**PROMOTING DISASTER MENTAL HEALTH PREPAREDNESS AMONG FAITH-BASED ORGANIZATIONS IN ALLEGHENY COUNTY, PENNSYLVANIA**

by

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**ABSTRACT**

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Psychological resiliency to disasters has been a growing focus of emergency management in recent years. The major psychosocial impacts of disasters include stress-induced psychological disorders, relational problems, increased substance abuse, and the disruption of beneficial social networks. These outcomes negatively impact resilience at individual and community levels. Demands for mental health interventions following disaster can rapidly overwhelm mental health providers’ ability to meet mental health needs. Recent literature has proposed training unlicensed mental health providers to augment the services of licensed mental health providers and chaplains. This paper describes an effort to strengthen disaster mental health response capacity through the integration of faith-based organizations as providers of disaster mental health and Spiritual Care services. This project was sponsored through collaboration between Christian Associates of Southwest Pennsylvania and the Allegheny County Department of Human Services.

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Outreach was conducted in eight communities in Eastern Allegheny County over a one-year period. Outreach activities involved interviewing faith leaders, presenting to ministerial associations, and organizing informational meetings. The three goals of the community outreach were to educate faith-based organizations about the role of faith-based organizations in disasters, to provide a point of contact for further information, and to encourage participation with the Allegheny County Volunteer Organizations Active in Disaster (VOAD). At the end of the outreach period, fifty-seven organizations were contacted, a total of four congregations expressed an interest in becoming active in disaster response, and four ministerial organizations began discussing their role in disaster preparedness and response.

Outreach activities resulted in marginal success in promoting continued participation. Four primary barriers became apparent: frequent leadership turnover, funding limitations, competing time commitments, and volunteer liability concerns. Additionally, a major finding suggests that an active VOAD is a crucial component of sustaining a well-organized reserve of volunteer personnel with a readiness to respond. This community organizing effort holds public health significance by identifying how faith-based organizations may potentially be a community resource to help alleviate the burden of psychiatric stress.

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# Common abreviations

|  |  |
| --- | --- |
| CASP | Christian Associates of Southwest Pennsylvania |
| CBT | Cognitive Behavioral Therapy |
| CISD | Critical Incident Stress Debriefing |
| CYS | Children and Youth Services |
| DCORT | Disaster Crisis Outreach Teams |
| DHS | Department of Human Services (Allegheny County) |
| DFP | Department of Federal Programs |
| DOA | Department of Aging |
| EOC | Emergency Operations Center |
| ESF | Emergency Support Function |
| FBO | Faith-Based Organization |
| GAD | Generalized Anxiety Disorder |
| ICS | Incident Command System |
| IOM | Institute of Medicine |
| MCI | Mass Casualty Incident |
| MDD | Major Depressive Disorder |
| MMRS | Metropolitan Medical Response System |
| NCTSN | National Child Traumatic Stress Network |
| NVOAD | National Voluntary Organizations Active in Disaster |
| OBH | Office of Behavioral Health |
| PD | Psychological Debriefing |
| PFA | Psychological First Aid |
| PTSD | Post-Traumatic Stress Disorder |
| PsySTART | Psychological Simple Triage and Rapid Treatment |
| SAMHSA | Substance Abuse and Mental Health Service Administration |
| SCU | Service Coordination Unit |
| SES | Socio-Economic Status |
| VPA | Volunteer Protection Act of 1997 |
| VOAD | Voluntary Organizations Active in Disaster |

# Introduction

In the post-September 11th era of emergency management, effective mitigation of post-traumatic stress is becoming recognized as an important component of community resilience necessary for disaster recovery. The burden of post-traumatic stress is felt by communities afflicted by disaster from the initial impact to long after the immediate hazards to physical health have been resolved. Some reports have documented psychological casualties to greatly outnumber physical casualties. [[1-4](#_ENREF_1)] Unlike physical injuries or disease, post-traumatic stress reactions are not outwardly visible and the long-term effects of traumatic stress exposure can impact both individual and community capacities for recovery. [[2](#_ENREF_2)]

Resilience to disaster-induced stress has become an area of focus for national and international disaster readiness imperatives. The Healthy People 2020 objectives has identified disaster mental health as an emerging issue requiring research to develop evidence-based interventions that reduce the burden of post-traumatic stress on recovering communities. [[5](#_ENREF_5)] The National Health Security Strategy has described resilient communities as being “prepared to take deliberate, collective action in the face of an incident and have developed material, physical, social, and psychological resources that function as a buffer to these incidents and help protect people’s health.” [[6](#_ENREF_6)] The Sphere Project outlines the psychosocial aspects of disaster as one of the cross-cutting themes in humanitarian response to disasters in the following statement: “Some of the greatest sources of vulnerability and suffering in disasters arise from the complex emotional, social, physical and spiritual effects of disasters.”[[7](#_ENREF_7)] A comprehensive public health disaster response plan requires interventions that strengthen the physical and mental components of human health. This paper will describe the implementation and outcomes of the Eastern Allegheny County Faith-Based Disaster Preparedness Initiative. This initiative attempted to strengthen disaster mental health response capacity in Allegheny County through partnership of faith-based organizations (FBOs) as Psychological First Aid (PFA) and Spiritual Care providers.

# Review of literature

This review will briefly describe the mental health impacts of disaster, discuss current mental health interventions, emphasize the shift to community-based interventions and “whole community emergency management,” and lastly highlight a few of the key limitations in disaster mental health research. The purpose of this review is to support the supposition that psychological resiliency is a necessary component for successful disaster recovery.

## epidemiology of disaster mental health

Unlike physical injuries, the psychological wounds inflicted on individuals exposed to mass trauma are often more difficult to identify. Disaster mental health research relies heavily on self-reported manifestations of behavior and by tracking the delivery of mental health services following the insult of a psychological stressor. Most epidemiological studies of traumatic stress assume a dose-response relationship where the intensity and duration of the event correlate with negative psychological outcomes. Disaster mental health research has not yet described a concise methodology of defining exposure metrics of traumatic stress. Furthermore, the complex interactions of individual and community dynamics contribute to a wide range of psychiatric responses to traumatic stress. From a planning and preparedness perspective, it is useful to understand the factors that engender risk as well as resistance.

Galea et al conducted a review of 192 different disasters documented since 1980 with the intent of specifically detailing the prevalence of Post-Traumatic Stress Disorder (PTSD). [[4](#_ENREF_4)] The year 1980 is significant because this was the first year that PTSD was defined as a mental health diagnosis in the *Diagnostic and Statistics Manual of Mental Disorders.* Of these 192 disasters, 86 studies described natural disasters and 106 described man-caused or technological disasters. Galea et al found that PTSD prevalence following man-caused disasters was predicated on an individual’s involvement in the disaster. For example, victims of man-caused disasters showed the highest prevalence of PTSD at 25-75%, while rescue workers demonstrated 5-20% prevalence of PTSD, and general populations demonstrated a 1-11% prevalence of PTSD. Reports chronicling natural disasters on the other hand did not draw clear distinctions based on an individual’s involvement in the disaster. Natural disasters exhibited a 5-60% range of PTSD prevalence, however most reports cataloged PTSD prevalence in the lower half of this range

In 2002, Norris, et al conducted a meta-analysis in attempt to definitively describe the mental health impact of 192 disasters during the period of 1981-2001. [[3](#_ENREF_3), [8](#_ENREF_8)] This analysis is probably the most comprehensive descriptive epidemiological study to date representing 61,396 individuals. The goal of this study was to describe the range of psychosocial outcomes following mass trauma and identify factors that predict these outcomes in the post-disaster environment. Norris et al coded measured mental health outcomes into levels of “impairment” according to six categories. The first category incorporated specific psychological problems including PTSD, Major Depression disorder (MDD), Generalized Anxiety Disorder (GAD), and Panic disorder. The second category identified was non-specific distress, which encompassed elevated stress-related complaints such as depression or anxiety that did not meet the *Diagnostic and Statistics Manual for Mental Disorders* criteria for mental health syndrome diagnosis. The third category cataloged health problems or concerns related to traumatic stress such as sleep disturbances, increased alcohol and/or drug use, and cigarette use. The fourth category classified “chronic problems of living” which included issues such as financial stress, interpersonal relationship conflict, family stress, and stress related to rebuilding. The fifth category identified was “psychosocial resource loss” which included the stress related to a decrease in “perceived social support, social embededness, self-efficacy, optimism and control.” Psychosocial resource loss also included perceived vulnerability to personal harm or violence. Lastly, the sixth category focused on “problems specific to youth.” This included a range of age-specific issues such as anxiety, sleep disturbances, and behavioral problems among younger children to increased deviance, delinquency, and academic problems observed in with older children and adolescents. The range of negative psychosocial outcomes underscores the importance of developing disaster mental health interventions to promote community resilience in the wake of mass trauma.

### Individual and community risk factors

There are numerous factors that contribute to individual and community vulnerability to negative mental health outcomes. Each community possesses unique social dynamics that can contribute to vulnerability and resiliency. A few articles have sought to summarize the factors that place individuals at risk of negative psychosocial outcomes. The following risk factors are a reflection of some of the general trends that have emerged.

Norris et al found that the most prominent factors influencing individual and community mental health outcomes included severity of exposure, age, gender, socioeconomic status (SES), and family factors. [[3](#_ENREF_3), [8](#_ENREF_8)] At the individual level, injury or threat to life was found to correlate to greater mental health distress. For rescue workers, mental health impact often was related to interactions with distressed populations, handling or identifying bodies, or disasters involving children. At the community level, Norris found fewer articles documenting the effects of collective loss. Often proximity to the epicenter is used as a factor to measure severity. Otherwise, the amount of community destruction and duration of recovery was found to correlate with worse mental health outcomes.

Norris reported that women and girls were susceptible to greater negative psychological outcomes compared to men and boys. Men were more likely to abuse alcohol than women. Norris recognized age as a proxy for experience. Previous disaster experience contributes to increased psychological resistance to mental distress. Among rescue workers, professional rescuers demonstrated greater mental health resiliency compared to volunteer workers. Concerning ethnicity, being a specific ethnicity was not as important as being a minority. More importantly, marginalized minorities were found to be at greater risk for negative mental health outcomes.

Lower SES and family factors generally correlated with greater negative impact on mental health. SES is often a difficult factor to measure because disasters can impact communities with similar SES characteristics. In a study following Hurricane Katrina, Abramson et al observed that SES was not found to be a predictor of negative mental health outcomes. [[9](#_ENREF_9)] Rather, Abramson et al suggests that social support and coping mechanisms were the greatest predictors of mental health following disasters and that supportive networks of social support are more important in predicting mental health than SES.

### Protective factors

Social support has been consistently found to be a protective factor that contributes to hardiness against traumatic stress. [[3](#_ENREF_3), [8](#_ENREF_8), [9](#_ENREF_9)] Leon reported that, following a disaster event; the extent of disruption of families, kinship groups, and social support networks within communities is a major predictor of the long-term impact of the disaster. [[10](#_ENREF_10)] Acierno et al reported that religious affiliation is a protective factor against negative mental health outcomes. [[11](#_ENREF_11)] The protective nature of religious affiliation may be partially explained by the social support role that religious participation often fills. Harris et al report that religious coping practices can induce mixed psycho-spiritual health outcomes. [[12](#_ENREF_12)] Positive religious coping tended to maintain a benevolent view of the Deity coupled with religious practices as a source of healing. In conjunction, relationship networks with other members of a faith community functioned as a source of social support. In contrast, possessing a negative view of the Deity or viewing the disaster as punishment tended to correlate with negative coping strategies and decreased social support. Additionally, Harris reported that religious response to trauma plays a role in coping effectiveness, citing that individuals who actively sought spiritual support demonstrated lower levels of PTSD compared to individuals who displayed negative religious coping strategies.

The literature suggests that healthy social support networks and effective religious coping strategies play a role in improving psychosocial resilience. Emergency management approaches should also seek avenues to integrate community-based capacities, including religious organizations, into disaster preparedness, response, and recovery plans.

## Sociological impacts

The goal of disaster mental health interventions is to promote resilience to the psychiatric stress of disasters. This paper would be remiss without a brief discussion of the dynamic interplay that creates both vulnerability and resiliency in human systems. However, a comprehensive discussion on human resiliency is beyond the scope of this paper. Shultz et al has defined a disaster as “an encounter between a hazard and a human population in harm’s way, influenced by the ecological context, creating demands that exceed the coping capacity of the affected community.” [[13](#_ENREF_13)] Adger et al suggests that social and ecological vulnerabilities to hazards that lead to disasters are influenced by either the “build up or erosion” of factors that contribute to community resiliency. [[14](#_ENREF_14)] Depending on the type and severity of the disaster, sociological disruption can create additional stressors that compound the post-traumatic stress burden of the incident. Many disasters result in the disruption of social networks and the social supports through evacuations, relocation, or destruction of housing. In addition to geographical disruption of social support networks, the economic impact of disasters can lead to increased crime which can further stress social networks. [[10](#_ENREF_10)]Abramson et al evaluated the predictors and prevalence of mental distress following Hurricane Katrina and concluded “socio-ecological frameworks suggest that a stronger social web that incorporates elements of security and resumption of social roles, social practices, and social institutions can provide a therapeutic effect.” [[9](#_ENREF_9)] Therefore hazard analysis and impact assessment of a disaster must consider more that individual psychological factors but also draw on a socio-ecological framework that can help mental health workers understand the role that social support networks have on individual mental health.

### Social resilience

According to Norris et al, resilience is defined as “a process linking a set of adaptive capacities to a positive trajectory of functioning and adaptation after a disturbance.” [[15](#_ENREF_15)] While there exists a wealth of literature on the components of human resiliency in a disaster context, for simplicity this paper will reference the core components of resiliency identified by the U.S. Department of Health and Human Services in the *National Health Security Strategy*. [[6](#_ENREF_6), [16](#_ENREF_16)] In summary, HHS has identified five interrelated components as being correlated with resilient communities:

1) Social connectedness.

2) Effective risk communication.

3) Integration of both government and non-government entities in strategic health planning.

4) Physical and psychological health of the population.

5) Social and economic wellbeing of the community.

### Social vulnerability

The concept of vulnerability involves more than simply the inverse of resiliency. Cutter, et al have defined vulnerability as “the pre-event, inherent characteristics or qualities of systems that create the potential for harm or differential ability to recover following an event.” [[17](#_ENREF_17)] An important step to any preparedness effort will necessitate a thorough vulnerability analysis coupled with a plan to mitigate identified vulnerabilities. Resiliency could be summarized simply as a system’s set of “adaptive capacities” whereas vulnerability could be summarized as the “potential for loss.” Given these rather simplistic definitions, communities could theoretically possess varied levels of both vulnerability and resiliency. It is at the critical intersections of vulnerability and resilience where disaster practitioners must strive to reduce vulnerability while strengthening resiliency.

## The “Whole Community Approach to Emergency Management” and community-based disaster mental health- Principles for planning and intervention

The United States Department of Homeland Security developed the “Whole Community Approach to Emergency Management” in 2011. This approach was developed out of a growing recognition that a government-centric approach to disaster response is inadequate and that successful mitigation, preparedness, response, and recovery requires the active participation of all affected stakeholders. [[18](#_ENREF_18)] Furthermore, in an era of shrinking budgets, the necessity of identifying the most efficient and cost-effective intervention approaches during all phases of the disaster cycle becomes even more critical. The Whole Community Approach to Emergency Management is defined as “…a means by which residents, emergency management practitioners, organizational and community leaders, and government officials can collectively understand and assess the needs of their respective communities and determine the best ways to organize and strengthen their assets, capacities, and interests.” [[18](#_ENREF_18)]

In practice, the Whole Community Approach builds disaster preparedness capacity during each phase of the disaster cycle by first seeking to “understand the actual needs of the whole community.” With this knowledge, emergency managers can then direct their efforts towards “engaging and empowering all parts of the community.” Finally, the Whole Community Approach strengthens the components of a community that “work well on a daily basis.” These steps are critical in building behavioral health surge capacity. McCabe describes “behavioral health surge” as the expected demand for mental health services following a disaster, which will rapidly overwhelm the service capacities of local behavioral health agencies. [[1](#_ENREF_1)] Furthermore McCabe suggests that community-based interventions would necessitate forming partnerships between local academic institutions, faith-based organizations, and local health departments in order to prepare them to meet the mental health needs of their communities in the event of disaster.

## Case identification, triage, and intervention: A framework for service delivery

One of the key challenges faced by behavioral health professionals during situations where many individuals are exposed to emotionally traumatizing events is how to best connect at-risk individuals with the most appropriate behavioral health resources. Some of the key barriers to mental health service utilization include a deficiency of knowledge about available resources, stigma, inadequate time or financial resources, or lack of perceived need. [[19](#_ENREF_19)]. Additionally, a limited behavioral health workforce can often be strained to adequately assess a community’s behavioral health needs, identify at-risk individuals, and implement an appropriate care program. The prevalent service delivery model among disaster mental health practitioners is a plan that typically involves some form of the three components of case identification, triage, and intervention. [[2](#_ENREF_2), [20-23](#_ENREF_20)] These steps follow a similar process that emergency medical providers have used for years in response to mass casualty incidents (MCIs) that overwhelm the resources and personnel available to deliver care. The key to the triage process is to sort individuals according to severity so that limited resources can be deployed efficiently to provide the maximum benefit in conditions of scarce resources. The delivery of disaster mental health services should follow a similar process that connects individuals with an appropriate level of mental health care.

### Case identification

Case identification is the first step in the process of ensuring that individuals at risk of developing traumatic stress-related mental disorders receive care. Case identification can be conducted through individual screenings carried out at disaster recovery centers or through door-to-door canvassing. At the most basic level, case identification is an organized process of differentiating individuals who are experiencing an expected degree of emotional distress given the realities of their circumstances from those individuals who are demonstrating indicators of traumatic stress-related pathology or psychiatric crisis.[[2](#_ENREF_2)] Case identification is the phase of care when disaster mental health workers trained in Psychological First Aid (PFA) and Spiritual Care may be particularly effective. PFA-trained disaster workers often are involved with other types of relief services such as sheltering, mass care, medical care, etc. which places these workers in a unique position of being able to make referrals to higher-levels of care.

Community-based case identification programs promote empowering community members to take an active role in the assessment and triage process. Macy, et al suggests that community-based programs should be “process-oriented” as opposed to “product-oriented.” [[24](#_ENREF_24)] This means that community members are active participants in the process of identification, triage, and care programs that are socially and culturally appropriate for the community involved. Community-based programs share many common features with the “Whole Community Approach to Emergency Management” by identifying the actual needs of the community, empowering all parts of the community, and supporting those components that work well on a daily basis.

### Triage

Once an at-risk individual has been identified, a process of triage must be in place to ensure that those in the most immediate need of behavioral health services are addressed in order of priority. Currently there are a variety of triage formats that have been validated as reliably triaging medically-cleared individuals to the appropriate level of mental health intervention. [[25](#_ENREF_25)] The Psychological Simple Triage and Rapid Treatment (PsySTART) has emerged as one of the more prominent mental health triage models. This model is endorsed by the Institute of Medicine (IOM), Substance Abuse and Mental Health Service Administration (SAMHSA), and the National Child Traumatic Stress Network (NCTSN). [[26](#_ENREF_26)] Triage will most likely be conducted by a licensed mental health professional with training to identify specific psychological conditions. [[2](#_ENREF_2)] Individuals in need of acute mental health intervention may have suicidal or homicidal ideations, severe exacerbation of pre-existing psychiatric disorders, and/or debilitating depression. [[2](#_ENREF_2)]

The PsySTART system screens disaster survivors and places them into one of four categories according to severity of symptoms [[27](#_ENREF_27)]. Individuals triaged “Green” will most likely only require PFA and basic emotional support. These individuals are at low risk of developing mental health disorders. Individuals triaged “Yellow” will most likely require intervention beyond PFA to include a secondary screening by a trained mental health professional to determine if a formalized treatment program is needed. These individuals are placed at a moderate risk of developing psychiatric disorders and will likely require some form of further intervention to mitigate negative mental health outcomes. Individuals triaged “Red” are at high risk of acute psychiatric crisis and require immediate crisis intervention by mental health professionals. Lastly, individuals triaged “Purple” have actively expressed a desire or have demonstrated intent to harm self or others. The PsySTART triage system utilizes a relatively concise series of twenty questions that licensed and unlicensed mental health workers can use to screen and triage medically cleared individuals for appropriate mental health services.

## Mental health interventions to reduce traumatic stress

The process of case identification and triage will connect individuals requiring mental health intervention to the most appropriate behavioral health practitioner. Any behavioral health intervention program must be guided by the careful oversight of licensed behavioral health professionals to protect traumatized individuals from further harm. McCabe et al promotes a disaster response model where “lay communities” provide an important source of disaster workers available to help address the mental health needs associated with the “behavioral health surge” that follows disasters. [[1](#_ENREF_1), [28](#_ENREF_28), [29](#_ENREF_29)] The scheme promoted by McCabe utilizes a variety of unlicensed volunteers that can augment the mental health and chaplaincy services directed by professional mental health providers. These “lay providers” would often be the point of first contact for disaster survivors. Lay providers would render basic PFA and/or Spiritual Care, make referrals, share information, and assist survivors in accessing essential services. Mental health professionals prescribe a range of options beyond basic PFA, which include structured psychotherapy programs and pharmacological interventions. [[2](#_ENREF_2)] In the following section, four of the better-known disaster mental health intervention approaches will be summarized. Psychological Debriefing (PD), which includes Critical Incident Stress Debriefing (CISD) and Cognitive Behavioral Therapy (CBT) are structured programs prescribed by licensed mental health professionals. Psychological First Aid, Spiritual Care and community-based interventions are led by licensed behavioral health professionals or chaplains but are likely to involve the assistance of lay providers and unlicensed volunteers.

### Psychological debriefing and critical incident stress debriefing

The psychological debriefing interventional approach is probably the oldest and until recently, the most practiced approach to manage mental health during acute phase post-traumatic stress. PD and CISD are usually a single “debriefing” session involving individuals who experienced a traumatizing event. The goals of PD and CISD are to reduce acute traumatic stress and to prevent PTSD. PD and CISD are based on the now outdated assumption that all traumatized individuals need to decompress in the immediate aftermath of the event. [[30](#_ENREF_30)] PD and CISD are approaches often used with first responders exposed to extremely stressful incidents. The CISD is still used to treat first responders and soldiers involved in traumatic experiences but is now rarely conducted among general populations of traumatized individuals. [[30](#_ENREF_30)] This approach to disaster mental health has been subject to a growing number of critical reviews that have provided evidence that PD lacks substantial evidence to support its continued use as a safe and effective psychiatric intervention. Furthermore, longitudinal studies have suggested that conducting indiscriminate PD among disaster survivors has resulted in worse mental health outcomes in the months and years following the event. [[24](#_ENREF_24), [30-33](#_ENREF_30)]

### Cognitive-behavioral therapy

Cognitive-Behavioral Therapy has gained growing support as a safe and effective disaster mental health intervention that provides assistance beyond basic PFA and emotional support. [[32](#_ENREF_32), [34](#_ENREF_34)] CBT approaches seek to first diminish the initial traumatic stress and secondly to reduce the incidence of PTSD. CBT is an interventional approach based on cognitive theories suggesting that traumatized individuals develop learned behaviors to avoid experiences that resemble or remind them of a traumatic event. CBT approaches attempt to “legitimize” an individual’s reaction to a traumatic experience then assist the individual in a healthy adaptive process. CBT generally views most problem behavior as “maladaptive” rather than pathological. Stress-induced behaviors are understood as a normal adaptive response to cope with a distressing situation or event. Maladaptive coping mechanisms may be beneficial in the short term but may not promote long-term mental health improvement. CBT assists survivors to analyze a problematic situation then break the problem down into manageable, goal-oriented interventions termed “proximal goal setting.” [[34](#_ENREF_34)] CBT supports the individual during the adaptive process to avoid developing behavior patterns that lead to psychiatric disorders such as PTSD. CBT approaches have demonstrated efficacy when provided to disaster survivors of all age groups including children. While research is ongoing, CBT is gaining widespread support as an evidence-based intervention that reduces traumatic stress and PTSD. [[31-35](#_ENREF_31)]

### Psychological first aid

Psychological First Aid is a series of steps that both disaster response workers and mental health professionals can take to help reduce the initial stress felt by individuals exposed to disaster-related psychological stress. North and Pfefferbaum define PFA as “a set of practical early interventions and principles administered by clinicians or non-clinicians to address emotional distress.” [[2](#_ENREF_2)] The National Child Traumatic Stress Network (NCTSN) and the National Center for PTSD have described PFA as an “evidence-informedmodular approach to help children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism” with the goal of reducing “the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping.” [[36](#_ENREF_36)] PFA is an approach that seeks to meet basic needs, provide comfort, reconnect individuals with social support, and provide referral to formal mental health or spiritual services if required. (See table 1) Either licensed professionals or lay volunteers assisting in rescue or recovery efforts may provide PFA. PFA is not intended to clinically diagnose mental illness nor is PFA intended to replace professional mental health treatment, counseling, or chaplaincy services. Rather, PFA is intended to reduce the emotional and psychological impact of the trauma so that disaster survivors can refocus their efforts toward healthy adaptive functioning that support a rapid recovery.

|  |
| --- |
| Table 1. Basic objectives of Psychological First Aid |
| 1. Establish a human connection in a non-intrusive, compassionate manner.  2. Enhance immediate and ongoing safety, and provide physical and emotional comfort.  3. Calm and orient emotionally overwhelmed or distraught survivors.  4. Help survivors to tell you specifically what their immediate needs and concerns are, and gather additional information as appropriate.  5. Offer practical assistance and information to help survivors address their immediate needs and concerns. |

Adapted from PFA, Field Operations Guide, 2006

### Spiritual care

Spiritual Care is a continuum of interventions typically provided by both clergy and lay people to support the spiritual needs of disaster survivors with the end goal of providing hope and resilience. According to the National Voluntary Organizations Active in Disaster (NVOAD), human spirituality is much broader than distinct religious activities and faith traditions. The NVOAD affirms the position that spirituality is a universal characteristic of the human experience. Furthermore, “spirituality” is defined as an individual’s “struggle for meaning and the relationship of the Human Spirit to transcendence and hope.” [[37](#_ENREF_37)] NVOAD posits that healthy individual spirituality leads to a sense of hope. A community that is able to maintain a sense of hope in an environment of extreme psychiatric stress is believed to contribute to the resiliency ultimately required for community recovery. The NVOAD has defined “Spiritual Care” as “anything that assists an individual, family or community in drawing upon their own spiritual perspective as a source of strength, hope, and healing” [[37](#_ENREF_37)] Similarly, Robert and Ashley explain that the goals of Spiritual Care are not to “shelter” or to help individuals “escape” from the trauma of the event but rather to “help those affected draw upon their own emotional and spiritual resources in the midst of their pain.” [[38](#_ENREF_38)]

In practical terms, “Spiritual Care” interventions can be as simple as actively listening to survivors share their experiences, providing emotional support, or meeting physical needs. Spiritual Care also includes organizing memorial services, offering spiritual counseling, or holding religious services. The NVOAD stresses the importance of accepting all expressions as “true” and “authentic” for individuals receiving care. [[37](#_ENREF_37)] Spiritual Care providers are not required to adhere to the same faith traditions as disaster survivors in order to be effective. The Spiritual Care approach as endorsed by the NVOAD stresses that providers must support the individual as he or she draws on his or her own spiritual resources as a source of hope and meaning in the post disaster environment.

Spiritual Care is a very broad category of disaster assistance, which can be delivered by individuals from a wide range of faith traditions. Due to the nature of providing Spiritual Care services in the post-disaster environment, providers may interact with disaster survivors who are very vulnerable. To ensure a uniform approach to care and to protect susceptible individuals from further harm the NVOAD requires that providers accept the following basic standards of care [[37](#_ENREF_37)]:

1. Offer presence and hospitality: Spiritual Care providers actively listen to survivors express grief, provide assistance with physical needs, reconnect families, and disseminate information. The compassionate presence of a Spiritual Care provider helps traumatized individuals feel a sense of hope, which is needed to take their next steps toward recovery.

2. Meet, accept and respect persons exactly as they are: The Spiritual Care provider must always remember that their role is to assist traumatized individuals draw upon their own spiritual resources as a source of hope and healing. This type of assistance requires a non-judgmental attitude.

3. Do No Harm: Never evangelize, proselytize or exploit persons in vulnerable circumstances; the post disaster environment is never an appropriate time to engage in intentional proselytism efforts.

### A comparison of psychological first aid and spiritual care

Spiritual Care and PFA share many similarities in their delivery approach, goals, and desired outcomes. [[37](#_ENREF_37)] Ultimately, the desired outcome of both PFA and Spiritual Care is to reduce traumatic stress and to support health adaptive functioning. Psychological First Aid draws on the discipline of psychology to guide emotionally distressed individuals towards healthy adaptive functioning. Conversely, Spiritual Care draws on an interfaith perspective to assist distressed individuals to draw on their own spiritual resources towards holistic resiliency. Both Spiritual Care and PFA emphasize meeting disaster survivors with a comforting human presence, meeting physical needs first, reconnecting individuals with their loved ones, and disseminating information. Furthermore, Spiritual Care and PFA services are often delivered by unlicensed disaster workers who are trained to recognize when it is appropriate to make referrals to professional medical, mental health, or chaplaincy services. One of the most notable differences between PFA and Spiritual Care is that PFA services are to be deployed during the acute or crisis phase of the disaster. As the disaster cycle progresses into the long-term recovery phase, disaster mental health services should transition from PFA into formalized intervention programs prescribed by licensed mental health professionals. Conversely, Spiritual Care services are needed during every phase of the disaster from the crisis phase to the full recovery.

### Community-based interventions

Traditional models of emergency management have emphasized the “restoration of place” but have overlooked the need to restore social networks and patterns that can facilitate health coping. Abramson suggests the implementation of “social reengagement activities” which can help restore social bonds that may have been disrupted by a traumatic event. Social reengagement activities include religious events, memorials, holiday traditions, cultural observances, or other similar activities which bind communities together through commonly held bonds. [[9](#_ENREF_9)]

In practice, community-based interventions may use a variety of techniques including PFA, Spiritual Care, and CBT with communities taking an active role in the assessment, design, and implementation of the procedures. The actions will be based on a community’s perception of the event which will facilitate community-specific responses through an in depth knowledge of the “cultural, social, and economic patterns of traumatic reactions.” [[24](#_ENREF_24)]

## Limitations of disaster mental health research

Disaster mental health research has advanced significantly in the post-September 11th era of emergency management. A greater emphasis has been placed on understanding the behavioral health impact that traumatic stress exerts on both individuals and communities. As a result emergency management doctrine and policy is departing from a government-centric model and is now recognizing the importance of integrating all stakeholders at each phase of the disaster cycle. Novel approaches are being sought of how to best access volunteer resources and pre-existing community-based capacities. Nevertheless, there are a few limitations in the current research.

A better metric is needed to assess exposure of traumatic stress levels particularly as it pertains to long-term mental health outcomes. Disaster mental health research is by nature difficult to conduct due to the reality that disasters are unpredictable in type, magnitude, and in their impact on communities. While imperfect, geographic proximity to the epicenter is often used as a proxy to exposure. [[39](#_ENREF_39)] However, not all disasters have a defined epicenter. Consider, for example disease outbreaks or the sustained threat of terrorism. Stress levels connected to these types of incidents would more likely be related to perceptions and experiences rather than geographic proximity. Furthermore it is generally accepted that not all people will process psychological stress in a uniform manner. Experiencing even the most severe psychological trauma does not absolutely imply that an individual will develop psychiatric pathology. [[30](#_ENREF_30)] In future events, disaster mental health research should seek to draw comparisons between the long-term outcomes of individuals who received basic PFA or Spiritual Care, those who participated in structured mental health intervention programs, and those who received no additional psycho-spiritual interventions.

Many commonly taught PFA curriculums and training programs teach unlicensed disaster mental health providers to recognize the basic indicators of individuals at risk of acute psychiatric crisis with the emphasis of making referrals. [[36](#_ENREF_36)] In disaster drills and exercises, unlicensed volunteer mental health workers have demonstrated that they can effectively screen disaster survivors for psychiatric risk factors. [[25](#_ENREF_25)] However, there does not exist any peer-reviewed case studies supporting the effectiveness of using lay providers to screen for psychiatric risk factors during an actual mental health response to a disaster.

PFA has gained considerable support as a disaster mental health intervention since the early 1990’s. A comprehensive study by Fox et al reviewed 58 separate incidents when PFA was used during the period of 1990-2010 to evaluate PFA’s effectiveness as a mental health intervention. [[40](#_ENREF_40)] This study reported widespread endorsement of PFA despite the lack of any substantial evidence that PFA can decrease traumatic stress disorders. Additionally, no controlled trials are available to evaluate harm or benefit. Fox reports that the overwhelming majority of expert opinion agrees that PFA can be considered “evidence-informed” and safe as an interventional approach. More research is required to better describe the long-term impact of PFA on the mental health outcomes of disaster survivors.

# Description of Allegheny County Department of Human Services, Office of Behavioral Health

Allegheny County Department of Human Services (DHS) was formed in 1997 following the consolidation of the Departments of Aging (DOA), Federal Programs (DFP), Children and Youth Services (CYS), and Mental Health/Mental Retardation/Drug & Alcohol/Homeless & Hunger Programs. [[41](#_ENREF_41), [42](#_ENREF_42)] The Office of Behavioral Health (OBH) is a department within Allegheny County DHS and is responsible for providing “a coordinated community-focused system of high quality and cost-effective mental health and substance abuse services including prevention, crisis intervention, treatment, case management and community services.” [[42](#_ENREF_42)] During times of disaster and crisis, the OBH functions in the role of conducting needs assessments and coordinating the delivery of services. The OBH typically serves as a coordinator of services rather than a direct provider of behavioral health services. During the preparedness phase of disaster, the OBH continually maintains a network of Service Coordination Units (SCUs). A SCU is essentially “an agency that coordinates and provides mental health services.” [[43](#_ENREF_43)] When activated by the OBH disaster coordinator, the SCU will go to the scene of the incident to conduct activities including assessment, monitoring, advocacy, coordination, and service authorization.The OBH works to maintain sufficient disaster mental health response capacity for the County of Allegheny by conducting routine coordination meetings with the SCUs, sponsoring training workshops, participating in drills and exercises, and serving as a source of information. SCUs are composed of behavioral health specialists from a broad range of organizations who provide behavioral health services on a routine basis.

When a disaster or crisis occurs the OBH integrates into the Incident Command System (ICS) primarily through Emergency Support Function (ESF) 8 and with a secondary role in ESF 6. [[44](#_ENREF_44)] ESF 8 is primarily responsible for coordinating the delivery of public health, medical, mental health, and mass fatality management services. The Allegheny County Emergency Operations Center (EOC) will be activated at which point the OBH disaster coordinator will respond to the EOC. This person will then mobilize the appropriate SCU personnel to begin assessing behavioral health needs at the scene of the incident. [[45](#_ENREF_45)] Once the SCU determines which services are required, the OBH can then request a variety of response teams including Disaster Crisis Outreach Teams (DCORT), CISD teams, or Spiritual Care services

There have been a few notable response efforts that have given DHS the experience that tested the agency’s ability to delivery disaster mental health services. In 2004 heavy rains from Hurricane Ivan resulted in major flooding to twenty communities within Allegheny County. Personnel from the OBH responded immediately by reporting to the EOC and setting up community-based emergency response centers. Staffing was increased to service public information lines and crisis hot lines. During the recovery phase, DHS staffed and coordinated the activities of the disaster recovery center, visited emergency housing centers, and went door-to-door to assess the needs of the flood survivors. The OBH was instrumental in identifying 1400 vulnerable older adults and 150 high-risk individuals and facilitated their placement in temporary emergency shelters. During the long-term recovery, various human services were also integrated into each effected community’s long-term recovery plans. [[46](#_ENREF_46)] The following year, the OBH was once again tasked with the challenge of providing relief and behavioral health services to those displaced by Hurricanes Katrina and Rita. OBH set up the Hurricane Katrina Engagement Center to provide a variety of services for approximately 360 displaced persons. In addition to behavioral health services, OBH took a lead role in case management, housing assistance, and staffing phone lines.[[47](#_ENREF_47)]

# Description of Christian Associates of Southwest Pennsylvania

Christian Associates of Southwest Pennsylvania (CASP) is an ecumenical organization that seeks to represent the mutual interests of over two thousand congregations over a ten-county region of Southwest Pennsylvania. CASP maintains the mission statement “To Serve as a Unifying Voice in the Name of Jesus Christ for the Mission of the Gospel and the Wholeness of Communities.” It is notable that CASP is the first Christian ecumenical organization in the United States to unite Protestant and Catholic faith traditions in a major metropolitan region. Since its founding in 1970, CASP has remained consistent with the goal of interfaith unity. CASP maintains an extensive network of partnerships and collaborations placing emphasis on initiatives that focus on education, social concerns, justice and equality. [[48](#_ENREF_48)]

One of CASP’s seven basic assumptions is the emphasis on “resources rather than programs.” CASP operates with few full-time personnel and low operating cost yet maintains an ability to organize, coordinate, and mobilize personnel and resources during times of need. CASP has a small staff of an Executive Minister, an Executive Administrative Assistant, a Director of Chaplaincy Services, and a board of approximately thirty religious leaders from the region. [[48](#_ENREF_48)] CASP’s efficient organizational structure coupled with the extensive network of affiliated FBOs enables CASP to bring a variety of resources and services to the aid of disaster survivors in a timely manner.

Since 2007, CASP’s has taken an active role as a coordinator of services during each phase of the disaster cycle [[48](#_ENREF_48), [49](#_ENREF_49)]. CASP is a participating member of the PA Region 13 Counter Terrorism and All Hazards Task Force, Pennsylvania Voluntary Organizations Active in Disaster (PA VOAD), and the Metropolitan Medical Response System (MMRS). CASP has helped organize and facilitate Spiritual Care and mass care responses to regional disasters and crisis events. CASP has organized and sponsored Spiritual Care training events to give “lay responders” the skills required to meet the physical, spiritual, psychological, and emotional needs of disaster survivors. Finally, CASP has led long-term recovery efforts and served the role as a fiduciary organization to process and distribute funds to support recovery efforts.[[49](#_ENREF_49)]

When a disaster or crisis response is required, a representative from CASP will integrate into the ICS through ESF 6 with a secondary role in ESF 8. [[44](#_ENREF_44)] ESF 6 is the support function that is primarily responsible for coordinating the delivery of mass care, emergency assistance, disaster housing, and human services. CASP will work closely with the OBH to determine the best method of delivering Spiritual Care and behavioral health services.

# Methods

The Eastern Allegheny County Faith-Based Disaster Preparedness Initiative is part of CASP’s and OBH’s broader efforts to strengthen faith-based disaster response capacity in the Southwestern Pennsylvania region. At the time of the implementation of this project, Allegheny County had many disaster mental health resources available; however, there was no organized Spiritual Care/PFA program involving FBOs that stood ready for activation. This initiative was designed to build upon the existing relationships, training, and experiences that had already been established during the previous years that CASP and OBH had collaborated in disaster preparedness and response efforts. The primary outreach focus was to promote the services of PFA and Spiritual Care. Other potential capacities were also encouraged, including the services of mass care, rebuilding, donation distribution, and case management. After consultation with representitives from both CASP and OBH, the geographical area of focus was the “East Hills” of Allegheny County. This region was selected because the North Hills and Chartiers Creek communities in the western suburbs of Allegheny County had already organized community-based recovery task forces following flooding in 2004. Additionally, the East Hills communities were recommended by the Executive Director of CASP as being a manageable outreach area given the limited funding and personnel available. The East Hills include the eight municipalities of Oakmont Borough, Verona Borough, Penn Hills Township, Wilkins Township, Plum, Monroeville, Turtle Creek, and Pitcairn. (See figure 1) This region composes an area of approximately 73 square miles and is home to approximately 122,000 residents. [[50](#_ENREF_50), [51](#_ENREF_51)] CASP maintains affiliations with approximately 70 organizations within this region representing a variety of interdenominational and interfaith traditions.



Source: Arc Geographical Information Systems, 2015

Figure 1. East Hills area of outreach focus

The goals of community outreach were threefold: to assess existing capacity, to educate and generate interest in disaster response, and to provide a point of contact for further involvement. The two primary outreach methods used were individual interviews with faith leaders and community forums that were organized with the support of faith leaders. These two methods permitted an atmosphere where leaders from FBOs could ask questions and learn about how their organization could be a resource in times of disaster. Emphasis was placed on encouraging interested FBOs to participate with the Allegheny County Voluntary Organizations Active in Disaster (VOAD) and attending PFA and/or Spiritual Care training. The project involved a process of first taking inventory of the present level of FBO involvement in the “East Hills” area of focus, followed by outreach to educate and recruit FBOs to participate with the Allegheny County VOAD. Finally, a formal report and presentation was submitted to representative of CASP and DHS.

## Phase one: Review of previous Spiritual Care and Incident Command System training

In the spring of 2008, CASP and OBH hosted a one-day training event to provide Spiritual Care Training and ICS training to 110 faith leaders and lay ministers from the Southwestern PA region. This conference was intended to increase the capacity of the region’s faith leaders to meet their communities’ unique spiritual and emotional needs in times of crisis and disaster.

Phase one of the data analysis consisted of reviewing the video recording of this event, compiling a contact list of individuals and organizations that received training, and reviewing after action reports and participant responses. The purpose of phase one was to achieve the following goals as a foundation for further preparedness outreach: to survey local disaster knowledge, experience, and training; to identify training shortfalls/areas for improvement; and to compile a contact list from CASP affiliated organizations for outreach and follow-up.

The participants in attendance represented a wide range of denominations and included both clergy and lay ministers. There were two sessions: a morning session covered the subject of Spiritual Care in disaster and crisis and an afternoon session provided an overview of the Incident Command System. Feedback included a one-page survey with Likert scale items ranging from 1-5 with opportunity for additional comments. After reviewing participant responses, the findings were discussed with the staff of CASP and OBH. A summary of the participant feedback and findings from this training event can be found in appendix A.

## Phase two: Follow-up

The goal of phase two of this project was to identify faith leaders who serve in the East Hills who also participated in the spring 2008 Spiritual Care training event. The original intent was to hold a meeting with CASP, OBH, and East Hills faith leaders to assess interest in further disaster response preparedness training, to provide a forum for networking and relationship building, and finally, to provide point of contact for future involvement. After compiling and reviewing a contact list, there were no faith leaders from the East Hills who were in attendance at the spring 2008 training event. After consultation with CASP and OBH, it was determined that the geographic area of outreach focus would remain the same despite the lack of previous disaster training and knowledge.

## Phase three: Outreach

This phase involved networking and outreach to faith organizations not then active in disaster response. Potential partnering organizations were identified through existing contacts with CASP and OBH. Outreach activities involved contacting potential FBOs by phone, e-mail, or in-person with the goals of organizing informational meetings, assessing potential interest and existing capacities, extending an invitation to VOAD participation, and lastly, to provide a point or contact for future involvement. A key component of the outreach phase was presenting to local ministerial associations. Additionally, during the outreach phase, a tri-fold informational pamphlet was developed as a handout to be distributed during community forums and individual interviews. A copy of the informational pamphlet is in appendix 2.

## Phase four: Reporting to Christian associates and the Allegheny COunty Office of BEhavioral Health

Next, a summary report was prepared for presentation to representatives of CASP and OBH. This document included a profile of organizations that expressed interest in volunteering personnel, resources, or facilities during times of disaster. This record included an individual point of contact and a brief description of some of the potential capacities and capabilities that each organization could offer in times of disaster or crisis. The information contained within this report was intended for use by both CASP and OBH to continue the ongoing process of strengthening the volunteer disaster response capacity in Allegheny County.

# Results

During the one-year period from April 2012 to April 2013, a total of fifty-seven FBO’s were contacted by phone, email, or in-person interviews. Of the organizations that were successfully reached, eight organizations expressed further interest in disaster participation or attending a VOAD meeting to learn more about disaster response. Once the interested organization was connected with the Allegheny County VOAD, the VOAD was expected to take over. During the course of outreach activities, CASP was invited on four occasions to give a formal presentation to ministerial associations. These presentations were beneficial because it permitted faith leaders to ask questions and voice concerns regarding how their ministerial association could be a resource for their respective communities in times of need.

# Discussion and recommendations

This initiative was a community development project centered on the goals of encouraging interfaith partnership to strengthen disaster mental health response capacity. While simple in principle, the challenges to building a unified coalition of FBOs are many. As community outreach progressed, it became apparent that there exist some key barriers that need to be addressed before achieving the goals set at the outset of this program. The following paragraphs will explain some of these key barriers.

## Frequent faith-based organization leadership turnover

Frequent leadership turnover was a common characteristic of many FBOs in the area of outreach. It is not clear exactly why this situation exists. Spiritual Care and mental health response capacity of FBOs is drawn from both faith leaders and members. It is important that members of FBOs have buy-in to disaster preparedness initiatives and not only faith leaders. During the outreach phase interim executive clergy persons unanimously expressed their approval of the need for faith communities to be involved in disaster preparedness and response. When asked if they would consider participating in an organizational meeting and attending training workshops, interim faith leaders were hesitant to begin any new programs until a permanent leader was in place. During an interview with an interim pastor of a Monroeville church, he discussed a wealth of lessons learned during his tenure as a pastor of a church involved in the flooding of the communities of Etna and Millvale, PA following Hurricane Ivan in 2004. This pastor was instrumental in successfully organizing long-term recovery efforts. Despite his in-depth disaster experience, he was not interested in beginning preparedness efforts as an interim pastor.

Recommendation: Executive clergy persons should consider designating an individual or committee from within their congregation to be a preparedness and response contact person for their organization. This will take the organizational burden off the interim clergy person permitting program continuity despite changes in executive leadership. Diverting this responsibility away from executive faith leaders will also allow opportunities for lay members to get involved in disaster leadership capacities.

## Funding limitations

The issues of budgetary limitations will always be a challenge for non-profit organizations and it is difficult to say exactly how much investment in preparedness effort is sufficient. The primary mission of FBOs is often distantly related to disaster preparedness and response. The problem lies in the reality that during times of crisis and disaster, communities expect local FBOs to respond with a variety of needed services. Many faith leaders acknowledged this “unofficial” duty could be overlooked until a disaster occurs. Furthermore, faith leaders expressed concern that they simply do not have resources in their organization’s budgets to conduct extensive preparedness programs. During a meeting with a board of elders from a large interfaith organization in Monroeville, the group suggested that their organization’s large community center could serve as a great location for mass care delivery and/or a disaster recovery center; however, they wondered who would pay for relief supplies. It was explained that relief supplies come from a variety of sources facilitated by the VOAD. This reassurance was met with skepticism related to distrust of government involvement.

Recommendation: Communicate that FBO disaster response does not necessarily have to cost a lot of money. Many training opportunities are available for voluntary organizations free of charge through local, regional, and state preparedness grants. Local, state, and federal preparedness grants are available to well-organized VOADs. This could greatly reduce the financial burden on any one organization. The availability of free or low cost preparedness training must be communicated and emphasized to the participating organizations. Belonging to a unified coalition of organizations will likely allow for more efficient procurement and deployment of resources.

## Competing time commitments

Many leaders assume that the role of disaster leadership is expected of them. In the words of a busy pastor of a newly formed East Hills church, “I’m not interested in sitting on boards and going to a lot of meetings, but if there are some actionable steps that we can do to get involved I think we would be interested.” This pastor expressed a sentiment heard in many of the interviews and conversations. The issue of competing time commitments required for preparedness planning is a natural concern for these leaders who are already very busy attending to the needs of their members and various ministries.

Recommendation: Each organization should designate a motivated individual as a disaster coordinator. The responsibilities for disaster preparedness and response should probably not rest on the FBO’s executive leader. VOAD affiliation can greatly lessen the burden of disaster preparedness and response by creating a forum to share information, resources, organize training, set planning agendas, and assess needs.

## Volunteer liability concerns

Throughout the course of community outreach, the question of litigation protection arose. Fear of litigation can potentially be a deterrent that hinders many valuable volunteers from offering their time and talent to communities in need. An outreach coordinator from a Penn Hills congregation presented a proposal to her board of elders to move forward with disaster preparedness policy for her church. Her board felt disaster preparedness was a great idea but they expressed concerns regarding the legal aspects that their members and organization may be liable for while functioning as a disaster relief organization.

Volunteer liability is a legitimate concern for any volunteer organization participating in disaster response, especially when providing services to vulnerable populations. It is beyond the scope of this paper to present a lengthy legal analysis regarding volunteer activities during a disaster; however there are a few notable points for consideration. There are federal and Pennsylvania “Good Samaritan” laws, which provide protections to volunteers. [[52](#_ENREF_52)] The Volunteer Protection Act of 1997 (VPA) is a federal law designed to encourage volunteerism by providing limited liability immunity to volunteers of non-profit organizations. One of the conditions for volunteers to meet the requirements for the provisions under the VPA is to be qualified to provide a specified service. Pennsylvania volunteer statutes contain similar language stating that volunteers providing a service as part of a volunteer organization must act according to an accepted standard. Services being rendered with the potential for harm typically require a standardized licensure of certification process. Spiritual Care and PFA lack a uniform credential to protect both volunteers and recipients. Liability of volunteer mental health workers has not yet become a major source of litigation in this region; however, as disaster mental health programs expand the issue of volunteer liability must be examined in greater detail.

Recommendation: Organizations should take responsibility to ensure that their members are appropriately qualified for the service that they are providing. Implicit is the need for an accepted Spiritual Care and PFA credentialing process. The following section will discuss credentialing in more detail. VOAD participation can greatly assist FBO to ensure that individual responsibilities are appropriate for their level of expertise and training. Additionally, organizations could benefit from a workshop led by a legal expert to allow volunteer organizations opportunity to ask specific questions pertaining to their organizational mission.

## The need for a recognized PFA/ Spiritual Care credential

Credentialing is important for two reasons: to ensure that traumatized individuals are receiving a competent level of care and to safe guard volunteers from liability. The dominant PFA curriculum has been developed through a collaboration of National Child Traumatic Stress Network and the National Center for PTSD. However, this program awards a certificate of completion only, not a credential. Other organizations such as the American Red Cross also have developed a PFA training program. Likewise, Spiritual Care training programs can vary across organizations and sponsors.

Recommendation: To maintain a consistent standard of care, there should be a VOAD-accepted PFA and/or Spiritual Care credential that would be required for any worker involved in disaster mental health services. One of the key roles of the VOAD is to implement a vetting process to ensure that qualified organizations and volunteers are participating in the relief and recovery services. The National VOAD standards of care have laid a foundational framework for minimal accepted standard of care. The local VOAD must interpret the Pennsylvania statutes in order to define the minimal training requirements and certifications expected of mental health volunteers. VOAD participation creates a forum where these issues can be resolved.

## The need for an organized VOAD

The role of a well-organized and cohesive VOAD cannot be overstated in its importance in organizing volunteer resources towards disaster readiness. The mission of a VOAD is to “build resiliency in communities” by serving as a “forum where organizations share knowledge and resources throughout the disaster cycle.” [[53](#_ENREF_53)] The NVOAD captures this mission statement in the guiding principles of the “four C’s” which represents Cooperation, Communication, Coordination, and Collaboration. It is especially important for small volunteer organizations with limited resources to integrate themselves into the emergency management system through their local or regional VOAD during each phase of the disaster cycle. For this project, outreach had begun with potential FBO partners prior to the organization of an Allegheny County VOAD. This created impediments because while some organizations expressed interest in becoming active in disasters, there did not exist a VOAD to which FBOs could affiliate with. The organizations were provided information about how FBOs can get involved in preparing for disaster but until a VOAD was organized, these organizations did not have an effective route to become integrated into the emergency management structure.

Recommendation: Disaster preparedness efforts within the volunteer sector should begin by establishing a cohesive VOAD. Once this element is in place, the VOAD should then prioritize the specific services requiring further development.

# Conclusions

This paper outlines one portion of a larger effort in Allegheny County to apply components of “Whole Community” emergency management in an attempt to expand disaster mental health response capacity. While this effort did not achieve the level of participation that was originally expected it, nevertheless, identified a few of the key issues that need to be addressed before volunteer groups can successfully respond to disasters. Most notably a VOAD should be established first, prior to attempting to organize individual organizations around a specific service such as mental health. Much more work remains to be done and community organizing should continue within the East Hills region.

This project contains a number of limitations. The author of this paper conducted the majority of the community outreach with assistance from the executive director of CASP and the Assistant Disaster Coordinator from the OBH. Given the small scale of this initiative, community outreach was constrained to a manageable geographic region as specified above. With additional funding and outreach personnel, this project could potentially generate greater participation from a wider variety of FBOs.

Outreach efforts were primarily limited to CASP-affiliated FBOs. There are many more FBOs in the East Hills region and greater Allegheny County that are a potential source of mental health and Spiritual Care volunteers. CASP-affiliated FBOs were chosen as a matter of convenience due to the pre-existing relationship networks involving CASP. Additionally, disaster mental health volunteers do not necessarily have to be drawn from FBOs. Other volunteer and/or non-profit organizations may be available with personnel and resources well suited for disaster mental health and Spiritual Care outreach during disasters.

CASP did not conduct a thorough hazard and vulnerability analysis prior to selecting the area of outreach focus. Hazards and vulnerabilities should be considered when prioritizing emergency preparedness planning and future outreach efforts. Assessing hazards and vulnerabilities first can assist in prioritizing outreach efforts.

This project did not have a coherent sustainment plan beyond the first year of outreach. Disaster preparedness and community readiness is an ongoing process given the dynamic nature of communities, leadership, and volunteer resources. Progress made in disaster readiness can quickly deteriorate if a well-designed sustainability plan is not included in the planning phase. This project was initiated with the intent of continuing outreach as one of the ongoing priorities of CASP’s disaster preparedness mission. Organized community outreach did not continue beyond the first year.

This project did not specify any formal data collection protocol. Data collection primarily consisted of informal notes taken during the interviews and outreach activities. Furthermore, with the exception of contact information for individual FBOs, CASP does not maintain any detailed records regarding membership, capacities, or resources of its affiliates. For the initial stages of community organizing, the emphasis was primarily to educate, generate further interest, and provide a point of contact for more involvement. If Allegheny County’s volunteer disaster mental health and Spiritual Care programs expand, outreach personnel should develop a more thorough capacities and capabilities inventory so that emergency coordinators can accurately measure and plan for future contingencies. The role of data collection and record keeping may be better suited as a VOAD responsibility.

# Public health significance

This project is significant to public health because it has identified some of the barriers to incorporating FBOs into disaster mental health preparedness efforts. This initiative also helped to highlight the role of a VOAD to organize loosely affiliated organizations toward specific preparedness goals. VOAD affiliation is the primary means by which volunteer organizations integrate into the emergency management structure. A well-organized VOAD could potentially reduce psychiatric stress by mobilizing the capacities of FBOs to meet the mental health needs of disaster survivors. FBOs are one prospective source of volunteers that help ensure that all individuals have adequate emotional and spiritual support to move forward with the challenges of disaster recovery. FBOs are often community-centered institutions that enjoy a high degree of trust and traumatized communities will look to these institutions for psycho-spiritual care. FBOs fill a unique role in the disaster cycle by possessing the capability to help address the emotional and spiritual dimensions of traumatic events in ways that government agencies cannot. Lastly, the principles and lessons learned during this community outreach effort help form a framework for community-based disaster preparedness that could be replicated in other regions. The services provided by FBOs during disaster events may help reduce the impact of psychiatric stress, ultimately supporting the mental and spiritual resiliency required before communities can make a holistic recovery.

# Appendix A

Summary of participants’ response

**“Disaster response training for Spiritual Care providers,” April 15th 2008**

**Prepared by Adam Gray**

**Overview:**

On April 15th, 2008 a disaster response training workshop was hosted by Christian Associates of Southwest PA and Allegheny County Behavioral Health at Seven Springs Resort. A total of 110 participants were in attendance and represented a wide range of denominations, including both clergy and lay ministers. This training workshop consisted of a morning and afternoon session. The morning session was led by Rev. John Wilson who spoke on the subject of Spiritual Care in disaster and crisis. Overall, participants expressed a high degree of ability to meet the Spiritual Care training objectives. On Likert scale questions ranging from 1 to 5, participants responded with an average rating of 4.44 or greater for questions pertaining to the morning session led by Rev. Wilson. The afternoon session was led by Herman Sieber who provided NIMS training. In general, the participants did not connect as well to the relevance of NIMS as they did to the morning session. Likert scale question ranging from 1-5 on the afternoon session ranged from 3.62-4.13. Overall, participant responses were very positive; however there were a few themes that emerged from participant feedback that should be taken into consideration for future training events.

**Logistics:**

Logistical feedback primarily included suggestions to ensure that coffee, water, and refreshments are available for all participants. Apparently, participants at the upper level did not have easy access to afternoon refreshments. Additionally, one participant expressed that the temperature during the morning session was too cool.

**Morning Spiritual Care session:**

Rev. Wilson received an overwhelmingly positive response. Many felt that his presentation was very informative, inspirational, and generated interest in the ministry of Spiritual Care. Many felt this provided a good starting point to further increase their knowledge on the subject of Spiritual Care.

**Afternoon NIMS training:**

Mr. Sieber received less positive feedback from participants. It seems that the primary criticism of the NIMS component was that participants were unable to connect the NIMS framework to their role as Spiritual Care providers. Many expressed that NIMS was hard to follow and was more applicable to public safety personnel. Some participants even expressed that NIMS was a “waste of time” especially when they learned that it could be taken online.

**Handouts and information:**

A few participants felt that handouts would have been useful for both morning and afternoon sessions.

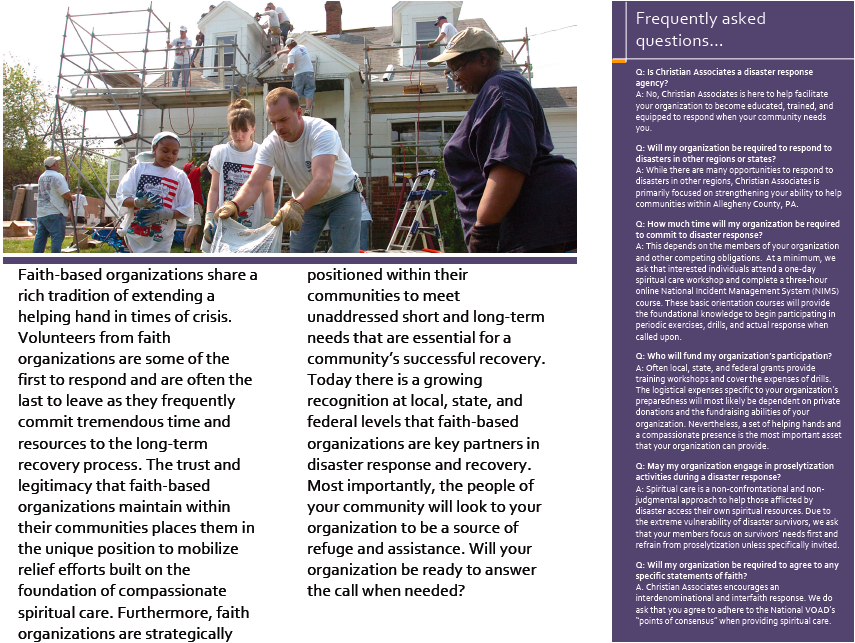
**Conclusion and suggestions:**

Overall, the training was a worthwhile investment evidenced by the majority of positive Likert Scale responses and mostly positive feedback comments. Rev. Wilson would make a good candidate for future Spiritual Care training workshops. The NIMS component of Spiritual Care training is certainly important and should be incorporated into future training events. The challenge is to find an expert that can clearly articulate how and where Spiritual Care providers fit into the NIMS framework. Some of the responses indicated that Mr. Sieber was brought in at the last minute as a presenter. Maybe with more notice he would have been able to meet the audiences’ educational needs more effectively. One suggestion would be for participants to complete ICS 100 and 700 as a prerequisite to Spiritual Care training. This would allow presenters to discuss the role of the Spiritual Care provider as it relates to the overall response framework.

# Appendix B

Trifold pamphlet





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