National
Voluntary Organizations
Active in Disaster

COOPERATION | COMMUNICATION | COORDINATION | COLLABORATION

DISASTER EMOTIONAL CARE GUIDELINES

National VOAD Emotional and Spiritual Care Committee

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National VOAD Emotional and Spiritual Care Committee
Disaster Emotional Care Guidelines

Table of Contents

SECTION ONE:
Background, Purpose and Scope

Background and Purpose

Founded in 1970, National Voluntary Organizations Active in Disaster (VOAD) provides forums for faith-based and non-profit organizations engaged in disaster preparedness, response, recovery and mitigation to come together and share knowledge and resources in service to survivors, first responders, and others in communities impacted by disaster.

Guided by four core principles – cooperation, communication, coordination and collaboration ("The 4 Cs") – National VOAD member organizations provide the leadership that builds strong, resilient communities and delivers hope in times of need, including in the essential area of emotional care.

National VOAD member organizations are committed to strive toward excellence throughout the disaster cycle in all areas of care, including emotional care. Members of National VOAD recognize that respectful conversation and patient building of relationships uplift the commitment to quality care – a commitment that gathers, unites, and serves as a beacon to others choosing to collaborate in helping communities recover through common and shared values.

For this reason, National VOAD is especially suited to proposing and promoting guidelines that shape practices in multiple areas of disaster care. Guidelines begin with *Points of Consensus* documents developed and approved by National VOAD member organizations, which outline essential standards, ethical principles, and operational principles related to various functions of VOADs. Based upon the *Disaster Emotional Care Points of Consensus* (*see Appendix C*), the following *Disaster Emotional Care Guidelines* are provided to assist organizations in implementing high quality disaster emotional care services to meet the needs of individuals, families, and communities across the disaster cycle. The National VOAD Emotional and Spiritual Care Committee has previously released the *Disaster Spiritual Care Guidelines* (*see Appendix D*)*,* which serves as a companion document and model for implementing high quality disaster spiritual care services.

Scope of DEC Guidelines

These National VOAD *Disaster Emotional Care (DEC) Guidelines* are intended to serve as a set of common core guidelines for National VOAD member organizations that currently have or that are interested in developing a disaster emotional care component to their overall service delivery. These disaster emotional care guidelines are based on the *Disaster Emotional Care Points of Consensus* (2015). The guidelines are also provided for reference and as a resource for all National VOAD member organizations (i.e. those who do not have DEC as a part of their service delivery), state and territorial VOADs, Community Organizations Active in Disaster

(COADs), and other partners engaged in disaster preparedness, response, and recovery, and for the general public.

The guidelines can be utilized for the following purposes:
- To provide orientation and guidance for organizations on the development, implementation, and maintenance of disaster emotional care services
- To enhance quality by providing benchmarks for the provision of disaster emotional care services based on research and best practices
- To develop basic guidelines for the training of disaster emotional care providers
- To share information and resources pertaining to disaster emotional care from experienced providers working within diverse communities and organizations
- To foster mutual accountability through collaboration among providers in developing, maintaining, and periodically updating emotional care guidelines
- To assure the public that those providing emotional care are using best practices
- To promote disaster emotional care among emergency managers and other partners in disaster preparedness, response and recovery, as well as to general (non-disaster specific) emotional care and behavioral health providers[1]
- To facilitate the planning and programming of disaster emotional care across the disaster cycle (preparedness, response, and recovery)
- To guide inter-agency and inter-disciplinary disaster emotional care efforts in the spirit of National VOAD's "4 Cs" of cooperation, communication, coordination, and collaboration.

National VOAD member organizations and other adjudicating bodies rightly exercise their own internal, self-defined standards of accreditation, licensure and/or certification in emotional care, including adhering to those standards that are regulated by state boards. These guidelines are intended to complement such standards by providing assistance in defining and reflecting quality disaster emotional care. The guidelines also provide a platform for members to learn helpful practices in disaster emotional care training, resources, etc., from one another.

Defining Disaster Emotional Care

Disaster emotional care and related terms used in this document are defined below. Sources of definitions are cited in footnotes. (*See Appendix E for a more comprehensive glossary of related terms.*)

Disaster

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[1] See Appendix B: Fact Sheet for Emergency Management on Disaster Emotional Care for more information on how DEC is an essential component of FEMA's Emergency Support Function (ESF) 6 – *Mass Care, Emergency Assistance, Temporary Housing, and Human Services* and ESF 8 – *Public Health and Medical Services*; and Recovery Support Function *Health and Social Services.*

A disaster is a sudden, calamitous event that seriously disrupts the functioning of a community or society and causes human, material, and economic or environmental losses that exceed the community's or society's ability to cope using its own resources.[2]

Disaster Emotional Care

Disaster emotional care (DEC) is an umbrella term that includes a wide range of services. Disaster emotional care providers offer comfort, support, and resources to individuals, families and communities throughout all phases of the disaster cycle. Grounded in concepts of resilience and behavioral health, and informed by research and best practices, disaster emotional care is intended to mitigate and prevent serious psychological consequences of disaster, to offer appropriate referral for those needing higher levels of care, and to facilitate psychological recovery and a return to adaptive functioning. Disaster emotional care providers are aware of and responsive to the social and cultural context in which disaster reactions and recovery occur.[3] Disaster emotional care may be delivered by licensed mental health professionals, licensed behavioral health professionals, or paraprofessionals who may include peer support teams, crisis intervention providers, and others with appropriate credentials and specialized training (*see Appendix E, Glossary*).

Emotional Support

Emotional support refers to reassurance, acceptance, and encouragement given by one person to another. Emotional support is one of the main components of psychological first aid. Every disaster responder or disaster recovery worker has the potential to contribute to the emotional wellbeing of disaster survivors and responders by offering emotional support. Specially trained animals also may be utilized by trained and credentialed handlers to provide comfort and support to both survivors and disaster workers.

Disaster Mental Health

Disaster mental health services include identifying the psychosocial needs of survivors and responders, promoting the coping and resilience of individuals and families, and connecting specific individuals and families with community mental health resources when needed. Disaster mental health workers also help communities mitigate the effects of disasters by providing family, neighborhood and community preparedness and resilience training. Disaster mental health services are offered during all phases of disaster, including preparedness, response and recovery. Disaster mental health responders are licensed professionals from the fields of counseling, marriage and family therapy, psychiatry, psychiatric nursing, psychology, school counseling, school psychology, or social work.[4]

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[2] International Federation of Red Cross and Red Crescent Societies
[3] National VOAD, ESCC, Disaster Emotional Care Points of Consensus #1
[4] American Red Cross, Disaster Mental Health Standards and Procedures

Disaster Behavioral Health

Disaster behavioral health is the provision of evidence-based mental health, substance abuse, and stress management services to disaster survivors and responders. Disaster behavioral health providers are licensed professionals and their services fall under the scope of both disaster emotional care and disaster health.[5] Disaster mental health and disaster behavioral health are overlapping terms and may be used interchangeably. The terminology used is often dependent on the setting in which services are provided.

Disaster Spiritual Care

Disaster spiritual care is a sustaining care that assists persons to draw upon their own inner and external religious or spiritual resources. In the context of a disaster, spiritual care providers respond to the poignant need for spiritual meaning and comfort by providing accompaniment, compassionate care, individual and communal prayer and appropriate ritual. Disaster spiritual care providers are sensitive to and aware of the varied expressions of faith and belief systems and traditions.[6] Some disaster spiritual care providers are also trained to provide disaster emotional care. Disaster emotional care and disaster spiritual care providers work closely together (*see Section 4, Relationships with Disaster Spiritual Care*).

Emergency Mental Health and Psychosocial Support

While the psychological and social impacts of armed conflict and natural disasters may be acute in the short term, they can also undermine the long-term mental health and psychosocial well-being of the affected population. These impacts may threaten peace, human rights and development within communities or entire countries. The "Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings"[7] (2007) emphasize advocacy, identifying gaps, protecting and supporting mental health and psychosocial well-being, and specifying psychological and psychiatric interventions. The key activities and messages for implementation focus on communities, governments, United Nations organizations, and nongovernment organizations. Psychosocial support often emphasizes the health of the community; disaster emotional care, as described in this document, is more frequently focused on the individual or the family that needs support.

The Need for Disaster Emotional Care

All natural and human-caused disasters have the potential to create significant distress within impacted areas, including overwhelming coping abilities and disrupting support systems. Many

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[5] U.S. Dept. of Health & Human Services, Office of the Assistant Secretary for Preparedness & Response
[6] National VOAD, Emotional and Spiritual Care Committee, *Disaster Spiritual Care Guidelines*
[7] United Nations, Inter-Agency Standing Committee, *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, 2007.

survivors, responders, and others affected by disasters will experience temporary distress reactions, while others are at risk of developing long-term behavioral health concerns such as depression, anxiety, substance abuse, and more. Pre-disaster level of functioning, degree of exposure during the event (threat of or actual loss of life; serious injury; property damage; etc.) and post-disaster access to care and support influence the psychological effects on disaster-impacted individuals, families, and communities.

The negative consequences of disaster exposure on emotional health and wellbeing are well-documented. In summarizing 160 separate surveys conducted across the world and following a wide range of natural and human-caused disasters, Norris, Friedman, and Watson (2002)[8], found that 9% of all studies identified minimal psychological impairment among disaster survivors, 51% of studies revealed moderate impairment, 23% of studies found severe impairment, and 17% of studies revealed very severe impairment.

Focusing specifically on the prevalence of developing post-traumatic stress disorder in the aftermath of natural or human-caused disasters, Neria, Nandi, and Galea (2007)[9] compiled results from post-disaster research that showed prevalence rates of PTSD in survivors of disasters ranging from 30-40%, and rescue workers from 10-20%, as compared to PTSD rates in the general population from 5-10%.

In the long term, most people who experience a disaster are able to bounce back to their same or similar level of functioning before the event, with many even experiencing post-traumatic growth, developing enhanced resilience through the struggle to cope with disaster-related problems. Elaborating on this further, Bonanno (2004)[10] writes that "many people are exposed to loss or potentially traumatic events at some point in their lives, and yet they continue to have positive emotional experiences and show only minor and transient disruptions in their ability to function". Thus, resilience is the norm.

Disaster mental health providers (licensed mental health professionals and paraprofessionals who are affiliated with VOAD member organizations and other trusted, established disaster and emergency response entities) are able to recognize the differences among common, 'expected' stress reactions, unexpected reactions, and diagnosable disorders. They are trained in evidence-informed or evidence-based models of disaster emotional care and thus are uniquely qualified to provide effective and appropriate services throughout all phases of the disaster cycle. National VOAD member organizations with disaster emotional care (DEC) programs need to provide or support access to formal training and continuing education for DEC providers in order to assure the general public that services are being offered by qualified persons.

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[8] Norris, F. H., Friedman, M. J., & Watson, P.J. (2002b). 60,000 disaster victims speak: Part II. Summary and implications of the disaster mental health research. *Psychiatry, 63*, 240-260.
[9] Neria Y; Nandi A; Galea S. (2008). Post-Traumatic Stress Disorder following disasters: A systematic review. Psychological Medicine 38:467-480.
[10] Bonanno, G. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist, 59,* 20-28.

These disaster emotional care guidelines are not meant to substitute for training and credentialing by established and respected organizations that provide disaster emotional care services. Neither are these guidelines intended to supersede or eliminate the policies of National VOAD member organizations that require DEC providers to meet state mental health licensure or certification guidelines and to follow legal requirements of their particular forms of licensure or certification.

Scope of National VOAD Member Services

Communities impacted by disaster draw upon their resilience and strength to withstand the immediate effects of disaster and to recover over the course of months and years. National VOAD member organizations bring their presence, resources, and expertise to help communities through this process. (*See Section 4 for a discussion of how disaster emotional care providers partner with state/territorial VOADs and with local communities.*)

Many National VOAD member organizations provide disaster emotional care services, which may include:
- Training for local, state, regional and national providers that equips them to provide sustainable services that address social, emotional and psychological resilience as an asset towards recovery
- Assessment of community disaster emotional care needs
- Deployment of trained providers to assist in coordinating appropriate disaster emotional care, as requested
- Programs, curricula and other disaster emotional care resources designed to serve the needs of diverse populations (e.g. children, older adults, etc.)
- Guidance and assistance in planning for and providing disaster emotional care services during anniversary events, community gatherings, and other commemorative observances
- Resources to assist local, state, regional, and national disaster officials to include direct disaster emotional care services as part of preparedness, response, and recovery activities.

As per the National VOAD *Disaster Emotional Care Points of Consensus* (*see Appendix C*), emotional care is provided across the disaster continuum, from preparedness to response and recovery. Accepted types of disaster emotional care include, but are not limited to:
- Preparedness activities
- Assessment activities
- Psychosocial support activities
- Early psychological intervention activities
- Recovery activities.

Among National VOAD member organizations, excellence in providing disaster emotional care services includes:

- Recognition of autonomy, which includes the right to refuse services
- Respect for and awareness of the psychological needs of individuals with disabilities, access and functional needs
- Respect for each person's rich diversity of heritage, language, and culture
- Commitment to ethical practices intended to protect vulnerable persons, including children, dependent adults, and others
- Commitment to collaboration with all disaster emotional care providers, local and deployed
- Commitment to confidentiality, except when required to break confidentiality to protect individuals from harm or when required by law
- Utilization of evidence-informed and evidence-based clinical tools (including assessment, triage, intervention, etc.) to determine perceived and real needs and assets
- Referral to resources within the community that can provide continued, additional or higher levels of care
- Knowledge of disaster-related and psychopathology responses.

Covenant for National VOAD Partners

The heart of National VOAD is embodied in the "4 Cs" of VOAD - cooperation, communication, coordination, and collaboration - in order to better serve people impacted by disasters. These four "Cs" describe a progression of efforts. Cooperating and communicating are the beginning of relationship - the first steps in helping work become more efficient and effective. Coordinating and collaborating are examples of maturing relationship, in which partners become inter-dependent, relying on each other to accomplish ever greater tasks together.

Staff and volunteers of member organizations of National VOAD aspire to these deeper relationships and work to uplift and support each other and each other's work. National VOAD member organizations' staff and volunteers share in all services, including disaster emotional care, seeking to include all partners in bringing valued contributions to serve the needs of affected communities.

National VOAD member organizations are concerned when National VOAD member organizations fail to meet the standards found in the *Points of Consensus*, because National VOAD *Points of Consensus* documents promote quality care for communities impacted by disasters. National VOAD member organizations address these concerns by seeking to share the rationale of the *Points of Consensus* with such groups and by seeking to promote the high standards these guidelines detail for the sake of those whom we serve.

SECTION TWO:
Essential Components of Disaster Emotional Care Programs

> *In order to deliver effective disaster emotional care, it is essential that providers engage in training and exercises and become affiliated with a disaster relief organization. Disaster emotional care providers have an important role in planning and mitigation efforts and contribute toward building resilient communities.*
> (*Disaster Emotional Care Points of Consensus* #3)

This section provides suggested guidelines to assist organizations in identifying, recruiting, and training disaster emotional care providers. It includes specific discussion of qualifications, experience, competencies, and accountability structures for the delivery of appropriate and effective disaster emotional care. Guidance is provided for organizations to fulfill their obligation to help emotional care providers maintain their own health and wellbeing before, during and after deployment as well as during steady-state times. The section includes a quick reference checklist to help disaster emotional care leaders provide the essential components for building and sustaining their teams.

Introduction

Disaster emotional care is provided across the disaster continuum from preparedness to response and recovery. Emotional care takes many forms, and emotional care providers are from diverse professional backgrounds (*Disaster Emotional Care Points of Consensus* #2). Disaster emotional care workers respond to the psychosocial and emotional needs of people affected by disaster. This includes members of the affected community as well as other disaster responders experiencing the stress of disaster response. Besides providing disaster emotional care during responses, disaster emotional care providers have an important role in planning and mitigation efforts and contribute toward building resilient communities (*Disaster Emotional Care Points of Consensus* #3).

Disaster emotional care services supplement, but do not supplant existing community mental health services. These services are provided without discrimination to race, color, ethnicity, national origin, immigration or citizenship status, socioeconomic status, veteran status, religious and spiritual beliefs, sex, gender identity, sexual orientation, age, or different physical and sensory abilities.

Disaster emotional care is not psychotherapy, nor a substitute for psychotherapy. (*Disaster Emotional Care Points of Consensus* #1e.) Long-term therapeutic interventions should not be conducted during the acute phase of a disaster response. Disaster emotional care providers need to be aware of and compliant with all regulations related to provision of services in the jurisdiction in which they are working. They also need to provide services only within the limits of their expertise.

Developing a Disaster Emotional Care Program

Staffing Strategy

Different organizations rely on different staffing strategies during the disaster response, based on their size, structure and service delivery model. Some rely primarily on paid employees while others depend heavily on volunteers. One strategy for utilizing paid employees is to offer the opportunity for select staff to transition to a disaster emotional care provider role during times of disaster.

Table 1: Strengths and Weaknesses of Paid and Volunteer Workforces

Model	Strengths	Weaknesses
All Paid Employees	- More consistent capacity and availability. - More awareness and control over who is part of workforce. - Employees are more likely to have relationships with each other before disasters. - Supervisory structures are likely already in place. - Survivor needs may be met more efficiently when employees provide services post-disaster to those with whom they have a pre-disaster relationship.	- Organizations' resources can fluctuate from year to year (people, material resources, money) making it difficult to ensure a sufficient workforce to meet the needs of large disasters. - Difficult to scale up services (finite number of employees, difficult to add employees quickly) - Daily work of employees is impacted when they are assigned to support disasters. - Boundaries may be tested when employees providing services post-disaster have pre-disaster relationships with care receivers. - Employees accustomed to working 40 hours/week may not be willing to work evenings and weekends or may expect overtime pay.
All Volunteer	- Volunteers are typically highly committed and passionate about the work they do. - Large pool of potential volunteers allows for flexibility in scaling to meet the needs of large disasters. - Allows for the option to include new (event-based) volunteers when necessary.	- Requires support by employees committed to volunteer management. - Volunteer schedules may be less predictable (e.g., cannot commit to 40 hours/week) requiring more people to provide necessary coverage. - Volunteer workforce may be constantly changing, making it difficult for volunteers to all have relationships with each other before disasters.

Model	Strengths	Weaknesses
	• Volunteers are more likely to be available during evenings, overnight and weekends, when employees are not used to working. • Provides supervisory and management opportunities for volunteers.	• Volunteers can come and go more easily than employees, making it difficult to know the size of the workforce at any specific time. • Quality assurance challenges – difficult to ensure that the program is being appropriately carried out according to program standards.
Blend of Paid Employees and Volunteers	• Combination of the strengths from both sections above.	• Combination of the weaknesses from both sections above. • Challenging to have volunteers and employees working side by side due to perceived inequities between the two groups and possible role confusion.

Eligibility Requirements for Disaster Emotional Care Providers

Eligibility criteria for disaster emotional care providers is another factor that organizations must consider. These criteria can cover a vast range of educational and professional requirements, from requiring workers to have independent mental health licensure to anyone who completes agency-specific training in a specific subset of disaster emotional care activities.

Table 2. Examples of Eligibility Criteria[11]

Model	Strengths	Weaknesses
Open Eligibility to Whoever is Interested	• Largest pool of eligible workers. • Recruitment is likely easier than other models.	• Quality assurance challenges. • Requires a potentially labor-intensive screening process. • Requires workers to take a significant amount of training. • Potential risk to survivors, other workers and the responder due to lack of knowledge and experience.
Eligibility Based on Work Experience (e.g. experience in a trauma center)	• Workers will have a consistent language to use • Required trainings do not need to cover topics that workers should already know.	• Adds employment verification step. • No guarantee that workers will have the same education or abilities because they have had similar work experience.

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[11] This chart was adapted from documents created during the *Disaster Mental Health Stakeholders Meeting* held February 24-26, 2016 in Washington, DC, and hosted by the American Red Cross.l./;

		• Recruitment pool is limited.
Eligibility Based on Licensure (e.g. independent licensure)	• Provides additional level of quality assurance since licensing boards require minimum educational and experience standards, monitor ethical violations and perform background checks more frequently than many organizations. • Required trainings do not need to cover topics that workers should already know. • Workforce would have a common language.	• Requires determination of which professions and licenses will be included – which means some licenses could be excluded. • Can create a culture of being "in" or "out" • Recruitment pool is limited.
Eligibility Based on Education Level	• Required trainings do not need to cover topics that workers should already know. • Workforce would have a common language.	• No guarantee that workers will have the same experiences or abilities because they have the same level of education. • Recruitment pool is limited.

Roles and Competencies for Disaster Emotional Care Providers

In addition to determining the appropriate workforce, organizations should also develop a leadership structure within their disaster emotional care workforce to ensure quality survivor services and appropriate supervision for workers. Below are examples of competencies to look for in disaster emotional care providers from entry-level positions to leaders.

Table 3. Competency Categories

Competency Factor	Key Issue	Definition	Primary Method of Development	Documentation
Personal attributes	Who I am	Inherent characteristics and qualities	Life experience, self-reflection, supervision, and mentoring.	Personal interview and recommendations
Knowledge	What I know	Theoretical and practical understanding of a subject area.	Structured learning (courses, workshops, personal study, etc.)	Documentation of successful completion of training program(s)
Skills	What I do	The ability and knowledge that enables one to do something well.	Structured learning and practice (courses, workshops, practical experience)	Documentation of successful completion of training program(s) and experience

Table 4. DEC Provider Level and Knowledge, Skills, and Attributes

Disaster Emotional Care Provider Level	Knowledge, Skills Attributes Category	Knowledge, Skills, Attributes
Entry Level	Communication, Relationship, & Problem Solving Skills	• Communicates effectively orally and in writing. • Listens actively and empathetically and takes appropriate action on behalf of survivors. • Accurately documents conversations and actions as detailed in program guidance. • Identifies survivor needs and refers to appropriate and available resources. • Connects effectively with survivors who are culturally diverse. • Guards survivor privacy and confidentiality. • Is open to taking direction from supervisor. • Able to work well in a collaborative setting. • Good interpersonal skills with survivors, colleagues, supervisors, external partners and the public. • Problem-solves with and for a survivor to support recovery. • Assesses situational challenges in the field and suggests workarounds. • Asks supervisor for help when appropriate.

	Knowledge of Emotional Care Techniques & Systems	• Basic knowledge of principles, procedures, techniques, trends, and resources for providing emotional care. • Basic knowledge of recognized crisis intervention support activities.
		• Basic knowledge of program guidance regarding documentation of survivor information and case details. • Basic knowledge of computer usage.
	Personal Attributes	• Empathic understanding, tact, emotional stability, patience, good observation skills, cultural awareness, resilience, flexibility, adaptability and an ability to work with others with an open, non-judgmental attitude
	Special Physical Characteristics	• Sufficient strength, agility, and endurance to perform during stressful (physical, mental and emotional) situations encountered on the job without compromising their health and well-being or that of others.
Supervisor Level	Communication, Relationship, & Problem Solving Skills	• Communicates effectively orally and in writing. • Provides appropriate input into ongoing work flow and reports. • Accurately documents conversations and actions with supervisees. • Conducts effective work unit meetings. • Identifies supervisee needs and makes appropriate material/equipment requests.
		• Connects effectively with workers who are culturally diverse. • Works efficiently with supervisees to maximize their potential. • Is open to taking direction from a manager. • Provides effective feedback to supervisees. • Able to work well in a collaborative setting. • Works well with survivors, colleagues, managers, external partners and the public.
		• Coaches others in problem-solving with and for survivors to support recovery. • Coaches others to document survivor information and case details as required. • Effectively reviews cases and provides feedback. • Assesses situational challenges in the field and suggests workarounds. • Recognizes work unit problems early and takes actions to correct. Asks manager for help when appropriate.

	Knowledge of Emotional Care Techniques & Systems	• Intermediate knowledge of principles, procedures, techniques, trends, and resources for providing emotional care. • Intermediate knowledge of recognized crisis intervention support activities.
		• Intermediate knowledge of program guidance regarding documentation of survivor information and case details. • Intermediate knowledge of computer usage. • Knowledge of coaching skills.
		• Experience providing disaster emotional care during at least one previous disaster.
	Personal Attributes	• Compassion, confidence, humility, ability to delegate, a positive attitude, passion for the mission, approachable, considerate, disciplined as well as having empathic understanding, tact, emotional stability, patience, good observation skills, cultural awareness, resilience, flexibility, adaptability and an ability to work with an open, non-judgmental attitude.
Manager Level	Leadership/ Team Building, Relationship, & Problem Solving Skills	• Envisions, designs and leads a diverse team of supervisors. • Provides appropriate support, feedback and recognition. • Motivates team building and provides cohesive team environment. • Understands the metrics needed to evaluate services and supervisees. • Plans strategically and provides appropriate input.
		• Builds effective relationships with individuals, groups and departments. • Effectively explains purpose, content and capability of systems to supervisees. • Works efficiently with supervisees to maximize their potential. • Openly takes direction from supervisor. • Represents organization with partners. • Able to work well in a collaborative setting.
		• Retrieves and sorts information and reports effectively. • Monitors and corrects performance. • Spots problems early and is pro-active in taking needed action. • Recognizes the need for additional resources to manage problems and conflict. • Asks for help when appropriate.

	Knowledge of Emotional Care Techniques & Systems	• Advanced knowledge of principles, procedures, techniques, trends, and resources for providing emotional care. • Advanced knowledge of recognized crisis intervention support activities.
		• Advanced knowledge of internal and external reports and sources of needed information. • Advanced knowledge of the purpose, content and capability of the agency systems. • Knowledge of team-building, supervision, conflict-resolution techniques.
		• Experience providing disaster emotional care on more than one disaster. • Experience supervising disaster emotional care providers on more than one disaster.
	Personal Attributes	• Cultural affinity, positive attitude, prioritization, warmth and empathy, competence, accountability, honesty, patience, integrity, flexibility, versatility, creativity, and ability to see the big picture
Instructor/ Trainer	Teaching Skills	• Effectively designs and prepares for training presentation. • Effectively presents information and adjusts teaching situation to meet the needs of the group. • Effectively listens to participant input and answers questions. • Effectively manages class time allowing participation without losing teaching time. • Provides appropriate feedback to participants and reports progress to sponsoring agency.
	Knowledge of Emotional Care Techniques & Systems	• Advanced knowledge of subject matter being taught. • Advanced knowledge of agency standards. • Advanced knowledge of technology used in class presentation or ability to arrange for technological backup when needed. • Knowledge of adult learning strategies. • Experience providing disaster emotional care during at least one previous disaster.
	Personal Attributes	• Warm, accessible, enthusiastic, caring, congenial, sense of humor, kind, flexible, patient.

Training Disaster Emotional Care Providers

> *Disaster emotional care providers help communities by offering preparedness and resilience training and help by responding to the psychosocial and emotional needs of individuals, families and fellow workers affected by disaster and/or experiencing the stress of the disaster. Therefore, their training should cover the basic tenets of disaster emotional care (ethics, self-care, informed consent, confidentiality, protecting personal privacy, and cultural competence) as well as the following accepted types of disaster emotional care: preparedness activities; assessment activities; psychosocial support activities; early psychological intervention activities; and recovery activities.* (*Disaster Emotional Care Points of Consensus* #2)

The content of training for disaster emotional care providers should cover the ethical standards and interventions employed in disaster emotional care across the disaster continuum. Refer to the sub-sections entitled *Ethical Foundations of DEC* and *DEC Interventions* for a more complete description of these concepts.

Disaster emotional care trainings can be offered in a variety of formats including instructor-led training (virtual and in-person), web-based training and self-directed learning. Whenever possible, role-play-based scenarios should be incorporated in training curricula.

Capacity Building

> *Capacity building involves identifying and recruiting appropriate disaster emotional care providers. In order to deliver effective disaster emotional care, it is essential that providers engage in training and exercises and become affiliated with a disaster relief organization.* (*Disaster Emotional Care Points of Consensus* #3)

Depending on the staffing strategy and structure, recruitment for disaster emotional care providers can vary widely. Not surprisingly, recruiting for volunteer providers can be more challenging than recruiting for a paid position.

Strategies for Recruiting Volunteer Providers

Targeted volunteer recruitment is a strategy to reach out to groups of potential volunteers that meet the specified eligibility requirements for an agency's disaster emotional care workforce. It focuses recruitment time and resources on groups with common backgrounds and interests thereby increasing the pool of individuals interested in becoming volunteers. To help build a diverse workforce, agencies should include in their targeted recruitment efforts organizations that have members with various cultural backgrounds, language competencies and geographic reach.

Organizations to consider for targeted volunteer recruitment include:
- National and local professional associations
- Colleges and universities
- Mental health agencies
- Community volunteer organizations

It is always best to recruit volunteers before disasters happen to ensure an adequate number of fully-trained disaster emotional care providers. However, some disaster responses may require additional providers who have not yet been identified and trained. Agencies should decide if they have the capacity to recruit and train new providers during an active disaster response. If an agency decides to incorporate new volunteers during a disaster response, the agency should already have policies and procedures in place to rapidly identify and train these volunteers.

Helpful tips for recruiting volunteers:
- Enlist the support of your current employees and volunteers in becoming volunteer recruiters.
- Display recruitment brochures at places of work and distribute at events.
- Promote speaking engagements at appropriate events.
- Ask for a few minutes at your departmental meetings to talk about the need for volunteers.
- When possible, provide continuing education credits for required training as an additional appeal to prospective volunteers.
- Utilize social media to publicize volunteer opportunities.

Utilizing Agency Employees as Disaster Emotional Care Providers

Agencies who rely on paid staff can provide opportunities for current employees to assume the role of a disaster emotional care provider temporarily during disaster responses. Agencies that utilize this structure should determine policies and procedures for recruiting, training and activating employees who are interested in this opportunity. Once these employees are activated during a response, they would not be expected to meet their standard job requirements until they are released from the response.

Deploying the Disaster Emotional Care Workforce

Staffing Considerations

Agencies should consider their capacity to utilize their disaster emotional care workforce on disaster responses. Many agencies only have the capacity to support local or regional response and recovery efforts while others may be able to deploy their providers outside of their region to support a national disaster. Agencies will not "self-deploy" to a disaster scene but will only provide care when authorized through a coordinated organizational response that works within the incident management system of the sponsoring organization.

Another way for an agency to utilize disaster emotional care providers is in a virtual capacity, supporting either a local, regional or national disaster operation. Virtual support could include remote support via a web-based portal, telephone, or telehealth. The following chart includes factors for agencies to consider.

Table 5. Deployment Options and Considerations

Deployment Options	Considerations
Local/Regional Support	- Providers need to balance their day-to-day responsibilities (family, childcare, etc.) with the increased demands of their disaster work. - Providers may be impacted by the disaster themselves or have family/friends who are impacted. - When supporting a large disaster locally, providers cannot easily remove themselves from the disaster for a significant amount of time, increasing their cumulative stress and potential for burnout. - Providers may be so focused on supporting others that they do not take the time to focus on their own losses and impacts from the disaster.
National Deployment	- Providers face stressors as a result of being deployed away from home and family/friends. - Providers may experience challenging living and working conditions with few options for respite. - Providers are likely to be working for and with new people every day. - Providers are able to leave the disaster location after a period of time and return to a non-disaster impacted area. - Providers may not have a local support system to help the provider handle post-disaster negative reactions.
Virtual Support	- Providers have the flexibility to work from home or their preferred location. - Providers can maintain a normal work schedule and volunteer virtually for shifts during off hours including evenings and weekends. - Providers are working independently which can feel isolating. - Friends and family may not understand the stress the provider is experiencing while virtually supporting a disaster response. - Providers who cannot deploy in person can still support disaster operations in a virtual capacity. - Providers can be frustrated by the inability to have face-to-face contact with survivors they are supporting.

Promoting the Wellbeing of Emotional Care Providers

Providing emotional care in disaster can be an overwhelming experience. The burdens of caring for others in this context can lead to compassion fatigue. Understanding important strategies for self-care is essential for emotional care providers. Disaster response agencies have a responsibility to care for their own staff during all phases of disaster deployment and to model healthy work and life habits. Post-deployment support processes for emotional care providers are also essential.
(*Disaster Emotional Care Points of Consensus #7*)

Organizations' leaders should furnish appropriate support during deployment. Support of disaster emotional care providers includes the following:
- Ensuring the safety of each disaster emotional care provider when responding to disasters;
- Mitigating worker risks of compassion fatigue or secondary trauma;
- Providing useful support, feedback and direction to disaster emotional care providers;
- Explaining clearly the expectations for job performance;
- Answering questions about disaster emotional care policies and procedures;
- Ensuring that each worker receives time off according to agency policies.

Agencies should employ a combination of strategies to promote the wellbeing of their disaster emotional care providers across the disaster cycle. These strategies can include:
- Implementing strategies to mitigate worker stress such as providing additional time off, shortening daily working hours, helping people prioritize work demands, or otherwise improving working conditions;
- Training supervisors in how to support their workforce and when to intervene when the impacts of stress are adversely affecting the workforce;
- Providing handouts and information sessions, before and after a deployment/response, focused on the potential emotional impacts of disaster response for both the individual provider and their family;
- Establishing policies and procedures for workers to report grievances/concerns;
- Facilitating the availability of confidential emotional support services for the workforce such as through an Employee Assistance Program;
- Offering trainings to the workforce focused on self-care and stress-reduction techniques.

Ethical Foundations of Disaster Emotional Care

All disaster emotional care providers are expected to maintain personal and professional integrity and act in an ethical manner at all times. Specific ethical standards include:
- *Practicing in a manner that is in the best interest of the public;*
- *Providing only those services deemed necessary;*
- *Promoting safety and protection of people affected by disaster;*

- *Practicing only within the competency areas of the provider's education and/or experience, and maintaining the limitations established by licensure or certification and the sponsoring agency's policy and procedures;*
- *Respecting people's rights and dignity, including privacy and self-determination;*
- *Maintaining a confidential survivor-provider relationship;*
- *Disclosing survivor information to others on a strict business-need-to-know basis;*
- *Avoiding dual relationships with survivors, whenever possible;*
- *Refraining from personal gain, including refraining from referring disaster survivors to his/her private practice/agency of employment.*

(Disaster Emotional Care Point of Consensus #10)

Accountability and Responsibility

All disaster emotional care providers are responsible for providing quality care, following designated protocols, taking care of themselves, and supporting their colleagues, within the limits of their professional expertise and skills. Supervision should be provided to ensure that all disaster emotional care providers are practicing within the disaster emotional care intervention standards to ensure ethical, quality survivor care.

Informed Consent

Informed consent requirements in the disaster setting are different from requirements in traditional mental health settings. In non-disaster settings, mental health professionals are required to obtain written informed consent before working with survivors. However, in a disaster setting, disaster emotional care providers are not expected to present a formal written informed consent policy before providing short-term support unless their organization requires a written consent prior to providing services. Additionally, where an informed consent policy might convey the beginning of a traditional therapist/client relationship, disaster emotional care support is brief and does not allow for formal mental health assessment or treatment.

Confidentiality and Protecting Individual Privacy

Safeguarding the trust of both disaster-affected survivors and disaster staff is an important part of the disaster emotional care provider's obligation to the people and communities they serve. Disaster emotional care providers are required to maintain the individual's privacy, treat all information as confidential, and comply with their agency's policies and other governing statutes on protecting privacy and personal information.

Cultural Awareness

Disaster emotional care providers respect diversity among colleagues in emotional and spiritual care, and within communities served, including but not limited to race, color, ethnicity, national origin, immigration or citizenship status, veteran status, religious and spiritual beliefs, sex, gender identity, sexual orientation, age, vocation, socioeconomic status, language, or different

physical and sensory abilities. Disaster emotional care providers strive for cultural awareness and sensitivity and adapt care strategies to address cultural differences in the individuals and communities they serve (*Disaster Emotional Care Points of Consensus* #9). Culture, race, and ethnicity can have a profound effect on a community's or individual's response to a disaster. Disaster emotional care services are most effective when survivors receive care that is in accord with their cultural beliefs and their access and functional needs, including disabilities. (*See Section 3 for guidance.*)

Disaster Emotional Care Interventions

Disaster Emotional Care interventions form a continuum of services from preparedness through disaster recovery.

Preparedness Activities

Preparedness activities focus on educating communities, families and individuals on the need to be prepared for disasters and on building resilience. Increasing an individual or family's level of preparedness for disaster can help them return more quickly to a pre-disaster level of functioning. Preparedness activities can include:
- School-based activities focused on disaster preparedness programming
- Community events focused on disaster preparedness, such as smoke alarm installations and resilience training
- Public messaging campaigns focused on specific preparedness steps, such as checklists to be prepared for hurricanes or wildfires

Community Resilience Building

Resilience is defined as the strengths of an individual or community to respond well to adversity. (*Disaster Emotional Care Points of Consensus* #5). An important aspect of preparedness is building the emotional resilience of communities, families and individuals to be better prepared to handle future disasters. Community-based trainings are one tool for building this kind of resilience.

Assessment Activities

Identifying emotional needs during a disaster response can be difficult due to the scope and intensity of the setting. People's emotional responses to disaster are influenced by a variety of factors, including degree of exposure, individual resilience and recovery environment (*Disaster Emotional Care Points of Consensus* #1h).

Environmental Assessment

Providers should be trained to continuously assess the environment where they are providing services. This assessment should focus primarily on the personal safety of the disaster emotional care providers and the safety of others.

Individual Assessment

Specialized training is necessary for effective disaster emotional care (*Disaster Emotional Care Points of Consensus* #1i). Training should include instruction on assessing the following three factors, which will guide the disaster emotional care provider's approach to providing support:

- Emotional responses and reactions;
- Risk factors of the individual including degree of exposure to the disaster;
- Individual resilience.

It is important to take each category of factors into consideration when identifying the emotional care needs of disaster-affected individuals. The combination of the three factors gives the provider a more comprehensive picture of the individual's need for mental health support.

Psychosocial Support Activities

All survivors and providers can benefit from support that focuses on increasing resilience and coping skills. Psychosocial support activities include assisting survivors and other disaster workers to cope effectively with the stress related to the disaster.

Psychological First Aid

All training should include information on psychological first aid. Psychological first aid provides immediate support to individuals experiencing stress experienced by the survivor after the disaster and fosters use of the individual's adaptive coping skills and resilience. In 2006, the National Child Traumatic Stress Network and the National Center for Post-Traumatic Stress Disorder developed a psychological first aid training that includes eight core actions. Since 2006, a number of national organizations[12], as well as many state and local emergency management and mental health agencies, have developed variations of psychological first aid training.

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[12] These organizations include the International Critical Incident Stress Foundation (ICISF), National Organization for Victims Assistance (NOVA), the American Red Cross, the World Health Organization (WHO), and John Hopkins Center for Public Health Preparedness.

The core actions of psychological first aid include[13]:
- contact and engagement
- safety and comfort
- stabilization
- information gathering: current needs and concerns
- practical assistance
- connection with social supports
- information on coping
- linkage with collaborative services

Individual Psychoeducation

Reactions to disaster stress vary widely. One individual may become extremely task-oriented and appear to be coping very well. Another may become disoriented or distracted. Psychoeducation provides information to individuals and families about expected reactions to stress and transition and loss in order to empower them, help them cope and build resilience. Educational brochures can be a valuable tool for providing individual psychoeducation.

Early Psychological Intervention Activities

For some survivors and workers, the actions of psychological first aid are not enough to alleviate their distress or mitigate long-term consequences. Additional interventions targeting specific survivor and responder needs may be necessary. These include crisis intervention, referral and advocacy.

Crisis Intervention

Crisis intervention is a time-limited and goal-directed intervention to assist survivors and disaster workers in resolving presenting problems, addressing stress, trauma and emotional conflicts resulting from a disaster. This method is used to offer immediate, short-term help to persons who experience an event that causes emotional, mental, physical, and behavioral distress or problems. Crisis intervention techniques help to lower physiological arousal, increase clarity of the current situation, mitigate dysfunctional thinking and introduce adaptive coping mechanisms.

Trainings should include information regarding the basics of crisis intervention and the actions taken. Crisis intervention usually:
- Is time-limited (two to three contacts);
- Is focused on problems of daily living (immediate reactions to the disaster situation);
- Is oriented to the here and now (alleviating distress and enabling survivors to regain equilibrium);

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[13] National Center for Child Traumatic Stress Network and National Center for PTSD, *Field Operations Guide for Psychological First Aid* (2006).

- Includes a high level of activity by the disaster emotional care provider (engaging with the survivor to identify immediate tasks for completion);
- Uses concrete tasks as a primary tactic of change efforts (the task development process involves survivors in achieving a new state of equilibrium);
- Is more directive than some traditional mental health work.

Critical Incident Stress Management

One crisis intervention model is Critical Incident Stress Management (CISM), a comprehensive, integrated, systematic and multicomponent crisis intervention program. It was developed to help manage traumatic experiences within organizations and communities. CISM is a "package of crisis intervention tactics that are strategically woven together to: 1) mitigate the impact of a traumatic event; 2) facilitate normal recovery processes in normal people, who are having normal reactions to traumatic events; 3) restore individuals, groups and organizations to adaptive function; and to 4) identify people within an organization or a community who would benefit from additional support services or a referral for further evaluation and, possibly, psychological treatment."[14]

Referrals for Additional Services

The next step on the continuum of disaster emotional care interventions is referral for additional services. A survivor should be referred to an available community mental health resource if he or she remains in significant distress after crisis intervention and/or could benefit from longer term services. Training should include information about when to refer survivors, available resources and agency requirements for making referrals.

For example, referrals should be made for services including:
- A formal mental health evaluation;
- Ongoing counseling or psychotherapy;
- Medication;
- More than the brief support provided by disaster emotional care providers;
- Immediate hospitalization;
- Community support group services (for example: grief or bereavement support, attention to problems experienced by children).

Financial Assistance

Some agencies provide financial assistance for disaster-related mental health expenses. Each agency should provide training and guidance that covers the circumstance, restrictions and procedures for providing financial support to meet mental health expenses.

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[14] Critical Incident Stress Management, Jeffrey T. Mitchell, Ph.D., http://www.lacombevictimservices.com/files/7314/3742/7593/CISM.pdf.

Advocacy

Advocacy entails assisting survivors and other disaster workers by helping them make their needs known and access needed support. Advocacy involves educating and empowering survivors to navigate resources and make important linkages, especially individuals who might otherwise avoid seeking help. It is especially important to advocate for high-risk survivors who can benefit from timely access to community resources and treatment.

Advocacy can enhance recovery by identifying survivor needs and, when necessary, communicating these needs to decision-makers, supervisors and/or providers of care, so that survivors receive appropriate, culturally responsive services.
Training should include the following potential advocacy opportunities:
- Helping individuals affected by disasters communicate their needs to supervisors and/or care providers;
- Providing culturally competent services;
- Marshalling resources for people with access and functional needs, including disabilities;
- Providing information about relief programs and services available;
- Explaining and accompanying people as they go through the process of applying for services;
- Facilitating timely access to evidence-based community treatment.

Agencies that are providing disaster case management may be valuable resources for advocacy in a disaster setting. Disaster emotional care providers should become aware of the various agencies that include advocacy as part of their disaster response and recovery services.

Recovery Activities

> *In order for communities to fully recover and integrate the disaster into their history, emotional care is essential as a part of program services. Disaster emotional care providers work with state and local Recovery Committees to offer services related to the disaster, encourage programs aimed at strengthening community resilience, and facilitate counseling and supportive services for persons in need.*
> (*Disaster Emotional Care Points of Consensus* #6).

Collaboration with partner agencies is essential during the recovery phase. Pre-existing and newly developed community programs are the primary emotional care providers during recovery. Disaster emotional care services during recovery can include:
- Counseling, support groups and other emotional support services
- School-based activities, after-school programming
- Community sponsored events
- Camps for children
- Public messaging campaigns focused on managing difficult emotional reactions after a disaster

Resilience-building trainings used during preparedness are also valuable during the recovery phase and should be geared toward the needs of the participants and their level of emotional recovery. Communities who have recently experienced a disaster are often interested in and willing to participate in resilience-building training.

Disaster emotional care providers can also assist community leaders during recovery by serving in a consultative role to help plan recovery efforts and to ensure that emotional care is incorporated appropriately.

Finally, disaster anniversaries can lead to difficult emotional reactions and an increased need for emotional support even among individuals and communities that have returned to their pre-disaster level of functioning. As a result, disaster emotional care providers are often called upon to support communities in anticipation of and during disaster anniversaries. Supportive activities can occur in the short-term, such as on the one- or six-month anniversary after a disaster, or longer-term, like five- or ten-year disaster anniversaries.

SECTION THREE:
Disaster Emotional Care for Diverse Populations

> *As a foundation of disaster emotional care, providers respect diversity among colleagues in emotional and spiritual care and within communities served, including but not limited to race, color, ethnicity, national origin, immigration or citizenship status, veteran status, religious and spiritual beliefs, sex, gender identity, sexual orientation, age, or different physical and sensory abilities. Disaster emotional care providers strive for cultural awareness and sensitivity and adapt care strategies to address cultural differences in the individuals and communities they serve.*
> (*Disaster Emotional Care Points of Consensus* #9)

Introduction

This section provides an overview of disaster emotional care considerations for diverse populations with increased vulnerabilities that need to be addressed across the disaster cycle. Each sub-section includes a description of the population presented, challenges facing this population in a disaster setting, barriers that affect access to care, strategies and recommendations for overcoming those challenges and what it means to provide excellent disaster emotional care for this group.

This section has a special focus on the following: age considerations, specifically children and the elderly; access and functional needs and people with disabilities; and culture in a broad sense of the term. It is not meant to be an exhaustive list of diverse populations; rather it provides a framework for considering how disaster emotional care is provided across a spectrum of unique needs. Some of the common emotional care themes that will be discussed in sub-sections across all populations (listed on the example chart in the sub-section on children) include protection and safety, hospitality and comfort, belonging and connectedness, understanding and listening, and empowerment.

Some individuals of diverse populations will have caregivers who are accompanying them in disaster situations, such as parents or guardians with children and adult children or spouses with their elderly family members. These caregivers will have their own needs and additional stresses in a wide-spread disaster situation, for example, following disaster there are often increases in domestic abuse, "While domestic violence escalates during and after a disaster, so do the barriers to resources due to the devastation the community is faced with."[15] DEC providers need to be in close communication with caregivers of vulnerable populations and attentive to warning signs that might require a referral for more direct intervention.

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[15] "Domestic Violence Advocacy: A Disaster Response", curriculum of the National Domestic Violence Hotline, 2014.

Disaster Emotional Care for Children and Youth

> *Children are particularly vulnerable to the mental health impact of disasters and lack the experience, skills, and resources to independently meet their mental and behavioral health needs. Mental and behavioral health effects are of specific concern in children of all ages due to the likelihood of lasting reactions…The mental health effects of disasters are typically overlooked in disaster management and often are not considered until well after an event when it is too late to affect optimal response or recovery efforts.* (National Commission on Children and Disasters 2010 Report to the President and Congress)

This sub-section has recommendations for the care of children and youth 0-17 years old by disaster emotional care (DEC) providers, which include a wide range of people with varying knowledge, skills, and attributes who interact with children and youth. DEC providers who have primary responsibility for children for a period of time will be more effective in their work if they have had preparation and training to provide care for the emotional needs of children following disaster and support resilience in children, as well as being able to identify children who require more advanced care.

Guidelines and Recommendations

Child Safety

Child safety includes both physical and emotional safety. DEC providers working with children need to be affiliated with a deploying organization that takes responsibility for their actions and makes sure they are trained and have received background checks on a regular basis. Basic safety practices need to be in place which includes everything from safe eating and sleeping procedures, particularly for infants and toddlers, to youth feeling like they have safe adults to connect with as they struggle with strong feelings and concerns related to the disaster or other traumas. All children need a sense of safety and protection in the chaos of the aftermath of disaster.

Unaccompanied Minors

The concern for safety takes on an even greater urgency when there are unaccompanied minors with the additional stress of separation from their families following disaster. When unaccompanied minors are in need of care, additional personnel and safety processes need to be in place. This may involve security personnel in a shelter situation, designated DEC providers who offer compassionate care with consistency and continuity, temporary guardianship, or foster care.

All disaster response agencies need to be prepared and aware of existing processes for reunification of unaccompanied minors with their families. These processes protect children sensitively and safely. National resources available to emergency managers and VOAD

member organizations as they plan for disaster events include the National Center for Missing and Exploited Children, which assists law enforcement with reunification of children and families, and the American Red Cross which has reunification procedures in place for mass care during disaster response.

Training

In order to provide the very best care for children and youth in disaster response and recovery, careful preparation and training is necessary. Required training for DEC providers should include:
- Understanding the impact of disaster on families and communities
- Knowing what to expect in a disaster response or recovery setting
- Basic child development and how it changes when children experience trauma
- Basic health and safety procedures following disaster often in a less than ideal setting
- Creating a welcoming and comfortable environment for all children
- Training on how to meet the needs of children with disabilities impacted by disaster, including accommodations
- Strategies for supporting resilience in all children
- Expressive opportunities for children with appropriate materials and adult support
- Awareness of different cultural expectations and needs of families, including increased challenges when language barriers are involved
- Ethics when working with children and families in a disaster setting

Referrals

Adults working with children and youth, following disaster need to be aware of physical, mental, and behavioral health concerns and warning signs that indicate the need for referral for more intensive care, including bereavement care. Consent for treatment is needed for interventions other than typical play and support activities. When intervention services are required for unaccompanied minors for medical or mental/behavioral health needs, the designated temporary guardian may be able to give verbal or written consent or court permission may be sought. For all children, DEC providers need to have an awareness of how, when, and where to make referrals, whether it is through existing community services or disaster-enhanced services.

Challenges and Care Strategies

Challenges

There are many challenges in working with children and youth following disaster. Young children are particularly vulnerable and unable to care for themselves. Children may have difficulty expressing their needs and fears in a manner that an adult readily can understand. Youth may feel like they can care for themselves while also feeling the stress of their lives being out of control, even more so than they would typically feel. Parents/guardians/caregivers are

often overwhelmed with the disaster and how they will meet their family's basic physical needs, let alone the emotional care needs of their children or themselves.

Families may find themselves in a situation where they feel they are not understood because of cultural or other differences. In multilingual families, including those whose primary language is American Sign Language, children may often be the translators, which adds stress and complexity to an already difficult situation. In families where children have a single parent, a grandparent or other guardian raising children, same-sex parents, stepfamilies, foster families, runaway minors, or a family member with access or functional needs including disabilities, there may be a sense of increased vulnerability which requires sensitivity and an expansive view of families or support systems for children.

With the particular vulnerabilities and moment-to-moment needs of children and families following disaster, there is an intensity about the work that can be challenging for even the most prepared and experienced DEC providers. Particular attention needs to be paid to self-care and team care.

The many challenges of working with children and families, as well as ethical considerations, make it all the more important to have consistent training and preparation of DEC providers, including emotional care and support. DEC providers will be able to respond more effectively, and most of all, do no further harm, to those already experiencing the trauma of disaster.

Care Strategies

The following chart is included as an example of how care strategies could be organized for use in a training setting or as a community resource for disaster emotional care for diverse populations.[16]

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[16] This chart was adapted from an emotional and spiritual care chart developed by a Church World Service (CWS) 2015 task force on Children and Disaster in consultation with: Members of the Development and Humanitarian Assistance (DHA) Advisory Group of CWS – UMCOR, PDA, American Baptist Churches USA, BDM/CDS, IOCC, Christian Church (DOC), ELCA, UCC, World Renew, CWS staff – and consultants Mary Gaudreau Hughes (OK Conference of Churches), Dr. Karen-Marie Yust (Union Presbyterian Seminary).

Table 6. Disaster Emotional Care for Children and Youth

Emotional Care Themes	Children's Needs	Adult Support

Protection and Safety	To feel safe and protected during a time of vulnerability	• Provide a safe space with trained and safe adults. Have a nurturing, friendly manner and presence at all times.
		• Guide children throughout their daily routines in a caring and interactive way.
		• Support children in safe eating and sleeping, particularly infants and young children, for example:
		  o Be present with young children who are eating so that you can prevent choking hazards.
		  o Put infants on their backs to sleep to reduce the incidents of SIDS.
		  o Give realistic reassurance, such as when the children hear a loud noise, "That's the air conditioner coming on. You are safe now and we will work to keep you safe."
		• Reach out to older children and youth in a safe, friendly manner, so that they know whom to turn to for support. They are able to sense that caring adults are there to protect them and keep them safe.
		• Look out for warning signs when more intensive physical, mental, and behavioral health care may be needed, as well as where and how to make referrals.

Hospitality and Comfort	To feel welcomed and comfortable, both emotionally and physically	• Welcome all children with a compassionate, calm and steady presence. • Invite, but never force children to participate. • Provide accessible space, materials, and activities for children with disabilities. • Provide youth with a space and materials that are interesting and engaging to them. Be friendly and welcoming while also giving them freedom for them to choose their level of participation. • Gently encourage some interaction with peers and adults among older children and youth who may withdraw into technology – cell phones, games, TV, etc.
Belonging and Connectedness	To feel like an integral part of	• Acknowledge the children's strong feelings and listen with empathy. • Support all children as they play with peers and other adults.

	a group or community	• Allow children the space and provide a compassionate adult presence as they begin to process their experience and grief, especially in the loss of a family member, family pet, or other loved ones. • Provide opportunities for alone time or one-on-one time for older children and youth with a caring adult or peer. Be aware of how they are relating to others in in the setting.
Understanding and Listening	To share deep feelings, as well as learn about the disaster at the level they ask or need to know and that is appropriate to their family situation	• Follow the lead of the children as they try to make sense of their experiences through imaginative play and stories. • Provide information in a simple truthful manner with sensitivity to the family situation when children ask or seek knowledge about the event. • Listen empathetically and non-judgmentally with particular attention to the capacity of the child for healing. • Provide opportunities for listening without intruding for older children and youth who may feel withdrawn, such as sitting together while playing a game or learning something together.
Creativity and Empowerment	To feel like their unique talents are acknowledged, appreciated and encouraged	• Attend to individual children with compassion and encouragement. • Observe and respond to both verbal and non-verbal expressions. • Provide a safe space and plentiful open-ended play materials to explore creatively. • Empower children and youth to use their unique talents to gain a sense of inner control and to help others. • Provide a variety of creative materials for older children and youth that require complex skills and some that require large muscle movement, such as creating giant sculptures or murals.

Gratitude and Kindness	To know that you are grateful for their presence and that you will continue to work to meet their needs	• Meet the needs of the children as they arise. Advocate for unmet needs. • Express gratitude for and with the children and their families. • Recognize and point out when you see children being kind to one another. Be a kind and intentional presence as you spend time with children. • Provide opportunities for older children and youth to express what their needs are and plan for being proactive in meeting some of those needs. Support them as they take steps to get their own needs met as well as those of their family and others.
Hope and Resilience	To have a sense of a better future where they can experience joy and wonder	• Follow the lead of the child in expressions of joy, delight, and laughter. • Acknowledge hope in the children's experiences and stories. • Recognize moments of mystery and wonder in the children's play. • Encourage children to help others as appropriate, while also providing materials and activities that support self-reliance and independence. • Encourage youth to get involved in authentic, helpful roles related to the disaster and response, as well as community resilience. • Connect children and youth when possible with a caring adult or caregiver in an existing network to continue the path to resilience over time.

Disaster Emotional Care for Older Adults

Not all older adults are more vulnerable to ill effects from a disaster than younger people are. In many cases, older adults have the life experience, wisdom, and mental resilience to survive, help others, and reassure people who are frightened or depressed by the events…Nonetheless, many older adults who are frail or have [disabilities] require assistance to survive and recover from a disaster…A lifetime of accumulated losses — such as deaths of family members and friends, declines in physical capabilities, losses of vital roles in the workplace and community, and reduced incomes — can make older adults more vulnerable to trauma during a disaster.
(Department of Veterans Affairs, CDC Healthy Aging Program, *CDC's Disaster Planning Goal: Protect Vulnerable Older Adults*)[17]

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[17] https://www.cdc.gov/aging/pdf/disaster_planning_goal.pdf, accessed 7/27/18.

Disaster emotional care (DEC) providers for older adults include a wide range of people with varying knowledge, skills, and attributes who interact with older adults during times of disaster preparedness, response, and recovery. DEC providers who have primary responsibility for older adults will be more effective in their work if they have had preparation and training to provide care for the emotional needs in this vulnerable population, as well as the ability to identify those who require more advanced care.

DEC providers need to be attentive to the needs of caregivers of older adults as well. Older adults may or may not be accompanied by a spouse, adult child, or other caregiver, including friends or neighbors or employees of organizations. When caregivers are accompanying older adults, it is important for DEC providers to realize the increased vulnerability and stress that the caregiver may also be experiencing. DEC providers can offer support, good communication, and educational resources about how to help their loved ones throughout the disaster cycle.

Guidelines and Recommendations

Emotional Wellbeing in Preparedness

Acts of preparedness for disaster are in themselves empowering and support the emotional well-being of older adults. Standard preparedness actions including making an emergency supply kit, creating an emergency plan, and staying informed about potential threats.

Disaster preparedness materials for seniors often focus on self-reliance. Acts of preparedness for disaster are empowering. DEC providers can offer support for seniors and their caregivers during the preparedness phase to help mitigate negative emotional effects of disaster.

Many older adults, particularly those that require assistance with activities of daily living (eating, bathing, toileting, dressing, transferring), understand that they will require help during disaster evacuation. They may or may not be fully aware of how their impaired physical mobility, diminished sensory awareness, emotional vulnerability, or effect of chronic health conditions may hinder their adaptability during disasters. DEC providers may help by raising awareness of the individuals themselves, as well as families and caregivers of older adults requiring assistance, by engaging in conversation and providing educational resources on the need to plan in advance for evacuation and other potential disaster-related needs.

Emotional Well-being in Response and Recovery

Older adults, particularly those with disabilities, may be more vulnerable than the general population in terms of physical safety, movement, and a sense of emotional well-being. This heightened risk is particularly relevant for older adults requiring assistance and those who have experienced a series of ongoing losses. While these guidelines focus on disaster emotional care, it is important for caregivers and response workers to understand how physical agility and emotional well-being overlap in terms of older adults' sense of safety throughout the disaster cycle. While disasters can be emotionally overwhelming for everyone, older adults may be

particularly sensitive to the crowding, noise, absence of physical accommodations, and lack of privacy in mass care shelters.

Training

Providing the very best care for older adults in disaster response and recovery requires preparation, training, and background checks. Required training should include:

- Understanding the emotional impact of disaster on older adults, their support systems, and their communities
- Knowing what to expect in a disaster response or recovery setting and what the barriers are for older adults to receive access to necessary services
- Basic human development and how trauma affects development throughout the life cycle
- Basic health and safety procedures following disaster, often in a less than ideal setting
- Creating a welcoming and comfortable environment for all older adults
- Strategies for supporting and strengthening resilience in older adults
- Training on how to meet the needs of older adults with disabilities impacted by disaster, including accommodations
- Opportunities for older adults to feel empowered and be appropriately expressive of their experience and feelings about the experience
- Awareness of different cultural expectations and needs of families, including increased challenges when language barriers are involved
- Ethics when working with older adults and families in a disaster setting
- How to support the unique needs of caregivers of older adults
- Knowing when to make a referral for more intensive emotional care or mental health services, including concerns related to care being provided by a caregiver
- Strategies for enhancing emotional well-being and social support for disaster emotional care providers

Referrals

Typical responses of older adults following disaster could include some of the following: sadness, anxiety, irritability, confusion, disorientation, memory problems, and difficulty making decisions. DEC providers working with older adults following disaster need to be aware of mental and behavioral health concerns and warning signs that indicate the need for referral for more intensive care, including bereavement care and management of complex grief reactions.

Challenges and Care Strategies

Challenges

Some of the challenges of providing disaster emotional care for older adults may include:

- Some older adults may not be able to be as independent as they would like to be, particularly after the chaos of a disaster. Encouraging independence as much as possible will minimize the emotional impact on the individual.
- People who develop a disability gradually over time may not recognize the extent of their impairment and may be reluctant or anxious about accepting help of any kind, including disaster emotional care.
- Dementia may cause an unrealistic assessment of their situation. Some older adults may be more vulnerable than they realize.
- Sometimes the emotional response of older adults, such as confusion, may be due to medications or medical issues and not necessarily the disaster event. It may be possible to engage health services and medical personnel to care for emotional needs of older adults through collaboration and consultation.
- Recent experiences of grief or compounded experiences of grief and loss with layers of traumatic experiences may make disaster emotional reactions even more intense.
- Older adults may lack access to disaster emotional care, such as lack of transportation, inability to ask, or lack of physical strength and mobility to get to the care they need especially if they live alone.
- Older adults may or may not have a caregiver with them in a disaster situation, even if they normally would. Unique challenges could be present either way. If caregivers are present, they may disagree with basic principles of disaster emotional care or with specific strategies which could cause confusion for the older adult, particularly if it is a family member.
- If a move is necessary following the loss of a home or ability to care for oneself, there may also be a loss of known support systems, including social networks which could greatly impact the emotional well-being of these older adults.
- Cultural considerations are important in caring for older adults. Many cultures honor and revere their elders in ways that mainstream U.S. culture does not. DEC providers need to be mindful and respectful of cultural differences.

Care Strategies

Strategies implemented by DEC providers that may be helpful to older adults include:

- Showing hospitality and welcome
- Asking what their needs are and/or determining needs through observation and conversation, which may include a wide range of support, such as safety or comfort measures, assistance with confusion, friendship, or bereavement care
- Attentive listening with understanding as they share their experience and feelings about the disaster or other losses

- Openly talking without judgement about episodes of tearfulness in response to loss-related triggers
- Supporting self-care techniques, such as eating well, good sleep, physical activity, keeping a journal, relaxation and calming techniques
- Encouraging them to make contact with family and friends as they are able and expand their support network which could include: connecting with community resources, faith communities, support groups, and other informal or naturally occurring supports
- If older adult caregivers are present, including them in communications as appropriate, offering respite if possible, learning from them as well as offering educational resources to them, and coordinating care with them
- Encouraging older adults to delay making major decisions until they feel more stable, as much as possible
- Empowering them to assist in their own recovery and contribute to the disaster relief effort as they are able, recognizing that they may have a rich history of coping with past crises with a repertoire of responses and adaptation strategies

Disaster Emotional Care for Persons with Access and Functional Needs, including Disabilities

The approach to serving people with disabilities before, during, and after disaster advanced by ODIC [the Office of Disability Integration and Coordination of FEMA] begins from the perspective that the autonomy and independence of a survivor with a disability must be recognized at all times. We believe that people with disabilities are best positioned to know what they need as they go through the process of a disaster recovery and that the wishes of the survivor must be respected.[18]

Access and functional needs refer to the needs of a wide range of people, including but not limited to those with disabilities, limited English proficiency, older adults, children, and those with low incomes. For the purpose of raising awareness among DEC providers of the importance of inclusive services, the focus of this sub-section of the paper attempts to address some of the challenges people with disabilities may face in a disaster setting.

It is important to recognize that people living with disabilities are a part of every demographic group. The Americans with Disabilities Act (1990) definitions of inclusion criteria cover both mental and physical medical conditions[19]. A condition does not need to be severe or permanent to be a disability. A condition may or may not be readily recognized. Many people with disabilities function independently, however they could still have significant limitations that may

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[18] Linda Mastandrea, Director ODIC of FEMA, email communication with the DEC guidelines writing group, 2/15/19

[19] Equal Employment Opportunity Commission regulations provide a list of conditions that should be concluded to be disabilities: deafness, blindness, an intellectual [and developmental] disabilities, partially or completely missing limbs or mobility impairments requiring the use of a wheelchair, autism, cancer, cerebral palsy, diabetes, epilepsy, Human Immunodeficiency Virus (HIV) infection, multiple sclerosis, muscular dystrophy, major depressive disorder, bipolar disorder, post-traumatic stress disorder, obsessive compulsive disorder, and schizophrenia.www.eeoc.gov, retrieved December, 2018.

require additional accommodations. DEC providers need to be aware that in times of disaster there may be people with a temporary disability as a result of the disaster, such as a person with a broken leg using crutches or someone with hip replacement whose rehab was interrupted. Pregnancy is another temporary physical condition that may require additional access to services.

Guidelines and Recommendations

Physical and Emotional Safety

Survivors with access and functional needs, including disabilities, do not ask for more support than what any citizen would expect, however those providing services, including DEC providers, may need to find different ways to accommodate those needs so that survivors can benefit from the support that is available. For example, navigating recovery resources and systems may be difficult for someone who is blind or has low vision when they are not accessible via assistive technology. Also, even though the law requires buildings to be accessible, mobility challenges may prevent a person from being able to access all post-disaster recovery options. It is known that persons with disabilities and seniors (often with access and functional needs or disabilities as well) are more likely to die during or after a disaster or have a more complicated recovery.[20] These populations may feel more emotionally vulnerable and have a fear of losing their independence.

Training

Providing the best care for all survivors in disaster response and recovery requires preparation, training, and background checks. Required training for working with survivors with access and functional needs, including disabilities, should include:
- Principle of independence and autonomy in supporting those with disabilities
- Understanding the impact of disaster on all families and communities
- Knowing what to expect in a disaster response or recovery setting
- Civil rights legislation, types of support needs, and accommodations
- Basic health and safety procedures following disaster, often in a less than ideal setting
- Active listening skills, including verbal and non-verbal communication
- Strategies for supporting and strengthening resilience, including an awareness that the circumstances of chronic disability may have led to strong resilience skills pre-disaster
- Awareness of community based and natural support systems
- Challenges and care strategies
- Ethics when working with people with disabilities
- Knowing when to make a referral for more intensive emotional care or mental health services
- Practice applying knowledge to realistic disaster scenarios

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[20] Disaster Preparedness and the chronic disease needs of older adults. Aldrich,N., Benson,W. Preventing Chronic Disease CDC, 2008. Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC2248

Challenges and Care Strategies

Challenges

Some of the challenges for providing disaster emotional care for persons with disabilities, access or functional needs may include:

- Some survivors may not be able to be as independent as they would like to be, particularly after the chaos of a disaster. Encouraging independence as much as possible will minimize the emotional impact on the individual.
- People who develop a disability gradually over time may not recognize the extent of their impairment and may be reluctant or anxious about accepting help of any kind, including disaster emotional care.
- Sometimes the emotional response of persons with some health-related functional support needs, such as confusion, may be due to medications or medical issues and not necessarily the disaster event. It may be possible to engage health services and medical personnel to care for emotional needs through collaboration and consultation.
- Recent experiences of grief or compounded experiences of grief and loss with layers of traumatic experiences may make disaster emotional reactions even more intense.
- Persons with disabilities or access and functional needs may lack access to disaster emotional care, such as lack of transportation, inability to ask, or lack of physical strength and mobility to get to the care they need, especially if they live alone.
- If a move is necessary following the loss of a home or ability to care for oneself, there may also be a loss of known support systems and social networks which could greatly impact the emotional well-being of a person with disabilities. Naturally occurring supports of family, friends, community groups, and a faith community may help to mitigate feelings of isolation and promote resilience.

Care Strategies

The following are common strategies for supporting those with access and functional needs:

- Respecting the independence and autonomy of a person with a disability or access and functional need is paramount. Ask if they would like help before providing assistance. For example, if the person has fallen, ask their consent before attempting to help them up.
- Let the survivor lead his or her recovery. DEC providers may be in a position to discuss with the survivor about whether they need accommodations to participate in or benefit from services and then help advocate for those accommodations, such as sign language interpreters, materials in alternate formats.
- Actively listen as they share their experience and feelings about the disaster or other losses.
- Support self-care techniques, such as eating well, good sleep, physical activity, keeping a journal, relaxation and calming techniques.

- Encourage them to contact family and friends as they are able to and facilitate expansion of their support network, which could include connecting with community resources, faith community, and support groups.
- Empower them to assist in their own recovery and contribute to the disaster relief effort as they are able, recognizing that they may have a rich history of coping with past crises with a repertoire of responses and adaptive strategies.
- Recognize personal bias towards assuming what a person might need based on what you see (e.g., blind or using a wheel chair), remembering that disabilities may be hidden.
- Show hospitality and welcome as you would for any person impacted by disaster.
- Inquire about personal care assistants (PCA) or others who may routinely assist the survivor. It is not uncommon for the PCA to become separated from the survivor during evacuations or lost to the survivor after catastrophic events. These caregivers may be crucial to helping manage activities of daily living and maintaining independence. Again, let the survivor take the lead in letting you know what would be helpful.

Disaster Emotional Care for Diverse Cultural Groups

It is vital for VOAD member organizations to integrate cultural awareness, sensitivity, and competency throughout the organization's structure and services. This sub-section has recommendations for providing disaster emotional care (DEC) to culturally diverse individuals, families, and communities throughout the disaster cycle.

While culture has different meanings, and across various disciplines there may not be a consensus on what precisely constitutes culture, for the purposes of this section we are utilizing the concept of culture as a broad term used to describe the existence of many cultures and sub-cultures within a society. Cultural diversity may include but is not limited to race, color, ethnicity, national origin, immigration or citizenship status, socioeconomic status, veteran status, religious and spiritual beliefs, sex, gender identity, sexual orientation, age, or different physical and sensory abilities.

In their 2003 publication, *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations,* the U.S. Department of Health and Human Services (HHS) elaborates on defining characteristics that distinguish diverse cultures:

> *Culture influences many aspects of our lives—from how we communicate and celebrate to how we perceive the world around us. Culture involves shared customs, values, social rules of behavior, rituals and traditions, and perceptions of human nature and natural events. Elements of culture are learned from others and may be passed down from generation to generation.*

The vast majority of people are part of a unique sub-culture – and likely, part of many unique sub-cultures, not just one – while also inhabiting characteristics of a dominant culture(s). Therefore, our understanding of how cultural diversity influences disaster preparedness, response, and recovery is both an internal and external process: Disaster emotional care providers are continuously learning about and seeking to understand other cultures of which

they do not belong, while simultaneously engaging in a process of self-examination and awareness about how their own cultural diversity affects their experiences as well.

The following guidelines and recommendations use the concept of cultural competency as a foundation for VOAD member organizations when addressing cultural diversity in disaster emotional care, throughout the disaster cycle. They are meant to be broad yet are still limited given the vastness of cultural diversity. In other words, there are countless unique cultures in the U.S. and abroad where VOAD member organizations are located and deploy, each with their own important considerations when providing disaster emotional care, all of which cannot be addressed here.

Therefore, VOAD member organizations can utilize these general guidelines when developing or updating existing standards, trainings, and practices for disaster emotional care, while also adapting and expanding upon them to apply to specific populations they may be serving as a part of their organization's mission.

Guidelines and Recommendations

Cultural Competency

Cultural competency is the practice of striving to gain an awareness and understanding of various attributes of diverse cultures that would enhance the ability of organizations, agencies, institutions and individual providers to more effectively serve a person, family, and/or community.

Developing cultural competency is a long-term process which is fluid, and in the context of DEC, also influenced by the unpredictable nature of disasters and the varying ways they impact diverse individuals, families, and communities. While disaster emotional care providers can become proficient in cultural competency, training and support in this area should never be considered complete: There are always evolving ways that people within diverse cultures express themselves, necessitating constant learning and developing new or adapting existing approaches to care.

Beyond informing training and delivery of core services, cultural competency should also be integrated into other aspects of a disaster emotional care provider's organizational scope and structure, including:
- Policy and procedures developed in relation to disaster emotional care, from hiring and supervision to programs that address staff wellness
- Advocacy for the assets, needs, concerns, challenges, etc. of culturally diverse populations within the broader field of disaster preparedness, response, and recovery
- Community engagement and outreach with culturally diverse individuals and organizations, throughout the disaster cycle.

These elements and others are further described in the following table.[21]

Table 7. Guiding Principles for Cultural Competence in Disaster Emotional Care

Guiding Principles for Cultural Competence	Applied to Disaster Emotional Care
Recognize the importance of culture and respect diversity	• Cultural norms and traditions are essential to the overall emotional well-being of diverse individuals, families, and communities, including informing how people cope with adversity • When disasters disrupt cultures, DEC providers can play an essential role in helping to re-establish rituals, access supports from within and across cultural groups, etc. • Cultural diversity is not uniformly expressed or manifested within any particular group, which must be validated and respected by DEC providers • Among DEC providers, awareness of "self" and how one's own culture impacts their provision of services in disaster settings isn't something that can be easily compartmentalized and should be continuously processed, in the context of work/volunteer service (as appropriate) and in one's personal life
Maintain a current profile of the cultural composition of the community	• In the response and recovery phases, VOAD member organizations must collaborate at all levels in providing and adapting DEC services for culturally diverse communities impacted by disasters, as state chapters- and, by extension, the local members who comprise state chapters –know the makeup of their communities best • Understanding and awareness of the cultural composition of the communities being served will bring forth both assets that can be potentially offered by and for culturally diverse communities, as well as draw attention to potential access and functional needs: Languages spoken (including American Sign Language), faith-based rituals and customs, etc.
Recruit DEC providers who are representative of the community or service area	• DEC provider organizations should strive for cultural diversity in their hiring of DEC staff and recruitment of volunteers

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[21] Table based on U.S. Department of Health and Human Services, *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations* (2003) and adapted for National VOAD member organizations offering disaster emotional care in a wide variety of settings and throughout the disaster cycle.

	• DEC providers should maintain awareness of the cultural makeup and assets of their trained staff and volunteers, so that DEC providers who are a part of, or experienced in, working with particular culturally diverse communities, including those who have especially relevant skills such as fluency in another language, can be called upon for consultation and/or deployment when disasters occur and DEC services are requested by state/local entities
Provide ongoing cultural competence training to staff and volunteers	• All staff who play a role in the provision of DEC – part-time and full-time, paid and volunteer, administrative and supervisory, etc. – should be trained in cultural competency on a regular basis, throughout the disaster cycle • Training in cultural competency can be on the general topic and therefore comprehensive of all culturally diverse identities and groups, but as resources allow, DEC providers should also provide more in-depth trainings (including via trusted third-party curricula, trainers, etc.) about specific culturally diverse populations • VOAD member organizations must remember that training in cultural competency and training in DEC are separate; a particular staff member or volunteer may be culturally proficient in working with a specific population(s), but before providing DEC to culturally diverse populations, they must also be trained in DEC • Training in cultural competency should be updated on a regular basis to reflect changing norms and customs within culturally diverse communities
Ensure that services are accessible, appropriate, and equitable	• Culturally diverse individuals, families, and communities that are or have perceptions that they are marginalized or isolated from general mental health and emotional care services before a disaster, may be more likely to distance themselves from disaster emotional care services after a disaster and during long term recovery because of either the actual or perceived reality that DEC services aren't aware or sensitive to their unique considerations and needs • DEC providers can mitigate against these barriers/potential barriers through addressing access and functional needs of culturally diverse communities in developing and delivering services throughout the disaster cycle, including ensuring that services are

	accessible for people with disabilities; listening to those staff/volunteers from diverse cultures as well as from those survivors or consumers accessing services; learning from these voices when mistakes are made and making changes accordingly
Recognize the role of help-seeking behaviors, customs and traditions, and natural support networks	• DEC providers must understand and respect that people respond to disasters differently, and these reactions are greatly influenced not only by individual circumstances (pre-disaster level of functioning, degree of exposure during event, etc.) but also by culture • Cultural influences affecting emotional reactions to both natural and human-caused disasters (from temporary feeling of distress to trauma and other mental health concerns) and throughout the disaster cycle, may range from subtle to very distinct differences compared to how other sub-cultures or dominant cultures commonly react • Cultural influences may also include resistance to DEC, in general or from specific DEC providers if there are perceptions (including based on reality) that those providers are "outsiders" • DEC providers should validate and/or accommodate various coping strategies, resources, collaborations with or referrals to other trusted providers from culturally diverse communities, etc., when possible and appropriate, in order to support culturally-sensitive DEC practices and facilitate effective care • DEC providers should seek out disaster spiritual care providers for consultation, collaboration or referral, when possible and appropriate, in order to address survivors' spiritual and religious diversity • Peer support, kinship care, and similar coping strategies may be particularly beneficial to culturally diverse individuals affected by disaster
Involve as "cultural brokers" community leaders and organizations representing diverse cultural groups	• National, as well as state and territorial VOAD member organizations should work to expand or maintain the membership of organizations representing culturally diverse populations at the national, state, regional, and local (county, city, neighborhood) levels: Offer time for presentations on cultural diversity during regular meetings, conferences and other events; support diverse leadership that reflects makeup of member organizations; incorporate cultural competency into chapter bylaws and committee goals, etc.

	• Collaboration between national and state and/or local VOAD member organizations is key when coordinating DEC for culturally diverse populations, particularly when specific cultural resources may be limited in certain disaster-impacted communities
Ensure that services and information are culturally and linguistically competent	• DEC services should be delivered and resources developed to be as accessible and relevant as possible to the culturally diverse populations being served, e.g. written materials translated or direct communications interpreted (professionally when possible), including in American Sign Language and braille; using appropriate visuals in materials that are representative of target populations; factoring in low literacy rates that may be present in certain diverse communities; etc. • Promote accessibility of DEC services based on language and culture during times without crisis, so that other providers and culturally diverse communities are already aware of these services for when a disaster occurs • Expand cultural and linguistic competence beyond direct services and materials to include websites, social media platforms, and other communications tools used by DEC providers
Assess and evaluate the program's level of cultural competence	• DEC providers should incorporate cultural competency into their overall program assessments and evaluations, from staff, volunteer, and survivor and responder surveys to other tools for collecting feedback and data

Referrals

Referrals provided by DEC providers for culturally diverse individuals, families, and communities, should include the following considerations:

- As a part of understanding a community's culture, DEC providers should become familiar with local resources available to those communities during times without crisis versus having to scramble to assemble information and contacts in the immediate aftermath of a disaster event
- Referrals should only be provided to trusted, known organizations, including in regard to national crisis hotlines, 2-1-1 and other information and referral services, etc.
- If little is known about the organization/service to which a person is being referred, the DEC provider(s) should contact the organization/service in advance with any specific questions that may be relevant to why the referral is being provided to the culturally diverse person being served

- DEC providers may not be able to take a "one size fits all" approach to referrals; collaboration with other providers such as disaster spiritual care or other culturally experienced providers outside of DEC, etc., may be prudent in order to find appropriate, relevant resources.

Challenges and Care Strategies

Cultural diversity should be embraced as a strength and asset of disaster emotional care, just as it should be celebrated in everyday life. Given its complexity and scope, however, there are many challenges related to addressing cultural diversity in DEC in addition to those included in the previous table.

Some additional challenges and approaches include:

Challenge: A particular cultural group or community is specifically targeted or disproportionately affected in an incident of mass violence or other traumatic event with human-caused intent to harm

When incidents of mass violence or other traumatic events occur (bombings, mass shootings, murders of prominent figures, etc.), it may be suspected or known that the perpetrator(s) committed the crime with the intention of targeting a specific cultural group. These incidents may be officially classified as hate or bias crimes, which significantly affects how those directly affected (survivors, their loved ones, responders, etc.) react to the event in addition to the overall trauma of the experience. The recovery trajectory in these incidents may be slowed and DEC providers need to be aware of the added distress connected to a lack of a sense of safety or a change in a personal sense of meaning, the impact on faith and spiritual beliefs, and the need for increased sensitivity to these challenges.

In the aftermath of such disasters, there may also be backlash against a cultural group or groups that share characteristics with the perpetrator(s). This is an unfortunate byproduct of prejudice that adds additional pain and suffering.

Finally, when incidents of mass violence occur that do affect specific culturally diverse communities, the "circle of impact" may be far outside of those directly affected. Communities around the country (and around the world) from the same cultural group may experience significant levels of vicarious distress, with DEC providers called upon to offer local support at community centers, houses of worship, vigils, rallies and protests, etc.

Care strategies: In all of these instances, the need for delivering culturally competent DEC is integral to effective care. In applying these recommendations, DEC providers must assess the nature of the incident and determine if it is known to be a hate or bias crime.

For example, it may especially be necessary that DEC be delivered by DEC providers who share the same culture as the affected community. These bicultural DEC providers may need

additional training in delivering trauma-informed care in the aftermath of a bias/hate crime. Collaboration between national, state, and local VOAD member organizations may be especially needed if local DEC providers have limited resources pertaining to the affected cultural group(s).

Challenge: *Issues of systemic injustice or inequality throughout the disaster cycle*

It is sometimes said that disasters are the "great equalizers" of society because they affect all groups within impacted areas; however, the reality is that they can expose and even worsen systemic inequalities experienced by many diverse cultures. People in dominant cultures may have greater access to resources during preparedness, response, and recovery, which can give unequal advantages in terms of risk and resiliency. Certain culturally diverse groups may experience discrimination or marginalization year-round. Discrimination or marginalization may be experienced from general emotional care and other traditional sources of support, community services, healthcare systems, schools, houses of worship, or even in the home. These experiences affect the ability to effectively prepare, respond, and recover from disaster events.

Care strategies: *When DEC providers work with individuals, families, and communities who express frustration, anger, despair, or other feelings of distress related to injustice or inequality during any disaster phase, it is important for them to draw on a core principle of DEC: empathy.*

DEC providers should offer validation, and if allowed, may also consider serving as advocates to help address any perceived or actual injustices or inequalities experienced by disaster survivors or others being served. When possible, DEC providers, and their organizations, should continuously play a role in advocating at the societal level for just and equitable disaster services for all culturally diverse communities who may experience disadvantages throughout the disaster cycle.

Challenge: *Confronting prejudice, bias, and discrimination in disaster settings*

Injustices and inequalities experienced by culturally diverse individuals, families, and communities at the societal level are also experienced at the personal level when prejudice, bias, and discrimination occur, and can happen to any of the cultural identities described in the introduction to this section. Disaster emotional care providers from culturally diverse backgrounds may also experience these acts themselves, or be witness to occurrences in disaster settings, including in interventions and practices from other DEC providers. When prejudices result in acts of bias and/or discrimination in DEC, this can significantly affect the quality of care for all parties involved, and indeed can contribute to further emotional distress and trauma.

Care strategies: *When DEC providers are informed of instances of bias or discrimination during a disaster, DEC providers should offer empathy. If appropriate, they may also assist individuals in filing complaints based on the protocols of the managing entity of the facility where the DEC is being delivered.*

Referrals to community-based or disaster-related legal services may also be appropriate. DEC providers should not give any legal advice related to claims of bias or discrimination.

Similarly, when DEC providers feel they may be the target of bias or discrimination during disaster, they should follow the protocols of their parent organization for discussing and/or reporting such incidents and draw on sources of support inside and/or outside their organizations to help cope during such a difficult situation.

DEC providers, like all people, may harbor their own prejudices against particular culturally diverse groups. These prejudices may be triggered or brought to light in some other way in a disaster setting. When this happens, it is important for DEC providers to honestly confront their attitudes or beliefs. This may include drawing on available supports, which can help them process such feelings, such as peer support and mentoring, supervision, and the aforementioned trainings in cultural competency. Together, these can help bring ingrained perceptions about cultural diversity to light and allow a safe space for examination, with a goal of working towards resolution that can in turn help DEC providers deliver safe, effective care for any and all individuals, families, and communities they serve.

SECTION FOUR:
Relationships and Integration of Disaster Emotional Care

Introduction

There was a 400% increase in global natural disasters from 1985 to 2007[22] and it is hypothesized that, by the year 2050, the number of people who will experience a disaster will grow from one billion to two billion people[23]. Research shows that those affected by disasters often experience a significant psychological and spiritual impact. For many disaster survivors, a successful recovery hinges on their ability to find meaning in their disaster experience and to integrate their disaster experience into their life story[24].

Strong relationships among disaster care providers serve to maximize positive and constructive outcomes, while minimizing the risks for tension, miscommunication and other common pitfalls that can occur through any type of disaster response, especially when there are many players in the field. Therefore, VOADs at all levels (national in scope to community-based organizations), and those who offer any array of disaster emotional care services (on tasks and initiatives large and small), must collaborate in the interest of working towards the common purpose of delivering effective disaster emotional care to individuals and families impacted by disaster.

This section will address issues regarding relationships between disaster emotional care providers and other groups with which they often work: disaster spiritual care providers, behavioral health providers in the local community, and state and territorial VOADs. Benefits of forming alliances, challenges, and recommendations for building strong working relationships will be discussed. The section will conclude with some suggestions for engaging disaster emotional care providers in each phase of the disaster cycle.

Relationships with Disaster Spiritual Care

> *Mental health professionals partner with spiritual care providers in caring for individuals and communities in disaster. Spiritual and emotional care share some similarities but are distinct healing modalities. Spiritual care providers can be an important asset in referring individuals to receive care for their mental health and vice versa. (Disaster Emotional Care Points of Consensus #8)*

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[22] Center for Research on the Epidemiology of Disasters, 2007.
[23] Ronan & Johnston, 2005.
[24] Aten, Moore, Denney, Bayne, Stagg, Owens, Daniels, Boswell, Schenck, & Jones, 2008.

Why build relationships?

Disaster emotional care providers, including disaster mental health professionals, partner with spiritual care providers in caring for individuals and communities in disaster. Spiritual and emotional care can share some similarities but are distinct healing modalities. Spiritual care providers can be an important asset in referring individuals to receive care for their mental health, and vice versa. Emotional and spiritual care providers each contribute to the health and wellbeing of other disaster responders in unique and valuable ways.

Similarities and differences

Disaster Spiritual Care (DSC) providers are often among the first care providers who have direct contact with those who have been impacted by disasters. Their support activities include the ministry of presence, providing compassionate listening, assessing immediate needs, stabilizing distress, increasing resilience, connection to requested religious and spiritual support, and other core actions of psychological and spiritual first aid. All DSC providers should be trained and vetted according to the DSC Points of Consensus and Guidelines.

There are many similarities between the provision of disaster emotional care and the provision of disaster spiritual care. The line between the two disciplines is not distinct. Both types of responders have background and experience in providing comfort to individuals and families in times of challenge or crisis. The list below provides some typical similarities between trained disaster spiritual care and trained disaster emotional care providers:

- Training and skills in providing care and creating an emotional rapport
- Ability to support self-care, coping, and decision-making in those they serve
- An ethical framework for their work
- Multi-cultural competency and appreciation of cultural differences between the provider and the care receiver
- Familiarity with grieving processes and recognition of crisis and trauma
- A professional responsibility to refer to higher levels of care when necessary
- Connection with and utilization of community resources

The following table highlights some of the differences between disaster emotional care and disaster spiritual care. There are undoubtedly more similarities and differences than what are described, but these factors are the most relevant and can provide a springboard to discuss the issues. Dialogue between disaster emotional care providers and disaster spiritual care providers is key to collaboration, understanding, respect and trust.

Table 8. Comparison Between Disaster Emotional Care and Disaster Spiritual Care

Topic	Disaster Emotional Care	Disaster Spiritual Care
Primary Focus	• Attending to emotional needs and concerns • Promotion of resilience and coping • Identification of risk of long-term psychological issues	• Attending to spiritual needs and concerns • Promotion of the individuals' ability to rely on faith as a source of healing and strength • Assistance with issues of meaning
Training	• Psychological issues, coping strategies, counseling	• Spiritual care and applying theological context to life circumstances
Language of Engagement	• Cognitive, emotional and behavioral strategies related to coping and stress	• Language related to meaning and faith
Intervention Strategies	• Crisis intervention • Coping skills training	• Religious or spiritual rituals and strategies

Benefits of relationships

First and foremost, disaster emotional care providers and disaster spiritual care providers are force multipliers for each other. There is usually more than enough work for the providers that are present at a disaster operation and often more responders are necessary to provide service to all the survivors who could benefit.

In addition, because each type of provider has a different perspective and approach, they can help each other take a holistic view of the survivor and his or her issues. If a survivor does not relate to a disaster emotional care provider, he or she may feel more comfortable talking with a disaster spiritual care provider, or vice versa.

Disaster emotional care providers are generally effective when the survivor is dealing with issues of depression, anxiety and other typical mental health issues. Disaster spiritual care providers are generally helpful with issues of meaning and grief, or when the survivor specifically has a need to question or discuss their spiritual questions.

If both types of providers have trust and respect for the other group, then the survivor will be well-served by being referred to the other type of provider when appropriate.

Challenges

As mentioned earlier, during a disaster response, there is often more work that any one group will be able to accomplish. The needs of the community are widespread and intense. Yet we have seen challenges faced by disaster emotional care providers and disaster spiritual care providers when they have tried to collaborate. This section is an attempt to describe and analyze those challenges.

Lack of trust
The most basic challenge between the two groups is a sense of mistrust. Seasoned responders may be concerned that the members of the other group will not provide effective service for the community. Disaster spiritual care responders may be concerned that disaster emotional care providers will pathologize and 'therapize' when survivors only need a 'ministry of presence', a listening ear and a soft shoulder. They may also be concerned that disaster emotional care providers are not drawing on the survivor's strengths and are instead focusing on mental illness.

Disaster emotional care responders may be worried that the disaster spiritual care providers are attempting to convert survivors, or might fail to respect the right of each individual and faith group to hold to their existing values and traditions, or that they might engage in manipulation, disrespect or exploitation of those impacted by disaster and trauma or are practicing a non-professional, superficial approach to counseling. In addition, some disaster emotional care providers may feel that engaging in spiritual discussions is distracting from helping survivors cope with the realities of the situation.

Undoubtedly, there have been responders in both fields who may have not understood the needs of the disaster survivor and provided ineffective or even harmful interventions. However, basic training in disaster response generally teaches responders the appropriate strategies to use with survivors. The National VOAD *Disaster Spiritual Care Points of Consensus* (*see Appendix C*) clearly discourages inappropriate and exploitative behavior and encourages interfaith spiritual care approaches. These DEC guidelines and the National VOAD *Disaster Emotional Care Points of Consensus* articulate the need for promotion of resilience rather than development of long-term therapeutic relationships.

Historical tensions and access concerns

Related to issues of trust, a frequent challenge of collaboration is concern and suspicion regarding events that have occurred in the past. Both disaster emotional care and disaster spiritual care providers have often worked hard to achieve respect from other disaster and emergency responders. Each group is understandably fearful of losing ground by sharing responsibilities with the other type of provider. They are afraid that their reputation may be tainted by association with the other group, or that the value of their services may be diminished by inappropriate behaviors of the other group that then become attributed to both groups. Finally, especially in operations which include crime scenes, there might be limited access to the community and the survivors, and each group wants to protect their access. During these

unique situations, both disaster spiritual care and disaster emotional care providers who are already embedded in or associated with the emergency services operations agencies have the most access.

Lack of knowledge and misunderstanding

Lack of familiarity and appreciation of what the other group can bring to the disaster response can also lead to a difficult working relationship. Disaster spiritual care providers often do not understand that "disaster mental health" or "disaster emotional care" is not about diagnosing serious mental illness or trauma reactions.

Disaster spiritual care providers and other types of responders may not know when it is appropriate to refer survivors or workers to disaster emotional care providers. They may believe that "disaster mental health" providers only address issues of psychiatric care or may believe that only people with psychiatric diagnoses need help. A similar misunderstanding is that disaster emotional care providers often do not understand that "disaster spiritual care" is not about converting impacted persons or assuming everyone wants religious care. (*See Appendix E, Glossary for definitions of these terms.*)

Specialized training and education

Another challenge is that the appropriate provision of disaster emotional care requires specialized training and skills. Many disaster spiritual care providers believe that their training qualifies them to provide disaster emotional care because they were trained in spiritual care. However, the training for disaster emotional care is so specialized that even licensed mental health professionals may not have completed specialized training in disaster or crisis intervention and be competent to provide disaster emotional care. The challenge is that anyone who wants to provide disaster emotional care services needs to understand and obtain the appropriate training, experience and technical supervision to be effective in the unique environment of disaster services. (*See Section 2 for a comprehensive description of training recommendations for disaster emotional care providers.*)

Recommendations for disaster emotional care providers

The benefits of working together far outweigh the challenges. Following are some recommendations for increasing the likelihood of a successful collaboration:
- Approach the relationship with an open mind. Allow yourself to be surprised by the value the other person may bring to the disaster setting.
- Foster an attitude of mutual trust and respect.
- Get to know your local disaster spiritual care partners before the event. Spend time informally discussing what your experiences have been and how you approach working with survivors in a disaster situation.
- Take disaster spiritual care training in order to understand more fully their perspective, approach and possible interventions.

- During a disaster operation, take the time to introduce yourself and learn more about the disaster spiritual care organizations on site. Be sure to connect with the coordinator for disaster spiritual care.
- When at a site where disaster spiritual care is present, meet the responders who are working there and determine the process for referrals to each other.

Relationships with Local Disaster Emotional Care Providers

> *Local providers of emotional care are an integral part of their communities pre-disaster and therefore are primary resources for also providing post-disaster emotional care services. Because local providers of emotional care are uniquely equipped to serve their communities, any emotional care services from outside the community support but do not substitute for local efforts. In this context, the principles of the VOAD movement – cooperation, communication, coordination, and collaboration – are essential to the delivery of emotional care.* (*Disaster Emotional Care Points of Consensus* #4)

Strong relationships with a local community are based on the four "Cs" of the VOAD movement – cooperation, communication, coordination, and collaboration – and are essential throughout all phases of natural and human-caused disasters. Each of the "4 Cs" are inextricably linked; when one guiding principle is strong, the others are more likely to be stronger, and when one is weak, the others are at risk of being weaker. This section lays out steps to forming effective working relationships with local disaster emotional care providers, based on the four "Cs."

Who are local providers?

Local disaster emotional care providers vary greatly in size and scope and are as diverse as the communities they serve. Providers may include disaster emotional care in their primary mission or may only offer disaster emotional care services in the context of a specific disaster event, including specialized DEC services operationalized during the long-term recovery phase.

Local disaster emotional care providers may include:
- Providers with a focus on a specific neighborhood, city, county, or multi-county region, including providers who may also focus on a specific population (children, youth, older adults, etc.)
- Community behavioral health programs (housed in health centers, counseling clinics, etc.)
- Healthcare providers (hospitals, clinics, primary care providers, etc.)
- Private non-profits, faith-based, and government agencies or programs
- Local chapters or networks of professional associations (National Association of Social Workers, American Psychological Association, National Child Traumatic Stress Network, etc.)
- College and university-sponsored agencies or institutions, including programs sponsoring research in disaster emotional care and/or direct service, community-based programs
- Task forces, committees, and coalitions that may include disaster emotional care providers with or without a specific focus on DEC, but who organize and network around DEC resources for their community.
- Individuals who are trained to provide disaster emotional care or who become trained in the aftermath of a disaster in their community. For the purpose of collaboration among

VOAD member organizations, these individuals should have an affiliation with a community agency, program, or institution or belong to a local affiliate of a National VOAD member organization.

- Communities of faith also care for both the emotional and spiritual care needs of their congregants and this care may be available to those outside their congregation when help is sought.

Providers with a state-wide focus

Disaster emotional care providers with a state-wide focus may also include any of the above agencies, organizations, programs, etc., with the one primary difference being their scope tends to be on an entire state or territory, versus a specific city, county, or region.

While state-wide providers are not local per se, for the purposes of collaboration, they are nonetheless crucial, not only because they often serve as primary points of access to local providers for VOAD member organizations national in scope, but also because they can bring together local providers across the state as well, throughout the disaster cycle.

Benefits of relationships

There are many benefits to forming relationships among national, state, and local disaster emotional care providers, including the following:

- Local providers are more likely to *know* their communities in terms of cultural awareness, demographics, history, customs, etc., thus aiding national providers in developing & delivering culturally competent DEC services
- Local providers are more likely to have staff and volunteers *from* the diverse communities they serve, and accordingly can bring unique assets to the provision of disaster emotional care, which national providers may lack, such as bilingual skills, bicultural awareness, etc.
- Local providers can serve as voices for affected communities, representing their unmet needs in disaster emotional care and other challenges being faced throughout the disaster cycle to National VOAD member organizations, and as a result be better equipped to advocate within their organizations or among other National VOAD or federal partners for the local communities. National VOAD member organizations can assist local disaster emotional care providers in increasing their visibility at the national level, helping them to find platforms for speaking on behalf of their affected communities.
- National providers of disaster emotional care may have access to financial or in-kind resources which can bolster or enhance state and/or local reach
- When major disasters occur, local providers may be incapacitated or overwhelmed, and so national providers can help to provide supplemental or temporary disaster emotional care to affected communities, which can enhance the capacity of local providers, allow them to be more flexible with resources, and give them time to rebuild or staff up to meet demands.

- Collaboration helps to establish pathways for cooperation, communication, and coordination throughout the disaster cycle. National VOAD member organizations reach out to state DEC providers, who in turn can facilitate contacts at the local level, who in turn can facilitate contacts at the neighborhood/community level. Concurrently, national disaster emotional care providers can help to facilitate contacts between local and state providers across state lines or to other national providers as needed.
- During long-term recovery, local DEC providers remain vital links for affected communities – they are in it for the long haul – and thus can continue to serve as primary contacts for collaboration, to continually monitor and maintain cooperation, communication, and coordination for National VOAD member organizations wanting to stay aware of ongoing needs of local communities in the event additional assistance may be needed at any point months or years after a disaster.

Identifying key state and local DEC stakeholders

In order to effectively collaborate with local and state DEC providers, it is important for National VOAD member organizations DEC providers to understand who the typical key players are at these levels, and their typical roles or functions in disaster emotional care. Three common points of entry for National VOAD member organizations seeking to pursuing opportunities for forming relationships with local DEC providers are:
- Regional, state, territorial or local affiliates of National VOAD member organizations;
- State, territorial and local VOAD or COAD chapters; and
- State and local government agencies or programs that have some role in providing DEC at the local level.

Regional, state, or local affiliates of National VOAD member organizations

For National VOAD member organizations which have regional, state, and/or local affiliate chapters, branches, offices, networks or other programs that offer disaster emotional care, these will serve as natural primary points of contact throughout all phases of disaster. Not all National VOAD member organizations will have such presence at the local level, however, and for those that do, their local affiliates may not be active in their state, territorial or local VOAD or COAD.

When a National VOAD member organization does have a local affiliate, it is important that the local providers be involved in initiating, developing, and/or maintaining collaborations with other National VOAD member organizations seeking to collaborate in disaster emotional care at the local level. National VOAD member organizations may also play a role in connecting their local affiliates with the local affiliates of national VOAD DEC providers, given the more limited capacity and/or resources local providers may have year-round or in the aftermath of major disaster events.

State and local VOAD Chapters

For National VOAD member organizations without local affiliates, state and territorial VOAD chapters can serve as entry points for pursuing opportunities for collaboration in disaster emotional care, including to connect national DEC providers with city, county, or regional VOAD and COAD chapters. State, territorial and local VOAD chapters may also have emotional and spiritual care committees, or equivalent sub-committees, which can provide specific points of contact in disaster emotional care for national organizations seeking to get involved at the local or state level. See subsection *Relationships with State and Territorial VOADs* for more information on state and territorial VOAD emotional & spiritual care committees.

State and local government agencies/programs

Other key local providers of disaster emotional care for which National VOAD member organizations should be aware are state & local government agencies and programs, including:

- State Disaster Mental Health and/or Substance Abuse Coordinators (DMHCs and DSACs) housed in each state/territory's Department of Health or equivalent office, and the National Association of State Mental Health Program Directors (NASMHPD), which sponsors a Multi-State Disaster Behavioral Health Consortium.
- Local and/or county Offices of Mental Health. Not every city/county may sponsor their own program in disaster mental health, but many do, including special programs such as FEMA Crisis Counseling Programs set up in the aftermath of major disaster events.
- State, county, and/or city Emergency Management Offices. Emergency managers may include state or local disaster emotional care providers in their Disaster Preparedness Playbooks.
- State, county, and/or city departments, offices, or programs focusing on public health, which, like State Disaster Mental Health Coordinators, may be housed in the state/local Department of Health (or equivalent), but which might have their own scope of services encompassing disaster behavioral health. Medical Reserve Corps (MRC) units are one example of such programs, as MRCs often include trained & credentialed teams of disaster emotional care providers who are active in their communities throughout all phases of the disaster cycle.

The following table serves as guide for identifying stakeholders from each of the groups described above.

Table 9. Key Disaster Emotional Care Stakeholders

State, Territorial, or Local Affiliates of National VOAD Member Organizations	• Initial and primary point of contact for national VOAD member organizations seeking to collaborate with local, community-based DEC providers • National VOAD member providers can also help their state, regional, or local affiliates get involved with their own VOAD/COAD chapters.
State, Territorial, and Local VOAD or COAD Chapters	• State and territorial VOAD leaders are natural initial and primary points of contact for National VOAD member organizations looking to collaborate with local DEC providers, especially those that don't have state, regional, or local affiliates within their organizational structure. • Some state, territorial, and local VOAD Chapters may also have established Emotional and Spiritual Care Committees, offering another point of contact for National VOAD member organizations seeking opportunities for collaboration throughout the disaster cycle.
State, Territorial, and Local Government Agencies/Programs	• State, territorial, and local government agencies and programs which address disaster emotional care may have associations with local National VOAD affiliates or their local/state VOAD chapter, and so can serve as additional points of contact for NVOAD member organization DEC providers looking for opportunities to collaborate.

Models for building relationships under the "4 Cs"

As many types of organizations as there are, there are that many models for collaboration, communication, coordination, and cooperation. There may be no 'one size fits all' approach for collaborating with local providers in disaster emotional care, but following are two models that feature common best practices in developing and sustaining community partnerships and that can be easily adapted by National VOAD member organizations.

The U.S. Department of Health and Human Services Office of Adolescent Health's *Engaging Your Community: A Toolkit for Partnership, Collaboration, and Action* (2012) offers the following steps,

1. Identify and initiate contact with state, regional, and/or local stakeholders providing disaster emotional care throughout the entire disaster cycle or a specific phase such as long-term recovery
2. Establish personal relationships, and begin to build trust
3. Clarify the goals and objectives each partner can accomplish via collaboration
4. Choose and implement a plan for collaboration that is mutually beneficial
5. Monitor, assess, and adapt the collaboration as needed, including after a major disaster event that may offer opportunities to learn what worked and what can be improved.

The *Ohio Community Collaboration Model for School Improvement* developed by the Community and Youth Collaborative Institute at Ohio State University (2008) also offers a framework for collaboration, which can be easily adapted for VOAD member organizations:

1. **FIND OUT** about each other's interests, needs, aspirations and resources
2. **REACH OUT** to potential partners on their own turf with specific offers of assistance and opportunities to work together
3. **SPELL OUT** the purpose of the collaboration and any terms or conditions of joint efforts, including who will do what, with whom, when, where, and how
4. **WORK OUT** the kinks as they arise and change your approach as indicated by the feedback you receive
5. **BUILD OUT** as you experience success by sharing positive results and promoting more innovative programs and services.

Recommendations for Relationships throughout the Disaster Cycle

Relationships between National VOAD member organization DEC providers and local DEC providers are beneficial throughout the disaster cycle. Following are examples of collaborative activities in which National VOAD member organization providers and local DEC providers can participate year-round, immediately before or during disasters, and during the short- and long-term recovery phases:

Table 10. Collaboration Across the Disaster Cycle

Preparedness	Response	Recovery
- Identify key local DEC providers - Facilitate introductions & exchange information on assets & other DEC resources available, during which phase(s) of the disaster cycle, and for specific types of disasters - Participate in local and/or state coordination calls, conferences, other events - Work with local providers to identify any unmet needs in disaster emotional care - Work with local providers to support or assist in the development of resources in DEC based on identified unmet needs - Enter into formal partnerships, agreements, MOUs, as needed - Advocate for inclusion of DEC in disaster preparedness plans and participate in local and/or state-wide disaster preparedness exercises - Invite key local DEC providers to serve on national and/or regional task forces, working groups, etc. - Engage with local providers on social media	- Initiate contact with local DEC providers, including operationalizing any roles as defined in formal partnerships, agreements, MOUs, etc. - Participate in national, state, and/or local response coordination calls/meetings, advocate for inclusion of DEC in agenda (or offer to help organize or participate in DEC-specific coordination calls & meetings), and invite local DEC providers to participate and play an active role in local, state, and/or national coordination calls & meetings - Continue to assess and identify unmet needs in DEC with local providers, share and develop new resources to address emerging needs	- Sponsor or participate in evaluation/"hot wash" debriefings, advocate for inclusion of DEC in the agenda of such exercises, and/or sponsor or participate in DEC-specific debriefings - Via local DEC providers, connect and offer support to Long Term Recovery Groups and other forums where ongoing needs in DEC can be addressed and coordinated - Facilitate access to funding opportunities & other forms of continued support during recovery for local DEC providers - Re-connect with local DEC providers for milestone disaster anniversary & trigger events

Potential Challenges and Suggestions for Overcoming Challenges

Inevitably when organizations come together, even under a common cause and in the spirit of the "4 Cs", challenges will arise that may inhibit or diminish effective and successful collaborations. The following table[25] offers a breakdown of common barriers in partnerships & 'minimizing strategies' to approach those barriers for National VOAD member organizations experiencing challenges in pursuing collaborations with local disaster emotional care providers.

Table 11. Challenges and Suggestions for Improving Local Collaboration

Potential Challenges in Collaboration	Minimizing Strategies
Recruiting and retaining partners • Interdependent relationships and collaboration are not valued or prioritized • Perception it is easier to do work alone • Informal opportunities for national, state, local DEC providers to get to know one another and continuously bring in new resources are not often available • There is limited time and resources to devote to initiating and nurturing collaborations • Leadership and other staff/volunteer turnover create vacuums in being able to focus on or sustain collaborations • During sustained periods when no major disaster has occurred, national, state, and/or local DEC providers may lose momentum or not feel the impetus of pursuing or sustaining collaborations • Individuals and agencies do not see collaboration as central to their work and success	• Find common ground that allows each person and organization to participate, while recognizing each other's diversity • Identify benefits of collaboration, and costs and losses of not collaborating • Find ways for each entity to get their goals met through the collaboration • Make collaboration a welcome part of the climate and culture of DEC • Help partners convince their top-level leaders that collaboration in DEC is worth the effort and part of the job • Offer resources and support within and between organizations in pursuing and maintaining collaborations when resources are strained or limited • Explore intentional ways to include untapped resources; try to be aware of persons and groups that are not at the table • Understand and identify attitudes that may inhibit collaborations in DEC across diverse organizations (e.g., idea that national organizations cannot understand local concerns) • Host introductory conference calls, webinars, or in-person meetings when possible, where the primary aim is to get to

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[25] Adapted from the *Ohio Community Collaboration Model for School Improvement* developed by the Community and Youth Collaborative Institute at Ohio State University (2008)

	know one another's staff, organization mission, resources, etc.
Turf and related conflicts • Multiple obstacles can block the convening of potential collaborations, including the disasters themselves, which add additional personal and professional demands and other stressors to key staff persons & volunteers who otherwise would serve as initial and primary points of contact in collaboration • People and agencies have different missions and perspectives in providing DEC • Agencies, whether national or local in scope, often compete for the same resources in sustaining operations • Perceptions that certain professions and agencies are more qualified, competent, etc. • When disasters occur, understandably local DEC providers can become very protective of impacted communities, including if particular populations were affected (children & schools, houses of worship, LGBTQ+, etc.) • Language and "alphabet soup" of organizations can heighten confusion and feeling overwhelmed at where to start, who to talk to, etc. • Historical rifts and turf issues can keep new partnerships from emerging, and can become re-enacted when disasters occur • Not all perspectives are valued equally • Cultural differences are both real and perceived, and historical prejudices and instances of exclusion, discrimination, etc., affect and influence collaboration	• Learn the mission, vision, goals, etc. of each collaborating partner and how they can/do contribute to communities served • Find common ground that allows each person and organization to participate in the collaboration based on strengths & other assets, while recognizing each other's differences and limitations • Find ways for each organization and entity to receive benefits from the collaboration, but especially the local DEC providers, as "all disasters are local" • Value each person and organization for its own worth in the community • Establish norms for high quality interactions and lead by example for other organizations seeking local collaboration • Build trust and relationships among community partners • Remember, there will never be enough resources to fully meet community needs • Draw on support from peer organizations, National VOAD staff, Emotional & Spiritual Care Committee leadership, etc., to help explore solutions to conflicts if they arise • Continuously emphasize partners' interdependence • Continuously emphasize the greater good of the community you serve • Develop "win-win" planning frameworks in which duplication of programs and services is good and sometimes needed • Create shared vocabulary and meanings that cross disciplines • Work to build up resources within national organizations that will serve diverse populations & communities • Use only strengths-based, solution-focused language and avoid blaming

	• Develop cross-training programs • Do not be afraid to talk about issues involving race, socioeconomic status, gender, sexual orientation, etc.; silence is more damaging than direct problem solving
Confusion and controversy • There are differences in opinions related to who should do what, when and for whom • People do not know what others do, and have perspectives on what others should be doing • Persons are not given permission to disagree • Roles and expectations may be interpreted differently • Simply having multiple stakeholders allows for confusion • Key points of contact in the collaboration are not necessarily accountable to each other, but rather to their own individual organization • Communication channels are limited, including during times of disaster response, which leads to miscommunication or inadequate communication	• Minimize a crisis orientation by being in constant, honest communication • Honor differences and disagreement in a healthy way by establishing a culture of shared trust and integrity • Invite partners to share their perceived roles for clarification of expectations; memos of understanding or a written commitment to collaboration may be helpful • Avoid blaming and deficit-centered attitudes by agreeing to use strengths-based, solution-focused language • Spend time and energy on consensus-building aimed at the shared vision and mission • Ensure that each partner sees how they fit the big picture and how it helps them • Convene the parties involved in the collaboration regularly to facilitate communication, planning, and accountability • Develop or share access to newsletters, list-serves, etc., that foster communication and resource sharing within the collaboration • Work strategically through local press, social media, etc., to celebrate collaborations

Relationships with State and Territory VOADs

> *It is imperative for each state and regional VOAD to have an active and engaged Emotional and Spiritual Care Committee.*
> (Disaster Spiritual Care Guidelines, National VOAD)

To successfully integrate disaster emotional care into disaster preparedness, response, and recovery activities, it is important for disaster emotional care (DEC) providers to be active and engaged in the VOAD movement. Joining a state or territory VOAD helps build successful working relationships.

Benefits of VOAD Participation

Active state or territory VOAD participation yields several benefits, including:

- A place at the leadership table: VOAD meetings are natural venues for convening stakeholders, including DEC providers, VOAD member organizations that facilitate DEC services for disaster survivors, and government partners.
- Building relationships and partnerships: Familiarity with and knowledge about the various providers of disaster services in an area can be invaluable when decisions are being made during a disaster situation. It has often been said that the time to exchange business cards is not during a disaster, but beforehand.
- Participation in planning discussions, preparedness activities, and disaster exercises: Engaging in these activities can help DEC providers identify gaps in services and improve service delivery.
- Consciousness-raising: State or territory VOAD attendance leads to increased visibility of disaster emotional care and provides opportunities to advocate for the resources needed to improve availability and quality of DEC services.

Establishing an Emotional and Spiritual Care Committee

Each state and territorial VOAD is encouraged to have a standing emotional and spiritual care committee (ESCC) to facilitate cooperation, communication, coordination, and collaboration among various providers of disaster emotional and spiritual care and with the VOAD membership at large. VOAD member organizations which provide disaster emotional care and/or disaster spiritual care would comprise the core members of an emotional and spiritual care committee. Other groups that might be included in the VOAD ESCC are VOAD member organizations which specialize in caring for diverse populations (*see Section 3*), and government partners tasked with planning for disaster emotional and spiritual care provision. Groups that ordinarily would not consider joining the VOAD movement may find a niche in the ESCC.

Examples of Emotional and Spiritual Care Committee Activities

Compliance
State and territory VOADs are expected to adhere to the National VOAD *Points of Consensus* pertaining to disaster emotional care (*see Appendix C*) and disaster spiritual care (see link in Appendix D). The ESCC assists VOAD member organizations by informing them of and encouraging their compliance with these agreements.

Planning
State and territory VOAD ESCCs play a key role in planning for effective disaster emotional care delivery by reviewing government emergency and disaster plans and contributing input to government entities tasked with disaster emotional care planning. Building strong relationships prior to a disaster can greatly improve the coordination of service delivery in a community's time of need.

Capacity-building
The state or territory VOAD ESCC can contribute to capacity building for disaster emotional care within its jurisdiction in a variety of ways. Some examples include:
- ESCC-sponsored presentations to community behavioral health providers to acquaint them with the basic tenets of disaster emotional care and to recruit additional volunteers into VOAD-affiliated organizations;
- mutual aid agreements between VOAD member organizations and community agencies to address the needs of vulnerable populations or address gaps in disaster emotional care services;
- regular disaster trainings and exercises to build the community's capacity for providing appropriate and effective disaster emotional care.

Response coordination
The state or territory VOAD ESCC has an important role to play in the event of any local disaster that necessitates the assistance of National VOAD partners. The state or territory ESCC can serve as:
- a clearinghouse for information;
- a conduit for obtaining National VOAD resources;
- a vetting committee for inviting outside aid organizations into the community.

Potential Challenges and Suggestions for Overcoming Challenges

Establishing and maintaining an effective ESCC

Having a successful state or territory Emotional and Spiritual Care Committee is effortful and requires intentional planning. First steps would include establishing a committee mission statement, setting clear goals, and creating a multi-year plan for growing the committee. ESCCs may decide to elect a chairperson, create a formal governance structure, and make regular reports at state, territorial, and local VOAD or COAD meetings. The National VOAD

Emotional and Spiritual Care Committee provides foundational documents, educational opportunities, and support for state and territory ESCCs (*see Appendix D*). Three state/territorial VOAD representatives serve as official representatives to the NVOAD ESCC and serve a liaison function with all state/territorial VOADs.

Encouraging participation

As with many VOAD activities, it is difficult to recruit committee members and obtain commitments to participate when a disaster is not imminent.   Some strategies for overcoming this barrier include:
- investing time in building relationships with potential members;
- stating a clear rationale for the emotional and spiritual care committee;
- holding educational events and disaster exercises;
- addressing topics that appeal to members' specific needs and interests.

Educating other VOAD members about the ESCC role
The state and territory VOAD can benefit from a strong emotional and spiritual care committee, and it is important to keep VOAD members apprised of the committee's activities. Some ways of doing so include:
- making presentations on emotional and spiritual care topics;
- providing regular committee reports;
- participating in disaster exercises to demonstrate the contributions of disaster emotional care.

Integration across the Disaster Cycle

Disaster emotional care should be integrated into all phases of the disaster cycle. Following are some recommended activities.

Preparedness

Disaster emotional care activities that can help communities prepare for disaster include:
- Fostering awareness of disaster-related emotional needs and concerns.
- Identifying trusted, credible, community resources (behavioral health services, etc.) to assist in the event of disaster.
- Building partnerships within the community and integrating disaster emotional care into disaster response and recovery plans.
- Implementing programs and providing public education to build psychological resilience in the community.

Readiness

Key components to capacity-building for disaster emotional care within and between VOAD member organizations include:
- Identifying and recruiting emotional care providers within the community, state, and territory. (*See Section 2.*)
- Promoting affiliation of providers with agencies and organizations with a disaster emotional care program that follows VOAD guidelines.
- Training disaster emotional care providers and including them in disaster exercises. (See recommendations in Section 2.)
- Forming relationships with disaster spiritual care, local behavioral health providers and other community resources, and state and territory VOADs. (*See Section 4.*)

Response

Disaster emotional care (DEC) activities during the disaster response phase include:
- Deploying DEC teams according to the processes and procedures developed by each VOAD member organization.
- Providing DEC services to individuals, families, and communities impacted by a disaster. (*See Section 2 for extensive discussion of DEC services.*)
- Offering public education materials to help communities recognize and cope more effectively with the emotional effects of disaster.
- Consulting with schools, behavioral health clinics, social services, hospitals, faith communities, and other potential support networks for disaster-impacted individuals and families within the community.

Recovery

During the recovery phase, disaster emotional care (DEC) providers assist communities by:
- Providing DEC interventions which focus on long-term recovery. DEC providers explore how survivors are thinking, feeling, and behaving after the disaster, and provide solutions that will enhance adjustment and recovery. (*See Section 2.*)
- Encouraging and equipping community support groups with the information they need to address emotional needs of disaster survivors.
- Participating in long-term recovery groups and VOAD-sponsored long-term recovery committees. DEC providers, especially those affiliated with local agencies, should be part of the community's long-term recovery efforts.
- Assisting communities in recognizing disaster anniversaries and planning appropriate events and supportive activities.

Appendices

Appendix A:
Checklist for Collaboration among Disaster Emotional Care Providers

This checklist summarizes strategies for fostering collaboration within the Voluntary Organization Active in Disaster (VOAD) movement between local, state, territorial, and national Disaster Emotional Care Providers, throughout the disaster cycle.

Introduction:

Disaster emotional care (DEC) providers vary greatly in size and scope and are as diverse as the communities they serve. Providers may include disaster emotional care in their primary mission or may only offer disaster emotional care services in the context of a specific disaster event, including specialized DEC services operationalized during the long-term recovery phase.

In order to effectively serve individuals, families, and communities, it is essential that DEC providers at the local, state, territorial, and national levels develop and sustain collaborative relationships throughout the disaster cycle.

CHECKLIST FOR COLLABORATION

Preparedness

☐ Identify key local, state, territorial, and national DEC providers:

1. Contact the National VOAD Emotional and Spiritual Care Committee (ESCC) to obtain information on which NVOAD member organizations provide DEC

2. Locate your state/territorial VOAD chapter contact information to obtain information on DEC providers who are state-wide in scope and to obtain information on local (city, county) VOAD/COAD chapters who will be able to facilitate connections with local DEC providers

☐ If you are a DEC provider but are currently not a member of your local, state, or territorial chapter, and/or are not a National VOAD member organizations (depending on your organization's size/scope), consider joining to further enhance your capacity for collaboration

☐ Once DEC providers are identified and contact information obtained, facilitate introductions & exchange information on assets & other DEC resources available, during which phase(s) of the disaster cycle, and for specific types of disasters (e.g., does your organization specialize in providing DEC to children? Are multi-lingual services available? Does your organization offer expertise in supporting survivors of incidents of mass violence? Etc.)

☐ After connecting with other DEC providers via VOAD and becoming a dues-paying member organization (or renewing your organization's membership), stay actively

engaged: Attend meetings regularly, participate in coordination calls, conferences, other events

☐ If your local and/or state VOAD/COAD chapter has its own ESCC, become involved; if not, help to form one

☐ During preparedness or times without crisis, work with other DEC stakeholders in disaster preparedness, response, and recovery to identify, assess, and create action plans for addressing any unmet needs in DEC of which your organizations are aware

☐ Enter into formal partnerships, agreements, MOUs, etc., with DEC providers and/or other stakeholders in disaster preparedness, response, and recovery, as needed

☐ Advocate for inclusion of DEC in local, state, territory, and/or national disaster preparedness plans, including disaster preparedness exercises and other activities

☐ Invite DEC providers to serve on task forces, working groups, etc.

☐ Engage with other DEC providers on social media to maximize exchange of resources and cross-promote services

Response

☐ Initiate contact with local, state, territory, and/or national DEC providers depending on the location, size, scope, and other variables surrounding the disaster event, including operationalizing any roles as defined in formal partnerships, agreements, MOUs, etc.

☐ Participate in national, state, territorial, and/or local response coordination calls and other meetings, advocate for inclusion of DEC in the agenda (or offer to help organize or participate in DEC-specific coordination calls & meetings), and invite and ensure the participation of those DEC providers who are closest to the affected communities to participate and play an active role in developing and carrying out coordination/meeting agendas

☐ Continue to assess and identify unmet needs in DEC with all DEC providers involved as well as other stakeholders in disaster preparedness, response, and recovery who are serving affected individuals, families, and communities, continuing to share and develop new resources to address emerging or evolving needs

Recovery

☐ Sponsor or participate in evaluation/"hot wash" debriefings, advocate for inclusion of DEC in the agenda of such exercises, and/or sponsor or participate in DEC-specific debriefings

☐ Via local DEC providers, connect and offer support to Long Term Recovery Groups and other forums where ongoing needs in DEC can be addressed and coordinated

☐ National DEC providers: Facilitate access to funding opportunities & other forms of continued support during recovery for local, regional, state, and/or territorial DEC providers

☐ Re-connect with local DEC providers for milestone disaster anniversary & trigger events

Appendix B:
Fact Sheet for Emergency Management on Disaster Emotional Care

Disaster emotional care (DEC) is an essential component of FEMA's Emergency Support Function [ESF] 6 – *Mass Care, Emergency Assistance, Temporary Housing, and Human Services*. DEC is also a critical component of ESF 8 – *Public Health and Medical Services*; and Recovery Support Function *Health and Social Services*). DEC may be a valuable skill of general (non-disaster specific) emotional care and behavioral health providers.

This document provides suggestions for emergency managers when considering the behavioral health implications of a disaster. The following tips should be used in collaboration with state, territorial, and/or local behavioral health providers who have expertise in disaster emotional care.

Guide for Emergency Managers on Working with Disaster Behavioral Health Providers[26]

Pre-planning

- Familiarize yourself with National VOAD *Disaster Emotional Care Points of Consensus* and *Disaster Emotional Care Guidelines*

- Create a list of possible disaster emotional care providers in the area. DEC providers may be affiliated with these organizations:

  o VOAD member organizations

  o Medical Reserve Corps (may have an emotional care provider on team)

  o Corporate support companies

    ▪ KonTerra

    ▪ Crisis Care Network

    ▪ Others

  o State Disaster Emotional Care team

- Identify disaster emotional care providers who work with diverse populations, such as:

  o Children and youth

  o Older adults

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1   [26]Adapted from Flynn, B. & Sherman, R. (Eds.) *Integrating Emergency Management and Disaster Behavioral Health, 1st Edition: One Picture through Two Lenses* (2017) Elsevier Publications.

- o People with functional and access needs, including disabilities

    - Councils for Independent Living and other disability rights organizations

    - Residential facilities for various populations, including people with substance abuse issues, development disabilities and others

  - o Diverse ethnic/cultural groups

- Invite disaster emotional care providers to join VOAD meetings, drills and exercises

  - o Include disaster emotional care experts in planning drills and exercises

  - o Add injects related to behavioral health issues

  - o Identify emotional care impacts to diverse populations

- Ask for consultation related to special events, e.g., anniversaries of tragedies or community commemorations

During an event

- Include disaster emotional care (DEC) providers on leadership teams

- Bring in specialists to attend to the needs of the impacted demographic groups

- Utilize DEC providers to plan for staff care

- Consult with DEC providers on mitigation of long-term psychological impacts

After an event

- Work with DEC providers to plan for anniversaries and memorials

- Use DEC experts to develop community resilience-building strategies

Appendix C:
Disaster Emotional Care Points of Consensus

NATIONAL VOLUNTARY ORGANIZATIONS ACTIVE IN DISASTER DISASTER EMOTIONAL CARE POINTS OF CONSENSUS

In May 2005, the Emotional and Spiritual Care Committee of the National Voluntary Organizations Active in Disaster (National VOAD) approved points of consensus regarding provision of early psychological intervention for persons affected by disaster. The following statements about Early Psychological Intervention were included: Early Psychological Intervention is valued, has multiple components, requires specialized training to deliver, and represents one point of a continuum of emotional care. This Points of Consensus document was subsequently incorporated into guidelines for disaster emotional care by National VOAD member organizations.

In 2013, the National VOAD's Emotional and Spiritual Care Committee appointed a new subcommittee to write an updated list of agreed upon principles to guide both National VOAD organizations and community care providers to prepare for, respond to, and promote recovery from disaster. In the spirit of the National VOAD "Four Cs" (cooperation, communication, coordination and collaboration), this document expands and replaces the 2005 Early Psychological Intervention Points of Consensus, complements the Disaster Spiritual Care Points of Consensus approved in 2009, and reflects current knowledge and ethical principles for disaster emotional care provision.

The following ten points of consensus are minimal standards, ethical, or operational principles specific to Disaster Emotional Care. To continue as a member of National VOAD, organizations are required to agree to abide by approved Points of Consensus. This document was presented by the Disaster Emotional Care subcommittee to the National VOAD Emotional and Spiritual Care Committee in May 2014. Guidelines to outline the implementation of the principles contained in this document are under development.

1. Basic concepts of disaster emotional care

a) Disaster emotional care is a valuable component of comprehensive disaster preparedness, response, and recovery.
b) Disaster emotional care promotes resilience, helps mitigate long and short-term psychological consequences of disaster, and facilitates recovery.
c) Disaster emotional care includes a range of supportive actions grounded in concepts of resilience and behavioral health.
d) Disaster emotional care activities are informed by relevant research and established best practices.

e) Disaster emotional care is not psychotherapy, nor a substitute for psychotherapy. However, it is often the first step that could lead to professional counseling and psychotherapy.

f) Disasters significantly affect everyone and their communities, including individuals, family and social networks, rescue workers, health care providers, faith communities and spiritual care providers, impacted businesses, and vulnerable populations.

g) People impacted by disaster will experience a range of emotional responses, of varying intensity and duration.

h) People's emotional responses to disaster are influenced by a variety of factors, including degree of exposure, individual resilience, and recovery environment.

i) Specialized training is necessary for effective disaster emotional care.

2. Types of disaster emotional care

Emotional care is provided across the disaster continuum from preparedness to response and recovery. Emotional care takes many forms, and emotional care providers are from diverse professional backgrounds.

Accepted types of disaster emotional care include, but are not limited to:
- Preparedness activities
- Assessment and triage activities
- Psychosocial support activities
- Early psychological intervention activities
- Recovery activities

3. Capacity building, readiness and planning components of disaster emotional care

Capacity building involves identifying and recruiting appropriate disaster emotional care providers. In order to deliver effective disaster emotional care, it is essential that providers engage in training and exercises, and become affiliated with a disaster relief organization. Disaster emotional care providers have an important role in planning and mitigation efforts and contribute toward building resilient communities.

4. Local community resources

Local providers of emotional care are an integral part of their communities pre-disaster and therefore are primary resources for also providing post-disaster emotional care services. Because local providers of emotional care are uniquely equipped to serve their communities, any emotional care services from outside the community support but do not substitute for local efforts. In this context, the principles of the VOAD movement – cooperation, communication, coordination, and collaboration – are essential to the delivery of emotional care.

5. Disaster emotional care and resilience

Resilience is defined as the strengths of an individual or community to respond well to adversities. Resilience can be both inborn and developed, and most people are inherently resilient. Research suggests that most people impacted by a disaster will return to pre-disaster levels of functioning and some people will grow as a result of the experience. Disaster emotional care providers should encourage survivors to recognize and strengthen their resilience as a part of disaster emotional care intervention.

6. Disaster emotional care in recovery

In order for communities to fully recover and integrate the disaster into their history, emotional care is essential as part of a program of services. Disaster emotional care providers work with state and local recovery committees to offer services related to the disaster, encourage programs aimed at strengthening community resilience, and facilitate counseling and supportive services for persons in need. Pre-existing community programs are the primary emotional care providers whose capacity to serve the community will be acknowledged, supported, and strengthened.

7. Disaster emotional care for the caregiver

Providing emotional care in disaster can be an overwhelming experience. The burdens of caring for others in this context can lead to compassion fatigue. Understanding important strategies for self-care is essential for emotional care providers. Disaster response agencies have a responsibility to care for their own staff during all phases of disaster deployment and to model healthy work and life habits. Post-deployment support processes for emotional care providers are also essential.

8. Disaster emotional care and its relationship to disaster spiritual care[27]

Mental health professionals partner with spiritual care providers in caring for individuals and communities in disaster. Spiritual and emotional care are important components of comprehensive disaster care; these share some similarities but are distinct healing modalities. Spiritual care providers are important partners in referring individuals to receive care for their mental health and vice versa.

9. Disaster emotional care and diversity

As a foundation of disaster emotional care, providers respect diversity among colleagues in emotional and spiritual care and within communities served, including but not limited to race, ethnicity, culture, gender, age, sexual orientation, spiritual/religious practices, socioeconomic status, and disability. Disaster emotional care providers strive for cultural awareness and sensitivity, and adapt care strategies to address cultural differences in the individuals and communities they serve.

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[27] See Light Our Way, 1st Edition, pp. 52-54

10. Ethics and Standards of Care

National VOAD members affirm the importance of professional standards of care and the obligation to follow legal and ethical guidelines. Adherence to common standards and principles promotes the delivery of effective and appropriate disaster emotional care.
Disaster emotional care services should incorporate the principles of:
- Personal and professional integrity
- Accountability and responsibility
- Recognition of the boundaries of one's competence
- Respect for people's rights and dignity, including privacy and self-determination
- Promotion of safety and protection of people affected by disaster

[Ratified by National VOAD Full Membership, May 2015]

Appendix D:
Resources

National Voluntary Organizations Active in Disaster (National VOAD)

Physical address: Mailing address:
950 N. Washington St.   P.O. Box 26125
Alexandria, VA 22314   Alexandria, VA 22314

Phone: 703-778-5088
Email: info@nvoad.org
Website: www.nvoad.org

Emotional and Spiritual Care Committee (ESCC) of National VOAD

Link: www.nvoad.org/emotional-spiritual-care-committee

ESCC Disaster Emotional Care Resources

Resources developed by the National VOAD Emotional and Spiritual Care Committee include:
- Disaster Emotional Care Guidelines
- Disaster Emotional Care Guidelines Quick Reference Guide (in development, 2019)
- Disaster Emotional Care Points of Consensus

Link: https://www.nvoad.org/resource-center/member-resources/?mdocs-cat=mdocs-cat-60&mdocs-att=null

ESCC Disaster Spiritual Care Resources

Resources developed by the National VOAD Emotional and Spiritual Care Committee include:
- Disaster Spiritual Care Guidelines
- Disaster Spiritual Care Guidelines Quick Reference Guide
- Disaster Spiritual Care Points of Consensus
- Light Our Way, 2nd Edition

Link: https://www.nvoad.org/resource-center/member-resources/?mdocs-cat=mdocs-cat-60&mdocs-att=null

FEMA Resources

National Disaster Response Framework
Link: https://www.fema.gov/media-library/assets/documents/117791

National Disaster Recovery Framework
Link: www.fema.gov/national-disaster-recovery-framework

Appendix E:
Glossary and Acronyms

Glossary

Access and Functional Support Needs:
Access and Functional Support Needs may include but are not limited to:
- Children and adults with physical, mobility, sensory, intellectual, developmental, cognitive or mental health disabilities
- Older Adults
- People with chronic or temporary health conditions
- Women in late stages of pregnancy
- People needing bariatric equipment
- People with Limited English Proficiency, low literacy or additional communication needs
- People with very low incomes
- People without access to transportation
- People experiencing homelessness

Community Organizations Active in Disaster (COAD):
COADs tend to be coalitions of community organizations that may or may not formally identify with the VOAD movement. In contrast to State or Territorial VOADs, COADs are more likely to be led by a government agency, like a county emergency management department.

Competencies:
Competence as a licensed behavioral health provider working in primary care refers to the knowledge, skills, and attitudes—and their interconnectedness—that allow an individual to perform the tasks and roles in that setting (adapted from Kaslow, Dunn, & Smith, 2008).

Confidentiality:
A principle of ethics requiring providers of mental health care or medical care to limit the disclosure of an individual's identity, his or her condition or treatment, and any data entrusted to professionals during assessment, diagnosis, and treatment.

Coping:
Coping refers to the human behavioral process for dealing with demands, both internal and external, in situations that are perceived as threats. This process is often an automatic action or set of actions taken in dealing with stressful or threatening situations. These actions/behaviors can be both positive (i.e., adaptive), for example, taking time to meditate or exercise in the middle of a hectic day; or negative (i.e., maladaptive, avoidant), for example, not consulting a doctor when symptoms of serious illness appear or persist.

Crisis Intervention:
The brief ameliorative, rather than specifically curative, use of psychotherapy or counseling to aid individuals, families, and groups who have undergone a highly disruptive experience, such

as an unexpected bereavement or a disaster. Crisis intervention may prevent more serious consequences of the experience, such as posttraumatic stress disorder.

Cultural Competency:
The practice of striving to gain an awareness and understanding of various attributes of diverse cultures that would enhance the ability of organizations, agencies, institutions and individual providers to more effectively serve a person, family, and/or community. Developing cultural competency is a long-term process and while providers can become proficient in cultural competency, training and support in this area should never be considered complete: There are always evolving ways that people within diverse cultures express themselves, necessitating constant learning and developing new or adapting existing approaches to care.

Cultural Diversity:
A broad term used to describe the existence of many cultures within a society, or larger 'monoculture'. Cultural diversity may include but is not limited to race, color, ethnicity, national origin, immigration or citizenship status, socioeconomic status, veteran status, religious and spiritual beliefs, sex, gender identity, sexual orientation, age, or different physical and sensory abilities. Additional aspects of cultural diversity include:
- Culture influences many aspects of our lives—from how we communicate and celebrate to how we perceive the world around us.
- Culture involves shared customs, values, social rules of behavior, rituals and traditions, and perceptions of human nature and natural events.
- Elements of culture are learned from others and may be passed down from generation to generation.

Disability:
- A physical or mental impairment that substantially limits one or more major life activities of such individual;
- A record of such an impairment; or
- Being regarded as having such an impairment

This does not apply to impairments that are transitory and minor. A transitory impairment is an impairment with an actual or expected duration of 6 months or less

Disaster:
A sudden, calamitous event that seriously disrupts the functioning of a community or society and causes human, material, and economic or environmental losses that exceed the community's or society's ability to cope using its own resources.

Disaster Behavioral Health:
The provision of mental health, substance abuse, and stress management services to disaster survivors and responders. Following an emergency event, it is common for individuals and families, as well as disaster responders, to experience distress and anxiety about safety, health, and recovery. Natural disasters, terrorist attacks, and other emergencies over the last several years, along with recent research on the impacts of these events, have highlighted the need for

disaster behavioral health capabilities. Behavioral health professionals trained in disaster response often work in shelters, medical and psychiatric facilities, or may engage in outreach and educational activities in communities to facilitate the resiliency and recovery of survivors and responders. (DBH) is an integral part of the overall public health and medical response to any emergency event. DBH addresses the psychological, emotional, cognitive, developmental, and social impacts that disasters have on survivors and responders as they respond and recover. Disaster behavior health services fall under the scope of both disaster emotional care and disaster health.

Disaster Behavioral Health Concept of Operations (ConOps):
Health and Human Services Disaster Behavioral Health ConOps outlines how federal and — state, local, territorial, and tribal (SLTT) collaboration utilizes the strength of the existing health and behavioral health structures to achieve success in both response and recovery. (This Concept of Operations plan (CONOPS) describes the conceptual framework and coordination for U.S. Department of Health and Human Services (HHS) federal-level behavioral health preparedness, response, and recovery for disasters and public health emergencies. The plan describes how HHS prepares for the behavioral health effects of a public health and medical emergency or disaster and transitions from normal day-to-day operations to coordinated department-wide response and recovery activities.)

Disaster Behavioral Health Provider:
A person who is licensed by a state, whose professional activities address a client's behavioral issues. Examples include psychiatrists, psychologists, social workers, psychiatric nurse practitioners, marriage and family counselors, professional clinical counselors, and licensed drug/alcohol abuse counselors.

Disaster Emotional Care:
An umbrella term that includes a wide range of services intended to offer comfort, support, and resources to individuals, families and communities throughout all phases of the disaster cycle. Grounded in concepts of resilience and behavioral health, and informed by research and best practices, disaster emotional care is intended to mitigate and prevent serious psychological consequences of disaster, to offer appropriate referral for those needing higher levels of care, and to facilitate psychological recovery and a return to adaptive functioning.
Source: National VOAD, Emotional and Spiritual Care Committee, *Disaster Emotional Care Points of Consensus,* ratified May 2015

Disaster Emotional Care Provider:
An individual affiliated with an established disaster relief organization with specialized training whose primary role is to provide disaster emotional care to individuals, families, communities and responders impacted by disaster. DEC providers include licensed mental health professionals, licensed behavioral health professionals, paraprofessionals, and crisis response and peer support teams with appropriate credentials and specialized training in disaster emotional care.

Disaster Emotional Care for Children and Youth:
For children and youth, disaster emotional care most often is provided through the intentional nurturing and attentive listening of caregivers trained to meet the needs of children in disaster through expressive and open-ended play activities (*see Section 3*). Children and youth less often would receive disaster emotional care from a mental health professional with a specialty in pediatric mental health.

Disaster Mental Health:
Emotional care for disaster survivors and responders delivered by licensed mental health professionals during all phases of disaster. Disaster mental health services include identifying the needs of survivors and responders, promoting the coping and resilience of individuals and families, and connecting specific individuals and families with community mental health resources when needed. Disaster mental health also includes helping communities mitigate the effects of disasters by providing family, neighborhood and community preparedness and resilience training.

Disaster Mental Health Providers:
Licensed professionals from the fields of counseling, marriage and family therapy, psychiatry, psychiatric nursing, psychology, school counseling, school psychology, or social work who are trained to deliver disaster mental health services.

Disaster Spiritual Care:
A sustaining care that assists individuals, families, and communities affected by disaster to draw upon their own inner religious or spiritual resources as a form of strength that bolsters the recovery process. In the context of a disaster, spiritual care involves responding to the poignant need for spiritual meaning and comfort by providing accompaniment, compassionate care, individual and communal prayer and appropriate ritual

Emergency Support Function:
Emergency Support Functions (ESFs) provide the structure for coordinating Federal inter agency support for a Federal response to an incident. They are mechanisms for grouping functions most frequently used to provide Federal support to States and Federal-to-Federal support, both for declared disasters and emergencies under the Stafford Act and for non-Stafford Act incidents.

Emotional Support:
Reassurance, acceptance, and encouragement given by one person to another. Emotional support is one of the main components of Psychological First Aid.

FEMA Crisis Counseling Program (CCP):
FEMA's Crisis Counseling Program helps individuals and communities recover from natural and human-caused disasters through community outreach and access to mental health services. The CCP is a short-term disaster relief grant for states, U.S. territories, and federally recognized tribes. CCP grants are awarded after a presidential disaster declaration. CCP funding supports

community-based outreach, counseling, and other mental health services to survivors of natural and human-caused disasters.

Functional Needs Support Services (FNSS):
FNSS are services that enable individuals with access and functional needs to maintain their independence in a general population shelter. Examples of support services include durable medical equipment, consumable medical supplies, and personal assistance services. Individuals requiring Functional Needs Support Services may have physical, sensory, mental health, and cognitive and/or intellectual disabilities affecting their ability to function independently without assistance.

Informed Consent:
A person's voluntary agreement to participate in a procedure on the basis of his or her understanding of its nature, its potential benefits and possible risks, and available alternatives.

National Voluntary Organizations Active in Disaster (National VOAD):
National VOAD, an association of organizations that mitigate and alleviate the impact of disasters, provides a forum promoting cooperation, communication, coordination and collaboration; and fosters more effective delivery of services to communities affected by disaster.

National VOAD Member Organizations:
National VOAD Member organizations represent a diverse group of organizations that provide a wide range of skills in service to people and communities impacted by disaster. All member organizations have service-oriented missions and include volunteer engagement as a key component of their operations. These member organizations are dedicated to whole community engagement and recognize that the VOAD movement values and practices represent a proven way to build resilient communities.

Paraprofessional:
A person to whom a particular aspect of a professional task is delegated but who is not licensed to practice as a fully qualified professional. In the context of disaster emotional care, a paraprofessional is a person who is specifically trained in disaster emotional care principles and interventions but who is not a licensed or certified behavioral health provider. Paraprofessionals may include: peer support personnel trained to provide crisis intervention or psychological first aid; disaster spiritual care providers with specialized training in disaster emotional care; and crisis-trained and credentialed handlers of specially trained animals used to provide comfort and support to survivors and disaster workers.

Post-Traumatic Growth:
Post-traumatic growth (PTG) describes positive changes experienced as a result of the struggle with a major life crisis or a traumatic event. Posttraumatic growth tends to occur in five general areas: new opportunities and possibilities; improved relationships with others; increased sense

of one's own strength; greater appreciation for life in general; and deepening of one's religious and spiritual life.

Post-Traumatic Stress Disorder:
Post-Traumatic Stress Disorder (PTSD) is a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, rape or other violent personal assault.

Psychoeducation:
The process of providing information and education. In a disaster setting, psychoeducation helps individuals understand when their reactions are due to the expected stresses of the disaster. Informing both survivors and workers that they are functioning as well as can be expected given the circumstances will promote their resilience and lead to more adaptive coping strategies.

Psychological First Aid (PFA):
Psychological First Aid (PFA) is an evidence-informed modular approach for assisting people in the immediate aftermath of disaster and crisis events to reduce initial distress, manage intense emotions, and to foster short and long-term adaptive functioning by promoting a safe, calm environment. It is used by first responders, incident command systems, primary and emergency health care providers, school crisis response teams, faith-based organizations, disaster relief organizations, and other care providers in diverse settings.

Psychopathology:
The term psychopathology refers to either the study of mental illness or mental distress or the manifestation of behaviors and experiences, which may be indicative of mental illness or psychological impairment.

Referral:
The act of directing an individual to a therapist, physician, agency, or institution for evaluation, consultation, or treatment.

Resilience:
The process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, spiritual, and behavioral flexibility and adjustment to external and internal demands. A number of factors contribute to how well people adapt to adversities, predominant among them (a) the ways in which individuals view and engage with the world, (b) the availability and quality of social resources, and (c) specific coping strategies. Psychological research demonstrates that the resources and skills associated with more positive adaptation (i.e., greater resilience) can be cultivated and practiced. Also called *psychological resilience.*

Risk Factor:
A clearly defined behavior or constitutional (e.g., genetic), psychological, environmental, or other characteristic that is associated with an increased possibility or likelihood that a disease or disorder will subsequently develop in an individual.

Trauma:
Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

Unaccompanied Minor:
An unaccompanied minor is an unemancipated child younger than 18, who has been separated from parents, legal guardians, other relatives, schools or childcare providers, and is not being cared for by an adult who, by law or custom, is responsible for doing so.

Acronyms

Acronym	Full Name
ADA	Americans with Disabilities Act
AFN	Access and Functional Needs
CISM	Critical Incident Stress Management
COAD	Community Organizations Active in Disaster
DEC	Disaster Emotional Care
DSC	Disaster Spiritual Care
ESCC	Emotional and Spiritual Care Committees
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, and other ("Q+") individuals who identify as a sexual and/or gender minority
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
PFA	Psychological First Aid
PTSD	Post-Traumatic Stress Disorder
VOAD	Voluntary Organizations Active in Disaster