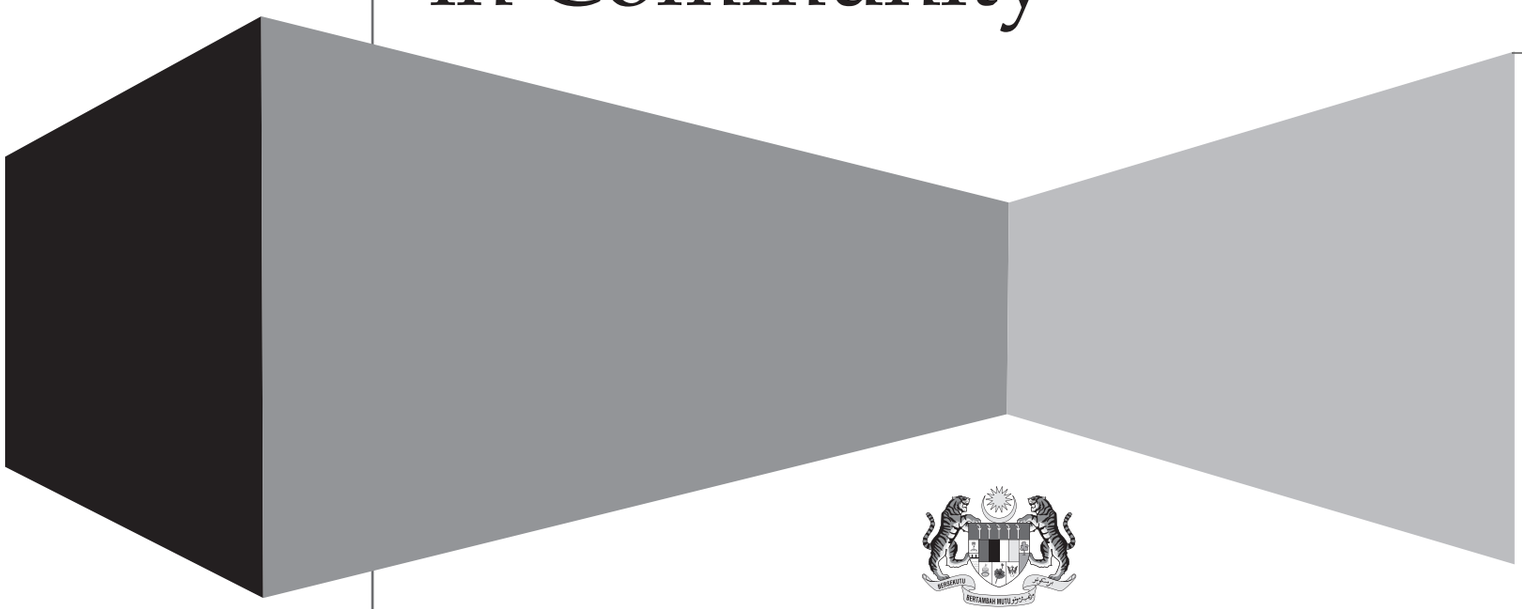
Manual on
Mental Health
and Psychosocial
Response to Disaster
in Community



Mental Health Unit
Non-Communicable Disease Section
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Ministry of Health Malaysia
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INTRODUCTION

When disaster happens, it may affect anyone in the population either directly or indirectly. During disaster, a large number of residents in the community get various mental effects. It has been shown that disaster poses an unexpected large psychological burden to individuals as well as to the family members and community. There would be a considerable change in daily life and activities.

It is considerably easy to identify the physical sufferings endured by victims of disaster. However, it is not so easy to identify psychological problems among victims. Studies have shown that in the early stages, any psychological changes in the victims are a normal reaction towards an abnormal situation and most victims will recover from the psychological and emotional impact due to the disaster. As such, they may not show any needs towards psychological aid. Nevertheless, there is a need provide mental health services and psychosocial support to the victims of disaster.

This training manual on mental health and psychosocial response to disaster in community was developed based on references and resources provided by mental health experts from psychiatric services; Mental Health Unit, NCD Section, Disease Control Division, Ministry of Health and World Health Organization (WHO).

OBJECTIVES

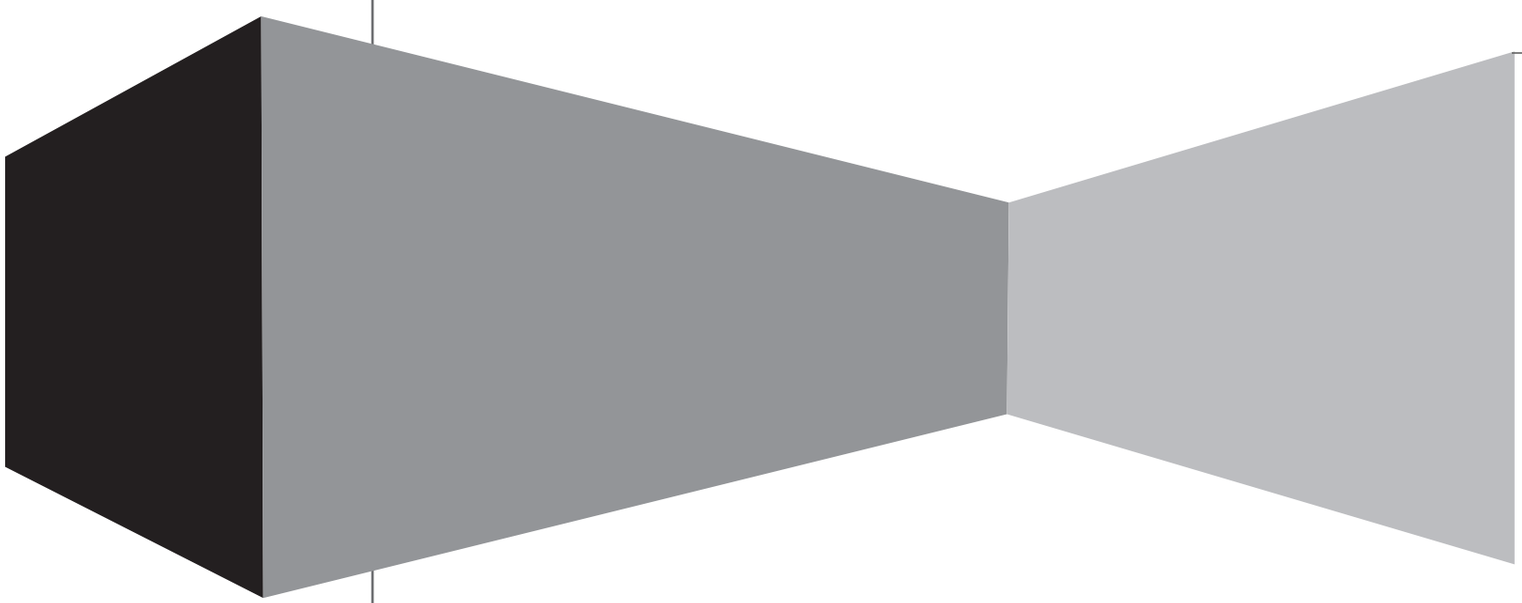
i. To recruit and train Mental Health and Psychosocial Response Team (MHPRT) with Basic Disaster Response Skills to prepare them in assisting community during disaster
ii. To provide basic knowledge on Mental Health and Psychosocial responses to Disaster
iii. To equip MHPRT with disaster management skills in assisting the community prepare for/cope with disaster
iv. To establish contact and networking for referral purposes

TARGET PARTICIPANTS

This manual is targeted to:
Community Psychosocial Response Team (CPRT) that can consists of:

i. Counselors,
ii. Clinical Psychologist
iii. Medical Doctors
iv. Public health Specialist
v. Psychiatrists
vi. Allied Health personnel
    - Medical Assistants
    - Nurses
vii. Supporting Team:
    - Rakan Pembimbing Perkhidmatan Awam (AKRAB)
    - Selected NGOs that have been appointed by MOH to be in the team (eg: PERKAMA, PSIMA, MERCY, Red Crescent, Aman Malaysia, Insaf Relief, Sathya Sai Baba, etc)

Module 1 :
Understanding Disaster And Mental Health



MODULE 1: UNDERSTANDING DISASTER AND MENTAL HEALTH

1. Background

In recent years, Malaysia has witnessed or experiences various forms of incidences such as building collapse, mudslide, and most recently floods and tsunami. In Malaysia one of the most unforgettable incidences was the collapse of the Highland Towers that resulted in 48 deaths in December 1993 with thousands more injured. This was probably the first disaster that was studied from a mental health response perspective in Malaysia. CH Lim (1994) studied 71 fire fighters who were involved in this disaster. He found significant emotional and behavioural symptoms that persisted 5-7 months after the event among the fire fighters. The greater level of symptoms was found in the workers who had longer exposure to the disaster site, those who were more severely affected emotionally during their duties and those who felt they were not able to cope. The study informs us that workers should not spend too long a time at a disaster site, they should be emotionally stable and prepared and should be debriefed.

Following Tsunami in 2004 efforts were made to develop a concerted response to the mental health and psychosocial aspects of disaster.

In Ministry of Health, Crisis Preparedness Response Centre (CPRC), has been set up in the Disease Control Division, Ministry of Health to respond to any form of disaster situation. The Ministry of Health has also develop a National Plan of Action for Disaster, and Guidelines on Management during Floods.

Although Malaysia may not experience the worst of disasters as compared to many other countries, the psychological and emotional impact is vast. As such, there is a need to develop a manual that focuses on mental health interventions at community level and psychosocial wellbeing that will strengthen capacity building of mental health care during disaster situations.

2. Understanding Disaster

2.1 Definition of Disaster

According to Directive 20 (National Security Council, Malaysia), disaster is defined as a sudden, catastrophic event, sudden misfortune or calamity. It is complex in nature and results in loss of lives on a large scales, destructions of properties and the environment leading to severe destructions in the activities of the community affected. It can be classified into Natural and Man-made disasters.

2.2 Types of Disasters

a) Natural disasters (floods, storms, drought, bushfire, beach erosion, landslide, earthquake, tsunami)
   i. Highland Towers collapse, Hulu Klang, Selangor (1993)
   ii. Land Slide, Km 34, Jalan Cameron Highlands (1995)
   iii. Landslide,Hill View (2002)
   iv. Tsunami in Kuala Muda Kedah dan Batu Feringgi Penang (2004)
   v. Land Slide Hulu Langat (2011)
   vi. Several Floods in various states including Kedah,Johor, Pahang and Kelantan

b) Industrial disaster (explosions, fire outbreaks, pollutions, hazardous emissions)
   i. Bright Sprkles fire and explosion, Sg. Buloh (1991)
   ii. Choon Hong Ship, fire explosion, Klang (1992)
c) Accidents involving transportation, and transferring of hazardous materials
d) High rise buildings and special structures collapse
   i. Collapsed of Sultan Abdul Halim Jetty, Pulau Pinang (1988)
e) Air accident (populated areas)
f) Train collision and derailment
g) Fire outbreak in densely populated areas/ high rise buildings or special structures
h) Hydro dam/ reservoir accidents
i) Nuclear and radiology mishaps
j) Poisonous gas emission (public places)
k) Haze
l) Others War/ terrorism
   i. Lahad Datu (2013)

3. Understanding Mental Health In Disaster

Disaster inflicts psychological burden. The aftermath may bring major life changes and uncertainty about future life, making everyday realities stressful. Among those who would be most vulnerable are the elderly, infants, the ill, the wounded and the handicapped. These groups may have substantial difficulty in coping with life after disaster and suffer from high levels of stress.

(i) Psychological Trauma
- Physical experience of disaster (shaking or sound of earthquake, flames or heat of fire, noiseor blast of explosion)
- Sufferings due to disaster (injury, death of loved ones, damage to home)
- Witnessing of disaster (corpses, fires, collapsed building

(ii) Grief, Loss, Anger, Guilt
- Grief over bereavement, injury, loss of household
- Guilt (survivor's guilt, unresolved issues)
- Anger towards surroundings (assistance delays, confusing information)
- Anger toward organizations or persons seen as responsible for an accidental disaster

(iii) Social and Lifestyle Stress
- Breakdown of life routines (school, work, neighbourhood,, care systems for children, elderly or handicapped)
- Burdens of new relationships and information
- Burden of receiving attentions as a survivor

4. Mental Health of The Disaster Response Worker

Disaster response workers are usually emergency personnel, health professional and may include volunteers from different background. They are exposed to long hours of works working under difficult and unpleasant surrounding. They need to be readily prepared in terms of physical and mental well- being prior to deployment .

4.1 Preparation & Readiness:
A individual needs to know if they are suitable to function as a volunteer in response to disaster.

Ask yourself the following:
1. What are your reasons for volunteering?
2. Can you rough it out-staying in tents, eating basic meals, using public toilets for a set period?
3. Can you accept increasing levels of stress?
4. How do you cope with stress?
5. Can your loved ones accept that you'll be away and perhaps risk harm to self?
6. Are you willing to undergo training, briefing and on your return to undergo debriefing?
7. Are you able to accept that you may not witness the benefits of your efforts?

An effective volunteer is:
1. Able to care and are empathetic towards those who are suffering.
2. Able to work as a team member and accept the views and opinions of others.
3. Able to express his or her own emotional issues freely.
4. Not trying to achieve an unrealistic wish through volunteering.
5. Not carrying too much 'baggage' – physical and emotional!
6. Able to feel satisfied with small successes
7. Equipped with the knowledge and skills appropriate for the community he or she is serving.

4.2 Stressors associated with disaster work:
- Exposure to dead bodies
- Fatigue
- Exposure to toxic agents
- Physically unfit
- Unfamiliar with surrounding and working environment
- Group stessors
- Loss of loved ones

4.3 Psychological effects of Disaster Response Worker:
- Stress specific symptomatology
- Identification victim
- Helplessness and guilt
- Fear of the unknown
- Hyperarousal, hypervigilance

(Refer appendix 1)

4.4 Psychiatric outcome of disaster:
- i. Acute stress disorder (ASD)
- ii. Post-traumatic stress disorder
- iii. Grief
- iv. Adjustment Disorders
- v. Anxiety Related Issues
- vi. Depressive Disorders

4.5 Approaches to manage stress among disaster response workers.
(Refer appendix 2)

5. Management of People With Disaster Related Mental Health Issues

5.1 Immediate information for victims/ survivor:
(What to do immediately after the event)
- Make sure you are not alone
- Talk about the incident with others
- Remind that the event is over and you are now safe
- Maintain good sleep hygiene
- Try to eat even if you do not feel like eating
- Do some physical exercise
- Avoid drug and alcohol/ stimulant

5.2 Other information for victims/ survivor:
(What to do few days after the event)
- Remind the reactions are normal
- Try to go back to normal routine as soon as possible
- Continue talking to family and other, do not reject support and afraid of her/his feelings
- Manage stress with relaxation, adequate sleep, proper diet and regular exercise
- If uncomfortable, do breathing exercise
- More careful in daily activities and driving (accidents are more common after severe stress)
- Allow time to deal with the memory
  (If these experiences continue to seriously distrupt life, please seek help from professionals)

5.3 Managing stress during disaster:
In disaster situation, stress is a common reaction in an abnormal situation. Individuals experiencing disaster can manifest stress in his/her own way. Victims of disaster needs to realized that they are not alone and everyone faces the same situation. In the aftermath disaster, several actions can be taken to cope with existing situation:
- Try to remain calm and be patient
- Listen carefully to instructions given by authorities
- Do not be afraid to ask for help in coping with situation
- Do not listen to/ act upon rumors
- Practice relaxation and deep breathing techniques
- Do things you find comforting such as reading, listening to music, exercising or socializing with friends
- Try to stick to your daily routine as much as possible, but do not expect everything to get back to normal right away

6. Psychiatric Outcomes In Disaster

6.1 Acute Stress Reaction:

- A transient disorder that develop in response to a traumatic event
- It can manifest in many ways eg: an initial state of daze, agitation and over activity, withdrawal, anxiety, narrowing attention, disorientation, amnesia, distress and avoidance
- Individuals with acute stress reaction are likely to develop PTSD which is a consequence of exposure to overwhelming event

Management of acute stress reaction:

- Assurance –acceptable conditions and not a form of mental illness
- Supportive therapy – focus on immediate needs
- Relaxation technique
  - Deep Breathing technique
  - Progressive muscle relaxation
- May require anxiolytic / hypnotic
- May require short-term follow-up – to identify mental illness

6.2 Post Traumatic Stress Disorder (Ptsd):

PTSD is a long lasting anxiety response following a traumatic or catastrophic event, experiences or witnesses a traumatic event such as actual or threatened death, serious injury to oneself or others or a threat of the personal integrity to oneself or others. It is the most characteristic mental disorder arising from trauma. It does not occur without a trauma experience. It is the only disorder with a stipulated cause. Among the key symptoms are intrusion, avoidance and hyperarousal. The onset and progression of PTSD can be affected by scale of traumatic experience.

Management of PTSD:

- Assurance –acceptable conditions and not a form of mental illness
- Supportive therapy – focus on immediate needs
- Relaxation technique
- May require anxiolytic / hypnotic
- May require long-term follow-up – to identify mental illness

6.3 GRIEF:

- Grief is universal for people with close emotional bonds to their friends and families.
- Since loss is a part of life, grief is extremely common
- Many trauma victims' psychological, physiological and interpersonal symptoms diminish over a period of days and weeks
- Grief can manifest as below:
  - Depressed mood
  - Thinking about the loss (emotion towards the loss)
  - Guilt feeling
  - Loss of interest Anhedonia
  - Hopelessness
  - Persistent guilt feeling
  - Insomnia
  - Loss of appetite
  - Loss of weight
  - Psychomotor retardation
  - Emotion towards ownself

Kubler-Ross PHASES OF GRIEF		
1	SHOCK & DENIAL	"No, not me!!!" • Shock • Unbelievable • Denial : 'maybe everybody else, but not me!!"
2	ANGER	"Why me??" • Frustation • Anger may be specific or diffuse : anger at God, friends, superior, politician etc • Difficult to comfort
3	BARGAINING	"Yes me, but" • Bargaining • Hope for a 'miracle' to happen
4	DEPRESSION	"Yes, me" • When it becomes clear that bargaining will not change the inevitable, depression may set in
5	ACCEPTANCE	"Yes, me, and I'm ready" • The stage of acceptance may be reached at some point • Recover from depression and continue to live

6.3.1 Management of Grief:

- Grief Counseling
- Encourage people to express the sad, uncomfortable and painful feeling
- Listen to their emotion
- Assurance. Normal and acceptable to experience sadness and grief over the loss
- Remind them the sad emotion may take some time to disappear
- Preparation for future

6.4 Adjustment Disorders:

Adjustment disorders can be characterized by emotional or behavioural symptoms in response to identifiable stressors. Within 3 months of the onset of stressors, it can manifest as:

- Marked distress
- Significant impairment in social or occupational (academic) functioning

Management of adjustment disorders:

- Brief supportive therapy
- Identify vulnerable group toward depression
- May require anxiolytic / hypnotic
- May require short-term follow-up to identify mental illness

6.5 Anxiety-Related Issues

6.5.1 Generalised Anxiety Disorder:

- Chronic exaggerated worry about everyday routine life events and activities
- Duration at least 6 months
- Significant distress or impairment in function

3 or more typical symptoms:

- restlessness
- easily fatigue
- difficulty in concentrating or mind going blank
- muscle tension
- sleep disturbances
- irritability

6.5.2 Panic disorder:

- Panic attacks, sudden feelings of terror that strike repeatedly and without warning
- Duration at least 1 month

4 or more symptoms:

- chest pain
- choking sensation
- chills or flushes
- dizziness, faintness
- fear of death
- feeling loss of control or going crazy
- palpitation
- paresthesia
- nausea or abdominal problems
- sweating, trembling or shaking

6.5.3 Phobia:

- Extreme disabling and irrational fear of something that really poses little or no actual danger
- The fear leads to avoidance of objects or situations and can cause people to limit their lives

6.5.4 Management of anxiety related issues:

- Anxiolytics
- Alprazolam and Clonazepam
- Medication to reduce symptoms
- Anti depressants – eg: tri-cyclic, SSRI,SNRI, NaSSR
- Counseling
- Brief Supportive Therapy

6.6 Depressive Disorders

Can be manifest in the following ways:

- Depressed mood
- Lassitude or fatigue
- Reduce concentration
- Loss of interest or pleasure
- Appetite disturbances
- Sleep disturbances
- Pessimism/ worthlessness/ guilt
- Thoughts of death or suicide

6.6.1 Major Depressive Disorders

5 or more of the following symptoms have been present during the same 2 week period; either depressed mood or loss of interest or pleasure:

- Depressed mood most of the day, nearly everyday
- Markedly diminished interest or pleasure in all or most activities
- Significant weight loss (5% of body weight in a month)
- Decrease or increase in appetite
- Insomnia or hypersomnia
- Psychomotor retardation or agitation
- Fatigue or loss of energy
- Feeling of worthlessness or excessive of inapproapriate guilt feeling
- Diminished ability to think or concentrate
- Recurrent thoughts of deaths

6.6.2 Management of depressive disorders:

- Brief supportive therapy (see insert)
- Anti depressants
- May require anxiolytic/ hypnotic

BRIEF SUPPORTIVE THERAPY

- Short-term therapy
- The goal is to maintain or increase self-esteem, adaptive skills and psychological functions
- Process
  - √ Praise
  - √ advice
  - √ appropriate reassurance
  - √ anticipatory guidance
  - √ clarification

7. Psychosocial Intervention Activities During Various Stages of Disaster

7.1 Pre Disaster

(a) Conduct Outreach program:
- Identifying potential affected locations & community
- Visiting people, schools, surau or mosque in the community to promote services
- Identify local people eg. Community Leaders, Religious Leader

(b) Recruitment of Mental Health and Psychosocial Response Team:
- Representatives from zones & districts
- Screening for readiness
- Those who have undergone training

(c) Educating the community:
- What to do & where to go when disaster happens
- The effects of Disaster to community

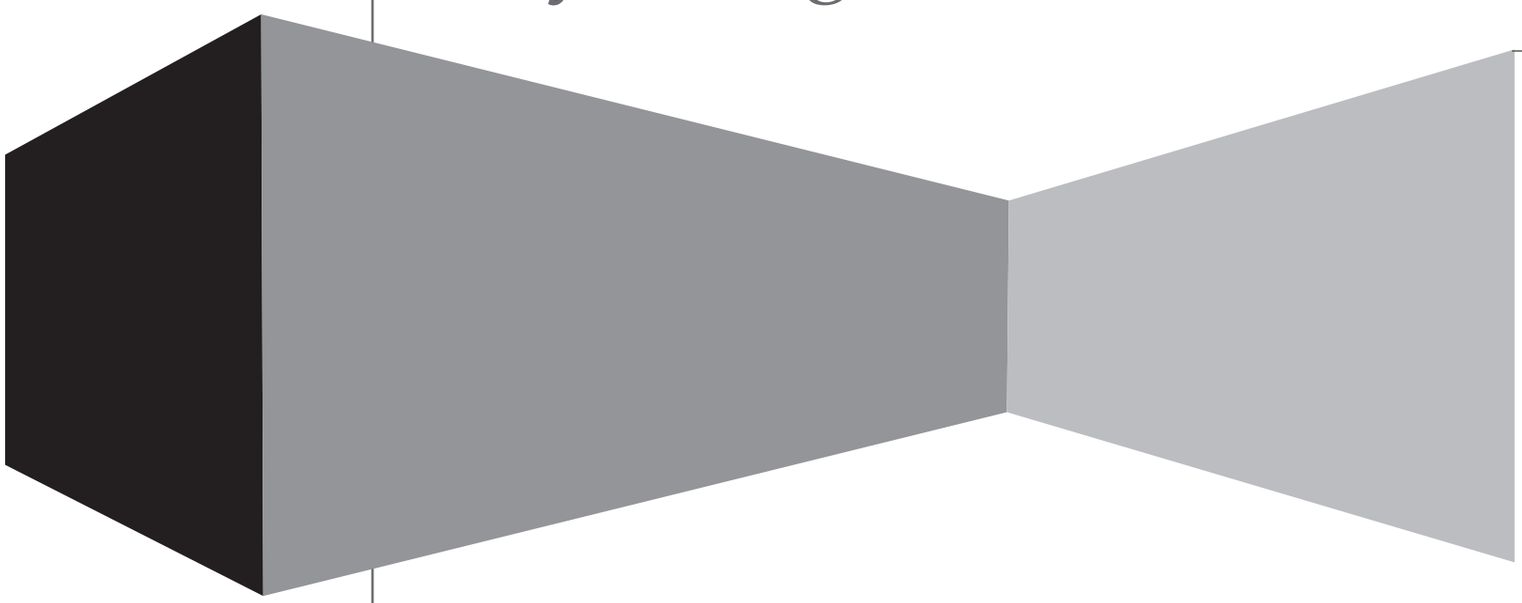
(d) Awareness through disseminations of Information:
- Flyers, pamphlets, brochures, tip sheets, posters
- Billboard,
- Radio, TV and Media promotions
- Lists of referral agencies

7.2 During Disaster:
- MHPR needs to triage victims or survivors
  - √ Triage for those who are distress, disturbed mental state and behavioural disturbance
  - √ Identify strength and risk factors
  - √ Assess the urgent needs of the affected people for referral
  - √ Link them to support or if appropriate, to mental health care
- Provide practical help (logistic,food,water and protection from environment)
- Provide Psychological First Aid (PFA)
- Distribute information in the form of pamphlets to the community should they need post disaster assistance
  - √ Pamphlets about Disaster
  - √ Lists of referral agencies
  - √ Symptom check list (What to do & Where to go)
- Media as a medium to disseminate info on “Wellness During Disaster”
  - √ Provide consistent information to media
  - √ Use media to facilitate the public understanding of mental health issues and the role of mental health workers

7.3 Post-Disaster:

- Post Mortem
- Feedback and follow up session for survivors & families & community
- Post deployment discussion for MHPR
- Crisis counseling
- Grief counseling and death notification support-
- provide advise during death notification
- On-going assistance for psychiatric referral & counseling follow-up when indicated eg. when involved death of family members
  Those survived or witnessed traumatic event
- Public education and community out reach
- Revisit community: Meeting the survivors & affected community for potential long term sequelae (after 6 months)
- PTSD
- Depression
- Pathological Grief: Delayed or prolonged

Module 2 :
Intervention At Community Level (Psychological First Aid)



MODULE 2: INTERVENTION AT COMMUNITY LEVEL (PSYCHOLOGICAL FIRST AID)

1. Introduction

Psychological First Aid (PFA) is an evidence-based modular approach to assist children,adolescents, adults and families in the immediate aftermath of disaster and terrorism. It can be given to anyone, including survivors and affected individuals experiencing acute stress reactions or who appear to be at risk for significant functional impairment or mental health problems. PFA can also be given to disaster workers. PFA is delivered by disaster response workers who provide early assistance and can also be delivered during the immediate aftermath of the disaster.

Five Steps to provide Psychological First Aid:

- Information
- Safety
- Basic Needs
- Extended Staff
- Identification of persons who are emotionally overwhelmed

2. Core Actions Of Psychological First Aid

1. Contact and Engagement
2. Safety and Comfort
3. Stabilization
4. Information Gathering
5. Practical Assistance
6. Connection with Social Supports
7. Information on Coping
8. Link with other services

2.1 Contact and Engagement

The aim of contact and engagement is to establish a connection with the victims in a non-intrusive manner:

- Introduce yourself and explain your role
- Ask for permission to talk
- Ask about the immediate needs eg: religious/ spiritual needs

2.2 Safety and Comfort

This means enhancing immediate and ongoing safety as well as provides physical and emotional support

Steps in providing safety and comfort:
- Ensure immediate physical safety
- Provide information to the victims, survivors or family about disaster response activities
- Offer physical comfort including basic needs
- Encourage social engagement

Safety and comfort is usually offered to those acute bereaved individuals. In acute grief condition following the death of a close family member or of loved ones, families may tear apart. Grief reactions vary from person to person. Some may cry and some don't. However, this does not mean that social support is unimportant. The family needs to be helped to understand and respect the differences in grieving and how they can help one another.

2.3 Stabilization

Stabilization is to calm and oriented emotionally-overwhelmed and distraught survivors. When dealing with stabilization, we are dealing with a person who wants to calm down but they can't.

Signs of person who are not stable:
- Fidgety at times
- Irritable, agitated
- Exhibiting strong emotional responses
- Looking fearful
- Frantic behaviour

Steps towards stabilization:
- Give the person a few minutes/moments (of privacy)
- Remain calm and quiet
- Offer support and help him/her focus on specific manageable goals
- List support from family and friends
- Teach the person breathing techniques
- Get the person orientated to the surroundings by providing him/her information (Grounding)

Grounding:

Grounding is to get individuals orientated to the surroundings
Ask the person to:
- Listen to and look at you
- Talk about a hopeful or positive situation
- Breathe in and out slowly and deeply from the diaphragm
- Name five non-distressing things he/she can see/hear/feel

For younger children/kids, ask them to identify colors that they see around them for eg. colour of the shirt they are wearing.

2.4 Information Gathering

Information gathering is about identifying immediate needs and concerns, gathering additional information and knowing what are major areas of concern such as:

- Nature and severity of experiences eg: how bad is the exposure
- Death of a loved one
- Concerns about post-disaster
- Concerns about safety of loved ones
- Physical illness, mental health condition and need for medication
- Loss of property

Things to consider when gathering information:

- Avoid asking the victims/survivors in-depth description of their traumatic experience
- When discussing the event, follow the lead of survivor
- Victims/survivors should not be pressed to disclose details of any trauma/loss

For survivors who may be anxious to talk about their experiences:

- Emphasize that what is most helpful is for them to give basic information that can help with current needs
- Tell them that they can discuss their experiences in a proper professional setting

2.5 Practical Assistance

Practical assistance is being offered to help survivors in addressing immediate needs and concerns:

- Identify the most immediate need (s)
- Clarify the need
- Discuss an action response
- Act to address the need
- Know what services are available
- Inform those affected about what they can realistically expect in terms of potential resources and support
- Help victims or survivors to set achievable goals.

2.6 Connection with Social Support

The connection with social support is important to establish ongoing contacts with primary support persons or other support sources, including family members, friends, and community helping resources.

2.7 Information on Coping

The goal is to provide information about stress reactions and coping to reduce distress and promote adaptive functioning. Coping skills is beneficial to recovery in disaster

- Provide basic information on ways of coping
- Teach simple relaxation techniques
- Discuss coping with families

2.8 Linkage with Collaborative Services

Links survivors with available services needed at the time or in the future.

Agencies Providing Services:

- Reconnect survivors to agencies that provided them services before the disaster:
  - Mental health services
  - Medical services
  - Spiritual support
  - Welfare services

If Referral to Mental- Health Care is Refused:

- Suggest an evaluation rather than treatment
- Normalize the idea of treatment
- Give educational materials
- Give information about different ways they can seek assistance
- Involve the person's spouse or partner in the discussion
- Follow- up on the issue

2.9 DO's and DON'TS in Delivering Psychological First Aid

Do 's:

- Observe
- Ask simple respectful questions
- Speak calmly and slowly, without jargon
- Be patient, responsive and sensitive
- Acknowledge the victim's strength

Dont's:

- Make assumptions about victims' experiences
- Assume everyone will be traumatized
- Label reactions as "symptoms" or
- Speak in tems of diagnoses
- Talking down to or patronizing the victims

2.10 Things to say and not to say for survivors whose family/ close friend has died

Things to say:

- What they are experiencing is understandable and expectable
- Use the deceased person's name
  (They will most likely continue to experience periods of sadness, loneliness or anger)

Things not to say:

- I know how you feel
- He is better off now, it was his/her time to go
- At least he/she went quickly, it was probably for the best
- It's good that you are alive
- Let's talk about something else
- You are strong enough to deal with this
- It could be worse, you still have a brother/sister/mother/ father
- Everything happens for the best according to a higher plan
- You did everything you could
- You will feel better soon
- You need to relax
- (To a Child) – You are the man/woman of the house now
- Someday you will have an answer

3. Basic Helping Skills

3.1 Basic Counselling Skills

Learning some basic skills of counseling is the first step on your journey. These basic skills include the:

- Pattern of sessions
- Active listening,
- Body language,
- Voice tone,
- Open ended and close questions
- Para-phrasing
- Summarizing
- Note-taking, homework and
- Other fun and informative stuff

3.2 Communication Skills

Communication is a transfer of meaning from one person or group to another. It focuses on the nature of meaning and ways to maintain the integrity of meaning through the process of dissemination and reception of a message. It is very important for the MHPRT to understand the way on how they communicate with the victims.

Ventilation	Active Listening	Empathy
• Meet people and interact • Help to talk what their experience • Share their feelings and emotions	• Look into the eyes • Respond occasionally • Avoid interruption • Be accepting • Emphatize	• Feel and experiences the pain as your own by trying to be in the other persons situation • Listening attentively • Great sense of relief of having been truly understood

4. Teamwork And Community Engagement

In working with a disaster situation, PST and CPRT may need to work with several government agencies and non-governmental organizations such as police, firefighters, rescue workers and other volunteers.

5 Managing Survivors And Family Of Survivors

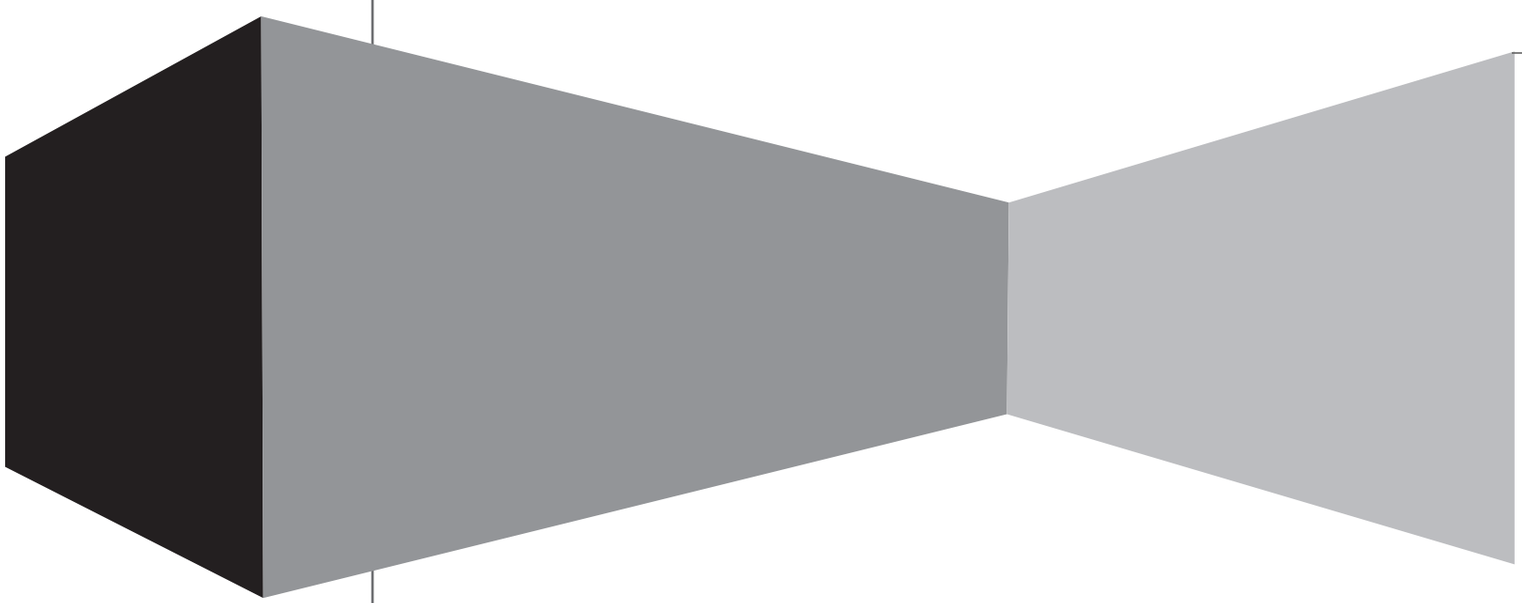
Survivors and their family need to be assisted in coping with stress associated with disaster. Special attention should be given to high risk individuals and supportive counseling given when needed.

6. Disaster In Multicultural Community: Cross Cultural Understanding

Cultural differences (ethnicity, age, gender, language, cultural taboos, values, etc):

- If you are not clear of familiar with the culture of the victims or community,, it is best that you should not approach too closely or make prolonged eye contact, or touch.
- Gather information on the cultural norms
- Identify the family's spokesperson when working with family

Mental Health Requirements of Disaster Response Workers



Appendix 1

Mental Health Requirements of Disaster Response Workers

Disaster response workers may be affected by stress during disaster operations.

- They may experience physical symptoms associated with stress, such as headaches, upset stomach, diarrhea, poor concentration, and feelings of irritability and restlessness.
- They may become tired of the disaster and prefer not to talk about it, think about it, or even associated with coworkers during time off. They may become tired of continual interaction with victims and may want to isolate themselves during time off.
- They may have feelings of frustration or guilt because they miss their families and are unavailable to their families both physically and emotionally due to their psychological involvement in the disaster, fatigue, and so forth.
- They may feel frustrated with family and friends when they are able to contact them because the relief workers feel that families and friends simply cannot understand the disaster experience. If family and friends become irritated, it can compound the problem, and temporary isolation and estrangement may occur.

How to Minimize Stress during a Disaster Operation.

The following are some ways to minimize stress during a disaster operation:

- As much as possible, living accommodations should be personal and comfortable. Mementos from home may help disaster workers to keep in touch psychologically.
- Regular exercise consistent with present physical condition and relaxation with some activity away from the disaster scene may help.
- Getting enough sleep and trying to eat regular meals even if the workers are not hungry will help. Workers should avoid foods high in sugar, fat and sodium, such as donuts and fast foods. Taking vitamin and mineral supplements may help the body to continue to get the nutrients it needs.
- Excessive use of alcohol and coffee should be avoided. Caffeine is a stimulant and should be used in moderation as it affects the nervous system, making relief workers nervous and edgy.
- Although relief workers need time alone on long disaster operations, they should also spend time with coworkers. Both experienced and new relief workers should spend rest time away from the disaster scene. Talking about normal things (home, friends, family, hobbies, etc.) other than the disaster is a healthy change of pace.
- Humor helps ease the tension. However, use it carefully as victims or coworkers can take things personally, resulting in hurt feelings if they are the burnt of “disaster humor”.
- When on the job, it is important for relief workers to take breaks during the day, especially if they find themselves making mistakes or unable to concentrate.
- Team members should try to stay in touch with family back home if they can. Communication helps prevent the sense of being strangers when they return after the disaster.

Team Leaders can take specific, practical action to prevent and reduce the effects of stress , consequently avoiding the personal and organizational costs associated with them. Steps include:

- Learning to identify and respond to stress in personnel.
- Educating team members in advance about the potential harmful effects of critical incidents.

Appendix 2

Approaches To Manage Stress Among Workers During Disaster:

Effective Management Structure and Leadership:

- Clear chain of command and reporting relationships
- Ensure logistics and support are adequately met for deployment, transportation and basic needs (security, food, water,shelter and toilet facilities)
- Provide relevant personal protective equipment (PPE)
- Available and accessible clinical supervisor
- Disaster orientation provided for all workers
- Shifts no longer than 12 hours with 12 hours off
- Briefings provided at beginning of shifts as workers exit/enter
- Necessary supplies available (paper, pens, PCs…)
- Communication tools available (phones, …)
- Clear Purpose and Goals (clearly defined intervention goals/strategies)
- Functionally Defined Roles
- Staff oriented and trained with written role descriptions
- When setting is under other agency's jurisdiction, roles clear
- Team Support
- Buddy system for support and monitoring stress reactions
- Positive atmosphere of support and tolerance.

Plan for Stress Management:

- Workers' functioning should be assessed regularly
- Rotate Workers between duties of different stress levels
- Breaks and time away from assignment
- Education about signs/symptoms of Individual and group
- Exit plan for workers leaving operation (reentry, efforts Number of tours of duty clarified)

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