionals is to recognize and refer those in need of treatment services to local behavioral health services and not to provide treatment themselves. Whenever possible, crisis counselors, in consultation with their team leaders, may follow up with survivors to ensure they have connected with the needed resources.

Please note that only a trained mental health professional can diagnose mental illness and provide psychotherapy, and a psychiatrist or medical doctor typically prescribes medication.

Crisis counselors may encounter developmental disabilities, cognitive impairments, dementia, traumatic brain injury, traumatic or complicated grief, and attention deficit hyperactivity disorder in some survivors.

The contents of this handout are not exhaustive. Crisis counselors should always seek the assistance of supervisors and clinical personnel in any situation where there is a question about a person's level of distress.

The following severe reactions may result from an increase in the level of stress brought on by the traumatic event:

Social Isolation

- Social isolation is a feeling of loneliness experienced by the patient as a threatening state imposed by others; a sense of loneliness caused by the absence of family and friends; or the absence of a supportive or significant personal relationship caused by the patient's unacceptable social behavior or social values, inability to engage in social situations, immature interests, inappropriate attitudes for his or her developmental age, alterations in physical appearance, or mental status or illness. It is important to be aware of the possibility of social isolation when counseling people who are known to have developmental disabilities, cognitive impairments, dementia, and traumatic brain injury.
- Symptoms:
  - Feelings of loneliness imposed by others
  - Feelings of rejection
  - Feelings of difference from others
  - Insecurity in public
  - Sad, dull affect
  - Uncommunicative and withdrawn behavior and lack of eye contact
  - Preoccupation with own thoughts or repetitive, meaningless actions
  - Hostility in voice and behavior

Paranoia

- Paranoia is an unfounded or exaggerated distrust of others, sometimes reaching delusional proportions. Paranoid individuals constantly suspect the motives of those around them, and believe that certain individuals, or people in general, are "out to get them." Acute, or short-term, paranoia may occur in some individuals overwhelmed by stress.
- Symptoms:
  - Belief that others are plotting against him or her
  - Preoccupation with unsupported doubts about friends or associates
  - Reluctance to confide in others due to a fear that information may be used against him or her
  - Reading negative meanings into innocuous remarks
  - Bearing grudges
  - Perceiving attacks on his or her reputation that are not clear to others and being quick to counterattack
  - Maintaining unfounded suspicions regarding the fidelity of a spouse or significant other

Suicidal Behavior

- Suicidal behavior is a severe reaction that may result from several psychiatric disorders. Most people who kill themselves have a diagnosable and treatable psychiatric illness.
- Symptoms:
  - History of attempted suicide (Those who have made serious suicide attempts are at a much higher risk for actually taking their lives.)
  - Family history of suicide, suicide attempts, depression, or other psychiatric illness
  - Depression with an unrelenting low mood, pessimism, hopelessness, desperation, anxiety, psychic pain, and inner tension
  - Sleep problems
  - Increased alcohol or drug use
  - Engagement in recent impulsive or unnecessarily risky behavior
  - Making threats of suicide or expressing a strong wish to die
  - Plans of self-harm or suicide
  - Allocation of prized possessions
  - Sudden or impulsive purchase of a firearm
  - Acquiring other means of killing oneself such as poisons or medications
  - Unexpected rage or anger

Psychiatric Disorders Most Often Associated with a Traumatic Event

If left untreated or if unresponsive to crisis counseling interventions, severe reactions may lead to a psychiatric disorder. These disorders may be preexisting or may result from an increase in the level of stress brought on by the traumatic event and include the following:

Depressive Disorders

- Depressive disorders are illnesses that involve the body, mood, and thoughts. They affect the way a person eats and sleeps, the way one feels about oneself, and the way one thinks about things. A depressive disorder is not the same as a passing blue mood. It is not a sign of personal weakness or a condition that can be willed or wished away. Without treatment, symptoms can last for weeks, months, or years.
- Symptoms:
  - Persistently sad or irritable mood
  - Pronounced changes in sleep, appetite, and energy
  - Difficulty thinking, concentrating, and remembering
  - Physical slowing or agitation
  - Lack of interest in or pleasure from activities once enjoyed
  - Feelings of guilt, worthlessness, hopelessness, and emptiness
  - Recurrent thoughts of death or suicide
  - Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

Substance Abuse

- Substance abuse is a pattern of substance use resulting in consequences in major life areas. Substance misuse is the use of a substance in ways or for reasons other than intended for that substance.

- Symptoms:

  - Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
  - Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
  - Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
  - Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

Acute Stress Disorder

- Acute stress disorder is an anxiety disorder characterized by a cluster of dissociative and anxiety symptoms that occur within a month of a traumatic stressor. The immediate cause of acute stress disorder is exposure to trauma—an extreme stressor involving a threat to life or the prospect of serious injury; witnessing an event that involves the death or serious injury of another person; or learning of the violent death or serious injury of a family member or close friend.

- Symptoms:

  - Being dazed or less aware of surroundings
  - Depersonalization
  - Dissociative amnesia
  - Reexperiencing the trauma in dreams, images, thoughts, illusions, or flashbacks; or intense distress when exposed to reminders of the trauma
  - Tendency to avoid people, places, objects, conversations, and other stimuli reminiscent of the trauma
  - Hyperarousal or anxiety, including sleep problems, irritability, inability to concentrate, an unusually intense startle response, hypervigilance, and physical restlessness
  - Significantly impaired social functions or the inability to do necessary tasks, including seeking help

Anxiety Disorders

- Anxiety disorders, unlike the relatively mild, brief anxiety caused by a stressful event, last at least 6 months and can worsen if not treated. Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance abuse, which may mask anxiety symptoms or make them worse. In some cases, these other illnesses need to be treated before a person will respond to treatment for the anxiety disorder. Specific anxiety disorders include panic disorder, OCD, PTSD, social phobia (or social anxiety disorder), specific phobias, and generalized anxiety disorder.

- Symptoms:
  - Each anxiety disorder has different symptoms, but all the symptoms cluster around excessive, irrational fear and dread.
  - Sometimes alcoholism, depression, or other coexisting conditions have such a strong effect on the individual that treating the anxiety disorder must wait until the coexisting conditions are brought under control.

PTSD

- PTSD is an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened. Traumatic events that may trigger PTSD include violent personal assaults, natural or human-caused disasters, accidents, or military combat. Not every traumatized person develops full-blown or even minor PTSD. Symptoms usually begin within 3 months of the incident but occasionally emerge years afterward. They must last more than a month to be considered PTSD. The course of the illness varies. Some people recover within 6 months; others have symptoms that last much longer. In some people, the condition becomes chronic.

- Symptoms:
  - Persistent frightening thoughts and memories of the ordeal
  - Emotional numbness, especially toward people with which the individual was once close
  - Sleep problems
  - Feelings of detachment
  - Being easily startled

Dissociative Disorders

- Dissociative disorders are characterized by a dissociation from or interruption of a person's fundamental aspects of waking consciousness (such as one's personal identity or history). All of the dissociative disorders are thought to stem from trauma experienced by the individual with this disorder. Dissociative disorders include dissociative amnesia, dissociative fugue, dissociative identity disorder, and depersonalization disorder.

- Symptoms:
  - The person literally dissociates himself or herself from a situation or experience too traumatic to integrate with his or her conscious self.

- Symptoms of one or more of the disorders are also seen in a number of other mental illnesses, including PTSD, panic disorder, and OCD.

Preexisting Psychiatric Disorders

In addition to the disorders described above, the following conditions may also have existed prior to the disaster.

Bipolar Disorder

- Bipolar disorder, or manic depression, causes extreme shifts in mood, energy, and functioning. These changes may be subtle or dramatic, typically varying greatly during a person's life as well as among individuals. Bipolar disorder is a chronic, generally lifelong condition with recurring episodes of mania and depression lasting from days to months; episodes often begin in adolescence or early adulthood, and occasionally in children.
- Symptoms of mania:
  - An elated, happy mood or an irritable, angry, unpleasant mood
  - Increased physical and mental activity and energy
  - Racing thoughts and flight of ideas
  - Increased talking, more rapid speech than normal
  - Ambitious, often grandiose plans
  - Risk taking
  - Impulsive activity (e.g., spending sprees, sexual indiscretion, alcohol abuse)
  - Decreased sleep without experiencing fatigue
- Symptoms of depression:
  - Loss of energy
  - Prolonged sadness
  - Decreased activity and energy
  - Restlessness and irritability
  - Inability to concentrate or make decisions
  - Increased feelings of worry and anxiety
  - Less interest or participation in and less enjoyment of activities normally enjoyed
  - Feelings of guilt and hopelessness
  - Thoughts of suicide
  - Change in appetite
  - Change in sleep patterns

Borderline Personality Disorder

- Borderline personality disorder is characterized by instability in moods, interpersonal relationships, self-image, and behavior. This instability often disrupts family and work, long-term planning, and the individual's sense of self-identity.

- Symptoms—A pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five or more of the following:
  - Frantic efforts to avoid real or imagined abandonment
  - A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
  - Identity disturbance—markedly and persistently unstable self-image or sense of self
  - Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
  - Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
  - Affective instability due to a marked reactivity of mood (e.g., intense episodic irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
  - Chronic feelings of emptiness
  - Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
  - Transient, stress-related paranoid ideation or severe dissociative symptoms

Eating disorders

- **Anorexia nervosa** is a serious, often chronic, and life-threatening eating disorder defined by a refusal to maintain minimal body weight within 15 percent of an individual's normal weight. Other essential features of this disorder include an intense fear of gaining weight and a distorted body image. Symptoms include the following:
  - Preoccupation with food
  - Refusal to maintain minimally normal body weight
  - Continuing to think of oneself as fat even when he or she is bone-thin
  - Brittle hair and nails
  - Dry and yellow skin
  - Depression
  - Complaining of hypothermia
  - Fine, downy hair growth on the body
  - Strange eating habits such as cutting food into tiny pieces or refusing to eat in front of others
- **Bulimia nervosa** is marked by a destructive pattern of binge eating and recurrent inappropriate behavior to control one's weight. It can occur together with other psychiatric disorders such as depression, OCD, substance dependence, or self-injurious behavior. Binge eating is defined as the consumption of excessively large amounts of food within a short period of time. Symptoms include the following:
  - Constant concern about food and weight
  - Self-induced vomiting
  - Erosion of dental enamel

- Scarring on the backs of the hands (due to repeatedly pushing fingers down the throat to induce vomiting)
- Swelling of the glands near the cheeks (a small percentage of people show this symptom)
- Irregular menstrual periods and a decrease in sexual interest
- Depression
- Sore throats and abdominal pain

OCD

- OCD is a psychiatric disorder characterized by obsessive thoughts or compulsive behaviors. While most people at one time or another experience such thoughts or behaviors, an individual with OCD experiences obsessions and compulsions for more than an hour each day, in a way that interferes with his or her life.
- **Obsessions** are intrusive, irrational thoughts or unwanted ideas or impulses that repeatedly well up in a person's mind. Again and again, the person experiences disturbing thoughts, such as "My hands must be contaminated; I must wash them"; "I may have left the gas stove on"; "I am going to injure my child." On one level, the sufferer knows these obsessive thoughts are irrational. But on another level, he or she fears these thoughts might be true. Trying to avoid such thoughts creates great anxiety.
- **Compulsions** are repetitive rituals such as hand washing, counting, checking, hoarding, or arranging. Individuals repeat these actions, perhaps feeling momentary relief, but without feeling satisfaction or a sense of completion. People with OCD feel they must perform these compulsive rituals or something bad will happen.
- Symptoms:
  - Repeatedly checking things, perhaps dozens of times, before feeling secure
  - Fear of harming others
  - Feeling dirty and contaminated
  - Constantly arranging and ordering things
  - Excessive concern with body imperfections
  - Being ruled by numbers—believing that certain numbers represent good, and others represent evil
  - Excessive concern with sin or blasphemy

Panic Disorder

- Panic disorder is characterized by recurrent panic attacks, at least one of which leads to a month of increased anxiety or avoidant behavior. Panic disorder may also be indicated if a person experiences fewer than four panic episodes but has recurrent or constant fears of having another panic attack.
- Symptoms:
  - Sweating
  - Hot or cold flashes

  - Choking or smothering sensations
  - Racing heart
  - Labored breathing
  - Trembling
  - Chest pains
  - Faintness
  - Numbness
  - Nausea
  - Disorientation
  - Feelings of dying, losing control, or losing one's mind
- Panic attacks typically last about 10 minutes, but may be a few minutes shorter or longer. During the attack, the physical and emotional symptoms increase quickly and then subside. A person may feel anxious and jittery for many hours after experiencing a panic attack.

Schizophrenia

- Schizophrenia often interferes with a person's ability to think clearly, distinguish reality from fantasy, manage emotions, make decisions, and relate to others. A person with schizophrenia does not have a "split personality," and almost all people with schizophrenia are not dangerous or violent toward others while they are receiving treatment.
- Symptoms of schizophrenia are generally divided into three categories (positive, negative, and cognitive):
  - Positive symptoms, or "psychotic" symptoms, include delusions and hallucinations because the patient has lost touch with reality in certain important ways. "Positive" refers to having overt symptoms that should not be there. Delusions cause individuals to believe that people are reading their thoughts or plotting against them, that others are secretly monitoring and threatening them, or that they can control other people's minds. Hallucinations cause people to hear or see things that are not present.
  - Negative symptoms include emotional flatness or lack of expression, an inability to start and follow through with activities, speech that is brief and devoid of content, and a lack of pleasure or interest in life. "Negative" does not refer to a person's attitude, but rather to a lack of certain characteristics that should be there.
  - Cognitive symptoms pertain to thinking processes. For example, people may have difficulty with prioritizing tasks, certain kinds of memory functions, and organizing their thoughts. A common problem associated with schizophrenia is the lack of insight into the condition itself. This is not a willful denial, but rather a part of the mental illness itself.

Schizoaffective Disorder

- Schizoaffective disorder is one of the more common, chronic, and disabling mental illnesses. It is characterized by a combination of symptoms of schizophrenia and an affective (mood) disorder.
- Symptoms:

- A person needs to have primary symptoms of schizophrenia (such as delusions, hallucinations, disorganized speech, and disorganized behavior), along with a period of time when he or she also has symptoms of major depression or a manic episode. Accordingly, schizoaffective disorder may have two subtypes: (1) depressive subtype, characterized by major depressive episodes only, and (2) bipolar subtype, characterized by manic episodes with or without depressive symptoms or depressive episodes.
- The mood symptoms in schizoaffective disorder are more prominent and last for a substantially longer time than those in schizophrenia.
- Schizoaffective disorder may be distinguished from a mood disorder by the fact that delusions or hallucinations must be present in people with schizoaffective disorder for at least 2 weeks in the absence of prominent mood symptoms.
- The diagnosis of a person with schizophrenia or mood disorder may change later to that of schizoaffective disorder, or vice versa.

Co-occurring Mental Illness and Substance Abuse

- Co-occurring mental illness and substance abuse are often referred to as co-occurring disorders. To recover fully, a consumer with co-occurring disorders needs treatment for both problems—focusing on one does not ensure the other will go away. Dual-diagnosis services integrate assistance for each condition, helping people recover from both in one setting, at the same time.
- What follows are some statistics, provided by the National Alliance on Mental Illness, on the prevalence of co-occurring disorders:
  - Roughly 50 percent of individuals with severe mental disorders are affected by substance abuse.
  - Thirty-seven percent of alcohol abusers and 53 percent of drug abusers also have at least one serious mental illness.
  - Of all people diagnosed as mentally ill, 29 percent abuse either alcohol or drugs.
  - Of people with a 12-month addictive disorder, 42.7 percent had at least one 12-month mental disorder.
  - Of individuals with a 12-month mental disorder, 14.7 percent had at least one 12-month addictive disorder.
  - Forty-seven percent of individuals with schizophrenia also had a substance abuse disorder (more than four times as likely as the general population).
  - Sixty-one percent of individuals with bipolar disorder also had a substance abuse disorder (more than five times as likely as the general population).
- Often, people can suffer from more than one psychiatric disorder at a time. In addition, people can suffer from psychiatric and medical disorders simultaneously and may need treatment referrals for both.

Treatment Approaches

This section identifies general treatment approaches for a variety of psychiatric disorders. The following interventions are used either alone or in combination, depending on the treatment approach chosen by the survivor in consultation with his or her mental health treatment professional.

- A comprehensive approach to treatment would include a combination of interventions, such as the following:
  - Connecting the person with a peer counselor
  - Referring the person to a support group
  - Supporting family communication
  - Enhancing spirituality
  - Establishing a personal connection with a health care provider
  - Assisting the person with the use of Internet-based supports
- It is important to note several additional points:
  - Medication is most effective when it is used as part of an overall treatment plan that includes supportive therapy.
  - Medication-assisted treatment is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance-use disorders. Research shows that when treating substance-use disorders, a combination of medication and behavioral therapies is most successful.
  - Support groups and community-based programs, as well as 12-step recovery programs, provide peer support to people suffering from substance abuse.
  - Cognitive therapy is used to help people think and behave appropriately. People learn to make the feared object or situation less threatening as they are exposed to, and slowly get used to, whatever is so frightening to them.
  - Healthy living habits may also help. Exercise, a proper and balanced diet, moderate use of caffeine and alcohol, and learning how to reduce stress are all important.

Ten Fundamental Components of Mental Health Recovery

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

- **Self-direction**—Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- **Individualized and person-centered**—There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result, as well as an overall paradigm for achieving wellness and optimal mental health.

- **Empowerment**—Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
- **Holistic**—Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and health care treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
- **Nonlinear**—Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
- **Strengths based**—Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- **Peer support**—Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
- **Respect**—Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in oneself are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
- **Responsibility**—Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps toward their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
- **Hope**—Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

The previous information comes from the *National Consensus Statement on Mental Health Recovery*, which can be found at http://store.samhsa.gov/product/National-Consensus-Statement-on-Mental-Health-Recovery/SMA05-4129.

Conclusion

This handout was designed to give crisis counselors more information about severe reactions to trauma and psychiatric disorders that they may encounter in a small number of disaster survivors. When a severe reaction or psychiatric disorder is suspected, the crisis counselor needs to alert the CCP team leader and clinical personnel. The crisis counselor should work should work with the survivor to determine if referral is needed, and then, the crisis counselor should make use of the resource linkage to refer the survivor to the appropriate resource. If possible, crisis counselors can follow up with survivors to see if they have made use of the referred services. Use of the Adult Assessment and Referral Tool is a way to keep track of survivors who may be suffering from severe reactions to disaster. As with all issues related to severe reactions and psychiatric disorders, use of the tool for this purpose should be done in consultation with CCP team leaders and clinical personnel.

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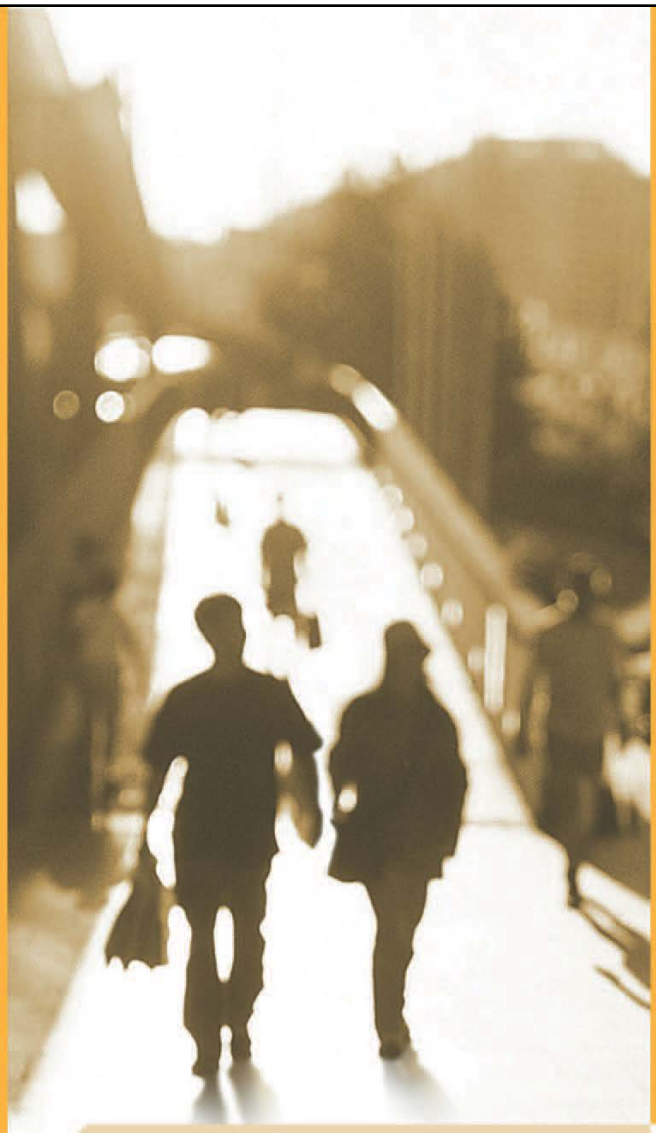
The Road to Resilience



The Road to Resilience

Discovery Health Channel

American Psychological Association

INTRODUCTION

How do people deal with difficult events that change their lives? The death of a loved one, loss of a job, serious illness, terrorist attacks, and other traumatic events: these are all examples of very challenging life experiences. Many people react to such circumstances with a flood of strong emotions and a sense of uncertainty.

Yet people generally adapt well over time to life-changing situations and stressful conditions. What enables them to do so? It involves resilience, an ongoing process that requires time and effort and engages people in taking a number of steps.

This brochure is intended to help readers with taking their own road to resilience. The information within describes resilience and some factors that affect how people deal with hardship. Much of the brochure focuses on developing and using a personal strategy for enhancing resilience.

WHAT IS RESILIENCE?

Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress – such as family and relationship problems, serious health problems, or workplace and financial stressors. It means "bouncing back" from difficult experiences.

Research has shown that resilience is ordinary, not extraordinary. People commonly demonstrate resilience. One example is the response of many Americans to the September 11, 2001 terrorist attacks and individuals' efforts to rebuild their lives.

Being resilient does not mean that a person doesn't experience difficulty or distress. Emotional pain and sadness are common in people who have suffered major adversity or trauma in their lives. In fact, the road to resilience is likely to involve considerable emotional distress.

Resilience is not a trait that people either have or do not have. It involves behaviors, thoughts, and actions that can be learned and developed in anyone.

SOME FACTORS IN RESILIENCE

A combination of factors contributes to resilience. Many studies show that the primary factor in resilience is having caring and supportive relationships within and outside the family. Relationships that create love and trust, provide role models, and offer encouragement and reassurance help bolster a person's resilience.

Several additional factors are associated with resilience, including:

- The capacity to make realistic plans and take steps to carry them out
- A positive view of yourself and confidence in your strengths and abilities
- Skills in communication and problem solving
- The capacity to manage strong feelings and impulses

All of these are factors that people can develop in themselves.

STRATEGIES FOR BUILDING RESILIENCE

Developing resilience is a personal journey. People do not all react the same way to traumatic and stressful life events. An approach to building resilience that works for one person might not work for another. People use varying strategies.

Some variation may reflect cultural differences. A person's culture might have an impact on how he or she communicates feelings and deals with adversity – for example, whether and how a person connects with significant others, including extended family members and community resources. With growing cultural diversity, the public has greater access to a number of different approaches to building resilience.

Some or many of the ways to build resilience in the following pages may be appropriate to consider in developing your personal strategy.

10 WAYS TO BUILD RESILIENCE

Make connections. Good relationships with close family members, friends, or others are important. Accepting help and support from those who care about you and will listen to you strengthens resilience. Some people find that being active in civic groups, faith-based organizations, or other local groups provides social support and can help with reclaiming hope. Assisting others in their time of need also can benefit the helper.

Avoid seeing crises as insurmountable problems. You can't change the fact that highly stressful events happen, but you can change how you interpret and respond to these events. Try looking beyond the present to how future circumstances may be a little better. Note any subtle ways in which you might already feel somewhat better as you deal with difficult situations.

Accept that change is a part of living. Certain goals may no longer be attainable as a result of adverse situations. Accepting circumstances that cannot be changed can help you focus on circumstances that you can alter.

Move toward your goals. Develop some realistic goals. Do something regularly – even if it seems like a small accomplishment – that enables you to move toward your goals. Instead of focusing on tasks that seem unachievable, ask yourself, "What's one thing I know I can accomplish today that helps me move in the direction I want to go?"

Take decisive actions. Act on adverse situations as much as you can. Take decisive actions, rather than detaching completely from problems and stresses and wishing they would just go away.

Look for opportunities for self-discovery. People often learn something about themselves and may find that they have grown in some respect as a result of their struggle with loss. Many people who have experienced tragedies and hardship have reported better relationships, greater sense of personal strength even while feeling vulnerable, increased sense of self-worth, a more developed spirituality, and heightened appreciation for life.

Nurture a positive view of yourself. Developing confidence in your ability to solve problems and trusting your instincts helps build resilience.

Keep things in perspective. Even when facing very painful events, try to consider the stressful situation in a broader context and keep a long-term perspective. Avoid blowing the event out of proportion.

Maintain a hopeful outlook. An optimistic outlook enables you to expect that good things will happen in your life. Try visualizing what you want, rather than worrying about what you fear.

Take care of yourself. Pay attention to your own needs and feelings. Engage in activities that you enjoy and find relaxing. Exercise regularly. Taking care of yourself helps to keep your mind and body primed to deal with situations that require resilience.

Additional ways of strengthening resilience may be helpful. For example, some people write about their deepest thoughts and feelings related to trauma or other stressful events in their life. Meditation and spiritual practices help some people build connections and restore hope. **The key is to identify ways that are likely to work well for you as part of your own personal strategy for fostering resilience.**

LEARNING FROM YOUR PAST
SOME QUESTIONS TO ASK YOURSELF

Focusing on past experiences and sources of personal strength can help you learn about what strategies for building resilience might work for you. By exploring answers to the following questions about yourself and your reactions to challenging life events, you may discover how you can respond effectively to difficult situations in your life.

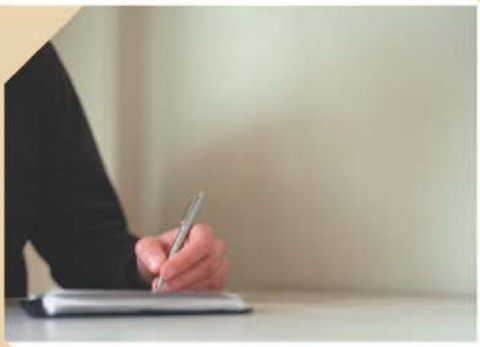
Consider the following:

- What kinds of events have been most stressful for me?
- How have those events typically affected me?
- Have I found it helpful to think of important people in my life when I am distressed?
- To whom have I reached out for support in working through a traumatic or stressful experience?
- What have I learned about myself and my interactions with others during difficult times?
- Has it been helpful for me to assist someone else going through a similar experience?
- Have I been able to overcome obstacles, and if so, how?
- What has helped make me feel more hopeful about the future?

STAYING FLEXIBLE

Resilience involves maintaining flexibility and balance in your life as you deal with stressful circumstances and traumatic events. This happens in several ways, including:

- Letting yourself experience strong emotions, and also realizing when you may need to avoid experiencing them at times in order to continue functioning
- Stepping forward and taking action to deal with your problems and meet the demands of daily living, and also stepping back to rest and reenergize yourself
- Spending time with loved ones to gain support and encouragement, and also nurturing yourself
- Relying on others, and also relying on yourself



PLACES TO LOOK FOR HELP

Getting help when you need it is crucial in building your resilience. Beyond caring family members and friends, people often find it helpful to turn to:

Self-help and support groups. Such community groups can aid people struggling with hardships such as the death of a loved one. By sharing information, ideas, and emotions, group participants can assist one another and find comfort in knowing that they are not alone in experiencing difficulty.

Books and other publications by people who have successfully managed adverse situations such as surviving cancer. These stories can motivate readers to find a strategy that might work for them personally.

Online resources. Information on the web can be a helpful source of ideas, though the quality of information varies among sources. The **APA Help Center**, online at www.helping.apa.org is a good site to check.

For many people, using their own resources and the kinds of help listed above may be sufficient for building resilience. At times, however, an individual might get stuck or have difficulty making progress on the road to resilience.

A licensed mental health professional such as a psychologist can assist people in developing an appropriate strategy for moving forward. It is important to get professional help if you feel like you are unable to function or perform basic activities of daily living as a result of a traumatic or other stressful life experience.

Different people tend to be comfortable with somewhat different styles of interaction. A person should feel at ease and have good rapport in working with a mental health professional or participating in a support group.

CONTINUING ON YOUR JOURNEY

To help summarize several of the main points in this brochure, think of resilience as similar to taking a raft trip down a river.

On a river, you may encounter rapids, turns, slow water, and shallows. As in life, the changes you experience affect you differently along the way.

In traveling the river, it helps to have knowledge about it and past experience in dealing with it. Your journey should be guided by a plan, a strategy that you consider likely to work well for you.

Perseverance and trust in your ability to work your way around boulders and other obstacles are important. You can gain courage and insight by successfully navigating your way through white water. Trusted companions who accompany you on the journey can be especially helpful for dealing with rapids, upstream currents, and other difficult stretches of the river.

You can climb out to rest alongside the river. But to get to the end of your journey, you need to get back in the raft and continue.

Information contained in this brochure should not be used as a substitute for professional health and mental health care or consultation. Individuals who believe they may need or benefit from care should consult a psychologist or other licensed health/mental health professional.

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For additional copies of *The Road to Resilience* brochure call 1-800-964-2000 or go to helping.apa.org

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Data Collection Forms

Project #

OMB NO. 0930-0270
Expiration Date 08/31/2015

Individual/Family Crisis Counseling Services Encounter Log

Provider Name _____ Provider Number _____

Date of Service (mm/dd/yyyy) _____ County of Service _____

1st Employee # _____ 2nd Employee # _____ Zip Code of Service _____

VISIT TYPE (please check the appropriate box)

Number of participants in this encounter (either Individual OR Family or Household)

Individual = 1 ☐ Family or Household (2 or more individuals) = 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more ☐

VISIT NUMBER ☐ First visit ☐ Second visit ☐ Third visit ☐ Fourth visit ☐ Fifth visit or later

DURATION ☐ 15 - 29 minutes ☐ 30 - 44 minutes ☐ 45 - 59 minutes ☐ 60 minutes or more

DEMOGRAPHIC INFORMATION

Number of MALES per age category in this encounter (indicate # in box)

preschool (0 - 5 years)	child (6 - 11 years)	adolescent (12 - 17 years)	adult (18 - 39 years)	adult (40 - 64 years)	older adult (65 years or older)

Number of FEMALES per age category in this encounter (indicate # in box)

preschool (0 - 5 years)	child (6 - 11 years)	adolescent (12 - 17 years)	adult (18 - 39 years)	adult (40 - 64 years)	older adult (65 years or older)

Ethnicity (for individual encounter, select only one; for family encounter, select all that apply)

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race of participant(s) in this encounter (select all that apply)

☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian/Pacific Islander ☐ White

Primary language spoken during encounter (select one)

☐ English ☐ Spanish ☐ Other (specify in box) _____

If any of the participants has a disability, or other access or functional need, indicate the type (select all that apply).

☐ Physical (mobility, visual, hearing, medical, etc.)

☐ Intellectual/Cognitive (learning disability, mental retardation, etc.)

☐ Mental Health/Substance Abuse (psychiatric, substance dependence, etc.)

LOCATION OF SERVICE (select one)

☐ school or child care (all ages through college)

☐ community center (e.g., recreation club)

☐ provider site/mental health agency (agency involved with Crisis Counseling Assistance and Training Program [CCP])

☐ workplace (workplace of the disaster survivor and/or first responder)

☐ disaster recovery center (e.g., Federal Emergency Management Agency [FEMA], American Red Cross)

☐ place of worship (e.g., church, synagogue, mosque)

☐ retail (e.g., restaurant, mall, shopping center, store)

☐ public place/event (e.g., street, sidewalk, town square, fair, festival, sports)

☐ temporary home (including friend or family homes, group homes, shelters, apartments, trailers, and other dwellings)

☐ IF HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN < AGE 18 LIVE IN THIS HOME.

☐ permanent home

☐ IF HOME: PLEASE CHECK THIS BOX IF ANY CHILDREN < AGE 18 LIVE IN THIS HOME.

☐ phone counseling (15 minutes or longer)

☐ If HOTLINE, HELPLINE, or CRISIS LINE, please **check here.**

☐ medical center (e.g., doctor, dentist, hospital, mental health or substance abuse specialty center)

☐ other (specify in box) _____

RISK CATEGORIES (select all that apply)

- ☐ family missing/dead
- ☐ friend missing/dead
- ☐ pet missing/dead
- ☐ home damaged or destroyed
- ☐ vehicle or major property loss
- ☐ other financial loss
- ☐ disaster unemployed (self or household member)
- ☐ injured or physically harmed (self or household member)
- ☐ life was threatened (self or household member)
- ☐ witnessed death/injury (self or household member)
- ☐ assisted with rescue/recovery (self or household member)
- ☐ had to change schools (for children or youth)
- ☐ prolonged separation from family
- ☐ evacuated quickly with no time to prepare
- ☐ displaced from home 1 week or more
- ☐ sheltered in place or sought shelter due to immediate threat of danger
- ☐ past substance use/mental health problem
- ☐ preexisting physical disability
- ☐ past trauma

EVENT REACTIONS (select all that apply)

Please indicate the total # of participants experiencing event reactions. ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more

BEHAVIORAL

- ☐ extreme change in activity level
- ☐ excessive drug or alcohol use
- ☐ isolation/withdrawal
- ☐ on guard/hypervigilant
- ☐ agitated/jittery/shaky
- ☐ violent or dangerous behavior
- ☐ acts younger than age (children or youth)

EMOTIONAL

- ☐ sadness, tearful
- ☐ irritable, angry
- ☐ anxious, fearful
- ☐ despair, hopeless
- ☐ feelings of guilt/shame
- ☐ numb, disconnected

PHYSICAL

- ☐ headaches
- ☐ stomach problems
- ☐ difficulty falling or staying asleep
- ☐ eating problems
- ☐ worsening of health problems
- ☐ fatigue, exhaustion

COGNITIVE

- ☐ distressing dreams, nightmares
- ☐ intrusive thoughts, images
- ☐ difficulty concentrating
- ☐ difficulty remembering things
- ☐ difficulty making decisions
- ☐ preoccupied with death/ destruction

☐ **COPING WELL: NONE OF THE ABOVE APPLY**

(If there are no participants experiencing the above event reactions, please check this box.)

FOCUS OF ENCOUNTER (select all that apply)

INFORMATION/EDUCATION ABOUT: ☐ reactions to disaster ☐ community resources ☐ this crisis counseling program

TIPS FOR:

☐ reducing negative thoughts ☐ managing physical and emotional reactions (e.g., breathing techniques) ☐ doing positive things ☐ problem solving

HEALTHY CONNECTIONS: ☐ mutual support/ building social network(s) ☐ participating in community action

other (specify in box) _____

MATERIALS PROVIDED FOR THIS ENCOUNTER

Were flyers, brochures, handouts, or other materials provided to this/these participant(s)? ☐ YES ☐ NO

REFERRAL (select all that were communicated)

- ☐ crisis counseling program services (e.g., group counseling, referral to team leader, followup visit)
- ☐ mental health services (e.g., professional, longer-term counseling, treatment, behavioral, or psychiatric services)
- ☐ substance abuse services (e.g., professional, behavioral, or medical treatment or self-help groups, such as Alcoholics Anonymous or Narcotics Anonymous)
- ☐ community services (e.g., FEMA, loans, housing, employment, social services)
- ☐ resources for those with disabilities, or other access or functional needs
- ☐ other (specify in box) _____

☐ **NO REFERRAL PROVIDED**

Reviewer Name _____ Signature _____ Date of Review _____

INSTRUCTIONS:
INDIVIDUAL/FAMILY CRISIS COUNSELING SERVICES ENCOUNTER LOG

When to Use This Form:
Complete this form immediately **after** the individual or family/household crisis counseling service is provided.

1. Complete this form for each individual or family/household that receives crisis counseling services of 15 minutes or more.
2. An individual or family/household crisis counseling encounter is defined as a contact where the discussion goes beyond education and assists understanding of current situations and reactions, involves review of options, or addresses emotional support or referral needs.
3. This form is not intended to be used as a survey. Do not ask the individual for any of the information on this form. Complete all items on the form based on your best observations and information you received during the encounter.

PROJECT #--FEMA disaster declaration number, e.g., DR-XXXX-State.
PROVIDER NAME--The name of the program/agency.
PROVIDER NUMBER--The unique number under which your program/agency is providing services.
DATE OF SERVICE--The date of the encounter in the format mm/dd/yyyy, e.g., 01/01/2012.
COUNTY OF SERVICE--The county where the service occurred.
1st EMPLOYEE #--YOUR employee number (must be numeric and no more than 6 digits).
2nd EMPLOYEE #--Employee number of your teammate during this encounter (must be numeric and no more than 6 digits).
ZIP CODE OF SERVICE--The zip code of the location where the service occurred.
VISIT TYPE--Was this encounter with one person (individual) or with two or more individuals living as a family or household (family or household)?
VISIT NUMBER--Based on your conversation, is this the first, second, third, fourth, fifth, or later visit for this person, family, or household to your program? All visits did not have to be with you. SELECT ONLY ONE.
DURATION--How long did your encounter last? SELECT ONLY ONE. If the encounter was under 15 minutes, record it on the Weekly Tally Sheet.
DEMOGRAPHIC INFORMATION--For each variable.

NUMBER OF MALES IN THIS ENCOUNTER --Please indicate the number of males for each age category that participated in this encounter. (You should record numbers into the boxes instead of checkmarks.)
NUMBER OF FEMALES IN THIS ENCOUNTER --Please indicate the number of females for each age category that participated in this encounter. (You should record numbers into the boxes instead of checkmarks.)
ETHNICITY--Based on your observations and your conversation, do any of the participants self-identify as Hispanic/Latino?
RACE--Based on your observations and your conversation with the participants, what race do you think participant(s) would identify as being? SELECT ALL THAT APPLY. If participant(s) are of more than one race, you should indicate all races that you believe to be represented. For a family encounter, if more than one race is represented, you should indicate all races that you believe to be represented.
PRIMARY LANGUAGE SPOKEN DURING ENCOUNTER(S)--Which language did you actually and primarily use to speak with this individual during the encounter? This may be different than the preferred language. If "OTHER" (not English or Spanish, may include sign language), fill in the other language that the person used. (SELECT ONLY ONE.)
PERSONS WITH DISABILITIES OR OTHER ACCESS OR FUNCTIONAL NEED(S)--Based on your observations and your conversation with the participants, does anyone have a physical, intellectual/cognitive, or mental health/substance abuse disability? SELECT ALL THAT APPLY.

- Physical: includes disorders that impair mobility, seeing, hearing, as well as medical conditions, such as diabetes, lupus, Parkinson's, AIDS, or multiple sclerosis (MS).
- Intellectual/Cognitive: includes learning disabilities, birth defects, neurological disorders, developmental disabilities, or traumatic brain injuries (e.g., Down syndrome, mental retardation).
- Mental Health/Substance Abuse: includes psychiatric disorders, such as bipolar disorder, depression, posttraumatic stress disorder (PTSD), schizophrenia, and substance dependence.

RISK CATEGORIES--These are factors that participants may have experienced or may have present in their lives that could increase their need for services. MORE THAN ONE CATEGORY MAY APPLY. SELECT ALL CATEGORIES THAT APPLY.
EVENT REACTIONS--Do not use this as a checklist during the encounter. Complete this based on your observations and the conversation AFTER the service is complete. SELECT ALL THAT APPLY. If the participants have no observable or reported problems, check "coping well: none of the above apply."
FOCUS OF INDIVIDUAL, FAMILY, OR HOUSEHOLD ENCOUNTER--What is the focus of the encounter? SELECT ALL THAT APPLY. If the focus is different from the categories listed, please select "OTHER," and fill in the blank with the primary purpose.
MATERIALS PROVIDED IN THIS ENCOUNTER--Did you leave any materials with the participant, family, or household? This refers to printed materials such as a brochure, flyers, tip sheets, or other printed information. SELECT ONLY ONE.
REFERRAL--Based on your conversations, you may have referred the participants for other services. In the REFERRAL box, select all of the types of services to which you referred participants. If you made a referral to a service not listed, please check the box labeled "other" and write in the specific type of referral.
REVIEWER--Team lead or direct supervisor to review completed form for accuracy and then sign and date (date of review).

Please submit the completed form to the designated person in your agency who will review the form.
Thank you for taking the time to complete this form accurately and fully!

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0930-0270. Public reporting burden for this collection of information is estimated to average 8 minutes per encounter, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, MD 20857.

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PROJECT #

Group Encounter Log

OMB NO. 0930-0270
Expiration Date 08/31/2015

Provider Name _____ Provider Number _____

Date of Service (mm/dd/yyyy) _____ County of Service _____

1st Employee # _____ 2nd Employee # _____ Zip Code of Service _____

TYPE OF SERVICE (select one before completing this log)

☐ GROUP COUNSELING (a group meeting where participants did most of the talking)

☐ PUBLIC EDUCATION (a presentation or group meeting where YOU did most of the talking)

CHARACTERISTICS OF ENCOUNTER

LOCATION of SERVICE (select one)

☐ school and child care (all ages through college)

☐ community center (e.g., recreation club)

☐ provider site/mental health agency (agency involved with the Crisis Counseling Assistance and Training Program [CCP])

☐ workplace (workplace of the disaster survivor and/or first responder

☐ disaster recovery center (e.g., Federal Emergency Management Agency [FEMA], American Red Cross)

☐ place of worship (e.g., church, synagogue, mosque)

☐ home (temporary or permanent residence, including friend/family home; group homes, including houses, apartments, trailers, and other dwellings)

☐ retail (e.g., restaurant, mall, shopping center, store)

☐ medical center (e.g., doctor, dentist, hospital, substance abuse specialty center)

☐ public place/event (e.g., street, sidewalk, town square, fair, festival, sports)

☐ other (specify in box) _____

SESSION NUMBER (select one)

○ First session of group expected to meet once

○ First session of group expected to meet more than once

○ Second or greater session of ongoing group

NUMBER of PARTICIPANTS PLEASE ESTIMATE

Number under age 18 _____ Number ages 18 -64 _____ Number age 65 and older _____ **TOTAL** _____

DURATION ☐ 15 - 29 minutes ☐ 30 - 44 minutes ☐ 45 - 59 minutes ☐ 60 minutes or more

GROUP IDENTITIES (select one)

Was the group composed ONLY or MOSTLY of any of the following:

☐ Children or youth (under age 18)? CHECK, if yes.

☐ Adult survivors (adults who were directly affected by the disaster)? CHECK, if yes.

☐ Public safety workers and first responders (e.g., police, fire, emergency medical services, rescue)? CHECK, if yes.

☐ Other recovery workers (e.g., health care, disaster relief, social services)? CHECK, if yes.

☐ Was the group composed of a mixture of the above or none of the above (i.e., no clear group identity)? CHECK, if yes.

Ethnicity (select all that apply)

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race of participants in this encounter (select all that apply)

☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian/Pacific Islander ☐ White

If any of the participants has a disability, or other access or functional need, indicate the type (select all that apply).

☐ Physical (mobility, visual, hearing, medical, etc.) ☐ Intellectual/Cognitive (learning disability, mental retardation, etc.) ☐ Mental Health/Substance Abuse (psychiatric, substance dependence, etc.)

FOCUS OF GROUP SESSION (select all that apply)

INFORMATION/EDUCATION ABOUT:

☐ reactions to disaster ☐ community resources ☐ this crisis counseling program

TIPS FOR:

☐ reducing negative thoughts ☐ managing physical and emotional reactions (e.g., breathing techniques) ☐ doing positive things ☐ problem solving

HEALTHY CONNECTIONS:

☐ mutual support/ building social network(s) ☐ participating in community action

other (specify in box) _____

Were flyers, brochures, handouts, or other materials provided to participants? ○ **YES** ○ **NO**

Reviewer Name _____ Signature _____ Date of Review _____

INSTRUCTIONS:
GROUP ENCOUNTER LOG

When to Use This Form:

1. Complete this form immediately after the group encounter is provided. COMPLETE ONLY ONE FORM PER GROUP.
2. Group sessions involve at least two or more unrelated participants (excluding staff).
3. Do not use this form for families. Use the Individual/Family Crisis Counseling Services Encounter Log.

PROJECT #--FEMA disaster declaration number, e.g., DR-XXXX-State.
PROVIDER NAME--The name of the program/agency.
PROVIDER NUMBER--The unique number under which your program or agency is providing services.
1st EMPLOYEE #--YOUR employee number (must be numeric and no more than 6 digits.)
2nd EMPLOYEE #--Employee number of your teammate during this encounter (must be numeric and no more than 6 digits.)

DATE OF SERVICE--The date of the encounter in the format mm/dd/yyyy, e.g., 01/01/2012.
COUNTY OF SERVICE--The county or parish where the group was held.
ZIP CODE OF SERVICE--The zip code of the location where you had the encounter.

GROUP CRISIS COUNSELING OR PUBLIC EDUCATION (SELECT ONE)
THE DATA ON THIS LOG CANNOT BE ENTERED OR COUNTED UNLESS YOU INDICATE TYPE OF SERVICE.

Group crisis counseling refers to services that help group members understand their current situation and reactions to the disaster, review or discuss their options, obtain emotional support or referral services, and/or develop or improve skills to cope with their current situation and reactions. In group counseling, participants do most of the talking.

Public education refers to services that provide general psycho-education to survivors on disaster services available and key concepts of disaster behavioral health. Common activities in this category include, but are not limited to, public speaking at community forums, in-service group meetings, and local government meetings. In public education, the crisis counselor does most of the talking.

LOCATION OF SERVICE--Where did this encounter take place? SELECT ONLY ONE.
SESSION NUMBER--Check the box beside the option that matches how many times the group has met and will meet. SELECT ONLY ONE.

NUMBER OF PARTICIPANTS--Use all four boxes to report the number of participants (not including staff) and estimate their age distribution. For example, for seven participants including no adolescents, three adults under age 65, and four older adults, write in 0, 3, 4, 7.

DURATION--How long did your encounter last? SELECT ONLY ONE. If less than 15 minutes, use the Weekly Tally Sheet form.

GROUP IDENTITIES--This refers to the possible identities and/or roles that the group members might share as a whole. "Primarily" means that the majority of group members shared the listed characteristic. For example, a group focused on children that had a few adults present would meet the definition of a group composed "only or mostly" of children. Groups do not necessarily have an identity. If so, check the last box.

ETHNICITY--Based on your observations and your conversation, do any of the participants self-identify as Hispanic/Latino?

RACE--Based on your observations and your conversation with the participants, what race do you think participants would identify as being? SELECT ALL THAT APPLY. For a family encounter, if more than one race is represented, you should indicate all races that you believe to be represented. If participants are of more than one race, you should indicate all races that you believe to be represented.

PERSONS WITH DISABILITIES OR OTHER ACCESS OR FUNCTIONAL NEED(S) --Based on your observations and your conversation with the participants, does anyone have a physical, intellectual, or mental health/substance abuse disability? SELECT ALL THAT APPLY.

- Physical: includes disorders that impair mobility, seeing, or hearing, as well as medical conditions, such as diabetes, lupus, Parkinson's, AIDS, or multiple sclerosis (MS).
- Intellectual/Cognitive: includes a learning disability, birth defect, neurological disorder, developmental disability, or traumatic brain injury, e.g., Down syndrome and mental retardation.
- Mental Health/Substance Abuse: includes psychiatric disorders, such as bipolar disorder, depression, posttraumatic stress disorder (PTSD), schizophrenia, and substance dependence.

FOCUS OF GROUP SESSION--What is the focus of this session/encounter? SELECT ALL THAT APPLY. If the focus for the group is different from the categories listed, please select "OTHER," and fill in the blank with the primary purpose.

MATERIALS PROVIDED--Did you leave any materials with the participants? This refers to materials such as a crisis counseling program brochure, flyers, tip sheets, or other printed materials. SELECT ONLY ONE (yes/no).

REVIEWER--Team lead or direct supervisor to review completed form for accuracy and then sign and date (date of review).

Please submit the completed form to the designated person in your agency who will review and sign the form.

Thank you for taking the time to complete this form accurately and fully!

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0930-0270. Public reporting burden for this collection of information is estimated to average 4 minutes per encounter per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, MD 20857.

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PROJECT #

OMB NO. 0930-0270
Expiration Date 08/31/2015

Weekly Tally Sheet
Brief Educational and Supportive Services Not Elsewhere Included

Provider Name

County or Parish

Provider Number

Week beginning mm/dd/yyyy

Employee ID

	NUMBER OF CONTACTS OR NUMBERS DISTRIBUTED							
TYPE OF CONTACT	SUN.	MON.	TUES.	WED.	THURS.	FRI.	SAT.	TOTAL
In-person brief educational or supportive contact								
Telephone contact by crisis counselor								
Hotline/helpline/lifeline contact								
Email contact								
Community networking and coalition building								
MATERIALS DISTRIBUTED	Do not include materials that are captured on individual/family or group encounter data collection forms.							
Material handed to people								
Material mailed to people's homes and/or left at a person's unattended home								
Material left in public places								
Mass media								
Social networking messages								

Note: If the number is zero, the field may be left blank.

Reviewer Name

Signature

Date of Review

INSTRUCTIONS:
WEEKLY TALLY SHEET
BRIEF EDUCATIONAL AND SUPPORTIVE SERVICES (NOT ELSEWHERE INCLUDED)

When to Use This Form:

This sheet is intended to capture all of the contacts you have had for a particular week that have not been captured on any other form. In other words, if you have completed an Individual/Family Crisis Counseling Services Encounter Log for someone, or if you have counted someone as a participant on the Group Encounter Log, you will not count that person or the materials handed out during those encounters here.

NUMBER OF CONTACTS OR NUMBERS DISTRIBUTED--For each day of the week, fill in the total number of contacts for each of the following types:

IN PERSON BRIEF EDUCATIONAL OR SUPPORTIVE CONTACT--The number of brief contacts with individuals, or groups of individuals, that did not result in indepth discussion or interaction of an educational or crisis counseling nature. Record this contact on the Weekly Tally Sheet when it is *less than 15 minutes*. (If your contact is more than 15 minutes, please fill out the Individual/Family Crisis Counseling Services Encounter Log.) If you also distributed materials during this interaction, you will record that under the "MATERIALS DISTRIBUTED" section of this form.

TELEPHONE CONTACT BY CRISIS COUNSELOR--The number of brief telephone contacts with individuals that did not result in indepth discussion or interaction of an educational or crisis counseling nature. Record this contact on the Weekly Tally Sheet when it is *less than 15 minutes*. (If your contact is more than 15 minutes, please fill out the Individual/Family Crisis Counseling Services Encounter Log.)

HOTLINE/HELPLINE/LIFELINE CONTACT--The number of calls that come into the hotline/helpline/lifeline designated for this Crisis Counseling Assistance and Training Program (CCP). Record this contact on the Weekly Tally Sheet when it is *less than 15 minutes*. (If your contact is more than 15 minutes, please fill out the Individual/Family Crisis Counseling Services Encounter Log.)

EMAIL CONTACT--The number of brief email contacts with individuals that did not result in indepth discussion or interaction of an educational or crisis counseling nature.

COMMUNITY NETWORKING AND COALITION BUILDING--How many people did you come into contact with for the purpose of networking within the community or building local coalitions? (Did you build relationships with community resource organizations, faith-based groups, and local agencies? Did you attend a community event to provide a compassionate presence and to be available to provide crisis counseling services, if needed? Did you initiate or attend an unmet-needs committee or long-term recovery meeting, or other disaster relief-oriented gathering?)

MATERIAL HANDED TO PEOPLE--How many packets or materials were distributed by handing them out to people with no or minimal contact? (One packet of information, even if containing multiple pieces, is counted as one.)

MATERIAL MAILED TO PEOPLE'S HOMES AND/OR LEFT AT A PERSON'S UNATTENDED HOME--How many packets or materials were mailed to people's homes and/or left at people's homes when they were not there (with no interaction with the people living in the homes)? (If you left a packet of information on a doorstep, count it as one material item left, even if the packet contained multiple pieces.)

MATERIAL LEFT IN PUBLIC PLACES--How many materials were left in public places?

For this crisis counseling program, the following may be captured by the crisis counselor or by the administrative program staff:

MASS MEDIA--How many mass media messages did you publish or broadcast? This includes newspaper ads, radio broadcasts, listserv mailings, advertisements, etc. *that were created or developed by the program*. This does not include surface mailing of materials, which is recorded above under MATERIAL MAILED. In general, the number of people "receiving" messages through mass media will be unknown (e.g., the number of people reading your newspaper ad is unknown), therefore, do not record the reach of the message - only the *number of messages* published or broadcasted.

SOCIAL NETWORKING MESSAGES--How many messages did you post via social networking mechanisms (e.g., Facebook or Twitter)? *Do NOT include the number of replies or posts made by outside parties.*

Please submit the completed form to the designated person in your agency who will review and sign the form.

Thank you for taking the time to complete this form accurately and fully!

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0930-0270. Public reporting burden for this collection of information is estimated to average 12 minutes per Weekly Tally Sheet, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, MD 20857.