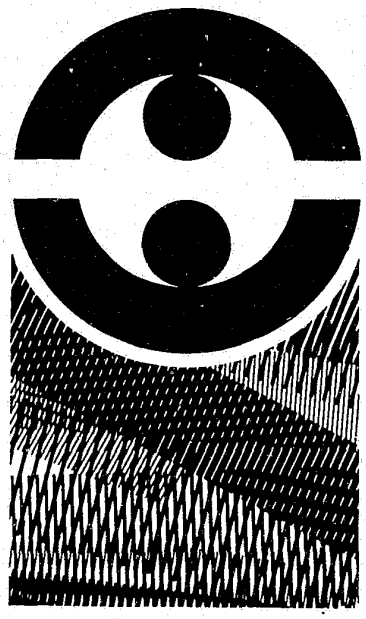
National Institute of Mental Health

Field Manual for Human Service Workers in Major Disasters



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

Field Manual for Human Service Workers in Major Disasters

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857

This Manual was prepared under Contract #278-75-0018 (SM) from the Disaster Assistance and Emergency Mental Health Section, Division of Special Mental Health Programs, National Institute of Mental Health.

DHHS Publication No. (ADM) 87-537
Alcohol, Drug Abuse, and Mental Health Administration
Printed 1978 Reprinted 1987

Table of Contents

INTRODUCTION

This Manual *has been devised to accompany the worker into the field. Its aim is to provide the worker with the essential information he will need as he works at the task of helping others who have experienced a large-scale natural disaster.*

The Manual *condenses and focuses the material contained in the* **Training Manual for Human Service Workers in Major Disasters.** *It offers key concepts as a framework and describes basic procedures for providing help.*

Resources frequently available to help disaster victims are listed. Each worker is encouraged to write in the additional agencies and sources he discovers in the process of his work. Maintenance of accurate records of client contacts and pertinent information is essential to an effective program. A suggested form for recording this information is included.

Experience indicates that it is wise to be sure that the workers and staff have adequate insurance and medical protection. Insurance should cover accidents to themselves and others who may be transported in vehicles. Medical protection should include obtaining tetanus shots or other advisable immunizations for staff and workers. In addition, identification stickers, wallet size cards, etc., can facilitate the workers' mobility in the disaster area. Law enforcement authorities should be consulted regarding access and identification.

Key concepts

1. THE TARGET POPULATION IS PRIMARILY NORMAL.

The recipients of help are generally adequate people, temporarily disrupted by a severe stress, but usually capable of functioning adequately under normal circumstances. True, there may be some people who were emotionally disturbed before the disaster and for whom the present upheaval may precipitate a mental illness. However, the task will not be to treat severely disturbed individuals directly, but to recognize their needs and help them receive professional care.

Most of the work at first will be to give more concrete types of help to *normal* people under stress, such as information about available services, how to get insurance benefits or loans, assistance with applications at Government agencies, health care, baby sitting, transportation, etc. Some of the most important help may be in simply listening, providing a ready ear, and indicating interest and concern.

People generally do not disintegrate in a disaster. Usually, they are found pitching in and helping others. However, as frustrations and disillusionment accumulate, more severe emotional reactions may surface.

People respond to active interest and concern. People undergoing great stress and pressure often tend to feel isolated, as if they are alone with their problems. By expressing interest in them and their concerns, by actively involving oneself in their resolution, one provides an invaluable service and usually

forestalls much more severe subsequent emotional distress.

People may reject help because of pride. They may feel disgraced because help was needed, or they might not want any help from outsiders. Tact and sensitivity are needed in bringing a new program of assistance into a community. That is why it is best to use as helpers community members who will be seen as neighbors and not as strangers.

2. AVOID MENTAL HEALTH LABELS.

Many people still tend to think of mental health as implying "crazy" or "freakish." Some will refuse if the help is identified in any way as mental health. New terms should be used, such as "human services," "recovery assistance," and "problem resolution."

3. BE INNOVATIVE IN OFFERING HELP.

Avoid the traditional model. "Human Services Workers" must be prepared to work in all sorts of situations and under all sorts of conditions. Don't wait for the client to seek help; instead, go out and find him. This may be done in outreach or case-finding activities involving leaving the office and knocking on doors or ringing doorbells.

4. FIT THE PROGRAM INTO THE COMMUNITY.

Needs will change over time and they will be different in different areas for many reasons. Subcultures will require special attention in order to meet what may be unique demands, determined by language, ethnicity, etc. The different stages of the disaster will present different problems.

ETHICS OF INTERVIEWING—CONFIDENTIALITY AND PRIVACY

A helping person is in a privileged position. Helping someone in need implies a sharing of problems, concerns, and anxieties—sometimes with intimate details. This special sharing cannot be done without a sense of trust, which is built upon mutual respect and which includes the explicit understanding that all discussions are confidential and private. No cases should be discussed elsewhere without the consent of the person being helped (except in extreme emergency where it is judged the person will harm himself or others). It is only by maintaining the trust and respect of the client that the privilege of helping can continue to be exercised.

PROCEDURES FOR HELPING

Crisis intervention

The basic theory underlying the process of helping is crisis intervention. This theory generally assumes that most people can take care of many problems in their lives. However, when equilibrium is upset by some stress, any person may temporarily be pushed off balance emotionally and show signs of disturbance. He will apply his usual coping mechanisms until he succeeds and the distress subsides. When the emergency is unique and the strain severe, he may not have any effective coping mechanism immediately available, so the person remains highly disturbed. Help is needed, and the help is most useful if provided as soon as possible.

The procedures used in helping in a crisis are as

many and varied as are the people to be helped. However, it is possible to describe some general steps in the helping process that apply to just about every situation. These do not necessarily follow in sequence, and some of the steps may not appear at all in some situations. In addition, it is possible that several of the steps may be going on at the same time.

The major steps are:

1. RAPPORT WHICH CAN BE ESTABLISHED THROUGH THE ART OF LISTENING.

Rapport refers to feelings of understanding, interest, and concern among two or more people. Rapport means:

a. *Making sure that each understands what the other is saying;*

b. *Having genuine respect and regard for the other;*

c. *Being nonjudgmental and accepting of another even if he has different attitudes and feelings;*

d. *Establishing trust by promising only what you can do, not what you would like to do;*

e. *Listening to an account of the disaster that may have been repeated many times, while the process of "working through" the feeling occurs;*

f. *Recognizing that many times what is actually said may cover vastly different feelings underneath.*

2. IDENTIFYING, DEFINING, AND FOCUSING ON THE PROBLEM.

A severe crisis often causes disorganization in thinking and functioning. One reaction to the many problems which have appeared is to feel overwhelmed and unable to do anything. It is helpful to select one problem, identify it as the most immediate, and focus on it first. It should be a problem readily solvable, for an immediate success will be important in bringing back a sense of control and feeling of confidence.

3. EVALUATING THE CLIENT AND HIS PROBLEM(S).

The worker has to evaluate the status of the person he is working with and the seriousness of the problem(s). A few of the possible questions are: How serious are his losses? What are his inner resources? Does he show his emotions or sit on them? In this way, capabilities and priorities can be established.

4. EVALUATING RESOURCES AVAILABLE.

Frequently, a person will have resources available to him which are personal and unique. Explore possible sources of help for the person's problems through family, relatives, friends, clergy, physicians, etc. Also, you can tell the person about the various relief agencies which have been set up to meet the special needs of the disaster-struck community. Some resources are listed beginning with page 26 of this *Field Manual.*

5. DEVELOPING AND IMPLEMENTING A PLAN.

Aim at working out a plan with the person(s) involved which will help the person back to the point

where he can resume his own independent functioning. Most important, promises should not be made for services or materials or solutions which may not be available.

THE ART OF LISTENING

Listening skills can be increased by keeping in mind some basic points:

Look at the person while listening

This indicates attention to him only.

Give occasional responses while listening

This tells the person speaking that what he is saying is understood. Sometimes it helps to paraphrase what has been said; it often gives the speaker another viewpoint.

Avoid interrupting

Let the other person finish his thoughts, unless there is real confusion and the details are coming out jumbled.

Be tolerant

Don't prejudge, don't moralize, and don't condemn. Even though there may be times when the client's feelings seem inaccurate or inappropriate, the worker should not try to tell the other person how he *should* feel.

Empathize

Empathy is a learned ability to see and to feel the experience of someone else as if it were one's own. It is based on sensitivity and the ability to recognize

when another person is going through certain feelings or emotional states.

Be cognizant of needs

Many disasters will cause special problems. However, the reactions and the needs of the people affected seem general. They are:

1. CONCERN FOR BASIC SURVIVAL
2. GRIEF OVER LOSS OF LOVED ONES OR LOSS OF PRIZED POSSESSIONS
3. SEPARATION ANXIETY CENTERED ON SELF AND ALSO EXPRESSED AS FEAR FOR SAFETY OF SIGNIFICANT OTHERS
4. REGRESSIVE BEHAVIORS, E.G., REAPPEARANCE OF THUMBSUCKING AMONG CHILDREN
5. RELOCATION AND ISOLATION ANXIETIES
6. NEED TO EXPRESS FEELINGS ABOUT EXPERIENCES IN THE DISASTER
7. NEED TO FEEL ONE IS A PART OF THE COMMUNITY AND ITS REHABILITATION EFFORTS
8. ALTRUISM AND DESIRE TO HELP OTHERS

PROBLEMS OF LIVING

The most common types of problems you will encounter are problems of living, such as locating a

missing loved one, inadequate temporary accommodations, unemployment, transportation, communication—by phone and mail, lost eyeglasses or lost medication, applying for disaster relief loans, getting building permits, how to do income tax after a disaster, where to find the temporary city hall, etc.

You need to be an information and referral source as well as someone with a trained ear. You will have to distinguish among those problems you can help with yourself (transportation, cleanup, help in filling out forms, etc.), those people you must refer to social services (getting loans, jobs, housing, etc.), and those few people you will recognize as needing professional services (depressions, immobility, client doesn't know who or where he is, etc.).

HELP AND SEEK-HELP BEHAVIORS

Following is a list of behaviors you can use as a guideline to identify individuals or families whom you can probably help and those whose conditions may require the help of a professional. Remember, referral will require tact and sensitivity.

Alertness and awareness

YOU CAN PROBABLY HANDLE THE SITUATION IF THE CLIENT:

1. Is aware of who he is, where he is, and what has happened;
2. Is only slightly confused or dazed, or shows slight difficulty in thinking clearly or concentrating on a subject.

CONSIDER REFERRAL TO A MENTAL HEALTH AGENCY IF THE CLIENT:

1. Is unable to give own name or names of people with whom he is living;
2. Cannot give date, state where he is, or tell what he does;
3. Cannot recall events of past 24 hours;
4. Complains of memory gaps.

Actions

YOU CAN HANDLE IF THE CLIENT:

1. Wrings his hands, appears stiff and rigid, clenches his fists;
2. Is restless, mildly agitated, and excited;
3. Has sleep difficulty;
4. Has rapid or halting speech.

CONSIDER REFERRAL IF THE CLIENT:

1. Shows agitation, restlessness, pacing;
2. Is apathetic, immobile, unable to arouse self to movement;
3. Is incontinent;
4. Mutilates self;
5. Excessively uses alcohol or drugs;
6. Is unable to care for self, e.g., doesn't eat, drink, bathe, change clothes;
7. Repeats ritualistic acts.

Speech

YOU CAN HANDLE IF THE CLIENT:

1. Has appropriate feelings of depression, despair, discouragement;
2. Has doubts of his ability to recover;

3. Is overly concerned with small things, neglecting more pressing problems;
4. Denies problems; states he can take care of everything himself;
5. Blames his problems on others; is vague in his planning; is bitter in his feeling of anger that he is a victim.

CONSIDER REFERRAL IF THE CLIENT:

1. Hears voices, sees visions, or has unverified bodily sensations;
2. States his body feels unreal and he fears he is losing his mind;
3. Is excessively preoccupied with one idea or thought;
4. Has the delusion that someone or something is out to get him and his family;
5. Is afraid he will kill self or another;
6. Is unable to make simple decisions or carry out everyday functions;
7. Shows extreme pressure of speech; talk overflows.

Emotions

YOU CAN HANDLE IF THE CLIENT:

1. Is crying, weeping, with continuous retelling of disaster;
2. Has blunted emotions, little reaction to what is going on around him;
3. Shows excessive laughter, high spirits;
4. Is easily irritated and angered over trifles.

CONSIDER REFERRAL IF THE CLIENT:

1. Is excessively flat, unable to be aroused, or

completely withdrawn;
2. Is excessively emotional, shows inappropriate emotional reactions.

TYPES OF MENTAL HEALTH PROBLEMS FOLLOWING DISASTERS

The more severe symptoms indicate the victim is no longer able to function appropriately in the situation. He should be referred for professional assistance when any of the following symptoms appear:

Psychosomatic

—vomiting, diarrhea, insomnia, loss of appetite, headaches, allergies, ulcers, bladder problems, extreme tiredness, weakness, and rashes. A physician should determine that symptoms are not of physical origin.

Loss

—bereavement (loss of loved ones); separation from loved ones (especially children); loss of limbs due to trauma; loss of familiar objects, possessions, lifestyle; loss of independence; loss of home or farmlands, livelihood, etc.

Social stresses

—divorce, separation, delinquency, alcoholism, drugs, family discord. These reactions most often appear in later periods after the disaster.

Sequelae of physical trauma

—broken bones, burns, pain, toxicity, changes in body image caused by disfigurement and invalidism, loss of memory.

Psychological

—nightmares, unreasonable anticipation of another disaster, difficulty in concentrating, severe depression, extended dazed feeling, nervousness, crying spells, hopeless feelings, irritability. More formal classifications are:

DEPRESSION

—severe sadness, feels hopeless, can't get out of bed, won't eat, cries, apathetic, unable to engage in usual activities, sleep disturbance, feelings of helplessness, unshakable feelings of worthlessness and inadequacy, withdrawal from others, does not respond to others.

DISORIENTATION

—confusion; doesn't know where he is, what's happening, what time it is, unaware of surroundings, memory loss, dazed.

HYSTERIA

—uncontrollable crying and upset, screaming, can't be left unattended, agitated, may show paralysis or numbness of parts of the body.

PSYCHOSIS

—marked personality change, irrational thinking and highly unusual behavior, may report sensations for which there is no determined cause, and may have delusions of grandeur or persecution.

When the conclusion is reached that the person needs consultation with a professional, encourage the person and offer assistance, if needed, in locating help. Enlist the assistance of family, physician, clergy-

man, psychologist, or friends in persuading the person to accept treatment, if necessary.

SPECIAL RISK GROUPS

The special risk subgroups represent some of those more frequently encountered when providing services in disaster areas. The list is not meant to be complete. Some communities will have a unique or unusual composition with a subgroup not identified below.

Age groups

Some age groups appear to be vulnerable in unique ways to the stresses of disaster. Problems will vary also depending upon the phase of the post-disaster period, with some of the problems appearing immediately and others appearing months later.

In general, children of all ages will show as their most frequent symptoms: sleep disturbances and night terrors, persistent fears about natural events, fears of future disasters, loss of interest in school, and a loss of personal responsibility with regressive symptoms (behaviors typical of a child much younger in age than the victim).

The most common symptoms to appear in adults are those of anxiety, depression, hostility, resentment, loss of ambition, sleep disturbances, and psychosomatic symptoms. Marital discord may appear, especially regarding money, caring for children, and responsibility for housework. There may be increasing neglect of self and, in extreme cases, suicidal preoccupation, thoughts, and acts.

The following tables indicate where these symptoms and others appear among various special groups

and suggest some responses to them.

PRE-SCHOOL THROUGH ADOLESCENCE

Table 1 summarizes the regressive, body, and emotional symptoms for four age-groups (birth-18 years), suggests treatment options, and illustrates the overlap among the age-groups both in symptoms and treatment responses. For all ages, body or somatic symptoms should be referred for medical care. Professional mental health treatment should be sought when efforts of parents and nonprofessional helpers do not seem to help emotional problems.

MIDDLE AGE

Most emotional problems tend to appear later on rather than in the immediate post-disaster period. They may appear as psychosomatic problems, relationship difficulties, occupational dissatisfactions, and others. Table 2 lists some of the symptoms and treatment options.

OLDER ADULTS

Elderly citizens of concern here are noninstitutionalized persons whose life sphere has become circumscribed primarily due to aging rather than to specific multiple disabilities. Older persons typically do not have highly active schedules during the day; they spend their time mostly with others of similar age and circumstances in daily routines which have become comfortable. Others are confined to house or apartment, frequently alone. When their familiar routines are disrupted by the disaster, and particularly when residential loss and relocation occur, symptoms appear. Not only may there be grief over lost loved ones,

Table 1. Summary table of behavior symptoms and treatment options: Age groups—1-18

Ages	Behavior symptoms			Possible treatment options
	Regressive	Body	Emotions	
1-5	Resumption of bed-wetting, thumbsucking, fear of darkness	Loss of appetite Indigestion Vomiting Bowel or bladder problems, e.g., diarrhea, constipation, loss of sphincter control Sleep disorders	Nervousness Irritability Disobedience Intractibility Tics (muscle spasms) Speech difficulties, e.g., appearance of stuttering Refusal to leave proximity of parents	Give additional verbal assurance and ample physical comfort, e.g., holding and caressing. Provide warm milk and comforting bedtime routines. Permit child to sleep in parents' room temporarily if necessary; if symptoms persist, refer to professional. Provide opportunity and encouragement for expression of emotions through play activities, e.g., finger painting, clay modeling, physical reenactment of disaster.
5-11	Increased competition with younger siblings for parents attention	Headaches Complaints of visual or hearing problems Persistent itching and scratching Sleep disorders	School phobia Withdrawal from play group and friends Withdrawal from family contacts Unusual social behavior, e.g., fighting with close friends or siblings Loss of interest in previously preferred activities Inability to concentrate and drop in level of school achievement	Give additional attention and consideration. Be gentle but firm while insisting on relatively more responsibility than would be expected from younger child. Temporarily lessen requirements for optimum performance in school and home activities. Encourage verbal expression of thoughts and feelings about the disaster. Provide opportunity for structured but not demanding chores and responsibilities at home. Rehearse safety measures to be taken in future disasters

Table 1. Summary table of behavior symptoms and treatment options: Age groups—1-18 (cont'd.)

Ages	Behavior symptoms			Possible treatment options
	Regressive	**Body**	**Emotions**	
11-14	Competing with younger siblings for parental attention Failure to carry out chores previously completed without complaint School phobia Reappearance of earlier speech and behavior habits	Headaches Complaints of vague aches and pain Loss of appetite Bowel problems Sudden appearance of skin disorders Sleep disorders	Loss of interest in peer social activities Loss of interest in hobbies and recreations Increased difficulty in relating with sibs and parents Sharp increase in resisting parental or school authority	Give additional attention and consideration. Temporarily lower expectations of performance at school and home. Encourage verbal expression of feelings. Provide structured but undemanding responsibilities and rehabilitation activities. Encourage and assist child to become involved with same-age group activities. Rehearse safety measures for future disasters.
14-18	Resumption of earlier behaviors and attitudes Decline in previous responsible behavior Decline in emancipatory struggles over parental control Decline in heterosexual interests and activities	Bowel and bladder complaints Headaches Skin rash Sleep disorders Disorders of digestion	Marked increase or decline in physical activity level Frequent expression of feelings of inadequacy and helplessness Increased difficulties in concentration on planned activities	Encourage discussion of disaster experiences with peers and extra-family significant others. If adolescent chooses to discuss disaster fears within family setting, such expression is to be encouraged but not insisted upon. Reduce expectations for level of school and general performance temporarily. Provide opportunity for involvement in rehab planning and participation to fullest extent possible. Encourage and assist in becoming fully involved in peer social activities. Rehearse safety measures for future disasters.

Table 2. Feeling and behavior symptoms and treatment options of middle-age group

Feeling and behavior symptoms	Treatment options
Psychosomatic problems, ulcers, diabetes, heart trouble	Provide medical care for physical symptoms.
Withdrawal, anger, suspicion, irritability, apathy	Persuade talking with family physician, clergyman, friends or professional help.
Loss of appetite, sleep problems, loss of interest in everyday activities	Help find medical and financial assistance.
	Keep channels of communication open with members of the family.
	Help family to recognize physical signs of depression and need for professional counseling.

there may be despair accompanying loss of property and objects, which is a loss of ties with the past. Table 3 lists treatment options for various symptoms.

Socioeconomic classes

Socioeconomic circumstances influence attitudes and reactions of people in stress situations, especially the readiness with which individuals will seek or accept help voluntarily for emotional distress. For example, persons in lower-economic circumstances are generally more inclined to seek medical rather than psychological treatment. By contrast, people in intermediate- and upper-income levels are more aware of

Table 3. Feeling and behavior symptoms and treatment options of elderly citizens

Feeling and behavior symptoms	Treatment options
Depression withdrawal Apathy Agitation, anger Irritability, suspicion Disorientation Confusion Memory loss Accelerated physical decline Increase in number of somatic complaints	Provide strong and continuous verbal reassurance. Assist with recovery of physical possessions; make frequent home visits, and arrange for companions. Give special attention to suitable residential relocations, e.g., familiar surroundings and acquaintances. Help in reestablishing familial and social contacts. Assist in obtaining medical and financial assistance. Reestablish medication regime. Provide escort and transportation services.

and less likely to resist accepting all kinds of help when needed. These social groups would also be expected to be more likely to understand the possibilities of longer-range benefits from early use of the services offered, i.e., heading off future problems by dealing with them now. Upper-income people might be less inclined, however, to welcome outreach and free services as compared with lower- and middle-income groups.

Disaster losses are also felt differently by people

who have less insurance, precarious job situations and skills, less knowledge about available help, and less confidence in Government (or others outside their own family or in-group) to help.

Cultural and racial differences

Cultural differences, especially of races and language, may be important. For these groups it is essential that outreach efforts be channeled through representatives or facilities within the subculture area. Differences of language and custom, if ignored, will lead to frustration by those attempting to offer services. Some behavior symptoms which may be observed among culturally different groups are listed in table 4.

Table 4. Feeling and behavior symptoms and treatment options of culturally unique groups

Feeling and behavior symptoms	Treatment options
Depression Apathy Feelings of helplessness and hopelessness Resignation (to God's will) Suspicion of help offered by "outsiders" Ignoring or rejecting available sources of outside help Tendency to close ranks and accept assistance only from family and close friends	Channel all assistance through local religious and community sources. Emphasize informational and educational assistance. Outreach all services with exception of those requiring special facilities such as hospitals and clinics.

Institutionalized persons

Individuals who are in institutions during a disaster are susceptible to frustration, anxiety, and panic as a consequence of their limited mobility and helpless dependence on their keepers or caretakers. The circumstances will vary widely depending on type of institution and inmate, but there are some common reactions which might be expected to occur in general medical hospitals, mental hospitals, adult and juvenile correctional agencies, and convalescent facilities. Symptoms and treatment options are offered in table 5.

Table 5. Feeling and behavior symptoms and treatment options of institutionalized persons

Feeling and behavior symptoms	Treatment options
Fear Frustration Anxiety Helplessness Anger Panic "Escape"	Assist in relocation to sound physical structures. Give reassurance and information regarding disaster status. Assist in making contact with loved ones and acquaintances. Encourage involvement in housekeeping and rehabilitation duties. Provide opportunities for group discussion of fears and anxiety.

People requiring emergency medical care

Those who are in need of immediate medical and surgical treatment, in addition to suffering from physical shock, may also experience severe anxiety due to separation from loved ones or a lack of information about the extent of damage to home, place of business, or the community itself. The degree of anxiety experienced by the injured person may aggravate his/her physical state and response to medical treatment. Having mental health services available, if possible, at medical treatment facilities during and following the disaster has been found useful.

Disaster relief workers' "burn-out" syndrome

Workers in all phases of disaster relief expose themselves to unprecedented personal demands in their desire to help meet the needs of the victims. Many workers devote all of their time to the disaster-created tasks, at least in the immediate post-impact period. Then, as order returns, some of the workers, especially volunteers, return to their regular jobs and at the same time attempt to continue with their disaster work. The result of the overwork is the "burn-out" syndrome—a state of exhaustion, irritability, and fatigue which markedly decreases the worker's effectiveness and capability. The best way to forestall the "burn-out" syndrome is to expect it, to be alert to its early signs, and to act authoritatively in relieving the stress. Four areas of symptomatology have been identified:

SYMPTOMS

Thinking: Mental confusion, slowness of thought, inability to make judgments and decisions,

loss of ability to conceptualize alternatives or to prioritize tasks, loss of objectivity in evaluating own functioning, etc.

Psychological: Depression, irritability, anxiety, hyperexcitability, excessive rage reactions, etc.

Somatic: Physical exhaustion, loss of energy, gastrointestinal distress, appetite disturbances, hypochondria, sleep disorders, tremors, etc.

Behavioral: Hyperactivity, excessive fatigue, inability to express self verbally or in writing, etc.

MANAGEMENT

The first step is to be aware of, to be alert for, and to recognize the symptoms when they begin to appear. The earlier they are recognized the better. All personnel need to be aware of the early symptoms so they may recognize them not only in themselves but also in their fellow workers. Any such observations, either about themselves or about others, should be reported to supervisors. The latter also need to be alert to any early symptoms in their staff so that they can intervene.

The supervisor should talk to the individual and try to get him to recognize the symptoms in himself. The supervisor should relieve the person from his duties for a short period of time. Guilt over leaving the activity is relieved by giving "official" permission to stop and by pointing out how the worker is no longer helping because of the loss of his effectiveness. He can be reassured that he can return and that he will have improved greatly as a result of his short recuperation. The supervisor should at first attempt to persuade the helper to take the time off, but, if necessary, he should

order it. The syndrome may appear early or well into the post-disaster period, from 2 weeks to a year. On the average it seems to take about 4 to 6 weeks for most of the symptoms to appear.

Disaster response programs

The worker should be familiar with "fade-out," the phenomenon of loss of enthusiasm, energy, and investment occurring in disaster relief programs (especially the emergent groups) in the post-disaster periods. This phenomenon seems most likely to occur during the disillusionment phase in which the problems are chronic, frustrating, and depressing. The agency reflects this in drop of volunteers, loss of sense of usefulness, and growing sense of confusion about the purposefulness of the agency.

The worker who is alert to this phenomenon may help avert it, in either his own or in other agencies he comes in contact with, by helping the agency to evolve into other activities and to develop new objectives.

SOURCES OF HELP

Following are listed various governmental and non-governmental relief agencies which may provide services after a disaster. Workers are encouraged: (1) to use the space provided to add the resources they discover in the process of their work with the victims and in the community; (2) to delete those agencies that are not providing services in this disaster; and (3) to add the names of individuals within the agencies who have been contacted and who may provide useful information and personalized assistance.

Governmental and Nongovernmental Disaster Relief Agencies

If you need . . .	You can get . . .	From . . .
Food	Emergency meals at shelters or mass feeding stations Food packages or emergency food orders Food stamps Emergency food money	Red Cross, Salvation Army Red Cross USDA Food and Nutrition Service Office of Economic Opportunity Community Action Agency
Clothing	Clothing or an order for clothing which any store will fill Loans to replace clothing Emergency clothing	Red Cross, Salvation Army Small Business Administration Community Action Agency
Housing or home furnishings	A place to sleep until housing can be found Temporary housing Household furnishings	Red Cross, Salvation Army Dept. of Housing and Urban Development Red Cross
Medical care	Emergency medical care and health service Help in getting medical care Emergency medical assistance	Public Health Service, Veterans Administration Red Cross, local health agencies Office of Economic Opportunity Community Action Agency
Emergency funds	Pay while jobless because of disaster Social Security Veterans benefits Emergency assistance	State employment security office Social Security Administration Veterans Administration Red Cross, Office of Economic Opportunity Community Action Agency
Legal assistance	Legal advice in solving disaster-caused problems	Federal Disaster Assistance Administration (for referral) Office of Economic Opportunity Community Action Agency

Governmental and Nongovernmental Disaster Relief Agencies (cont'd.)

If you need . . .	You can get . . .	From . . .
Employment advice	Job help	State Employment Commission Office of Economic Opportunity Community Action Agency
Income tax assistance	Tax help for disaster victims	Internal Revenue Service
Property cleanup	Help to clear away disaster debris from your property Debris clearance from farm or other rural property	State and local officials Agricultural Stabilization and Conservation Service
Home repair or reconstruction	Loans to rebuild or repair your home and replace your furniture Insurance; or a mortgage to fix up your home Supplementary funds for repairing your home Help to repair your home	Small Business Administration Veterans Administration Federal Housing Administration Red Cross Mennonite Disaster Service
Business repair or maintenance	Loans to repair or replace your business Loans to help you keep your business going	Small Business Administration Small Business Administration
Farm repair or maintenance	Loans to repair or replace your farm home and buildings, fencing, equipment and livestock Emergency conservation measures Help in getting feed for your livestock	Farmers Home Administration Agricultural Stabilization and Conservation Service Agricultural Stabilization and Conservation Service
Moving assistance	Trucks and labor	National Guard
Official information	General public information and assistance	Federal Disaster Assistance Administration

Agency Involvement in Disaster Assistance (partial list)

FEDERAL

Department of Health, Education, and Welfare (DHEW)

Public health and welfare functions.

National Institute of Mental Health (NIMH)

Carries out crisis counseling and training activities in Presidentially declared disasters

Department of Housing and Urban Development (HUD)

Temporary housing

Federal Disaster Assistance Administration (FDAA). Coordinates all Federal services in Presidentially declared disasters

Department of Labor

Unemployment insurance

Department of Agriculture

Food stamps—food commodities
Farmers Home Administration (FHA)—disaster loans

Department of Defense

Defense Civil Preparedness Agency (DCPA)
Assistance to communities on public property losses and damages
Works with local Civil Defense

Small Business Administration (SBA)

Disaster loan program for homes and businesses

STATE

Department of Vocational Rehabilitation

Medical care and retraining for injured persons

Department of Public Assistance

Assistance to welfare clients (Federal assistance program)

Department of Health

Immunization
Preventive health measures as necessary

Department of Mental Health

(Referral of disaster victims with mental health needs)

National Guard—except when called into Federal service

Civil Defense

Assistance to communities on damage to public facilities. (Some States have separate disaster preparedness agency)

LOCAL CITY/COUNTY GOVERNMENT

The local/county level counterparts of State government provide the following services:

City/County Government

Declaration by public proclamation of emergency

when situation cannot be handled by existing relief agencies, private and governmental, operating in the normal manner

Civil Defense

1. "To prepare comprehensive plans and programs for the civil defense in both enemy caused and natural emergencies. . . ."
2. Establishes Control Center
3. Coordinates all efforts

Police Department

1. Suppresses criminal activity
2. Disperses crowds
3. Controls traffic
4. Organizes and controls within the damaged area
5. Alerts through telegraph section

Fire Department

1. Alerts through telegraph section
2. Minimizes or prevents fire
3. Assists with water supply, street clearance, and demolition

Associated General Contractors

1. Rescue and engineering services
   a. Clears streets
   b. Repairs bridges
2. Bulldozer operations

Department of Health and Hospitals

Medical services, including emergency first aid, ambulance service, etc.

Health Division

1. Sanitation
2. Immunization
3. Vital statistics
4. Public health nursing

Coroner's Office

Collection, identification, and burial of dead

Department of Streets

1. Clear and maintain the streets for traffic
2. Formulate and enforce emergency traffic regulations in cooperation with police
3. Collect and dispose garbage/rubbish

Department of Public Utilities

1. Rehabilitate and maintain water supply, lighting, heating, and power
2. Coordinate activities of privately owned utilities

Bi-State Transit

1. Provide vehicles, fuel, etc.
2. Provide drivers

Civil Air Control

1. Reconnaissance
2. Movement of key personnel and light equipment

Telephone

Communications

Radio Amateur Civil Emergency Services (RACES)

Short-wave radio

Radio/TV Networks

Communications

Human Relations Commission

Volunteer committee responsible for protection of citizens. Subcommittee includes churches.

Department of Welfare

Responsible for all emergency welfare services, including feeding, housing, and financial assistance. Augmented by ARC and private social welfare agencies.

VOLUNTARY AGENCIES (PARTIAL LIST)

American National Red Cross (ARC)

1. In addition to emergency assistance, provides food, clothing, rent, transportation, temporary home repairs, medical and health needs, furnishings, personal occupational supplies and equipment, and other essentials.
2. Refers families to Government disaster programs, provides additional assistance to families with major needs for whom such Government programs are not available.

Catholic Charities

Wide variety of services which differ from one diocese to another

Christian Reform World Relief Committee

Building advisors—builders, interviewers

Church of the Brethren

Cleanup, building

Mennonite Disaster Service

1. Cleanup, building
2. Some feeding and child care

Salvation Army

1. Feeding
2. Shelters
3. Counseling
4. Household furniture, etc.

Seventh Day Adventists

1. New and used bedding
2. Clothing and comfort kits, diapers (warehouse—Lansing, Michigan)

Society of St. Vincent de Paul

1. Food
2. Clothing
3. Assistance to aged and infirm, poor, children

Volunteers of America

1. Feeding
2. Sheltering—differs from place to place

Church of the Latter Day Saints (Mormon)

1. Food
2. Clothing
3. Shelter
4. Cleanup, rebuilding, household furniture
5. Mental health counseling

CLIENT INFORMATION FORM

A Client Information Form should be filled out for each client. The sample format included in this *Manual* may be used or modified to meet the needs for a particular program. Forms should be kept current with all information and actions in reference to the client. By this means the service project office will be able to assess the kinds of services needed and utilized during different phases of the post-disaster period and the problems encountered in getting these services.

CLIENT INFORMATION FORM

Worker's name: _____

Name of client: _____

Permanent address: _____

Temporary address: _____

Current phone no.: _____ Ethnicity: _____

Age group (*circle one*): 0-19, 20-39, 40-59, 60+ Sex: M___ F___

Language preference (if other than English), _____

Name and address of closest relative to contact in case of emergency: _____

_____ Phone no.: _____

Complete all items as fully and accurately as possible:

(1,2) Give the date of contact and amount of time spent directly with the client in hours and fractions thereof, e.g., ½ hour, 1½ hours, etc.

(3) Describe the most pressing problem presented *as it appears to you*, e.g., grief over loss of loved one, depression about loss of property or income, general emotional distress related to disaster itself or its effects, apparent pre-existing

disturbance aggravated by disaster, etc. List in table below.

(4) Give your estimate of severity of the problem for the client as *mild, moderate* or *severe.*

(5) Indicate disposition of problem, e.g., gave direct assistance in the form of transportation; verbal support for emotional distress; referred to: Red Cross Housing Authority, medical care, professional psychological assistance, etc.

Contacts

(1) Date	(2) Length of contact	(3) Presenting problem	(4) Se-verity	(5) Disposition

☆ U. S. Government Printing Office: 1987 - 181-350 (73902)