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CRISIS INTERVENTION PROGRAMS FOR
DISASTER VICTIMS: A SOURCE BOOK AND
MANUAL FOR SMALLER COMMUNITIES

Kathleen J. Tierney
Barbara Baisden

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Disaster Research Center

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Principal Investigators:
Dr. E. L. Quarantelli and
Dr. Russell F. Dynes

Project Officer:
Dr. Calvin Frederick, Chief
Mental Health Disaster
Assistance Section,
National Institute of
Mental Health

CONTENTS

I	INTRODUCTION	
	The Present State of Empirical Knowledge About the Effects of Disaster	2
	Why Mental Health?	4
II	MENTAL HEALTH NEEDS AND RESOURCES IN THE RURAL UNITED STATES	
	Rural and Urban Settings: Similarities, Differences and Varieties	6
	Characteristics of Contemporary Rural Life	9
	Mental Illness in Rural America	12
	Rural Attitudes Toward Mental Illness and Treatment	14
	Mental Health Resources in Rural America	15
III	MENTAL HEALTH NEEDS IN DISASTERS	
	A Study in Contrast: Two Disasters and Their Psychological Effects	18
	Buffalo Creek	18
	Xenia	22
	Xenia and Buffalo Creek: Differences That May Make A Difference	26
	The Present State of Empirical Knowledge About The Mental Health Consequences of Disasters	28
	Crisis Intervention: A Strategy for Meeting Disaster- Generated Needs	36
IV	DESIGN AND METHODOLOGY OF THIS STUDY	
	Objectives of the Research	40
	Methodology	47
	Advantages and Disadvantages of the Research Design	52
	What the Research Can and Cannot Tell Planners and Practitioners	54
V	EMERGENCY MENTAL HEALTH AND CRISIS INTERVENTION NEEDS AND RESOURCES IN TWELVE U. S. TOWNS	
	Scoring the Communities	57
	Mental Health Resources in the Areas Studied	59
	Evaluation of Mental Health Resources	60
	Community Assessment of Mental Health Services	61
	Mental Health vs. Other Groups As Care-Givers Common Patterns of Human Service Resources	64
	Evaluation of Human Service Resources	65
	Community Assessment of Human Service Resources	67

Percentage of Population Change and Resource Scores	71
Actual and Potential Crisis Needs in Sample Communities	78
Prevalent Community Needs	79
Relative Importance of Three Types of Needs	84
Groups Needing Social and Mental Health Services	87
Impact of Disaster on Community Needs	89
Perceived Need for Mental Health Counseling in the Disaster Setting	90
Conclusion	91
VI MATCHING NEEDS AND RESOURCES	
Strategies for Planning and Implementing a Mental Health Disaster Response in the Smaller Community	94
Pre-Impact Phase: Planning for Service Delivery	95
Impact and Emergency Period: The Provision of Psychological First Aid	100
The Post-Disaster Period: Long-Run Program Options	113
APPENDIXES	
I Public Law 93-288 Title IV - Federal Disaster Assistance Programs	126
II Rules and Regulations for Implementation of Section 413 of the Disaster Relief Act of 1974	133
III Training Manual for Human Service Workers in Major Disasters--Table of Contents	141
SELECTED ANNOTATED BIBLIOGRAPHY	
I General Social-Scientific Writings on Disaster and Disaster Planning	144
II Recent Literature on Rural Mental Health Needs and Programs and Selected Works on Community Mental Health and Crisis Intervention	147
III Mental Health Consequences of Disaster and the Delivery of Services to Victims	161
REFERENCES	170

TABLES

4.1	Sample Communities	49
5.1	Configuration of Mental Health Resources	59
5.2	Distribution of Sample Communities by Percentage of Total Possible Mental Health Score	61
5.3	Distribution of Communities, Compared on Scores for Mental Health and Human Service Resources	65
5.4	The Distribution of Mental Health and Human Service Resources in Twelve Communities	69
5.5	Size of Community Population and Resources Scores	70
5.6	Percentage of Non-White Population and Resources Scores	71
5.7	Median Family Income and Resources Scores	72
5.8	Choice of Care-Giver by Community	74
5.9	Choice of Care-Giver by Occupation	74
5.10	Resource Scores for Disaster and Control Towns	76
5.11	Disaster Communities *	81
5.12	Control Communities *	82
5.13	All Communities * * Problems Receiving Most Frequent Mention As "Most Serious" * Problems Receiving Most Frequent Mention As "Next Most Serious" * Problems Receiving Most Frequent Mention As "Least Serious"	83
5.14	Percentage of Informants Choosing Rankings of Social Services, Mental Health and Material/Financial Needs	85
6.1	1975 Incidence of Federally Declared and Non-Declared Disasters in the Continental U. S. by Size of Largest Community in Impacted Area	113

MAP

Counties in the Continental U. S. Impacted by Natural Disaster Agents in 1975	112
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PREFACE

Purpose and Organization of This Report

This monograph has been written, in part, as a consequence of the growing interest in the delivery of emergency mental health services to residents of disaster-stricken areas. It is designed to provide knowledge of both a theoretical and a practical nature which can aid personnel on the state and local level in planning and carrying out disaster-related mental health programs that are efficiently and effectively organized. In short, our focus in the report is on making recommendations for post-disaster mental health programs based on systematic research findings. Although the report attempts to take into account the characteristics of the smaller community--the rural area or small town relatively far removed from the resources of the large urban complex--the findings and recommendations it contains should be of even wider interest and applicability.

Similarly, while the monograph at first may appear to be focusing on a relatively specialized topic, namely, crisis intervention needs and resources in small towns and the question of how resources might best be mobilized in a post-disaster emergency mental health effort, dealing adequately with this topic has meant delving into a number of more general areas. In fact, the report contains a considerable amount of information for any mental health professional or any layperson interested in mental health problems of rural populations and the local resources available to remedy them: issues of disaster mental health; characteristics of individual and group behavior in disasters; and emergency mental health program development.

The focus of this monograph is both theoretical and empirical. It contains discussions on recent literature in the fields of psychology, community mental health, rural sociology, and disaster research. The monograph also reports on the findings of a recent research project, funded by the Disaster Assistance and Emergency Mental Health Section of the National Institute of Mental Health and conducted by personnel of the Disaster Research Center of The Ohio State University, which aimed at assessing both the need for services of a crisis intervention nature in non-urban communities in the United States and the availability of local resources capable of providing such services. Much additional data of a descriptive nature is provided so that richness of detail is not neglected in the course of abstract hypothesizing.

The emphasis in the report is both academic and applied. Serious consideration is given, for example, to questions of disaster mental health, such as the issue mentioned above, concerning the number, nature, characteristics, severity, and duration of the emotional problems experienced by disaster victims. At the same time, however, we recognize that local caregivers will want to provide helping services to victims of disasters despite the fact that the long-term psychological consequences of disasters have yet to be fully understood, and that they want advice about how to design and implement such services. Therefore, we have included in the report a detailed section of recommendations, grounded in current knowledge, for setting up an emergency mental health response to disaster.

Chapter II of the report is devoted to a discussion of the nature and types of mental health needs that exist in rural areas of the United States. The literature on urban and rural lifestyles, on rural-urban differences in rates and types of mental disorder, and on varying attitudes towards the treatment of mental health problems is reviewed. This chapter focuses on ways in which large cities and small towns contrast with each other and ways in which they are similar, with an eye towards noting the implications of these similarities and differences for mental health service delivery, both during normal times and in disasters.

Chapter III contains a treatment of what is presently known about the mental health needs of disaster victims. Two contrasting case studies are presented in an attempt to orient the reader to the complexity of issues of disaster mental health. Commonly stated myths about psychological reactions to disaster are matched against empirical findings on the prevalence of symptoms of mental disorder and stress following disasters as well as against the reports of persons directly involved in mental health service delivery in disaster-impacted communities.

Chapter IV describes the overall research strategy and the methodology of the Disaster Research Center's study on emergency mental health and crisis intervention needs and resources in small U. S. communities. The steps followed in conducting the research are discussed, as are both the advantages and the disadvantages of the chosen research strategy.

In Chapter V, the findings of this year-long project are reported. Contained in the chapter are profiles of typical configurations of resources of both a mental health and a human service nature found in the communities studied. Particular emphasis is placed on the overall capabilities inherent in the resource networks of each community, particularly those capabilities believed to be essential to the performance of effective emergency mental health functions--outreach, round-the-clock service, use of indigenous community workers and the like. There is focus on both formal and informal care-giving networks, with the latter receiving a substantial amount of attention. Scoring of resource capabilities in the sample communities reveals interesting patterns, that are described and analyzed in this chapter. A large portion of Chapter V is devoted to a discussion of the mental health-related needs of rural residents, which are found to be numerous and wide-ranging and are discovered to resemble those of urban-dwellers in some respects and differ from them in others. Informants' views on the need for counseling services by disaster victims are also reported and discussed. Since over one-half of the communities studied in the course of the research had been impacted by disasters in the recent past, much of the information reported in this and other chapters deals with disaster effects experienced on the community, organizational, and individual levels. Thus, the effects of disaster on community needs, as well as on the operation of various mental health and human service agencies, are touched upon.

In Chapter VI, an attempt is made to combine all this data and to set forth guidelines for the planning and operations of disaster-related emergency mental health programs. The focus is on the kinds of services that can be delivered at the local level, by local people, in response to local

disaster-generated problems. The mental health response on the community level is charted through various phases--pre-disaster planning, emergency period operations, post-disaster programs--and detailed programmatic recommendations appropriate to each phase are outlined. We have attempted to advance recommendations in this chapter that are general enough to be widely applicable and specific enough to suggest concrete strategies. Many references are provided for those wishing even more detailed information for use in workshops, seminars, and training programs in disaster mental health. Throughout the chapter, program flexibility and applicability to areas that are relatively poor in resources, e.g., highly trained personnel, are emphasized. Throughout the monograph, and above all in this last chapter, we attempt to convey a sense of what the disaster setting is really like: of what problems of coordination in the delivery of services can be expected to arise; of what problems are most likely to be encountered, and when; and of what kinds of therapeutic efforts are most likely to succeed in the aftermath of disaster.

No single written work can be all things to all people. However, we believe that this report will be of use to:planners as well as practitioners; trained mental health professionals as well as human service agency professionals and interested laypersons; in communities of any size, but particularly in the small town; and to communities at any point in the disaster response, but preferably before disaster strikes, as an aspect of good overall community planning.

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E. L. Quarantelli, Ph.D.
Principal Investigator
Co-Director, Disaster
Research Center
Professor of Sociology

INTRODUCTION

Disasters have complicated the existence of the human race throughout recorded history. In anthropological and historical records, in fiction, in the popular press, even in the Bible, catastrophes created by the natural elements appear along with war, famine, and disease as major causes of the misfortunes of humankind. Worldwide, thousands of lives are lost each year as a result of natural catastrophes, and the social and economic impact of disaster is frequently crushing. Disasters occurring in Third World and developing societies, such as the recent devastating earthquakes in Nicaragua, Turkey, and China, have an even greater potential for dealing a crushing blow than do those striking modernized societies simply because the resources of the latter societies are relatively greater. Nevertheless, societies such as our own are by no means immune from the devastating consequences of disasters. For example, in the United States, in the years 1972-1976, 207 disasters were of a magnitude requiring a Federal Disaster Declaration; these catastrophic events involved the loss of hundreds of lives, the disruption of the life routines of thousands of survivors, and the necessity for millions of dollars in financial assistance to stricken areas.

In spite of the lone tradition linking disasters and the fate of the human race and in spite of the fact that major disaster events are an almost weekly occurrence in the United States, more myths than truths exist today regarding how people actually behave when disaster strikes. The notion that panic behavior is a common phenomenon in disaster events is one example of an erroneous popular belief that has been refuted by empirical research. Media accounts reporting instances of panic flight reactions at disaster sites have long been common. At times, entire communities have been described as rushing to flee a potential site of disaster impact; however, the reality in the pre-impact period is that the vast majority of community residents can scarcely be induced to evacuate their homes, even when the possibility of damage and destruction is imminent.

Many more examples of erroneous thinking about other realms of human behavior in disasters could be cited. Of course, the reason why it is important to refute myths about disaster behavior is not simply because they are untrue. The correction of misconceptions is important because incorrect ideas are sometimes acted upon, not only by individuals but also by officials responsible for community disaster planning and response. For example, there have been cases where local officials had warning that disaster would strike, but did not pass this information on to the community because they felt that doing so would create panic flight among residents. Many individuals could have benefitted from a warning period to secure their homes and possessions and to prepare to endure the disaster impact.

The sociologist W. I. Thomas noted many years ago that "Situations defined as real are real in their consequences." Because definitions of the situation that are based on faulty knowledge can have consequences

detrimental to human life and property in the disaster setting, it is very important to dispel stereotypic notions about disaster behavior and to replace these with solid empirical knowledge.

The Present State of Empirical Knowledge About the Effects of Disaster

Fallacies such as the "panic myth" cited above abound in spite of--or perhaps because of--the relative lack of systematically obtained knowledge about the impact of disaster on human behavior. At this time, it may be said in general that the oldest and most commonly accepted definition and conception of disaster is economic, with financial and material losses receiving the most emphasis, that the social consequences of disaster have been studied somewhat less frequently and more recently, and that, with some notable exceptions, the psychological aftermath of disasters has yet to be subjected to systematic study.

Perhaps it is a consequence of the materialistic values of the American way of life that the severity of a disaster is most frequently expressed in terms of the material damage that occurs. Or perhaps physical destruction is emphasized because it is more dramatic and more readily visible than some of the more subtle, hidden, and long-term changes communities undergo after disasters. Whatever the reason, dollar losses are mentioned early in public and official accounts of disaster events and are usually given more extensive coverage than are discussions of the loss of life, the injuries, and the social dislocation disaster typically leaves in its wake. Federal agencies unwittingly perpetuate this financial/economic definition of disaster by stressing dollar amounts in outlines of losses and by equating disaster magnitude with the amount of financial aid that is disbursed.

It has been only relatively recently--in approximately the last twenty-five years--that researchers have begun taking an interest in understanding the social characteristics and consequences of disasters and in describing and analyzing the effect of disaster on aspects of life that are less obvious than bricks and mortar, streets and buildings. During that time, there has been an increased interest in substituting fact for myth in a number of areas concerned with social and community response to disasters. Fritz (1961), Form and Nosow (1958) and Barton (1970) were among the first to systematically treat such topics as stages in community disaster response, changes in patterns of behavior such as roles, tasks, and the division of labor in the period following disaster, the effect of disaster on community solidarity, and the role of disaster in the creation of new groups, norms, and values. The bulk of this early research was based on first-hand observations by researchers in the disaster setting; this provided an opportunity for the systematic gathering of information about what generally occurs in disaster communities that did a lot to dispel mythological notions based on the isolated, unique, or dramatic occurrence. Many of these pioneering inquiries into the social aspects of disasters were conducted by such organizations as the National Opinion Research Center (NORC) at the University of Chicago and by the Disaster Research Group of the National Academy of Sciences, as well as by individual researchers working at various universities.

Research on the social aspects of disaster behavior gained further impetus with the establishment of the Disaster Research Center (DRC) at the Ohio State University in 1963. DRC is the oldest disaster research center in the world and the only one in the United States devoted to the study of organizational and community responses to disasters. DRC is structured so that teams of trained researchers can leave on short notice for the disaster scene and, thus, are able to observe the organizational and community response to disaster as it unfolds. Since its founding, to date, DRC has conducted upwards of three hundred disaster studies worldwide, utilizing both field and survey research methods. Products of the research include books of a general nature such as Dynes's Human Behavior in Disasters (1976), in addition to monographs, reports, journal articles and other writings designed to be of interest to behavioral scientists as well as to those responsible for the planning and execution of emergency operations in times of disaster. Most of DRC's research has focused on community, organizational, and group responses to disasters. Public safety organizations, Civil Defense organizations, the Red Cross and community general hospitals are examples of the kinds of organizations studied. Social scientific concepts such as the division of labor, tasks, social structure, organizational domains, communications, and decision making have also been analyzed in the disaster context. The research tradition discussed above has resulted in the closing of important gaps in knowledge, so that it is possible to state that a substantial amount is now known about the social aspects of disasters.

At present, however, the same claim cannot be made about the effects of disaster on the psychological functioning of individuals. Too little is known about this important area, and there is a tendency for members of the general public to believe that disasters have a wholly detrimental effect on the psychological well-being of their victims. Common stereotypes about the behavior of individuals in disasters perpetuate the notion that disasters lead to increases in mental illness among stricken populations. This view, evident in journalistic accounts of disaster, is not entirely absent from scholarly studies on the topic. For example, one article reporting on the body of literature on psychological consequences of disaster (Kinston and Rosser, 1974) notes that many psychologically and psychoanalytically oriented writers presume that severe psychopathology is a relatively frequent consequence of disasters. On the other hand, while the number of scholarly writings devoted to the psychological effects of disasters has increased markedly in the last five years, in the main, findings have failed to provide support for the notion that disasters result in severe psychological disturbance in victims. Instead, research findings are beginning to provide support for the hypothesis that a very, very small number of disaster victims sustain long-range psychological damage as a result of disaster experience, that a somewhat larger, but still relatively small, portion of the stricken population may be expected to manifest at least transient symptoms of various forms of emotional disturbance following disaster, and that the most common and widespread difficulties experienced by victim populations are those involving problems in everyday living. In short, while researchers appear to be becoming aware of at least the gross categories of problems that manifest

themselves following disasters and their relative frequency, the overall question of the nature, types, and intensity of disaster-related psychological problems has not yet been definitively settled.

In addition to the efforts being made by researchers to better understand the impact of disaster on the psychological functioning of the individual, there have been organized efforts, beginning approximately five years ago, to deliver mental health services to victims of natural disasters. 1972 saw the first direct involvement of the National Institute of Mental Health (NIMH) in a disaster-related mental health response when an outreach/crisis intervention program was funded by NIMH to provide counseling and preventive mental health services to victims of the Wilkes-Barre, Pennsylvania flood. Since that time, mental health professionals and volunteers in other disaster-stricken areas, having heard about programs of this nature or having perceived the need for such services on their own, have also engaged in the provision of counseling and other services as a part of a community mental health recovery effort. Indeed, the provision of mental health services to disaster victims, a phenomenon which was virtually unknown ten years ago, has now become a common occurrence in communities stricken by major disasters and is actually specified as an element in federal disaster relief.

Why Mental Health?

Why has the delivery of emergency mental health services to victims of disaster assumed such importance in recent years? Briefly stated, the increasing belief that the delivery of mental health services should be an aspect of each community's response to disasters can be seen, in part, as a consequence of the overwhelming success of the community mental health movement of the 1960's, which was institutionalized by the passage of the 1963 Community Mental Health Centers Act. Acceptance by local individuals and by mental health practitioners of several of the values contained in the community mental health ideology--the value placed on the community as a focal point for service delivery, the emphasis on prevention and on innovative treatment strategies like crisis intervention, and, especially, the emphasis placed on the external social environment as a potential source of individual problems--appears to have led logically to the conclusion that disaster victims, being individuals who have collectively experienced marked disruption of their everyday lives, need specialized mental health services every bit as much as do those who appear at mental health clinics exhibiting symptoms of psychological disorder. (See Taylor, Ross, and Quarantelli, 1976, for a more comprehensive discussion of the relationship between the values of the community mental health orientation and the delivery of disaster-related mental health services.)

Matching this concern on the local level, in the past few years the National Institute of Mental Health has taken an increasing interest in the delivery of counseling services to disaster victims, and its role in the provision of these kinds of services is now specified by federal law. Section 413 of the Federal Disaster Relief Act of 1974 states that the President is authorized, through the National Institute of Mental Health,

to provide counseling services, together with financial assistance, to local and state agencies for the relief of mental health problems caused by major disasters. (See Appendix I for the text of the law.) Additionally, there is within the National Institute of Mental Health a special Disaster Assistance and Emergency Mental Health Section which is available to assist with mental health activities in Presidentially declared disasters. Thus, changing attitudes about who can benefit from mental health services, new legislation and changing institutional arrangements are all forces acting to increase the salience of issues surrounding the planning for and delivery of mental health services to individuals in disaster-stricken communities.

This report, which stresses the disaster-related mental health needs of residents of smaller communities geographically removed from large urban centers, is itself a consequence of the newly forged federal commitment to providing psychological first aid in the form of crisis intervention services as an element in federal aid to disaster stricken communities. The use of crisis intervention techniques and other forms of short-term psychotherapy in the disaster setting will be discussed in detail in later chapters. Before turning to the topic of mental health needs in disasters, however, we will discuss briefly the needs, resources, and attitudes towards mental illness which exist today in the smaller communities in the United States.

MENTAL HEALTH NEEDS AND RESOURCES IN THE RURAL UNITED STATES

Rural and Urban Settings: Similarities, Differences and Varieties

The shape of any program--the problems it addresses and means by which it does so--is determined by the way those problems are initially defined. It is essential, therefore, to look at how rural and urban areas are alike, how they differ, and how rural areas themselves vary.

The very term, "rural America" is misleading, evoking as it does images of dichotomy and of uniformity. That is, that everything about rural life is other than, indeed opposite to the life of cities: agricultural vs. industrial; easygoing vs. aggressive; even provincial and narrow minded vs. sophisticated and tolerant. Smith and Zopf (1970) take cognizance of this stereotype:

Nothing seems more apparent than the contrast between the city and the country. However, one who attempts to set forth the specific differences...to distinguish accurately between rural and urban, is immediately confronted with some serious difficulties, obstacles that are not readily perceptible.

(p. 23)

Even though the two are generally treated as mutually exclusive, it seems that, regardless of the basis of differentiation used, analysis uncovers some inconsistency or weakness in the scheme.

The message further conveyed by the stereotype is that there is a single rural lifestyle that is constant from West Coast town, through Midwestern farmland, to the hamlets of the Seaboard region. Smith and Zopf (1970) here call attention to the tremendous range of categories between X_1 , the farm, and X_n , the great metropolitan center. For example, their notion of the rurban community--in which the urban features of the nucleus are approximately in balance with the agricultural activities of the open country part of the locality (p. 261)--provides a convenient mid point between the two extremes and a way of beginning to refine the categories.

The literature shows considerable disagreement among social scientists on the rural/urban distinction per se and even its importance as a topic for study. According to Glenn and Hill, (1977):

Recent American data reveals moderate to substantial farm-non-farm differences on a few kinds of attitudes and behavior, but since farm people now are only about 4 per cent of the population, the farm-nonfarm distinction cannot account for much of the total variation of any kind of attitudes or behavior. The kinds of attitudes and behavior which differ substantially...usually differ monotonically by community size; hence, "ruralism" seems to some extent to characterize residents of the smaller dense

settlements and, to a lesser extent, those of intermediate-sized cities. Furthermore, city residents with rural backgrounds tend to retain rural attitudes and behavior characteristics, size of community of origin being a stronger predictor of some attitudes than size of community of current residence...The explanatory utility of size of community of origin and of residence seems less than that of age and education but at least as great as that of several other explanatory variables..., such as family income and occupational prestige.

(p. 36)

The current state of the art is such that definitive statements on the relative difference between rural and urban are difficult to substantiate. What the evidence at hand does demonstrate, however, is that, in general, similarities among various rural and urban settings outweigh differences, and that as much diversity as uniformity can be discovered within each of the setting types.

Factors of population size and density, economic base, social differentiation and stratification, and income levels all vary from place to place in the nonmetropolitan communities of the United States. For instance, in towns surrounding large cities, population density may be relatively great, with most people commuting to work; while some vast areas of the West are practically uninhabited. Depending on geographic location, rural economics can be based on agriculture, mining, education, scattered mills and/or Welfare. People falling below the poverty level range from about 11 per cent in affluent farming belts, to 50 per cent in the South, the Appalachians and the Ozarks (Segal, 1973). One can discover small "rural" communities at considerable distances from major cities that evidence quite urbane lifestyles, just as one can find rather large towns that manifest relatively "backward" patterns of living. Advantage, then, lies in visualizing a rural-to-urban continuum and not a dicotomy, since a continuum model leads to flexible definitions that yield fruitful comparisons rather than dramatic but self-limiting contrasts.

Both the conventional wisdom and social science have noted a considerable urban to rural cultural diffusion in recent generations. Factors of mass communications, mass economics, industrialization, and back-and-forth mobility all combine to make country life increasingly like that of cities. Rural America has come to have a growing share in the social and economic problems that have long been characteristic of metropolitan areas. Rural communities have become so urbanized, some argue, that unified planning approaches for major service programs are justified (Hofstatter, et. al., 1972). Views like these are prompted by a real concern for people, a push to get some kind of service where none exists, and a very necessary interest in efficiency. Unfortunately, the assumption seems to be that "boilerplate" programs, designed at

Federal and State levels for use primarily in cities and larger towns, will be equally acceptable in the hinterlands. Such programs may or may not be efficient but they will probably not be very effective. Rural communities are not yet identical with cities, and, while they are moving in this direction, important differences will persist (Glenn and Hill, 1977). Those who see only the unarguable similarities or who assume that, in time, all differences will be obliterated, might consider the following:

Culture can, and obviously does, move bilaterally between open country and city, but this does not mean that ruralism and urbanism are exportable commodities. There is no such thing as urban culture or rural culture but only various culture contents somewhere on the rural-urban continuum. The movement of zoot suits, jazz, and antibiotics from city to country is no more a spread of urbanism than is the transfer or diffusion of blue jeans, square dancing, and tomatoes to the cities a movement of ruralism to urban centers.

(Dewey, 1960, p. 65)

Recent data reveal moderate to substantial differences in those kinds of attitudes and behavior that are likely to be highly relevant to the issues of mental health and mental health services. It seems that these differences, which will be discussed shortly, tend to vary by community size, with the largest communities differing from the medium sized communities about as much as the medium sized differ from the smallest. Again, the utility of a continuum model becomes apparent. Clearly, attitudinal and behavioral differences associated by size of community will not--should not--become unimportant simply because the most truly "rural" section of the population is becoming a proportionately smaller part of our society. In actuality, the rural segment, which by U. S. Census Bureau designation includes inhabitants of farms, nonfarm open country and dense settlements of 2,500 or less, has remained stable over the past fifty years at about 25% of the total population. While there are fewer farmers today, rural communities have grown, their populations being fed by people leaving the farms, as well as by in-migration of city people to work in newly established industries, to commute, and to retire (Segal, 1973). In addition to the 26.3% of the 1970 census tabulated as rural, another 31.3% were classified as non-metropolitan, that is, living in intermediate sized communities of 2,500 to 249,999 (Taeuber, 1972). While the terms "rural" and "nonmetropolitan" are not precisely equivalent, it is safe to assume that a substantial number of people live in towns that are relatively isolated from the resources and cultural values of major centers. Thus, developing programs of service delivery more closely tailored to the needs of these smaller communities is an important priority.

The information presented below is general and is intended to provide an overview of relevant social science research on the rural and nonmetropolitan U. S.; it is meant to be suggestive rather than prescriptive.

There are inconsistencies in some of the findings, i.e., those regarding the relative vulnerability of women, racial minorities and the elderly to stress and emotional disorder, and those regarding overall impairment rates, which varied widely--anywhere from 10% to 41% in the studies cited. Thus, it is urged that professionals in each particular community use an overview as a starting point, going on from there to assess local needs, to find those people who are most vulnerable, those who, under conditions of stress, are likely to require mental health intervention, and to develop programs compatible with the community milieu. Knowledge of this type is especially important for the planning and delivery of services when disaster strikes.

Characteristics of Contemporary Rural Life

In a provocative work on rural/urban differences, Dewey (1960) observed that variation occurred around five basic qualities: anonymity; division of labor; heterogeneity; impersonal, formalized relationships; and symbols of status which are independent of personal acquaintance. Let it be remembered that these are relative qualities, found to a lesser degree in more rural settings and to a greater degree in more urban ones.

That there is less anonymity in rural areas is illustrated by the oft-repeated truism that "in small towns everybody knows everybody else's business." Whether or not this is actually the case, it is a fact that the fewer people there are, the easier it is for each to know--or to know about--a greater proportion of the total populace.

Likewise, the fewer the people in a community, the more likely it is that the necessary work of life will be shared among generalists rather than divided by specialists. Rural people, because of the lack of local expertise, often have to service themselves, instead of purchasing the services of others.

Because people know more about each other and do more of the same kinds of things, they are more like each other, more homogeneous. There is a greater likelihood that what will be accepted or rejected by the few, will be accepted or rejected by the many.

For much the same reasons, less anonymity and more homogeneity, relationships with others outside the family are more personal, informal, and generally longer lasting. People know each other by name as well as by role or title, and "standing" in the community is more often determined by what is known about a person than by status symbols, such as titles, badges of authority, or material possessions.

More recent research shows that some of the sharpest demarcations between small communities and urban-metropolitan settings falls into two broad categories: those concerning beliefs, values and interpersonal relations and those relating to socio-economic status. Studies on attitudes and behavior (Glenn and Hill, 1977), political structure (Knoke and Henry, 1977) and the rural church (Nelson and Potvin, 1977) indicate

that conservatism is still a way of life in rural America. This conservatism, in the view of Knoke and Henry, "has been a more durable, pervasive orientation..., suffusing not only politics but religion, morality, and lifestyle. Grounded in the values of moral integrity and individualistic self-help, rural Americans traditionally have long been suspicious and disdainful of urban centers." (p. 52).

This conservatism and traditionalism is manifested in guarded views on big government, big business, big labor, resistance to social change, and to newcomers, particularly if these are members of a racial or cultural group which is perceived as "different," "strange," or "other" than the basic population stock (Knoke and Henry, 1977). That dependence on self remains a major virtue is well illustrated by one community leader, interviewed in our study, remarking, "People don't ask much for help--if they aren't really more self-reliant, they try to be." The moral value attached to being able to help oneself, and the implied or suspected moral failure if one is not, is evident in the fact that when rural people do go outside the immediate family for help it is often to the church. Quite telling is the remark of another of our informants who felt strongly that the church should be the one to take care of people when they really need and deserve help.

With regard to socio-economic matters, it is well documented that there are several areas of deprivation among rural populations. Although some urban groups, particularly inner city blacks, black youth and women, may be as bad or worse off than rural people, in general, the proportion of people falling below the poverty level is twice as high in rural as in metropolitan areas--20-25% as compared to 11%. Unemployment rates for agricultural workers are considerably higher; underemployment is widespread, chronic and severe. The result is that nearly as many rural people fall into marginal income brackets as do into outright poverty (Segal, 1973). The lower cost of living in rural areas makes up less than half the difference in actual income (Dillman and Tremblay, 1977).

Although terms such as "slum" are continually associated with city life, substandard housing is actually twice as prevalent in rural as in metropolitan areas; so are poor living conditions as measured by degree of crowding, existence of plumbing, and quality of drinking water. Although more rural people are home owners, tight credit, an absence of building codes and an expectation of depreciation have combined to limit both the quantity and quality of rural housing (Dillman and Tremblay, 1977).

Historically, fewer rural residents have completed high school, and the pattern continues with proportionately higher drop-out rates. Functional illiteracy is still a significant problem--an estimated 3 million in 1960 (Segal, 1973). Given the minimum educational requirements for gaining entry into desirable occupations or simply for living in an increasingly complex society, relative disadvantage is likely to persist.

Rural regions suffer from relatively high levels of mental and physical health impairment, particularly from chronic conditions (Hollister,

et. al., 1973, Segal, 1973). At the same time, these areas have fewer health and social service resources, and there is a continuing shortage of adequately trained personnel. Geography and lack of mobility are factors limiting the accessibility and, thus, the utilization of those resources that do exist. In short, what emerges is a cyclical pattern-- people enjoying less regular preventive health care receiving infrequent and perhaps inadequate treatment from too few hands, leading to ever greater imbalances of supply, demand and need.

The entire range of problems outlined above, from socio-economic to those of value differences and the conduct of interpersonal relations, fall with special severity on the aged. By 1975 the United States had crossed a threshold; more than 10% of our population was over 65, making us officially an "aging" nation. Many older people never moved away from rural areas, others who migrated to the cities during and after World War II are apparently moving back to their home communities to retire. Whatever the cause, growing numbers of these older people --some 5.5 million-- are concentrated in the small towns of America (Youmans, 1977). Even for rural areas their incomes are markedly low. While industrial development has done much to improve the quality of life for most rural people, it has left the elderly further behind.

If inadequate transportation is a problem for older people in the city, and it most assuredly is, then it is an even greater barrier in rural areas where public conveyances are either non-existent or prohibitively expensive, and where essential health, social and recreational resources may be widely scattered.

Not surprisingly, the rural elderly report poorer physical and mental health than do their counterparts in urban areas. In a 1971 study, "the rural elderly reported double the proportion of cardio-vascular difficulties, and slightly greater proportions having respiratory, sense organ, endocrine, urinary, and psychiatric problems." (Youmans, 1977, p. 88)

The effects of poverty, poor health and isolation are reflected in recent studies of value orientations and attitudes of the rural elderly. Briefly, they found these older people have a more negative outlook on life, less motivation toward achievement, greater hopelessness and despair, more worry about their financial condition, less satisfaction with their housing and health, find their lives more dreary, and rate their communities less favorable in terms of visiting patterns, neighborliness and general benefits (Youmans, 1977).

Born in the early years of this century or before, older Americans internalized the values of a truly "folk" type of society. Life has changed dramatically around them, however, as rural areas have become increasingly industrialized and modernized. For many, adjustment has been difficult, often painful. In the view of Youmans, who has conducted extensive research on aging, older people who are members of minority groups have been placed in double jeopardy.

These older people, such as rural black Americans, rural American Indians, and rural Spanish-speaking people, experience the trauma of witnessing the disappearance of the cultural ways that gave meaning and significance to their lives. Rejected, lonely, and out-of-touch with contemporary values and behavior, many of them have little to look forward to and little to live for. They tend to be the forgotten and neglected people passed by in the modernization process.

(1977, p. 84)

Racial minorities everywhere have long felt the impact of the same constellation of poverty, ignorance and isolation from the mainstream of social and political life that have beset the aging. After all, membership in one minority group is much like membership in another. This is essentially a national rather than a rural problem. We will say only that rural life has proved no kinder to minorities than has urban. If rural populations in general suffer more deprivation, minorities suffer it most. Meanwhile, the somewhat ameliorating effects of the civil rights movement of the sixties are slower to be seen and felt outside the cities.

It is not our purpose to depict life in rural America as stagnant or hopelessly frozen in a primitive past. This is far from the truth. As we have indicated, the country is moving cityward, or perhaps vice versa. Moreover, country life has many inherent qualities that make it attractive to those who live there and to the many who yearn to. At any rate, mass communication, industrial development and mobility, and other features of our complex modern society have bestowed on rural areas many of the advantages of progress as well as the problems. There will always be city-country differences to take into account; however, we tried to point out the areas where those differences are greatest and most relevant to the planning process.

Mental Illness in Rural America

Since the 18th Century, proponents of country living have applauded its tranquil, natural quality and the benefits accruing to the inner person from closeness to family, neighbors, and the land. There is a widespread belief that the harshness of the city, the stresses and strains of succeeding in an aggressive environment generate mental illness, while a rural existence is conducive to mental health. Research indicates that this may be another stereotype.

During this century numerous epidemiological studies have been conducted with the aim of finding both treated and untreated cases of a wide range of mental disturbances. The vast bulk of this work has been concerned with relating mental illness to variables such as age, sex, and social class.

In a review of the literature, Dohrenwend and Dohrenwend (1974), found that nine of these studies reported data from both rural and urban segments of the population, thus giving some comparisons of rural and urban impairment rates.

They found that in one study comparing rural and urban populations, the total rate for all psychiatric disorder was higher in the rural setting; there was one tie; and in the remaining seven studies higher rates were found in the urban settings. None of the differences were very large, however, with the median difference for total rates being around 1%.

Although total rate differences, as reported in this research, were small, rates for specific categories of mental illness varied more widely. It seems that the functional psychoses are found more often in rural areas, while the rates for neurosis and personality disorder are higher in urban settings.

In another recent study reported by the New York Times (1977), Leo Srole discussed data collected in the early 1960's. He found that people in rural areas and intermediate sized towns reported 20% more symptoms of psychological disturbance than did big city residents.

Several epidemiological studies have looked specifically at rural areas, in order to determine which, if any, groups might be more vulnerable to mental illness. Conventially, rates of impairment have been related to variables such as age, marital status, education, occupation and income level, as well as to sex, race and locale within a given area. The findings are somewhat inconsistent, as they have been in studies looking only at urban populations. Actually, one of the similarities to be found in both urban and nonurban settings is that the same general groups tend to be more exposed and vulnerable to stress. Looking at a number of rural studies, principally in North Carolina (Hollister, et. al., 1973), Florida (Schwab and Warheit, 1972), and Nova Scotia (Leighton, 1967), a composite emerges. High risk groups in nonurban areas tend to be:

- the unmarried (single, divorced, widowed) as opposed to married people
- the less educated, unskilled and lower income groups as opposed to the middle class
- those living in outlying areas as opposed to small town residents
- women rather than men
- the elderly rather than the young
- nonwhites rather than whites

The most universal relationship, as it has been ever since Hollingshead and Redlich published their classic, Social Class and Mental Illness (1958), is the one between low social class and high rates of impairment. The stresses and strains of bare economic survival appear to take a definite toll on mental health. Although less striking, there is a significant relationship of impairment rates to factors of sex, age and race. In one study of just these variables the authors remark on the position of blacks. It can be argued that these same remarks apply with considerable force to the position of women, the very old, the very young, and members of other minority groups.

From a sociological perspective, our finding that blacks as a group had higher rates of symptomatology than whites can be attributed to their position in the class structure. In both relative and absolute terms, blacks are poorer, have less political power and have been subjected to both prejudice and discrimination in our society--in Weberian terms, their capacity to compete for material goods, external living conditions and rewarding life experiences has been limited by the institutional structures of American life.

(Warheit, et. al., 1973,
p. 27)

In short, members of each of these groups, particularly those from the lower classes, "...are more likely to be influenced by a greater number of stressful life events and to have fewer internal and external mediating factors at their disposal..." (Warheit, p. 27)

Interestingly, although rural populations in general show slightly lower impairment rates than do city dwellers, within rural areas themselves those living in outlying districts tend to be more susceptible to stress than town residents (Segal, 1973). Relating this to data showing higher impairment rates for single people and those of lower socioeconomic status, it would appear that a salient factor in the incidence of mental disorder is that of isolation, whether it be emotional, social, or physical.

Leighton, et. al. (1967), believe that the degree of community integration, as measured by broken homes, inadequate leadership, and unclear goals, is also an important factor. Their findings indicate that in well integrated communities, people of all kinds show fewer and less severe symptoms than do people of all kinds in poorly integrated communities.

Rural Attitudes Toward Mental Illness and Treatment

Research in rural areas is showing increasing levels of acceptance of both mental illness and of mental health services, at least at the attitudinal level. Most view mental hospitals without the degree of fear and

misunderstanding that once prevailed. Responses of people in general and rural people in particular indicate that the majority will tolerate someone who has been mentally ill, if the relationship is not too close. As a result of the spread of the community mental health movement and widespread educational efforts on the part of mental health professionals, people are distinctly better informed about mental illness than in the past. In surveys of rural populations, most persons recognize mental illness to be a serious problem, consider conditions such as alcoholism and drug abuse to be forms of mental disturbance, and believe that much can be done to help people with mental health problems. Almost everyone agrees that it would be good to have a psychiatrist in town (Edgerton and Bentz, 1969).

On the behavioral level, however, the situation is improving at a slower pace. An extensive review of the literature on public attitudes (Rabkin, 1974) suggests that campaigns to inform people about mental health and illness have resulted in a cognitive rather than a behavioral acceptance. It is easier to express tolerance than to act upon it, especially, perhaps, in smaller towns where sanctions on behavior are more easily applied.

Mental hospitals may be verbally acknowledged as places for the treatment of mental illness, but they continue to be utilized mainly for custodial care. This is due primarily, but not exclusively, to their uneven accessibility to the communities they serve. Whether or not mental hospitals are used for treatment depends also upon local sentiment, which, in fact, in some communities is negative (Weiss, et. al., 1967). The makeup of the legislation may also determine, in part, how, why and when mental hospitals are used.

Rural people still shy away from intimate relationships with the mentally ill; when people encounter someone who has been labeled "mentally ill," they are not pleased to meet him (Rabkin, 1974), although there is somewhat more acceptance or allowance of "place" to eccentric behavior that has a different label.

In much the same manner, rural people accept, even welcome, the presence of mental health practitioners in their midst--for others. Growing numbers are availing themselves of professional services for a wider range of problems, particularly where mental health centers have assumed an outreach stance. Yet the majority continue to take their own problems to their ministers, their regular doctors, or perhaps to "natural helpers"--friends or personal service givers, such as beauticians and shopowners--who are known to be good listeners and to have a fund of common sense.

Mental Health Resources in Rural America

It would be a serious mistake and not at all productive to attribute failure to seek professional help only to negative attitudes or lack of

individual motivation. The decision to seek or not to seek help arises from a complex of intrapersonal, interpersonal and structural factors, from a dynamic interplay of perceptions, values and attitudes. So, too, is this decision affected by the accessibility of resources and the availability of information about them.

Currently, all states have large public mental hospitals, which, for the most part, are readily accessible only to those living nearby. Most towns have general hospitals, whose efforts to meet mental health needs are hindered by poor psychiatric facilities and untrained personnel. Some rural towns, though by no means all, have private mental health or child guidance clinics; some have college counseling facilities. Hot-lines and alcoholism/substance abuse programs are fairly common. The greatest growth in past years has been in the construction of Community Mental Health Centers funded by the Community Mental Health Centers Act of 1963 and 1965. At present about 40% of all Community Mental Health Centers are located in rural counties. One-third of all rural counties have a Community Mental Health Center, and one-third of the people living in these counties are in a Community Mental Health Center service or catchment area (Segal, 1973, pp. 50-51).

Our findings and those of others show no relationship between the presence or absence of other mental health resources and that of Community Mental Health Center. Some communities are fortunate in having both, some have one or the other, many have none. Counties with low median incomes have obtained Community Mental Health Centers faster than others; however, predominantly nonwhite counties have not shared in this growth--only about 7% are covered.

One important factor determining Community Mental Health Center construction is that of state or regional politics (Foley, 1975). Some states, notably North Dakota, Florida, Kentucky and those in New England, got an early start on comprehensive planning and were able to take advantage of the 1963 Act. Other states in the Midwest, the far West and the South have not been as farsighted (Segal, 1973, pp. 56-57).

Given the scarcity of mental health resources in rural settings, it is not surprising that relatively few people are aware of and utilize them. Nor is it surprising that existing clinics, centers and practitioners are patronized mainly by the white middle class. Unfortunately, except where good working relationships with welfare and other social service agencies generate referrals, members of the highest risk groups are notably absent from caseloads. And it is precisely these groups which still attach the most stigma and have the least motivation to seek out services (Reissman, 1967; Hollingshead & Redlich, 1958). Yet the presence of mental health resources invariably creates a market for their services, so that treatment becomes more common where it is more readily accessible (Rabkin, 1974). Thus, the basic issue concerns adequate delivery that is sensitive not only to what professionals have to offer but also to what each community might need.

Community need is a difficult concept to define. It is a relatively simple matter to describe the mental health problems of rural America. In addition to the epidemiological patterns and the attitudinal and behavioral variances already presented, one can list the specific kinds of emotional troubles experienced by rural people. They are no different than those seen in urban people: acute situational crises; long term adjustment difficulties; intra and interpersonal problems manifested in marital, family, and social difficulties; psychosomatic complaints; and adjustment problems related to developmental stages such as childhood, adolescence, midlife and aging. These the mental health profession has the skills and the tools to help.

What is perhaps the overriding need in rural areas is for mental health planners and practitioners to be aware of and sensitive to certain characteristics of rural life that have been touched on throughout this chapter and are summarized below:

- proportionately large numbers of the socially and economically disadvantaged
- pride in independence and self-sufficiency
- lower levels of acceptance of the label of mental illness, resulting in a tendency to underestimate mental health problems
- general tendency to reject the unfamiliar and the specialized
- propensity, when seeking help, to go first to family, friends, doctors, and ministers
- physical limitations of distance, transportation and professional manpower shortages

With these in mind, mental health programs can be designed that are compatible with existing community patterns--beginning "where people are." Programs built around the givens of rural life may seem less sophisticated, less professionally oriented, but they will have a better chance of acceptance and support, both in normal times and in times of disaster.

When a tornado, flood or fire strikes, or there is any traumatic occurrence that intensifies human need at the same time that it disrupts the systems and structures that customarily meet these needs, planning becomes almost a luxury. The pressure is to do, to act. Anything that is done beforehand in the way of assessing actual and potential community needs and idiosyncracies will provide invaluable information and direction. Happily, the types of programs and activities that have been found to be effective in helping victims, which will be elaborated upon in later chapters, will suit the smaller community. Or, to put it another way: the town that has planned and provided for meeting the psychological needs of its citizens in the manner that smaller town dwellers find most acceptable will find that it already has the guidelines and basic strategies for an excellent disaster intervention program.

III

MENTAL HEALTH NEEDS IN DISASTERS

A Study in Contrast: Two Disasters and Their Psychological Effects

Perhaps the best way to introduce the reader to the variety and complexity of questions about disaster mental health is to discuss briefly two recent disasters that were, by any standard, among the most serious in our nation's history: the 1972 Buffalo Creek, West Virginia, flood and the 1974 Xenia, Ohio, tornado. The two disasters have been chosen for treatment here because both occurred in small towns, because both have been the subject of social scientific research into mental health consequences of disasters, and because the two disasters appear to have differed markedly in their impact upon victims' mental health.

Buffalo Creek

The Community

The community of Buffalo creek is "rural" by anyone's definition. Located in Logan County on the western side of the Appalachian Mountains, it consists of a group of settlements lining one of the many hollows along the sharp mountain ridges, scarred by strip mining. At the top of a hollow three forks merge, forming the Buffalo Creek. The valley floor along the creek ranges from fifty to two hundred yards in width and stretches for a distance of seventeen miles. The creek ultimately flows into the Guyandotte River. Sixteen small villages are located along the strip of land in the Buffalo Creek hollow.

In 1972, 5,000 persons lived in the hollow; perhaps one-half of what the population had been in previous decades. The mechanization of coal mining was the factor responsible for the exodus from the area, and the people who remained in the area were those who could profit from mechanization.

Residents of Buffalo Creek enjoyed an income sufficient to maintain a lifestyle of relative affluence compared with the rest of the population in the Appalachian region. At the time of the disaster, the majority of the population of Buffalo Creek depended directly or indirectly on the coal mining industry as their primary means of support. Although a number of persons in the community were receiving some form of public assistance, welfare was not a way of life in the hollow:

Sixty percent of heads of households were working regularly, some 15 percent were retired and living on pensions, and an additional 25 percent were drawing checks for disability, unemployment, death and so on.

(Erikson, 1976, 126)

Buffalo Creek was an extremely close community before the flood; neighbors knew and cared about one another. The residents took pride in their possessions and land, knowing they had refurbished what had previously been company shacks into comfortable homes. People were likely to describe the kind of relationships they enjoyed with one another more in familial or kinship than in mere friendship terms. There was a deep sense of mutuality that comes from sharing as equals in the same way of life. In short,

One the eve of the disaster, then, Buffalo Creek was home for a close nucleus of people, held together by a common occupation, a common sense of the past, a common community, and a common feeling of belonging to, being part of, a defined place.

(Erikson, 1976, 131)

The Disaster

Middle Fork, one of the three forming Buffalo Creek, served as a reservoir for coal mine refuse, dust, shale, and impurities. When the debris built up sufficiently, it formed a makeshift dam, or impoundment, holding back black, murky water for reuse by the mining company in coal processing. Every year, 200,000 tons of refuse were dumped into the impoundment.

The days before February 26th were wet and rainy, although no more than is normal for that time of year. On that Saturday, at 8:01 a.m., the dam collapsed without warning, releasing 132 million gallons of black water--a "mud wave," one witness called it. Rock and debris, dislodged by the bursting of the dam, became part of the writhing mass of water which thrust its way through Buffalo Creek, taking with it houses, automobiles, trailers, and whatever else stood in its path.

In the three hours before the last of the water merged with the Guyandotte River, most homes in the creek had been inundated, and many of them were totally destroyed. The contour of the land had been reshaped, and trees were left without foliage. Everything in the valley was covered with black sludge. Strwn over the valley floor, buried in houses and hanging from trees were the bodies of the 125 fatalities.

The Aftermath

The Emergency Response

The National Guard and Civil Defense responded within hours, opening an access road and transporting the injured to hospitals. The Salvation Army and Red Cross were on the scene, setting up refugee centers and distributing needed supplies. Federal agencies responsible for disaster response and recovery came to Buffalo Creek in full force. The Office of Emergency Preparedness allocated \$20 million for emergency relief, and the

U.S. Army Corps of Engineers engaged in clean-up. The U.S. Department of Housing and Urban Development (HUD) moved mobile homes into the area to shelter the many who were homeless. Thirteen trailer camps were set up to house nearly 2,500 persons.

Consequences of the Disaster for Victims' Mental Health

Subsequent to the disaster, community residents filed against the coal company for damages, claiming psychic impairment. In 1974, the plaintiffs in the case were awarded \$13.5 million in damages, with the court finding that the disaster experience had indeed been psychologically crippling to victims. Psychologists, psychiatrists and sociologists called into Buffalo Creek to conduct research as a part of the lawsuit reported that even two years after the flood, survivors were still suffering from depression, anxiety, emotional instability, hypochondria, insomnia, apathy and a variety of other problems. Of the 615 individuals interviewed, over 90% were diagnosed as suffering from some emotional disorder (Titchener and Kapp, 1976).

What accounts for the widespread occurrence of these kinds of symptoms in this population? According to Erikson (1976), the trauma experienced by victims of the Buffalo Creek flood was so intense because it was not only an individual trauma, but also a blow to the solidarity of the community, a "collective trauma." He defines the latter as "a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of community." (1976, 154) The two dimensions of trauma are seen as closely related, with the one serving to reinforce the other.

Erikson describes the following as important aspects of the individual trauma experienced by the survivors who were interviewed:

1. Numbness and exhaustion due, in part, to the repression of the intense feelings of grief, loss and horror that accompanied the disaster experience.
2. Preoccupation with death, due to the fact that survivors had been confronted with the sight of the corpses of family members, friends and neighbors.
3. Survivor guilt; the feelings of those who lived that they had survived at the expense of others, resulting in self-punishment.
4. Grief over the sudden and almost total loss of home and property that represented a lifetime of labor and sacrifice.
5. Loss of confidence in the natural order of things, resulting in a deep sense of confusion and fatalism.

Titchener and Kapp (1976) list the following as common symptoms which were exhibited by victims of the flood: anxiety, grief, despair,

severe sleep disturbances, nightmares, obsessions and phobias about water, depression, listlessness, apathy, loss of sociability and a lack of ambition and interest in life.

In Buffalo Creek, Erikson argues, it was the collective trauma experienced that served to aggravate individual trauma, impeding individual psychological recovery and conferring "a degree of permanence to what otherwise might have been a transitional state of shock." (1976, 185) Two factors seem important in accounting for collective trauma. The first is the fact that the disaster victims greatly outnumbered the non-victims. In most disasters, the ratio is reversed, meaning that the many who are comparatively well off are available to aid the few who are in desperate need. With so many experiencing intense crisis, involving physical and emotional damage, victims could not do much to help one another. Assistance had to come mostly from the outside and, thus, from the first victims were robbed of a sense of communality and control. Second was the fact that the relocation of the homeless in trailer camps was done on a random, haphazard basis, effectively destroying what remained in the way of old neighborhood ties. One victim is quoted as saying, "We don't have a neighborhood anymore. We're just strange people in a strange place." (Erikson, 1976, 211)

The loss of feeling of communality and its impact on the survivors of the flood, vividly expressed by victims in interviews, is also reflected in more objective indicators: theft increased after the flood; alcohol and drug use became more prevalent; marital problems were more common; and juvenile delinquency increased. There was also an increase in the rate of reported illness after the flood; this increase was particularly marked in reports of backache, sore muscles and other symptoms commonly associated with tension. (Erikson, 1976)

No researchers have attempted to argue that the Buffalo Creek disaster was typical in terms of its mental health consequences. Indeed, the work which has been done in Buffalo Creek has attempted, among other things, to account for the extensiveness and severity of the symptoms of psychological disturbance discovered among victims. Erikson's distinction between individual and collective trauma is one such attempt--one that seems quite sound. Lifton and Olson (1976) cite the following as factors they believe account for the widespread psychological impairment the flood left in its wake:

1. the suddenness of the flood;
2. the element of human blame that was present, due to the mining company's carelessness about the safety of the dam;
3. the fact that survivors were essentially forced to remain in continued close contact with the consequences of the flood, with little hope that things would change;

4. the geographic and social isolation of the Buffalo Creek area.

Perhaps a look at the individual and community response to the Xenia tornado will help shed light on what is typical and what is unique where psychological consequences of natural disaster are concerned.

Xenia

The Community

Xenia, whose name is derived from the Greek word for "hospitality," is a southwestern Ohio town of 25,000 located in Greene County on the outskirts of Dayton. Xenia's predominately lower-middle class population consists mainly of community natives. The close proximity of two prominent black universities--Central State and Wilberforce--a large air force base and Dayton, a city of nearly a quarter of a million, all give Xenia more social and cultural diversity than many small towns. The majority of Xenia's working people are employed in Dayton, although there is some light manufacturing in the town and its environs.

The lifestyle in Xenia is similar to that of many bedroom communities around the U.S. The local vote is heavily Republican in federal, state and local elections. In 1974, single-family dwellings predominated, and 75% of the residential dwellings were owner-occupied. Most people shop in Dayton, and local trade was on the decline even before the tornado.

The Disaster

On April 3 and 4, 1974, over 148 tornadoes passed through more than 200 counties in 13 states in what was the most massive outbreak of tornadoes in the history of the United States. At 3:50 P.M. on April 3rd, a tornado watch was issued for Dayton and west central Ohio counties, including Greene County. A tornado cloud had formed when a thunderstorm moving northeast from Cincinnati collided with colder air. At 4:20, a tornado touched down at Bellbrook, five miles southwest of Xenia, and began moving northeast toward the town. Tornado warnings were announced by radio, by television and by police cruisers equipped with loudspeakers from about 4:00 P.M. in Xenia. In spite of warning efforts, it did not occur to many people that a tornado might actually touch down in Xenia.

The tornado cut a path through Greene County about sixteen miles long, averaging between 2,000 and 3,000 feet in width, with winds estimated at times to be near 250 MPH. The funnel touched down in Xenia at 4:40 P.M. and proceeded in a northeasterly direction, destroying or damaging residential areas, schools, a cemetery, the downtown business district and Central State University in nearby Wilberforce. Five minutes after it had entered Xenia, the tornado dissipated itself in the open country. Thirty-three individuals died in the tornado. Over 1,000 survivors, or approximately 5% of the population, were treated for tornado-related injuries. The destruction in Xenia was extensive;

two major residential areas, and the central business district were almost entirely destroyed. One incomplete survey revealed that 1,135 homes were totally destroyed, 511 incurred major damage, and 1,500 sustained minor damage. In addition, over 100 businesses, city facilities, and churches were destroyed or damaged. The dollar losses resulting from the tornado in Xenia were estimated at \$177 million. In other words, the devastation by the tornado resulted in the need to rebuild about one-fourth of Xenia and to repair extensively another one-third of the community.

As was the case in Buffalo Creek, the Xenia disaster sharply disrupted community life. The Xenia tornado was indeed a community-wide disaster, and it was a rare household that did not feel the effects of the tornado. All institutional sectors showed evidence of dislocation. For example, economic disruption was massive; business losses were staggering, and a little over a third of Xenia's population experienced interruptions in employment for a month or longer. Additionally, the slow pace of downtown redevelopment occasioned intracommunity conflict involving local interest groups. The educational sector of the community was also affected by the tornado. Since some schools had been destroyed, students were sent to nearby schools and double sessions were initiated. The school day was shortened and athletic programs were cancelled. Approximately half the children attended at least two different schools in less than six months. Family life was similarly disrupted, with taken-for-granted routines radically altered for some time after the tornado. Almost one-half of those evacuated from their homes were out of their houses for more than two weeks, and a substantial number of families lived in homes they did not consider permanent for months. Yet, as will be indicated, this disruption did not result in collective trauma of the kind seen in Buffalo Creek, nor did it eventuate in the appearance of severe psychopathology among victims.

The Aftermath

The Emergency Response

Individual and organizational responses during the first hours after the disaster were swift and effective. Search and rescue missions, performed by the Xenia Fire Department, nearby police and fire units, and units from Dayton, were called off by 12:40 A. M. the next morning. The number and identity of casualties were known early; no victims were buried for days or entirely lost. The Red Cross opened a shelter within hours after the disaster, and the local radio station broadcast only disaster-related programs. Resources of various kinds were brought from nearby Dayton. In short, local, state, and federal aid was reasonably swift in coming, was reasonably sufficient, and generally was provided efficiently and effectively. Even more important, there was no evidence of individual or organizational panic or immobilization, and the community responded rationally to meet the needs of the situation.

Of particular note, for the purposes of this discussion, is the fact that one aspect of the community's disaster response involved efforts by both established mental health agencies and new groups to provide mental health services to victims. One established agency was involved in attempting to provide counseling of a crisis intervention nature immediately after the disaster impact and in the months that followed, and two additional groups emerged in the days following the tornado to assess needs, to provide broad human services and referrals, and to engage in advocacy on behalf of victims. These three organizations believed strongly in outreach to victims, in prevention of problems, as opposed to their clinical treatment, and in the use of innovative methods for dealing with the crises victims were experiencing.

Consequences of the Disaster for Victims' Mental Health

Three types of mental health related responses have been identified by Taylor, Ross and Quarantelli (1976) in the report on their research on individuals in the stricken community: mental illness, mental health problems and problems in living.

According to this research, the Xenia tornado did not generate or precipitate serious, long-term psychopathology among tornado victims. Indications of hysterical breakdowns, loss of contact with reality, or severe psychological disturbances were not found among disaster victims either in the short or long run. Taylor, Ross and Quarantelli note that:

There was little demand for services oriented towards severe disaster-related psychopathology. In fact, organizations which specialized in providing more long-run clinical treatments through the use of psychotherapy, drugs, or hospitalization actually experienced a decline in the demand for their services subsequent to the tornado.

(1976, p. 275)

This decrease in the more severe forms of psychological dysfunction and in the demand for clinically oriented kinds of services occurred in spite of the fact that many mental health practitioners expected a post-disaster increase in the incidence of mental illness.

The second type of psychological reaction, mental health problems, or "Difficulties primarily associated with the lack of positive psychological adaptation...rather than the presence of some underlying disease process," (Taylor, Ross and Quarantelli, 1976, p. 73) were prevalent after the tornado, but findings still do not suggest that there was a widespread incidence of mental health problems among the tornado victims. While various subjective and objective indicators of mental health reveal that "a significant number of the population exhibited mental health needs after the tornado" (Taylor, et. al., 1976, p. 273), the incidence of mental health problems was well below what was anticipated by the personnel of local mental health service delivery and by the citizens themselves. Additionally, what mental health problems appeared were usually of a minor and short term nature.

In a survey conducted on a random sample of the population of Xenia, six months after the disaster, the Disaster Research Center (DRC) found that only nine per cent of those surveyed reported their emotional/mental health to be "poor" or "very bad." However, 56% did report feeling depressed or low on occasion after the disaster. In addition, 27% reported having had sleeping problems at some time since the tornado; 15% admitted to some loss of appetite, and 25% reported having had headaches. But a second survey conducted 18 months after the disaster indicated that the incidence of most of these symptoms declined dramatically in the year following the tornado. There was, however, one important exception, the significance of which is not yet wholly understood, some victims were more likely to report being depressed a year and a half after the tornado than they were in the first six months afterwards. This finding could indicate that some mental health problems may be longer-lasting or may emerge later than others; but more study is needed before this assertion can be made.

In terms of social adjustment, both positive and negative consequences of the disaster were discovered. For example, two per cent of the respondents reported that relationships with friends and family had deteriorated since the disaster, but 27% reported that these relationships had improved for them. Similarly, while three per cent of respondents report their marital relationship to be less satisfying since the disaster, 28% reported them to be more satisfying. Apart from victims' own subjective perceptions, objective statistical data used to measure stress among the impacted population indicated mixed effects also. For example, there was no significant change in either marriage and divorce rates or suicides as compared with pre-disaster rates; deaths resulting from heart problems decreased, but there was an increase in reported physical illness. Only three per cent of the population reported any increase in the use of alcohol after the tornado, but seven per cent actually claimed to have decreased their consumption. In the year after the tornado there was an overall rise in the number of cases filed in all courts -- including juvenile court -- but, at the same time there was also a significant decline in the actual number of offenses reported to the police.

With regard to the demand for mental health services after the disaster, Taylor, Ross and Quarantelli note, "There was no massive onslaught of clients seeking the services of either existing or newly emergent disaster mental health agencies and groups. In all, less than ten per cent of the total population received services from the various mental health agencies in Xenia in the six months after the disaster." (1976: p. 272) This figure dropped in half, or to about five per cent, who reported that they used any of the agencies in the year following the disaster.

The data, therefore, indicates that victims of the Xenia tornado did apparently experience a variety of mental health problems; however, these were usually minor and short-term in nature. In fact, many individuals felt that they were emotionally and psychologically healthier

after the tornado. For instance, about 70% of Xenians indicated that they were better able to cope with adversity for having responded to the challenges the disaster presented.

The third type of psychological consequence of disaster, problems in living rather than mental illness or mental health problems, appeared to be the largest cause for concern after the tornado. The amount of destruction incurred posed considerable immediate difficulties for victims. Most problems that surfaced were of the sort typically dealt with by social or human service agencies. For example, in one DRC survey where a sample of the population was asked to rank the need for different kinds of services, youth problems, public transportation, and recreation programs were ranked highest, followed by free food, continuing education programs, and low cost housing. Counseling was ranked twentieth on the list of needed services.

In summary, the victims of the Xenia tornado, unlike those of the Buffalo Creek flood, did not evidence symptoms of either mental illness or severe, prolonged mental health problems. The actual incidence of cases of severe psychopathology was minimal, and the most frequently manifested symptoms were of the anxious/depressive variety, which were generally of mild intensity. Problems in living -- difficulties associated with obtaining food, shelter, clothing, and community services -- were quite severe after the tornado, especially in terms of victims' subjective perceptions of their needs.

This does not mean that there was not a need for services of a mental health nature after the tornado. On the contrary, we would argue that the data shows that there was a clear need for some types of services -- particularly emergency mental health or crisis services -- by some people, at some time after the disaster. Moreover, the widespread evidence of problems in living certainly indicates the existence of a continuing stress situation with relevance for the mental health of at least some of the population. Although no exact data exist to measure their effectiveness, local attempts to deliver mental health services almost certainly had a positive effect on the recipients.

Xenia and Buffalo Creek: Differences that May Make a Difference

As has been emphasized throughout this discussion, the Buffalo Creek flood was so atypical as almost to be unique, in terms of the psychological consequences it reportedly had for victims. In order to avoid a tragic reoccurrence of this kind of event, it might be useful to ask if something might have been done to reduce the severity of the problems that emerged.

Individual trauma resulting from the flood was, understandably, massive. But apparently it was the additional blow to the solidarity of the community in the weeks and months following the flood that magnified

the effects of the victims' trying experience. The populace was reportedly so overwhelmed by the devastation of the disaster that a feeling of helplessness and dependence on outside aid occurred, which was probably detrimental to efforts to reinstate a sense of communality. Although neighbors and family members labored long and hard to help one another, it was not possible for local people to organize any sort of sustained effort to reach those who were most affected. The isolated nature of the locale meant that nearby communities could not become involved in extending personal, neighborly, supportive kinds of aid. The material assistance given, while sufficient, was dispensed by an impersonal bureaucracy, administered by outsiders. After the homeless were relocated in their trailers, anything that was left of the old ties were obliterated. Thus, victims of the flood were robbed of the sense of adequacy, of mastery, that comes from collectively responding to the challenges of a crisis -- the positive kind of feeling that many individuals belonging to disaster-stricken communities express during the recovery period. In short, there was an absence in Buffalo Creek of what Fritz (1961) has termed the "therapeutic features" of disaster; psychologically speaking, the flood victims experienced all of the bad and none of the good effects of community crisis.

In Xenia, on the other hand, there was evidence of the kind of increased community solidarity, intensified collective effort, and general optimism Fritz has noted in his studies of disaster-stricken communities. People were able to help one another in very meaningful ways and to regain a sense of collective strength. An important part of this helping behavior involved the extension of psychological support to victims through formal, as well as informal, helping networks. Xenia possessed a comparatively elaborate network of mental health and human service agencies even before the tornado. Many of these organizations became involved in the disaster response (although not always in an efficient, effective way), but perhaps even more important, new local groups formed for the expressed purpose of giving victims whatever kinds of support were needed. Also, resources for providing counseling and other types of human services were available from nearby Dayton, had these been needed. Thus, although there was no prior planning for the delivery of mental health services to disaster victims, Xenia was, at least potentially, able to meet the crisis-related needs of community residents.

No one would naively argue that it was solely the lack of provision of emergency mental health services to the victims that made the long-term effects of the Buffalo Creek flood so severe. It is obvious that some organized, ongoing, indigenous effort to provide crisis services in a supportive and neighborly fashion might have lessened the effects of the trauma suffered by the flood victims. We think that communities should learn from the disaster experiences of both Xenia and Buffalo Creek and should plan on the community level for an appropriate response to disaster-related needs of all kinds, including those of mental health. Since part of planning involves knowing what to plan for, we will discuss what recently has been learned about disaster-related mental health needs, noting how these findings differ from what conventional wisdom leads us to expect.

The Present State of Empirical Knowledge About
The Mental Health Consequences of Disasters

To say that most people equate the term disaster with intense and prolonged human suffering, anguish, loss, and despair is almost to state the obvious. Even the common sense observer would agree that the impact of a tornado, an earthquake, a hurricane, or the water surging from a crumbled dam goes far beyond the immediately recognizable loss of life and the sheer physical damage and destruction associated with such events, impressive though these may be. As the above examples indicate, what is even more important about a large-scale disaster is the disruption and destruction of community life, the marked alterations of routine patterns of social expectations and day-to-day personal habits which follow in its wake. While the physical impact of a disaster may be over in a few minutes as in Xenia, these other consequences extend for weeks, months, and even for years. A major disaster does far more than wreck buildings and sever lifelines; it interrupts the rhythm, cycles, and very social fabric of community life.

Disasters are part of a class of collective stress situations, in that, since they disrupt social life, they also induce psychological stress for their victims. But how do human beings respond in these collective stress situations? Can it be assumed that the social disruption occasioned by a large-scale catastrophe also creates psychological disorder or malfunction among victims? The answer to this question is two-fold: how people are believed to respond and how they actually respond. Although much more intensive, systematic research is needed in order to satisfactorily answer both of these questions, the general answer is clearly indicated by current research evidence.

Folk Wisdom

For some time conventional wisdom has held that human beings do not react well to large-scale catastrophes. It is commonly believed that when people are faced with the threat or the actual occurrence of a major disaster, they disintegrate physically, mentally, and morally. They engage in bizarre, antisocial, irrational and destructive acts, such as wild and disorderly panic, looting, and other forms of criminal deviance. Popular beliefs about how people react to extreme stress situations are so grim that hysterical breakdowns and psychotic episodes are thought to be common among disaster victims in the short run and a wide variety of forms of severe psychopathology are expected to be manifest among victims in the long-run. In short, the image is essentially that disasters create or exacerbate severe forms of mental illness for their victims.

These common stereotypes of how persons respond to and are affected by disasters are not new. While there are undoubtedly many reasons why such stereotypes exist, one of the basic reasons is that mass media and

journalistic accounts often reinforce and support such beliefs. This can be seen in the images played up by news and magazine accounts of disasters dating as far back as the late 1800's and early 1900's. For example, in a Harper's magazine article of 1889, survivors of the Johnstown, Pennsylvania flood were described as "crazed by their sufferings." A Saturday Evening Post account of the devastating hurricane which hit Galveston, Texas in 1900 wrote of 500 people who went "insane almost in unison" following the disaster. Similarly, Harpers Weekly wrote that the 1906 San Francisco earthquake and subsequent fire brought about cases of "men gone mad." While the terminology used in these articles is, of course, outdated, they do nevertheless illustrate the long history of the view of disasters leading to severe psychopathology.

Perhaps even more important, the same general stereotypes continue to be emphasized in present mass media accounts of disasters. Following a series of major floods in 1973, Newsweek, for example, reported that once the immediate post-impact period is over, a new reaction starts to appear among victims -- this one a "kind of shared psychosis that hits just about everyone affected directly or indirectly by the event." The story then goes on to assert that within a few weeks after such a catastrophe, symptoms of emotional problems will become disturbingly obvious: the number of successful suicides rises by about a third; hospital admissions for psychiatric reasons run at double the normal rate; and the frequency of accidents skyrockets. Indeed, the picture painted by this story is a grim one.

While numerous other examples of journalistic writings which advance similar ideas could be cited, we all know that most people do not believe everything that they read in newspapers or magazines. Or do they? How widespread in actuality is the belief that disasters trigger extreme emotional and psychological reactions among the general public? Two surveys have recently been undertaken to ascertain empirically what the general public actually does believe about human behavior in disaster situations. The first, a survey conducted by Dennis Wenger and his colleagues in the state of Delaware (Wenger, Dykes, Sebok, and Neff, 1975), found that large blocs of the population do, in fact believe that disasters evoke extreme reactions in their victims. For example, these researchers report, among other things, that 74% of those surveyed agree with the statement that "immediately following the impact of a disaster, victims are in a state of shock and unable to cope with the situation by themselves." The second survey conducted by Blanshan (unpublished paper, 1975) in a small community in Ohio not far from Xenia only months after the tornado produced similar findings. The attribution of problems of a mental or psychological nature to victims of disasters was widespread among the population surveyed. In other words, according to these studies, the general public does, indeed, hold to the image that disasters produce extreme psychological and emotional reactions in their victims.

But what do psychiatrists, psychologists, and other experts in the mental health field have to say about human response to disaster? Like

the mass media and a majority of the general public, a large number of mental health professionals also assumes that extreme emotional and psychopathological reactions are a typical consequence of disasters. While the terminology used varies somewhat, psychiatric and psychoanalytically oriented writers like some of those who conducted research in Buffalo Creek often note that immediately after impact, victims of major natural catastrophes can be expected to display what is often termed the "disaster syndrome." This condition is supposedly characterized by an unrealistic absence of emotion, inhibition of activity, docility, indecisiveness, lack of responsiveness and automatic behavior on the part of disaster victims. During the later post-impact phases, victims are likely to exhibit reactions such as: an increase in the use of alcohol and other drugs; acute, traumatic neuroses; tormenting memories and guilt feelings over survival; and irrational hostility and scapegoating.

An often cited numerical projection of the numbers of victims likely to display psychological disorders was set forth over two decades ago by Tyhurst, one of the first professionals writing on the subject. According to Tyhurst (1951), about 12-25 per cent of a disaster-affected population will show grossly inappropriate behavior, anxiety and effective states, hysterical reactions, and psychosis. Another 75 per cent will be "dazed, stunned, bewildered" or otherwise exhibit the disaster syndrome noted above.

On the whole, until the last few years the issue was not whether severe pathological reactions occur in victims of disasters, but the question was what were the incidence and duration of these assumed problems.

Of course, as was asserted in the first chapter of this report, when the "panic myth" was discussed, "situations defined as real are real in their consequences," the importance of the beliefs and perceptions held by professionals and the general public is the implication they have for what is done in a disaster situation. It is apparent that people do not come into disaster situations with blank minds about the ways in which human beings are expected to react. Rather, there are common beliefs even before a disaster occurs about the response to be expected. The general tendency is to assume that victim populations will exhibit varying degrees of extreme psychological disorder, although the popular vocabulary is to frame these disorders in terms of a state of "shock" or of an "emotional" reaction. Typically, anecdotal stories circulate about "unusual" behaviors on the part of some victims. Experts on human behavior allegedly, and in some cases actually, reinforce these folk tales and beliefs. Thus, true or untrue, the widely held image that disasters evoke extreme psychological responses is bound to affect people's overall perception of what prevails in such a situation.

Empirical Findings

How accurate are these widespread common sense beliefs about human response to collective stress situations? Most of these conjectures are based either on isolated anecdotal examples and occasional clinical cases of severe post-disaster problems or on the somewhat questionable assumption that research findings based on wartime could be extended to natural disasters. It was not until the past three or four years that systematic research was actually undertaken to determine how human beings react psychologically and emotionally to disasters. The findings from these recent studies suggest that the belief that disasters trigger the widespread incidence of severe emotional and pathological reactions is one of the major myths which exist about human response to extreme collective stress.

Researchers tend to agree that very few people break down in the face of major disasters and that incapacitating psychological reactions are actually rare phenomena in catastrophes. If anything, the seeking of help for severe psychological disorder is notable for its absence. Mental illness on any scale does not seem to be any more a major consequence of natural disasters than it is a result of other kinds of collective stress situations such as the large-scale World War II air bombings studied by Janis (1951) or the civil disorders in Northern Ireland researched by Peipert (1975).

Other research can be cited which corroborates this notion, while at the same time indicating that disaster is not entirely without psychological impact. In a study conducted to determine whether disaster leads to increased stress in the victim population, Hall and Landreth (1975) collected community-level data on changes in arrest records, school attendance, suicide, and a number of other statistics considered to be related to individual stress following the 1972 Rapid City, South Dakota flash flood. They also collected data on a sample selected from the 550 families relocated to mobile homes following the flood. They reported that for the 18-month period following the disaster no significant increase occurred in the community in:

1. The number of attempted or actual suicides, or single car accidents (often considered suicide attempts).
2. The rate of juvenile delinquency.
3. The number of citations for driving while intoxicated.
4. The number of automobile accidents.
5. Infant mortality.
6. Rates of scarlet fever, strep throat, and hepatitis.
7. The number of prescriptions written for tranquilizers.

However, they did find changes in several areas which seem to indicate that at least some people were worse off psychologically following the flood. Divorces and annulments increased significantly in the seventeen months after the flood. There was also a significant increase in the number of arrests for public intoxication and in applications for Aid to Dependent Children.

Although victim families housed in the public trailer parks did not evidence greater involvement in selected deviant and illegal activities (e.g., public intoxication) and did not utilize community mental health center services any more than did the general population, members of these families did appear to manifest symptoms of stress.

The authors concluded that, while the flood did not engender a major community mental health crisis, it did result in an increase in social stress for non-affluent victims. They also concluded that the stresses of group life in government-sponsored mobile home parks set up after disasters are probably detrimental to the psychological well-being of residents in that this way of life tends to destroy victims' natural helping networks. Or, to be more precise, it was not only the impact of the disaster itself which affected victims' psychological well being, but also the more long-term impact of somewhat inefficient and ineffective federal relief efforts which partially accounts for the stress manifested by victims.

Thus, while few researchers would claim disasters create severe and chronic mental illness on a wide scale, victim populations do seem to undergo considerable stress and strain and do experience varying degrees of concern, worry, depression, anxiety, together with numerous problems in living and adjustment in time of disaster. Approximately ten studies have been undertaken in other disaster-stricken communities, and they tend to corroborate this view. The communities include: Wilkes-Barre, Pennsylvania (flood); Omaha, Nebraska, (tornado); Topeka, Kansas, (tornado); Los Angeles, California, (earthquake); Monticello, Indiana, (tornado); and Buffalo Creek. Except for the Buffalo Creek study, none of the research found a link between disaster and severe psychopathology. However, the studies agree almost unanimously that disasters do induce symptoms of psychological stress among victims and fairly extensive problems in living which may, in turn, contribute to further emotional difficulties. Incidentally, most of the studies also point out that mental illness was falsely anticipated in the first few days after impact. When these reactions failed to materialize, existing mental health agencies usually found it difficult to gear up to adequately meet the actual kinds of mental health and human service needs which did exist among victims.

What, then, were some of these needs? The research indicates that the needs of disaster victims are many, complex and interrelated, reflecting the combined physical, material, psychological and social damage that disasters inflict. During the immediate emergency period, disaster victims face multiple problems characterized by varying degrees of urgency, difficulty and emotional impact. These commonly include loss

of a loved one, total or partial loss of home and possessions, physical injury, disruption or loss of employment, sudden relocation, separation from familiar surroundings, and extreme demands on physical endurance. That many disaster victims exhibit signs of stress upon having to face such circumstances almost goes without saying. It is obvious that any one of these problems might conceivably have adverse effects on an individual's mental health; in concert, if allowed to persist, such problems could place the individual in an extreme crisis situation.

Many examples can be cited showing how varied and complex disaster-generated needs can be. Regarding client problems encountered during the course of Project Outreach, a crisis intervention service instituted to provide aid to the victims of the 1972 Pennsylvania floods created by Hurricane Agnes, McGee (unpublished) reports that the highest percentage of the project's clients, 19.58%, expressed "emotional problems," with "property damage," "medical," "financial," and "living conditions" next in order of frequency. Anecdotal evidence is presented by McGee concerning individuals so overwhelmed by demands that they could not decide what to do first and of persons too exhausted and discouraged to attempt to help themselves. Other categories of needs mentioned by McGee include persons faced with having to adjust to temporary housing and persons who had experienced other extreme personal or family difficulties close to the time of disaster. Bowman, a mental health professional who participated in the emergent crisis intervention response to the Monticello, Indiana, tornado of 1974 tells of victims' overwhelming need to relate their disaster experiences to someone willing to listen, and to be made aware of how to go about obtaining a range of disaster-related services. Volunteers from the Monticello Neighbor-to-Neighbor Team consequently played the role of the "friendly listener" and kept up-to-date on where to refer clients to services. (Bowman, 1975)

Other evidence indicating the wide-ranging nature of disaster-related needs is provided in the final report of the Omaha Tornado Project, a group which received funding under Section 413 of the new disaster law to provide mental health services to victims of the 1975 Omaha, Nebraska, tornado. Problems mentioned most frequently by adults during the months following the tornado included "lack of leisure time, interpersonal stress, children getting under foot, depression, sense of loss, and the consequent grieving process that must be worked through." (Omaha Tornado Project, 1976) Volunteers working with this group performed a variety of services for individuals, including: listening to victims relate their tornado experiences; giving victims assistance in obtaining information about needed services; and providing counseling on an informal, one-time basis. An interesting finding of this study--and one with implications for disaster-related service delivery--is that victims overwhelmingly did not consider themselves potential "clients" in need of mental health or counseling services.

Groups with Special Needs

Although little solid, systematic data exists on the differential psychological impact of disaster on various community groups, many programs concerned with the delivery of disaster-related mental health services have attempted to focus on groups believed to require particular attention and perhaps special services. Target groups mentioned most frequently are children and the elderly. For example, in the early 1950's, attempts were made to study the impact of the 1953 Vicksburg tornado on children in the affected population (Bloch, Silber and Perry, 1953). After the San Fernando Valley earthquake of 1972, crisis mental health services were offered to families with children for the purpose of reducing the children's disaster-related fears. (Howard and Gorden, 1972) Similarly, the notion that older individuals may find it particularly difficult to adapt in the wake of disaster is expressed over and over in the literature. Moreover, the elderly are designated as a group needing special attention in almost all proposals and program outlines for delivering services to disaster victims.

Many other potential target groups can be identified. A partial list of such groups might include: the poor; minority group members; persons who had been receiving the services of some community agency prior to the disaster; and previously hospitalized patients. These kinds of groups, together with children and the elderly, constitute logical target groups on the basis of the assumption that their members probably had needs or lacked coping resources prior to the disaster, which the disaster may have exacerbated. Another potentially needy category can be seen as consisting of persons upon whom the disaster had a particularly intense impact. Seen in this manner, a hypothetical set of target groups might include: families who lost one or more loved ones; those who lost their homes and had to relocate; the uninsured or underinsured; and those left unemployed by the disaster.

Assessing potential disaster-related mental health needs involves more than the a priori identification of target groups, however. This is true for several reasons. First, it should be emphasized again that research on the psychological consequences of disaster has not yet firmly established that some groups of victims need services of a mental health nature more than others. On the contrary, in one survey on post-disaster needs, elderly individuals manifested a relatively high need for "hard" services (housing, financial aid, income maintenance, medical services), together with a relatively low need for counseling and other "soft" services (Poulshock and Cohen, 1975). Second, communities will differ in the distribution of post-disaster needs, just as they differ on an everyday basis. Today, American communities have much in common with one another, but they also differ in important ways, ways which have consequences for what services are needed most. Moreover, different kinds of disaster agents affect populations differently and create a variety of needs and stresses. For example, total loss of possessions, with insurance compensation, is more characteristic of floods than of tornadoes or hurricanes; thus,

larger numbers of "relocated" and "uninsured" persons can be expected in a flood situation. Similarly, a comparatively localized agent, such as a tornado, may impact heavily on a part of the community occupied by low-income or non-white families, and a particular constellation of needs may subsequently emerge. With these kinds of considerations in mind, then, we wish to stress the fact that, no matter how logical they may seem, pre-disaster assumptions about what groups in the population may most need disaster-related services are no substitute for accurate, thorough needs assessment after disaster strikes.

Stages in the Appearance of Disaster-Related Mental Health Needs

Another aspect of post-disaster needs involves the time dimension. Research on community response to disaster events indicates that communities go through stages in their response to and recovery from disasters. Community needs and subsequently organizational tasks are known to vary according to the disaster phase in which a community finds itself. For example, Dynes (1974), following Powell, divides disaster impact into eight time stages: predisaster conditions, warning, threat, impact, inventory, rescue, remedy and recovery. Dynes notes that these stages are characterized by the differential involvement of various community organizations, by varying types of organizational behavior and by different community norms. Barton (1970) distinguishes the following phases of community response: the predisaster period; the detection and warning period; the period of immediate response; the period of organized social response; and the long-run post-disaster period, in which permanent disaster effects begin to be seen.

This stage-like quality can also be seen as characteristic of the individual's response to disaster. The needs of individuals, or groups of affected individuals, may also be seen as occurring in phases, with different problems coming to the fore in different post-disaster periods. For example, in a disaster-stricken locale, the most common needs manifested in the immediate post-impact emergency period may be for food, shelter, first aid, information about the whereabouts of loved ones, and an opportunity to ventilate feelings in the presence of a sympathetic listener. These kinds of needs may be superseded in later days by the need for help with clean-up, the need for information about available material aid and social services and the need for assistance in coping with exhaustion, frustration and discouragement at the amount of work that still remains to be done. During the long-term recovery period--say, nine months to a year after the disaster--the most acutely felt needs of victims may be for legal aid or for more and different kinds of community programs. At this time, some people may still be struggling with insurance problems or with unemployment, or may be experiencing difficulty adjusting to the long-term consequences of the disaster.

Disaster impact, disaster recovery, and long-term redevelopment are events community members experience together. This, of course, means that many community members will experience the same types of needs at approximately the same time. Fortunately, this also means that

programs can be devised for the entire community which recognize the stage-like character of disaster-generated needs and which perform different functions for victims in different stages. Additionally, the knowledge that needs change as time passes indicates the necessity for periodic reassessment of both needs and services provided as the disaster experience recedes into the past.

Crisis Intervention: A Strategy for Meeting Disaster-Generated Needs

It seems rather surprising that the widespread mythological belief that disasters trigger mental illness has, in the past, had such a minor impact on the kinds of services delivered in large-scale community-wide disasters. Perhaps this is due to the fact that in American society, losses resulting from disasters tend to be defined almost solely in economic terms. In the past, disaster relief organizations focused mainly on insuring that victims were provided with food, clothing and shelter in the immediate emergency period and that property and physical facilities were restored in the long run. No deliberate, organized attempt was made to deal with the psychological and emotional losses suffered by disaster-impacted populations.

The situation began to change in 1971-1972, however. For the first time, attention was being paid to the mental health of victims of some of America's major disasters. Following these catastrophes, local and outside groups launched efforts to deliver psychological support to victim populations. To date, disaster-related mental health services have been provided in a number of communities, including: the San Fernando Valley in California; Wilkes-Barre, Pennsylvania; Corning, New York; Buffalo Creek; Rapid City, South Dakota; Xenia; Monticello, Indiana; Brandenburg, Kentucky; Canton, Illinois; Omaha, Nebraska; the Grand Teton Dam region of Idaho; the Big Thompson Canyon region in Colorado and several Appalachian communities which sustained damage in the spring floods of 1977. The nature and scope of the services provided to victims varied considerably from case to case. Some programs consisted of reaching out to provide emergency mental health and crisis services, but there were, in the beginning at least, an equal number of attempts to offer traditional clinical and psychotherapeutic treatments.

Over time, however, crisis intervention and the provision of supportive services have come to be defined by those actually involved in service delivery in time of disaster as the most appropriate, effective techniques to employ in dealing with the problems of disaster victims. (See Tuckman, 1973; Schulberg, 1973; Zarle, Hartsough, and Ottinger, 1973; Kirn, 1975; Heffron, 1975; Taylor, Ross and Quarantelli, 1976; and Frederick, 1977, for discussions of crisis intervention as an aspect of disaster response. For a more thorough treatment of the principles of crisis intervention theory, see Caplan, 1964.)

The judgment that strategies employing the principles of crisis intervention may be the most useful strategies for mental health service deliverers to adopt following disasters seems to rest on several foundations. One foundation is the finding cited above that disasters do not result in serious mental illness or sustained and severe psychiatric impairment for any significant segment of the victim population. Another is the apparent lack of increase in demand--and often, the decrease in demand--for psychotherapy and related clinical services following disasters:

It was borne out by our experience that traditional mental health services in clinic settings seem to be appropriate to the needs of a limited number of people, usually those who are displaying serious emotional distress...Post-disaster mental health programs face the challenge of establishing services for essentially "normal" and "healthy" people who are experiencing some emotional difficulty that stems from the losses and stress resulting from natural disaster.

(Omaha Tornado Project, 1976, 13)

Perhaps most important, those involved in post-disaster mental health service delivery have witnessed first-hand the great variety and cumulative nature of victims' post-disaster psychological reactions and, therefore, have become aware of the necessity of adopting an open, flexible approach to the provision of mental health services. Often, they learned the overwhelming need of victims is for the rendering of immediate, tangible aid on any number of fronts. The notion that the delivery of effective mental health services involves the provision of aid in whatever areas seem most pressing to victims is commonly advanced, as in Kirn's discussion of the participatory role the community mental health center worker should play in the days immediately following the disaster:

CMHC staff must do whatever needs to be done. They must behave as good neighbors would, but it is most important that they be there: digging out, sawing trees, and so forth. Especially in sudden disaster, real physical needs are dominant, and the situation does not lend itself to playing formal mental health roles.

(Kirn, 1975, 4)

McGee sums up the role of the crisis intervention worker, both during normal times and in the post-disaster setting in the following manner:

It is difficult to imagine any problem which would fall outside the scope of appropriate response by a crisis intervention agency. There are no eligibility requirements for clients of a crisis service. The crisis worker is best conceptualized as an ombudsman, facilitator, or expeditor in

behalf of people with any type of problem. The need for food, clothing and shelter can be just as much of an emergency to a family as the need for impartial mediating intervention in an angry family dispute. Both types of human problem should receive equal attention with suicide threats and attempts when they are brought to a crisis intervention service by a client or another community agency.

(unpublished paper, 1-2)

Three other themes predominate in the reported experiences of those faced with providing mental health services in times of disaster which indicate why an outreaching, crisis intervention model seems appropriate. One is the notion that victims require services where they are, rather than in a mental health facility or in some other traditional setting. Another is that the mental health worker in disaster must act as a resource for knowledge about other community services and must be aware at all times of what other agencies and groups are doing. Again, there is the notion that providing this kind of information and referral during times of extreme uncertainty--and indeed even physically bringing the victim to the place where he or she can receive aid--is performing a real mental health function. A third theme expressed in writings on disaster mental health services stresses the use of paraprofessionals and volunteers in outreach and crisis intervention activities. It is seen as especially important to enlist the aid of individuals who are already perceived as friendly helpers or resources by community members; e.g., clergy.

The rationale for adopting a crisis intervention approach to disaster mental health has been summarized by Frederick in the following way:

It has been shown repeatedly that traditional psychotherapy is often quite inappropriate (in the post-disaster setting)... Radical departures from some orientations are a sine qua non to effective crisis treatment. People need help in very material ways. It can be mentally and emotionally therapeutic simple to go through the process of making arrangements to get a loan, transport someone in a car to another part of the city where a relative or loved one may be, to arrange for care of children, to help provide more living room so that cramped, crowded conditions of space are alleviated, which have long been known to contribute to psychological difficulties.

(1977,19)

A concluding point on the relationship between disasters and psychological problems perhaps needs to be made. As has been indicated, crisis intervention techniques have been practiced in the aftermath of disaster, and their use in future disasters is widely advocated. However, the assumption that crisis intervention techniques are the most effective way to reduce the likelihood that disaster victims will manifest serious psychological disorders is just that--an

assumption. Actual research evidence is currently insufficient to definitively support such an assumption. To be able to state once and for all whether mental health services are needed in disasters, and to state what kinds of mental health services these should be, we must first answer two separate but related questions. The first question concerns whether psychological disorders do, in fact, arise out of extreme environmentally induced stress and, if they do, what the exact nature and duration of these disorders are. The second is whether alternative sources of social and psychological support can, indeed, mediate the impact of these stressful environmental events on the individual. Stated succinctly, we need to know whether the creation of new helping networks can enhance a victim's ability to cope with stressful events.

The evidence indicated unequivocally that disasters do provoke extreme environmental stress for their victims. However, the claim that this stress has the potential for inducing more long-run symptoms of psychological disorder in otherwise normal individuals has not yet been supported. On the contrary, most research assessing the effects of stressful life events on psychological functioning suggests that the individual psychological reactions or symptoms which arise out of these kinds of events are as transient as is the environmental stress which induces them. This implies that, for the majority of individuals symptoms of disturbance will disappear as the extreme situation alters. (See Dohrenwend and Dohrenwend, 1974; Hinkle, 1974; Holmes and Rahe, 1969.)

It is this conclusion which supplies the basic rationale favoring the use of crisis techniques in extreme situations. The underlying reasoning is that, if providing additional sources of social and psychological support can change a victim's environment, it is possible to shield the victim from some of the stress induced by disasters, thus reducing the chance that otherwise transient disorders will persist.

DESIGN AND METHODOLOGY OF THIS STUDY

OBJECTIVES OF THE RESEARCH

Using the rationale that crisis intervention/emergency mental health programs for dealing with disaster-related problems must build upon existing capabilities, we attempted to obtain baseline information about the needs and resources which now exist in our rural areas and small towns. Both DRC and the National Institute of Mental Health, which funded the study, believe that the information gathered will be useful to local planners, officials, mental health professionals and human service workers who can use it for developing programs to meet disaster-related needs.

In general, the interest was in gathering data that could be applied to the following six questions:

1. What are the general demographic, economic, social, and political characteristics of the area studied?

The focus in this phase of the research was in learning about some of the characteristics of life in each of the areas studied to better understand the non-urban setting. Besides providing information about rural and small-town lifestyles, such factors as income, occupation, ethnicity, religion, and others have been shown to be related to incidence of psychological disturbance, to attitudes about mental illness and mental health, and to a variety of patterns of service utilization, including utilization of mental health services. Additionally, we expected that community characteristics, such as size and racial composition, might relate not only to mental health and human service needs of community residents but also to the number and nature of community resources and to their use by the respective communities.

2. What are the mental health and human service resources available in the areas studied?

This aspect of the research focused on learning about what organizations, individuals, and groups exist in non-urban U.S. communities, which either actually or potentially give support to individuals in times of emotional crises. Again, it should be noted that we studied what presently exists, with an eye toward assessing the potential for adaptation to a disaster situation.

Three kinds of emergency mental health/crisis intervention resources were focused upon: 1) formal mental health agencies; 2) human service agencies responsible for providing a wide range of community services, from income maintenance and child protection to recreational programs; and 3) informal caregivers.

Formal agencies with trained personnel having a clear-cut responsibility for promoting mental health in the areas studied were, of course, of major

interest. The research was designed to discover, among other things, the extent to which such facilities exist in non-urban communities, what kinds of programs are offered, and what populations are served. Attention was paid to the question of whether or not emergency mental health services are offered, and whether any kind of community outreach is emphasized, since these services and activities might be needed following a disaster. Information was also gathered on referral patterns between mental health facilities and other community organizations, informants' perceptions of the adequacy of local mental health services, perceptions of public awareness of community mental health services, and the existence of gaps in services.

Because a relative lack of community resources is one of the distinguishing characteristics of life in non-urban U.S. communities, we knew that formal mental health agencies would not always be present in the communities studied. Additionally, given this relative paucity of mental health resources, we expected that other community organizations, e.g. Welfare, Public Health, and the Courts, might serve a variety of functions and might conceivably provide more services of a mental health nature on an everyday basis than would their urban counterparts. Thus, there was an interest in learning whether, and to what extent, crisis intervention, counselling, outreach, information and referral, and other such services were performed by human service organizations, either as a planned aspect of service delivery or informally, in the absence of other community resources. As with informants in the mental health sector, we were interested in how human service professionals rated the local mental health and human services resources and in their ratings of community awareness of these services.

Informal care-givers constituted the third category of community resources focused upon in this research. We were interested in learning not only about the activities of established and designated community organizations which deal with peoples' problems but also about the identity of individuals to whom community residents typically turn in crises. All community informants were asked the questions, "If someone were experiencing a lot of stress or some sort of personal emergency, what would he or she be likely to do about it in this community?" and, after discussing a variety of problems community residents might face, "What do people usually do who have problems like these?" The questions were designed specifically to discover whether formal agencies of a mental health or human service nature are commonly sought out or whether less formal contacts (e.g., the minister, the family doctor) predominate for people experiencing crises in these communities.

Several factors combined to create an emphasis on informal care-givers in this research. One is, of course, the documented finding that the prevalence of mental health problems can be expected to far exceed treated cases. Thus, it can be inferred that many persons either do without help or seek it through sources other than formally designated agencies. Second is our impression that, in spite of some findings arguing that the attitudes of rural and small-town persons toward the treatment of mental health problems and mental health agencies and practitioners in general are becoming more positive (Edgerton and Bentz, 1969), there may still be a marked tendency in some small communities for people to shun agencies with explicit "mental health" labels due to

unwillingness to incur stigma. We also expected that the typical small town emphasis on independence and self-sufficiency might act to reduce utilization of public human service agencies except in cases of extreme need. Indeed, a widespread reluctance on the part of citizens to use such agencies was borne out in the remarks of many of our informants. Besides these factors, there was also the notion that, on the whole, problem-solving in non-urban communities might be approached by more traditional, personalized means through contacts resembling primary, rather than secondary, relationships. Finally, there were the findings of several studies concerning help-giving in disasters, which indicate that informal and family networks often play a more important role in giving assistance than do formal relief organizations (Drabek, 1968) in these kinds of crises.

It was hoped that information about who residents of non-urban communities turn to for informal or "stopgap" crisis counselling on an everyday basis might be of help to persons responsible for such tasks as needs assessment, program development, and the recruitment and training of crisis counselors should they be necessary following a disaster.

In addition to discovering what organizational capabilities exist in the communities in our sample, we were also interested in finding out how resources are arranged in each community; there was an effort made to outline typical configurations of resources or typical systems. We were interested in knowing whether certain agencies were invariably present in even the smallest communities, whether certain groups of organizations tend to occur together, and in similar questions. We also attempted to relate resource configurations and organizational richness to such variables as population size, median community income, and changes in population to determine whether any of these factors were consistently associated with either presence or absence of community resources.

3. What kinds of crisis intervention and emergency mental health needs exist in the areas under study?

In this part of the research, an attempt was made to discover, through the use of community informants, the most prevalent problems and needs in the communities studied. Informants were shown a list of twenty-two problems and were asked to classify them according to their seriousness for community residents. The problems listed represented a very wide range, from those which would, by any standard, be indicative of mental illness (psychosomatic problems, depression, suicide) through problems which would be sufficiently stress-producing to have consequences for the individual's mental health (marital problems, drinking) and problems in living (housing, unemployment, living conditions). A wide variety of problems were chosen due to the nature of the subject matter of this study--that is, its dual focus on emergency mental health needs of rural populations and on disaster related needs, two topics about which little that is definitive is known.

Concerning the needs of disaster victims, as was noted above in the discussion of mental health in disasters, relatively little is known for certain about the nature, range, duration, and incidence of mental health

problems after disasters. Studies suggest that on balance disaster victims do experience emotional discomfort as a result of the disaster event, although this stress is not usually seriously incapacitating in the long run. There is also evidence that disaster victims, at least in the short run, see the need for various kinds of tangible aid, listening, and friendly support as more compelling than the need for traditional counselling services. This is, of course, the reason for advocating the use in the disaster setting of crisis intervention techniques similar to those employed with individuals experiencing other kinds of emotional crises, e.g., loss of a family member. A decision was thus made to cast as wide a net as possible when attempting to obtain judgments on community problems and needs, so that the relative importance of the various kinds of problems might be clearly established.

Concerning the mental health and human service needs of populations in rural communities the research that has been performed has yielded disparate findings. Different methods of needs assessment have been employed, and needs have been defined in a variety of ways. For example, Edgerton, et. al. (1973) carried out a population survey, administering the Health Opinion Survey (HOS) to a rural population. This survey, relatively common in needs-assessment (see Leighton et. al., 1963 and Warheit, Holzer, Bell, and Arey, 1975) for other rural studies using this method), focuses solely on mental or emotional symptoms, particularly as these relate to stress. Thus, while the survey is excellent for gauging prevalence of psychiatric symptomatology, there is no data gathered on other individual and community needs which might eventually result in psychiatric emergencies particularly if exacerbated by disaster or some other community crisis. Another survey (Willie, 1971), concerning health care needs in a rural-urban area, used community informants and focused only on the disadvantaged. While the survey did obtain rankings of mental health needs as well as a variety of mental-health relevant needs (e.g., ambulatory care needs, needs of the elderly, nutritional needs), these categories were not detailed enough to be truly enlightening. A psychiatrist in rural practice (Guillozet, 1975) notes that marital and intrafamilial problems are seen most frequently among his patients and that acute situational crises are often seen; however, this generalization is based on treated cases from a single practice. To complicate matters further, Huessy (1972) observes that there is a tendency for rural areas to underestimate the extensiveness of their mental health needs.

Other techniques were employed in an effort to obtain information about needs of community residents in disaster and control towns. All informants, both agency professionals and community influentials, were asked to rank "mental health needs," "social or human service needs" and "material and financial needs" in order of their importance or urgency in each community. All informants were asked whether there are groups or individuals in the community needing mental health or social services and not receiving them. Reasons for this were sought in cases where lack of access to services were reported. Finally, informants were asked to judge whether natural disasters and community crises generate a need for counselling by trained personnel.

Since the sample includes both disaster-impacted and non-disaster-impacted rural communities, we felt that a number of important questions regarding needs could be answered by means of this approach. It could be

determined, for example, how important mental health needs are viewed in rural communities, relative to other needs. The most prevalent problems in rural areas, as perceived by residents, could be identified. It would be possible to learn whether the needs and problems of disaster communities, as judged by informants, differ in number, nature, or degree from those of similar non-impacted communities and whether emotional or mental health problems (anxiety, depression and the like) are considered more prevalent or serious in disaster communities.

4. What types of crisis intervention and emergency mental health services are delivered in the communities studied?

In this phase of the research, two major areas were focused upon. First, we attempted to learn what kinds of emergency mental health and crisis intervention services are provided on an ongoing basis in the non-urban communities studied. This effort involved learning about whether, and to what extent, it is actually possible to obtain 24-hour crisis care in these areas; which organizations provide these services; what kinds of problems are encountered; what social and demographic characteristics clients exhibit; and what treatment strategies are employed.

Second, we attempted to learn whether efforts were made to deliver services of a mental health/crisis intervention nature in the disaster-impacted communities studied. Because the formally organized provision of mental health services in disaster is a comparatively recent and still uncommon phenomenon, we expected to be able to document relatively few cases of this kind. However, we believed that obtaining information on what few programs had been carried out, particularly those in small towns, might provide planners and service providers in other areas with insights into the emotional and other needs of disaster victims as well as into strategies of program design and operation.

As was the case with rural communities in general, we were interested in knowing about the nature and types of services delivered in disaster-stricken communities, in who delivered them, to whom, and in response to what kinds of needs. In the disaster-impacted communities we also attempted to discover whether the emergency mental health/crisis intervention services delivered were in any way distinctive, when compared to those which are normally provided as part of ongoing programs, in terms of such aspects as: 1) who provided services; 2) what kinds of services were offered; 3) where, when, and to whom they were provided; and 4) by what means they were provided. If outreach, non-traditional methods of therapy, paraprofessionals and volunteers, and the like were utilized, we were interested in learning whether and why these were thought to be advantageous.

Particular attention was paid to the question of whether or not mental health and human service agencies experienced changes along any of several dimensions following the disaster. Whether caseloads changed; whether the nature of problems encountered changed; and whether the nature of the relationships among agencies altered after the disaster were all questions the research attempted to address. Additionally, there was an interest in

determining whether any new citizen groups emerged to provide services of a mental health nature to victims. If such groups were active in disaster communities, we wanted to gain information about the scope of their activities, as well as their relationship to ongoing community agencies.

5. What political, social, transportation, and service boundaries affect accessibility to and utilization of existing services?

It is practically self-evident that limitations exist on the provision of mental health services in rural communities that are not present in more populous areas. These limitations and barriers are of various kinds.

One such barrier is the supply of mental health professionals, which tends to be very low in the non-urban setting; unfortunately, the need for services is in all probability, not proportionally low. As one writer notes:

In rural and outlying areas, the struggle to provide acceptable levels of mental health counseling may demand more effort than is required to supply acceptable basic medical care. The distributional problems are more severe with psychiatric care manpower than with primary care physicians. Among 55,000 non-federal practicing physicians in 1970, there were 16,500 psychiatrists rendering patient care. In 1969, a National Institute of Mental Health (NIMH) survey disclosed that in excess of 96 percent of non-federal psychiatrists practice in urban areas. An estimated 6,400 practicing clinical psychologists and 4,400 counseling and school psychologists were primarily urban-center based.

Rural areas rarely have a tradition of locally available social and mental health services. Notwithstanding the availability of funds from state as well as federal sources in many instances, rural communities rarely demand these services that are traditionally available to urban areas. More than one-fourth of the nation's population resides in towns of under 2,500. This significant minority shares the stresses of the American population as a whole and bears its share of disrupted marriages and family dissolution. Indeed, rural areas have an unusually high proportion of low income residents as well as the special problems of agriculture-based economics during times of rapid inflation.

(Guillozet, 1974, pp. 249-250)

Those residents of rural areas and small towns wishing to avail themselves of mental health services must also contend with the barrier posed by distance. Because of the scarcity of resources in many non-urban areas, their scattered nature, and the relative lack of development of public transportation, those who are far from services may not even be aware of them, much less utilize them. Additionally, distance almost certainly provides the greatest barrier to those persons who may most need services: the old, the poor, and individuals and families with multiple problems. Distance is a variable believed to be extremely important for the understanding of

patterns of utilization of health care services of all kinds. In the area of rural mental health, Cohen (1972) found distance to be a significant factor affecting use of outpatient services in a rural mental health center serving a large catchment area. Use of outpatient services was reduced by 50% at 30 miles distance from the center and 66% at a distance of 60 miles. He concluded that "at distances of 30 miles or more from the center, utilization rates for outpatient services were likely to drop from 50 to almost 80 per cent" (Cohen, 1972, p. 80). He added, however, that community attitudes towards mental health also had an effect on utilization, regardless of distance. (For a more comprehensive treatment of research on the influence of distance on health service consumption, see Miller, 1974).

Lee, Granturco, and Eisdorfer, 1974, also cited negative attitudes towards mental health services as a major factor leading to non-utilization of mental health services by rural poor and concluded that:

Despite four years of full-time operation and 12 years of consultative work, the comprehensive community health center is still not viewed as a major resource for problem solving by lower-class poor in the catchment area. Problems of the delivery of mental health services to the community are not only related to the geographic propinquity, temporal availability, and the visibility of the center, but also to clients' definition of what constitutes mental health problems and their fear of being identified as mentally ill.

(1974, p. 339)

This research was designed in particular to gather information about this last-mentioned area: the social and attitudinal factors which influence access to mental health services in rural areas. We attempted to determine whether social barriers of any sort exist which would act consistently to exclude certain individuals or groups, be they particular age groupings, members of ethnic groups, foreign-language-speaking groups, or socio-economic groupings. We also attempted to determine whether general community attitudes towards mental illness and mental health services tend to influence utilization patterns.

Barriers and boundaries discouraging use of services such as those mentioned above--shortage of trained personnel, distance from facilities, poor transportation, social exclusion, attitudes about mental illness, stigmatization--are all relevant to the disaster setting, because disasters have the potential for intensifying many of them. Thus, we felt that knowledge about the extensiveness of such limiting factors in rural communities during non-disaster times would have direct implications for disaster planning as well as for strategies of service delivery during the post-disaster period.

6. How effective are the services delivered to meet existing emergency mental health/crisis intervention needs in the areas studied?

Massive funding would be required to evaluate the effectiveness of emergency mental health and crisis intervention services in rural areas. We could not attempt to perform this task comprehensively and definitively within the scope of this research project.

A decision was made that it would probably be most useful to attempt to obtain data on the effectiveness of programs which were devised in disaster-stricken communities to meet disaster-generated needs. This was done by gathering information about the appropriateness and efficacy of these programs from a variety of sources. These included personnel involved in the programs, other mental health and human service professionals, community leaders, and consumers of services. It was our intention to devise a set of generalizations and recommendations about the modes of service delivery that seem to work best in disasters.

Methodology

The Sample

In selecting a sample of communities in which to carry out the research, several considerations were involved. First, in recognition of the fact that U. S. communities differ in their vulnerability to disasters, a sample of communities had to be developed which would include communities of moderate to high disaster vulnerability. Thus, an early step was to identify high-risk areas in the continental U. S. Second, since the research specifically concerns localities, outside urban areas, which have recently experienced disasters, it was necessary to locate communities within high risk areas which were both rural and disaster-stricken. A complete list of localities impacted by disasters during the chosen year was obtained from the 1975 Red Cross listing, "Earthquakes and Weather-Related Disasters Affecting 75 or More Families."

One problem in this stage of the research was that of developing an operational definition of "rural" which would be relevant to our research concerns. The United States Census Bureau classifies rural areas on the basis of size, yet, for several reasons, community size alone was not a useful criterion for the purposes of our research. One reason, of course is that the research involves community responses to real and potential disasters. Disaster agents occurring in the sparsely settled open country, while perhaps devastating to the isolated farms or settlements they strike, do not affect large enough numbers of persons to be considered disasters in the social sense of the term. Another reason is that our focus on community resources requires that we conduct research in localities with sufficiently large populations to provide at least rudimentary human services on the local level.

Of equal importance was our awareness that what we were actually seeking was information about the quality or style of life in non-urban areas, rather than merely data from communities of less than 2,500 inhabitants. Few, if any, established guidelines exist for making this kind of distinction. We felt strongly that residents of a town of 2,500, located five or ten miles from a metropolitan center, might be much more cosmopolitan in outlook and might have access to many more resources than residents

of a community of 15,000 in a predominantly rural state or residents of a community of 20,000 80 miles from a large city. As Smith and Zopf point out:

Nothing seems more apparent than the contrast between the city and the country. However, one who attempts to set forth the specific differences between the city and the country, to distinguish accurately between rural and urban, is inevitably confronted with some serious difficulties...Regardless of the basis selected for the differentiation, usually some inconsistency or weakness in the scheme will appear...distinctions made on a basis such as the size of the community, legal incorporation or the lack of it, the possession of a charter...may be quite inadequate for sociological purposes.

(1970, pp. 23-24)

Thus, we concluded that what we were, in fact, seeking was information about needs and resources in communities characterized by a relative absence of urban dominance--that is, communities fifty or more miles from a large city--together with a relative lack of specialized mental health services.

Once we had located communities of this kind which had experienced natural disasters of several types (tornadoes, hurricane, floods), we then matched these communities with non-disaster, or control, communities in the same states, that were similar along a number of sociocultural dimensions we anticipated would be relevant for both community needs and resources. These variables were: 1970 population; 1960 to 1970 population change; median income; distance from nearest federally assisted comprehensive community mental health center; percentage white population; and economic base. Reasonably good fit was obtained between disaster and non-disaster communities. Greater accuracy in matching was not possible, given the number of dimensions employed and the additional criteria. (See Table 4-1 for the listing of the sample communities and their sociocultural characteristics.)

In addition to conducting research in these twelve sample communities, DRC studied five other disaster-impacted small towns. Two of these--a midwestern town with a population of 5,000 and a border state town with a population of about 1,600--sustained major damage in the massive April 1974 outbreak of tornadoes. These two communities were of particular interest because, in both cases, there had been an organized effort to provide mental health services to disaster victims.

Field studies were also carried out immediately after impact in three communities which experienced disasters early in 1977. This group of communities consisted of a midwestern town of 12,000 and an eastern community of 30,000 which were overwhelmed by the blizzards of January and February, 1977, and a small Appalachian mining community inundated by flood waters in April, 1977. In these three communities, our interest was in determining, through firsthand observation, whether and to what extent emergency mental health/crisis intervention services were contemplated or actually delivered to victims.

CITY	AGENT	1970 POPULATION	1960-1970 POPULATION CHANGE	MEDIAN INCOME	MENTAL HEALTH CENTER	PERCENTAGE WHITE	ECONOMIC BASE
Minot, N.D.	River Flood	32,290	+ 5.5%	9355	in community	99%	Schools Hospitals
Bismarck, N.D.	Control	34,703	+25.4%	9756	in community	99%	Manufacture Schools
Charleston, Mo.	River Flood	5,131	-13.2%	5241	30 miles	70%	Wholesale Manufacture
Hayti, Mo.	Control	3,841	+ 2.8%	5025	20 miles	68%	Wholesale Professional
Panama City, Fla.	Hurricane Flood	32,096	- 3.5%	7292	in community	75%	Manufacture Public Admin.
Fort Pierce, Fla.	Control	29,721	+17.6%	5825	in community	50%	Agriculture Construction
Eagle Pass, Tx.	Tornado	15,364	+27.0%	4370	none	Spanish 96%	Manufacture Retail
Uvalde, Tx.	Control	10,764	+ 4.6%	5853	none	Spanish 55%	Retail Construction
Warren, Ark.	Tornado	6,433	- 4.7%	5820	40 miles	65%	Manufacture Wholesale
Hope, Ark.	Control	8,830	+ 4.9%	5876	60 miles	66%	Wholesale Manufacture
Canton, Ill.	Tornado	14,217	+ 4.6%	9437	30 miles	99%	Manufacture Entertainment
Monmouth, Ill.	Control	11,022	+ 6.2%	8732	30 miles	99%	Manufacture Retail

Table 4.1 Sample Communities

The final aggregate of communities was one capable of supplying information on a number of salient topics. First, from the twelve matched communities came uniform, quantifiable data on perceptions about the resources available for emergency mental health/crisis intervention services in non-metropolitan areas; perceptions concerning mental health and other community needs in impacted and non-impacted localities; evaluations by professionals and community leaders of the adequacy of local mental health and human services, and also of community awareness of these services; and a number of other subjects. Second, from those small communities which had in the past experienced disaster, came general observations about helping behavior in disasters in addition to information about the most common emotional problems encountered and conclusions about what kinds of problem-solving methods actual service deliverers found most effective. From the recently impacted communities came additional observations about the perceived emotional needs of victims and about available community resources, together with information about the perceived importance of mental health services in the immediate post-impact period.

Data Collection

Since the inception of DRC in 1963, research teams have been involved in some 350 field studies of disasters in the United States and overseas. A typical DRC data collection strategy involves sending teams of field personnel to the site of a large-scale disaster while the response is ongoing, in an effort to obtain first-hand data about community response to the emergency. In-depth interviews are subsequently conducted with personnel responsible for various phases and aspects of the disaster response, and other data are gathered. Products of DRC research include scholarly papers and monographs in addition to reports, journal articles, books, and a newsletter devoted to broad problems of disaster preparedness and response of interest to those in disaster planning and operations.

In the research on emergency mental health/crisis intervention needs and resources, the same basic procedure was followed: that is, teams of trained interviewers traveled to the communities in the sample and conducted interviews with key community personnel, spending up to one week in each community. Interviewers contacted agency heads in all major mental health and human service organizations and administered an open-ended interview guide covering the areas discussed above. In addition to interviewing persons in these major organizations, field workers also determined whether other auxiliary resources, indirectly related to mental health, were present in each community (e.g., Alcoholics Anonymous, Senior Citizens Programs, Red Cross), interviewed representatives of some of the organizations, and prepared an "Inventory of Community Mental Health and Human Service Resources" for each community studied.

Community leaders were also believed to be important sources of information on community needs and resources. Field workers were instructed to contact persons in each community reputed by community sources to be influential in major institutional sectors, such as religion, law and the courts, city government, education, and the medical sector. A particular effort was made to contact community influentials

who might, by virtue of their positions, be knowledgeable about the extent and types of emotional crises experienced by community residents. Physicians in family practice, hospital emergency department personnel, juvenile court judges and probation officers, law enforcement personnel, health department officials, and lawyers were among the kinds of persons sought out.

Community leaders were administered the portions of the interview guide concerned with emergency mental health needs and resources and with rating service adequacy. They were also used as sources of information on community attitudes toward mental health and on patterns of service utilization.

In the communities stricken by disaster in 1974, persons who were key in developing programs and delivering services to meet victim's emotional needs were interviewed about all aspects of the organized attempts to provide mental health services, including their perceptions about the effectiveness of these efforts. In the three communities impacted during 1977, workers interviewed members of organizations involved in immediate relief efforts, persons working in mental health facilities (where these were present in the community) and other persons actually or potentially involved in counseling victims, e.g., clergy and social service workers.

A total of 147 in-depth interviews were conducted in the twelve sample communities over a period of seven months in 1976-77. Additionally, approximately fifty unstructured exploratory interviews were conducted in the other communities, all during 1977.

While they were conducting field work in the seventeen communities, DRC workers also attempted to collect a number of community statistics considered to be indirect indicators of the mental health needs of community residents. It was believed that, through the analysis of such data, some generalizations could be made concerning possible crisis intervention needs in disaster and control communities, and that these indicators could be compared to determine whether they showed any difference in magnitude. Examples of statistics sought include: divorce and unemployment rates; welfare caseloads; mental health and social service agency caseloads; arrest and court records; records of school absenteeism; drug sales; records of hospital emergency department visits and hospital admissions.

A host of problems was encountered in this phase of the research. Much of the data collected from the twelve sample communities was, in the end, not useful for purposes of comparison. Often, needed data was simply not available in any form. When data did exist, the form in which it was recorded frequently did not permit comparisons among communities; moreover, even though the research focused on records of events that were relatively recent, primary records had often been destroyed, and, therefore, statistics could not be converted into comparable form which would allow for cross-community comparisons. Additionally, it was common for organizations to radically change their record-keeping procedures over time, further confounding efforts towards obtaining uniform data. Organizations tended to use data classifications unsuitable for the purposes of the research.

Gaps existed in the records of some agencies; these were sometimes due simply to the absence of a position devoted to permanent record-keeping. (Of course, many such agencies were very small, with two or three full-time employees.) Increasing these difficulties was the fact that access to some records was refused on the grounds of client confidentiality and even, in one case, on the grounds that the organization in question was involved in a lawsuit at that time. Thus, despite considerable effort, we were unable to assemble indices capable of yielding comparative, quantitative data on the sample communities.

In summary, the data gathering problems can be traced back to numerous factors. To cite just a few:

In the majority of U. S. communities, both large and small, mental health and social service agencies do not cooperate to engage in the systematic, ongoing collection of comparable client data.

Across the spectrum of U. S. communities, there is even greater variety among agencies in record-keeping practices. Differences in terminology and classification of client problems abound; variety, not uniformity, is the rule.

Organizations vary widely in the extent to which record-keeping is a priority. In small, direct-service agencies, for example, record-keeping is among the first functions to be suspended in times of high demand for their services.

In the case of both agency and other community data the data had been collected for purposes other than this research. This meant of course that the data was kept in categories and classifications different from those which we would have preferred, but, more important, it meant that little was known about the accuracy and reliability of the various statistics.

We believe that these data gathering difficulties merit mention here because the great variety and unevenness in record-keeping practices, both within and across communities, constitutes an obstacle which other planners, service deliverers and researchers will have to overcome. Those interested in assessing mental health needs in rural areas, those involved in developing emergency mental health programs in these areas, and those engaged in evaluating the effectiveness of ongoing programs should be mindful of the difficulties inherent in using data which has already been gathered for other purposes.

Advantages and Disadvantages of the Research Design

This research project broke new ground by attempting to systematically study disaster-related crisis intervention needs and resources in America's small towns and rural areas. Research findings, however, are only as good as the methods used to obtain them. We believe that, in the case of this research, the strengths of the strategies adopted outweigh the weaknesses.

One advantage of the design is that it attempted to focus on the need for services in the communities studied as opposed to the demand for such services. In other words, we tried to learn about the needs that exist, independent of both the supply of services and of data on who is utilizing those services that exist. Demand for and utilization of services are affected by many factors besides need, and for program-planning purposes it is important to gain knowledge about the nature and range of services actually required or desired by the population--knowledge which is not influenced by the supply of services.

The perceptions of knowledgeable community members were used in obtaining data on typical community problems, and very wide latitude was allowed for the identification of needs. This, of course, made possible the discovery of community problems and needs which may not have been anticipated beforehand and which otherwise might have been overlooked. The polling of community informants is also advantageous in that it is inexpensive, when compared to population survey methods, and in that it can be accomplished in a relatively short period of time.

Conducting field work in the sample communities was useful because it provided researchers with some first-hand knowledge of community life. Face-to-face contact with agency personnel helped researchers better appreciate the challenges of providing mental health and human services on limited resources. Also, there was the opportunity to discuss disaster-related mental health programs with persons who had been involved in developing and implementing such programs.

Perhaps the most significant advantage of the design is its comparative focus. The research design allows for comparisons to be made along a number of dimensions: between disaster and control communities and between the perceptions of professionals and those of community leaders, for example. Through the selection of disaster-impacted and non-impacted communities, it is possible to determine whether or not disaster experience sensitizes community residents to questions of disaster mental health and to see whether different needs are cited as crucial.

One possible weakness of the research design is that field studies were conducted some time after disaster impact--as long as two years after the disaster event for some communities. Memories, no matter how vivid at first, fade rather quickly, and there is a tendency for individuals to interpret events retrospectively and to remember selectively. Fortunately, in this research informants were not required to recall or reconstruct chronologies of post-disaster events or to report extensively on their own or others' past activities. Rather, the questions were of a general nature. Thus, while not eliminated, problems surrounding long-term recall were somewhat reduced.

Another possible drawback of the design involves the use of informants to report on mental health related community needs. Informants are "one step removed" from the population experiencing the needs, and this introduces the possibility of selective perception, bias, and outright distortion.

A survey administered to a random sample of the population of each community would have been a good instrument for assessing community needs; however, budgetary constraints and the overall scale of the research precluded the use of this kind of survey. Additionally, we believe that qualitative research of the type conducted in this study is perhaps better suited to the exploratory stage of research than are survey methods.

Another argument favoring the use of community informants in this kind of research is that their perceptions concerning community needs--especially the perceptions of community influentials--have a great deal of influence on the number and types of services that come to be offered in a community as well as on who uses these services. Thus, the impressions community influentials have about the need for crisis intervention or other mental health services after disasters or about the relative importance of mental health needs in their communities may ultimately have more impact on the provision of disaster-related mental health services than will the actual needs of victims. For this reason, we felt that gathering information on these kinds of impressions would be worthwhile.

While we would be even more confident about the research findings if they were supported by large quantities of community-level statistics, in many cases, as indicated above, these kinds of figures were simply not available in usable form. A reduction in the scale of the study, to focus in depth upon a small number, might have yielded a few community-level indices with possible mental health relevance. This option was rejected in the interest of comprehensiveness, representativeness, and comparability of findings.

What the Research Can and Cannot Tell Planners and Practitioners

The findings of this study are, of course, preliminary and are limited to the group of communities studied. However, the conclusions and recommendations that will be advanced will be of a sufficiently general nature to be widely applicable in the disaster context. The study's findings should be a good source of information about perceptions that informants in small U.S. towns now have about community needs in general and disaster-related mental health needs in particular. The findings also present a clear and comprehensive description of the nature, types and arrangement of mental health and human service resources available for ameliorating needs in the areas studied. Additionally, material of both a general and specific nature is included, which should be of help to those responsible for planning and implementing programs for the delivery of crisis intervention/emergency mental health services to communities stricken by disaster.

This monograph does not attempt to definitively settle the question of the impact of disaster on the individual psyche. So far, we have attempted to supply some information about what kinds of emotional and emotionally-related problems typically occur in the aftermath of disasters and how members of some communities have attempted to deal with them.

More important, this study cannot tell the local mental health planner or practitioner specifically what kind of crisis intervention program should be instituted in a given area to deal with disaster-related needs. As has already been discussed, communities differ in their characteristics, and disasters differ in their impact to such a degree that one ideal plan cannot, and probably should not, be devised. Local personnel must decide for themselves, on the basis of local realities, what kinds of services to provide and how best to deliver them. In all probability, their decisions will be based on a variety of factors, including: the geographic, demographic and socio-cultural characteristics of the impacted area; the extensiveness and severity of the damage done by the disaster agent; immediate needs of victims; the characteristics of the existing organizational networks; the availability of community resources, especially trained personnel; and the potential for additional funding.

What those findings, conclusions and recommendations collected in this report can offer is valuable input into these types of decisions. Input will be provided in later sections through the report's emphasis on:

1. relating what others have done and found effective in the post-disaster setting;
2. suggesting general rules and strategies for delivering mental health services in rural communities;
3. discussing several options that are open to local personnel interested in launching a post-disaster mental health recovery effort; and
4. providing information on where to seek additional technical assistant and support for local efforts.

In the chapter that follows, we will report data concerning the ongoing and disaster-related needs of rural populations and the resources which now exist to meet these needs. This information will, in turn, serve as a basis for later recommendations which can be put into practice in the local setting.

EMERGENCY MENTAL HEALTH AND CRISIS INTERVENTION
NEEDS AND RESOURCES IN TWELVE U. S. TOWNS

As previously stated, one major goal of this study was to obtain baseline information about community resources in rural areas that are either directly or indirectly supportive of mental health, particularly those resources capable of providing emergency mental health services. Baseline data on resources was gathered because we believe that, while post-disaster community problems may be both quantitatively and qualitatively different from pre-disaster problems, the two are not entirely unrelated and because, given this fact, it seems most practical for communities to plan for a disaster-related mental health response that builds upon existing capabilities.

Building upon existing resources in community emergencies may seem a simple, obvious suggestion, yet to understand how this might actually occur in a disaster situation it is necessary to understand how communities actually respond in disasters.

The occurrence of a community-wide disaster places great demands on the community affected. Some of these demands are entirely new--the need for large-scale search and rescue, for example--and some represent quantitative increases in old demands, such as the care of the sick and injured. Whether old or emergent, these demands mean that the community has a new and different set of tasks to perform, many of them extremely urgent and all of them taking place in an atmosphere of uncertainty. In order to carry out these tasks, new groups emerge and novel forms of organization are improvised; often, innovative ways of doing things are discovered and untraditional patterns of authority and decision making become evident. For this reason, people tend to believe that communities react to disaster in an unorganized manner.

By and large, however, this is not the case. Rather than being characterized by total lack of organization, the post-disaster community scene manifests new forms of organization that have emerged to respond to disaster-generated demands. The emergence of new forms of organization to deal with the new community subtasks created by the disaster agent is often accompanied by the creation of new community resources. Food, clothing, and personnel are sent to the community from the outside, for example. It is equally typical, however, to see existing community resources mobilized into different areas to meet new demands. A high school gymnasium is designated as an emergency shelter; nurses from the general hospital work as Red Cross volunteers during the emergency period; corporations volunteer employees to work on clean-up crews; and so on. Thus, while the post-disaster period evidences much that is novel in terms of organization, resources previously present in the community constitute important "building blocks" in the organized disaster response. Moreover, the main challenge communities face after disaster is not a shortage of resources but rather the need for integrating and coordinating the resources that are on hand. (See Dynes and Kreps, 1972, for a more thorough discussion of the emergent community system and its relationship to disaster planning.)

Use of existing resources in planning for and implementing a mental health response to disaster may be even more important in the rural than in the urban area. While in the main our findings show that the areas in which research was conducted are not impoverished organizationally, more facilities and personnel are needed than are available, and many community agencies, particularly mental health agencies, are functioning up to capacity during normal times. Thus, it appears that in the emergency situation rural areas and small towns can ill afford to waste the mental health and human service resources that do exist and, therefore, should make a special effort to see how these might be mobilized. Just as is the case with other community sectors, planning for the mobilization of psychological supportive services can make a great difference in the adequacy and effectiveness of disaster-related mental health services.

Of course, community resources of a mental health and human service nature need not be viewed as existing only in agencies carrying those kinds of labels, and for this reason, our research focuses not only on established organizations, but also on informal care-giving networks existing in the communities studied. We did, however, begin our study of community resources by attempting to gain a thorough understanding of the state of existing organizational capabilities in each community.

Scoring the Communities

We divided community resources under the rubrics of Mental Health and Human Services. What we termed mental health resources are those agencies or individuals, with formal mental health training, which are designated providers of mental health services. By community mandate, they have a clear cut and central responsibility for the promotion and maintenance of mental health through the provision of services that are generally defined by traditional psychiatric treatment models. Since the passage of the Community Mental Health Act of 1963, all governmentally funded centers, as well as a number of privately funded clinics, have defined their treatment more specifically in terms of the ten essential service categories outlined by the Act. These are inpatient care, outpatient care, emergency services, services to those partially hospitalized, consultation and education, diagnosis, rehabilitation, pre-care and after-care of the hospitalized, training, and research and evaluation.

While the research was in progress, the numbers of essential services were increased and the categories were somewhat modified. Our research design was, nevertheless, appropriate, since at the time of the study, community mental health centers were still adhering to the older guidelines. The services now designated as essential are aftercare, alcoholism services, children's services, consultation and education, day care, drug abuse services, emergency services, geriatric programs, pre-screening, rape crisis services, transitional care, and 24-hour services.

Human service resources are those agencies and organizations which are mandated to meet a wide variety of social, economic and cultural needs, from income maintenance and family and child welfare, through recreation, law enforcement and help for special populations such as minority groups and the

elderly. The service domains of these resources often overlap with mental health, and in the process of dealing with the problems presented to them, they may exercise a counseling/supportive/therapeutic capacity that contributes to mental health. Particularly in rural areas, where designated mental health resources are relatively scarce, we expected that other community agencies might be providing a great deal of day-to-day services of a mental health nature.

These two groupings, mental health and human services, were looked at separately and together in order to apprehend the overall pattern of resources in the communities studied as well as the interrelationships among them and the effects of their combined efforts in behalf of mental health.

Initially, we developed a list of twelve mental health and eighteen human service resources which included the many types of agencies commonly found throughout the country. In each of the six disaster and six control towns a resource inventory was taken. Additional resources were also recorded when found. This inventory yielded typical configurations of the kinds of mental health and human service resources found in our sample, and likely to be found throughout rural America.

In addition to simple presence or absence in a community, each item on the list was also inventoried for program, that is for the range of services each resource provided. To aid in the comparison of one town to another, and of one type of service to another within a given town, a scoring system was devised. Each item was given equal weight, with a potential score of five. We recognized that some items are more significant for mental health than others, however, of necessity we limited our efforts to measuring the quantity of services, the evaluation of their quality being far beyond the scope of this project. Mental health resources were scored separately from human service resources, and then totaled, giving three sets of scores which could be compared differentially. The maximum possible score for mental health was 60, for human services, 90, with 150 possible for a total community score. All scores were converted to percentages for purposes of standardized comparison.

We found that the inclusiveness of the inventory list and its sensitivity to the nature of the direct and indirect services provided made this a reliable method of assessing the general level of the overall range of services, with a scoring system sufficiently sound to enable us to draw general conclusions from the data.

Our next step was to obtain frequencies and configurations for each type of service provided by each resource, with a special eye toward those types of services which are potentially most useful for crisis intervention and emergency mental health programs. For example, we wanted to see which agencies offered, and how often, direct rather than or in addition to indirect services--emergency services as opposed to consultation for example, or outreach as opposed to information and referral. We also tried to determine if the patterns of service provision varied from the six disaster towns to the six towns in the control group.

The final step of our analysis was to take a closer look at those six communities which had experienced a disaster, to identify those agencies which had helped victims, and to examine the nature of these relief efforts.

Mental Health Resources in the Areas Studied

Common Patterns of Resources

The most prevalent constellation of mental health resources in the twelve communities studied is a combination of a general hospital which, in some manner, treats psychiatric patients, a hotline and/or an alcohol substance abuse program, and either a Federally funded, a county administered, or a satellite community mental health center. This is the pattern in seven of the twelve communities. Some of the seven have more types of resources or more than one of the types mentioned above, while the remaining five have fewer.

Table 5-1 depicts graphically what we found.

Table 5-1

Configurations of Mental Health Resources

	Disaster				Control			
Public Mental Hospital								
Private Mental Hospital								
General Hospital with Psychiatric Facilities	X	X		X	X			
General Hospital that Treats Psychiatric Patients	X	X	X	X	X	X	X	X
Drug Alcohol Program	X	X	X		X	X		X
Hotline	X	X		X	X	X	X	X
Federally Assisted CMHC	X	X		X	X	X		
State/County CMHC							X	
Satellite CMHC		X				X	X	
Outpatient MH Clinic			X	X		X		X
Children's Residential Facility								
College Health Center	X	X			X			X
Other		X						

As can be seen, the most nearly universal mental health resource is the general hospital. Ten of the communities have a general hospital which treats mentally disturbed patients, though does not have psychiatric facilities. The hospitals in four of the communities do have specialized psychiatric facilities, while three of the towns have both types of general hospital. Only one town has neither. None of the communities has either a public or a private mental hospital within the immediate vicinity, although one community is only about a half-hour's drive from the nearest state institution.

The next most common resources are the hotline, or telephone crisis counseling service, and the alcohol/substance abuse program. Four towns have both, five have one or the other, while the remaining three have neither.

Community mental health centers, at various funding and staffing levels, are fairly common, appearing in eight of the twelve towns. Fortunately, the most frequently found type--the Federally assisted community mental health center--is also generally the most liberally funded and sophisticated. We found only one community mental health center and three satellites administered by State/County. One of the larger towns in our sample enjoys the presence of both a Federally assisted center and a satellite which brings mental health services close to those who might have trouble availing themselves of the main center. In the other two communities the satellites are branches of larger community mental health center located elsewhere in the same county or in a neighboring county. Operations in satellites like these tend to be limited. Most of the staff is part-time, usually driving from the main center to man the satellite a few days per week, while what full-time resident satellite staff does exist it is usually spread so thin it can meet only the most emergent of needs. We found certain instances, for example, of some professional from a relatively distant agency coming to town as infrequently as once every two weeks to provide mental health services, often of a specialized nature. The quantity of actual service was so slight in these cases that we could not deem them "resources" in and of themselves, and therefore they do not appear on the table of configurations. We did, however, include these services in our tally of the frequency with which ten specific mental health services were offered by the various kinds of mental health resources in each town.

As the table shows, private outpatient clinics or mental health centers and college health facilities were distributed unevenly in half of the sample. None of the communities has a residential treatment facility especially for children. There is no apparent relationship between the presence of private resources and that of community mental health centers.

In the overall supply of mental health resources in all twelve categories, we find no significant variance between disaster and control towns. In sheer number of existing agencies, disaster and control communities were identical, each group having 22.

Evaluation of Mental Health Resources

Gross totals on numbers of resources give no indication of the richness of the program of each one or of the overall supply of mental health services available in a given town. Our next step, therefore, was to examine the nature, the number and the general availability of the services provided by each resource. As explained earlier, a scoring system was devised assigning each resource equal weight with a potential score of five. The maximum possible score for the 12 mental health resources was 60. When scores were obtained and converted to percentages a distribution appeared. Scores tend to fall on the lower half of the range, with an average score of 25.5%.

Table 5.2

Distribution of Sample Communities
by Percentage of Total Possible Mental
Health Score

<u>Scores</u>	<u>Number</u>
0 - 10%	2
11 - 20%	4
21 - 30%	3
31 - 40%	0
41 - 50%	2
51 - 60%	1
61 -100%	0

On the whole, the picture looks somewhat better than the scores would indicate. To begin with, it is highly unlikely that any community--rural or metropolitan--with the exception of the very largest, would possess all of the possible types of mental health resources. Nor is such abundance a requirement for good care. What small-to-intermediate-sized town needs both a private and a public mental hospital? The mental health profession has long advanced and has empirically supported the notion that institutionalization is not the preferred mode of treatment except in a small minority of cases. Actually, it seems feasible that the availability of a well-equipped general hospital, providing appropriate facilities and psychiatrically trained personnel, would adequately meet any local need for inpatient care. As our research shows, most communities do have hospitals which make some effort to meet the needs of psychiatric patients. While such efforts are not yet at an optimal level, it is reasonable to assume that inpatient psychiatric facilities are available to the vast majority of people who might need them.

With regard to outpatient and counseling services, the picture is somewhat less encouraging. It is true that, just as a small-to-intermediate-sized town would not need three kinds of mental hospital, it would also not need three types of community mental health centers. However, there is evidence that many more people both need and want the services of a mental health center than can get them. Caseloads at many agencies are growing to the point of overload, and our findings indicate that a significant proportion of the respondents rate their local mental health agencies as inadequate in terms of accessibility and available staff time. Better than half the towns in our sample had some sort of community mental health center and/or private facility. The lowness of the scores, however, indicates that this is not enough to meet needs even in those towns which have such facilities.

Community Assessment of Mental Health Services

Representatives of the mental health and the human services professions and community leaders in each of the towns studied were asked to assess the level of mental health services in their communities and also the level of

awareness of these services among the general public. We found that, in general, about half of the respondents rated local services as "adequate." Mental health professionals and community leaders were slightly more likely than human service professionals to rate services as adequate or better. Favorable responses were not universal among mental health workers, however, as about 40% openly stated that local services could and should be doing more than they are.

The responses of community leaders are noteworthy in that they consistently assess the level of mental health services in their communities higher than do members of either profession. The remarks of some agency workers suggest that such positive evaluations may be a form of "boosterism" or, perhaps, a denial of problems. In at least one community, a professional believed that the local political structure is such that both mental health and social services are systematically discouraged because the politicians feel they are neither wanted or needed. In another, a mental health professional stated that:

...in a small community like this, mental health is a back door and mental health takes a back seat to everything and nobody wants to admit anybody has any mental health problems. They... particularly the power structure...denies the fact that there is any such problem existent or if it is existent they don't care what happens to it as long as nobody mentions it in public. And they will not grant the local match money generally...

There appears to be more criticism of mental health services in disaster as opposed to control towns, particularly among members of the mental health profession. Even though these resources in disaster communities scored slightly higher, ratings of adequacy are significantly lower among all three groups of respondents. It could be that the services in communities affected by disasters, having been put to a more severe test, have been found more lacking or at least more disappointing. These differential ratings may also be the result of a phenomenon noted by Wright (forthcoming), which is the tendency for attitudes about disaster-related organizations to become polarized simply because the organizations have become more visible as a consequence of aiding victims. Thus, while mental health and human service agencies have supporters, their increased publicity also means they have critics in the community.

Criticism sometimes focuses on lack of financial and political support, sometimes on shortages in professionally trained personnel. Most often, however, it has to do with low levels of community awareness of, knowledge about, and subsequent utilization of mental health services. More than half of all respondents said that awareness as "low," more than a fourth answered "moderate," leaving only small percentages who felt awareness of local services was "widespread." Mental health professionals, followed by human service professionals, then community leaders rated awareness levels lowest.

Various reasons were put forth to explain the lack of awareness. One worker said, "...there's not a great deal of visibility of some of the needed resources like mental health, and I think there's a reluctance on the part of people to understand all they do...so they tend to be somewhat ignorant of what they do."

Others said that the poor were too busy just surviving and the middle class too busy evading their emotional problems to attend to information on available services. More than one professional recognized that many people were not getting help, nor would they unless outreach was built in as a component of mental health programs.

Following the pattern observed in measuring adequacy levels, we found awareness to be rated generally lower in disaster as opposed to control towns, with the exception of mental health professionals who seemed to feel that half of the population in their communities had at least a moderate awareness of local mental health services.

In order to more clearly see where those gaps are that might explain both the somewhat low resource scores and perceptions of service and awareness levels, as well as to identify those strengths which might be built upon in planning crisis intervention and emergency mental health services, we tallied the frequencies with which specific services were provided by mental health resources, particularly the clinics and counseling centers.

It seems that all community mental health centers, private clinics and college health facilities spend the major part of their energies on direct services to address the ongoing and emergent needs experienced by clients. If a person has a current mental health problem and goes to one of these resources, chances are that he will be helped in some fashion, since almost every single agency offered outpatient and emergency counseling services. In the event of a disaster, then, these agencies would have the expertise and manpower to mobilize and supervise a mental health relief effort.

Generally, fewer efforts are made on behalf of prevention. Community mental health centers are required to provide, or to be working toward, provision of the ten essential services (now twelve),* many of which are preventive in nature. Unfortunately, ever-present shortages in fundings and in trained personnel, as well as an understandable tendency to give priority to immediate problems, severely restrict those efforts and activities which, if carried out, might greatly reduce the need for crisis readiness for day-to-day operations.

Most of the mental health centers we observed were experienced in providing consultation and education that can be helpful in the advanced planning process. Through consultation and education, agencies can build community knowledge about mental health and related problems that might arise in the wake of disaster, and can hopefully urge support for the planning and provision of crisis intervention and emergency mental health services that will be ready as the need arises. Most mental health centers also have the capacity for training volunteers and paraprofessionals for crisis intervention. Such auxiliaries are not only necessary in mass emergencies, given the shortages in professional staffs, but, have been shown to be among the most effective providers of emergency counseling in both disaster and everyday situations.

* In 1975, legislation was introduced amending the Community Mental Health Centers Act, increasing the number of services termed "essential."

The frequency with which we observed hotlines, especially of the 24-hour crisis-oriented variety, was encouraging. In disaster, there is great need for a well-known, easily accessible source of information and short-term intervention that can channel affected people toward that part of the system which best meets their needs. The relatively low cost and simplicity of operations make hotlines quite feasible in communities with limited financial resources.

Mental Health vs. Other Groups as Care-givers Common Patterns of Human Service Resources

The configurations of human service resources are quite similar across the entire sample. Each town has, to some degree, almost all of the items specified on our inventory list. Physicians and the Red Cross were found throughout. Eleven towns have a welfare department, a family service agency, a senior citizen agency, agricultural extension agents, a ministerial association, and a law enforcement agency. Ten towns have a public health department, a public recreation department, group work agencies for children (usually scouting and "Y" programs), and a probation officer. And nine towns have a childrens' service Agency and an Alcoholics Anonymous group. This accounts for 14 of the 18 specified human service resources. Of the remaining four, school psychologists, the Salvation Army and a United Fund planning and fund-raising agency are found in only six of the communities studied, while one lone town enjoys the benefits of a mental health association. All communities but one have additional human service resources other than those we specifically looked for, the average number of these "other" resources being about two per town. As with mental health resources, we found no significant difference on overall numbers of resources between disaster and control towns.

All communities in the sample, then, are fairly similar in terms of number and configuration of human service resources, yet there is a slight variance which is worthwhile to note. Those towns not having a welfare department do tend to have a family and/or childrens' services, sometimes combined, sometimes separate. Communities not having family or childrens' services do tend to have welfare and/or public health nurses. Moreover, as we shall see later, if one or more of these four major resources are missing, those that are present tend to be stronger and offer a wider variety of direct services.

There also appears to be some relationship between absence of specified resources and presence of resources we designated as "other." For example, the town having the fewest specified resources, lacking in eight of the inventory items, interestingly enough has seven "other" resources, far above the average number of two.

The data on community resources may be easier to interpret if the community is conceptualized as a system, comprised of a number of sub-systems which function to meet community needs. Any community system may be depicted as containing a health and welfare subsystem which exists with other systems operating to meet demands generated by various aspects of community life. Within the health and welfare subsystem are networks of community resources-- e.g., hospitals, clinics, community mental health centers, private social

service agencies, public health and welfare organizations--which vary in their number, strength and degree of interdependence. The outlines and functioning of these kinds of care-giving subsystems can be seen to vary considerably from one community to another and within the same community over time.

Systems are conceptualized as responding to environmental demands. It is, therefore, the case that existing subsystems--in this case, subsystems comprised of health and welfare organizations--develop patterns of responding to demands. Sudden increases in demands can lead to the emergence of new groups, which become integrated into subsystems; it has been noted, for instance, that this kind of emergence frequently occurs after disasters. However, it is also possible to identify patterns which have evolved over time in any community. It is these kinds of patterns that we have attempted to discover in the sample communities. On the basis of the data obtained, it seems that one or the other of the types of psychological support resources we have identified--either the mental health or the human services resources--is more abundant or more highly developed. Our hypothesis is that where there is a shortage of one type of resource, relative to demands, the other type is more fully elaborated. In other words, when inadequacy exists in one part of the care-giving system, other parts may compensate by doing more of the work.

This hypothesis is helpful in explaining some of the differences we observed between mental health and human service resources as two separate components of the basic care-giving system.

Evaluation of Human Service Resources

Human service resources were scored in the same manner as mental health resources, except that the maximum possible score was 90. We then added both scores together for a combined community score. All scores were converted to percentages so comparisons could be made. As the table below shows, human service scores were higher, falling in the upper half of the range.

Table 5-3

Distribution of Communities, Compared on Scores for
Mental Health and Human Service Resources

<u>Scores</u>	<u>Mental Health</u>	<u>Human Services</u>	<u>Combined</u>
0-10%	2	0	0
11-20%	4	0	0
21-30%	3	0	0
31-40%	0	0	0
41-50%	2	0	3
51-60%	1	0	6
61-70%	0	4	3
71-80%	0	4	1
81-90%	0	3	0
91-100%	0	1	0

There are a number of possible explanations for the discrepancy between mental health and human service resource scores. Mental health resources, as we measured them, have a natural tendency to fall below the maximum possible because few communities have or need all the types of agencies we identified as potentially existing. The inventory list of mental health resources, in order to be inclusive, was somewhat redundant. Mental health, after all, is a relatively specialized field. Human service needs, on the other hand, are broader and more general than mental health needs, touching more people in more ways. Human service agencies, thus, come in greater variety. Traditionally, different types of agencies have been developed and organized to address differential needs, or at least similar needs from different perspectives. For example, a family with multiple problems might go to a welfare department for financial help and a family service agency to learn better child-rearing skills, while various members of the family are involved with other specialized resources--the mother in a job training program, the father attending Alcoholics Anonymous meetings, and the children enjoying the recreation and character-building services of an agency summer camp. It is likely that most of the human service resources identified in our inventory will be found in most communities. This was borne out in our research.

Moreover, human services have a much longer history in this and other countries. There simply has been more time for communities to develop their armamentarium of resources. Another factor is that of funding. Financial support for human services comes from many parts of both the public and private sectors. Taxes support, at least partially, the majority of the resources we looked at, while special interest groups assume financial responsibility for others.

Are these reasons, though, sufficient to explain the magnitude of the variance in service levels between mental health and human service resources in our sample communities? It should be noted that measurement was based not only on sheer numbers of resources, but on quantity of direct service that has mental health functions. To obtain the maximum score, an agency must be providing a range of direct and indirect services which would prove useful in meeting crisis intervention and emergency mental health needs in the event of a mass emergency.

We tallied the frequency with which counseling, outreach, volunteer/paraprofessional and information and referral were offered by human service resources in order to determine which agencies tended to be most engaged in these critical services and would, therefore, be recognized by the community as sources of help in times of trouble. Logically, such agencies would be invaluable components of a crisis intervention or emergency mental health program. Being familiar to people, they would have a better chance of acceptance and utilization; having material and physical assistance to offer, they could provide tangible, immediate aid that would help quickly establish the trust and confidence essential to mental health counseling, and they would operate without the "mental health" label--a label which, as one of our informants succinctly stated, "does not help anybody in the mental health business."

Welfare departments, family and childrens' service agencies and public health departments, particularly their nurses, generally have a corps of experienced, familiar counselors. Much of the counseling done on mental health related matters is informal, but this is not necessarily a weakness. They do possess the skills required for dealing with people in crisis. Some have had mental health training, while others are in a position to make excellent use of training programs conducted by local mental health professionals. Moreover, they are accustomed to providing outreach and home visiting, thought to be appropriate in disaster mental health efforts.

The Red Cross, of course, is a natural source of help for people in disaster. Group work, senior citizen and minority-oriented agencies already have tie-ins to these special populations, and perhaps more directly address some of their particular needs.

Ministers, doctors, policemen, and, in many cases, agricultural extension agents are all familiar with the role of crisis counselor. Clergy and physicians especially have the advantage of being the ones often turned to first for emotional assistance.

Each of the groups mentioned could perform well as emergency mental health workers, since in all communities they are currently providing the kinds of direct service that would come into play. Indirect service, however, meaning here information and referral, is provided so commonly that it may be more of a hindrance than a help to a program where widespread disruption has occurred, making organization and coordination mandatory. It is desirable in most emergency situations that there be only a few well known and well informed purveyors of information about available services. It is more feasible to widely publicize one or two information and referral centers and to keep them abreast of the services that are currently being provided, which may change rapidly in the post-disaster period. We also noted a tendency for some human service resources to satisfy themselves with information and referral rather than becoming more actively involved in direct service.

Community Assessment of Human Service Resources

Professionals and community leaders were asked to assess the adequacy and public awareness of social services in their communities, just as they were for mental health services. Overall, the level of social service is seen as being about the same, possibly slightly below, that of mental health. About half rate them "adequate," 8.6% "superior," and a full third judge them "below average" and "inadequate." Averaging all communities, mental health and human service professionals were in general agreement regarding their assessments of social services, with human service workers being a bit more critical of their own agencies. Community leaders, as usual, rated social services higher than either professional group.

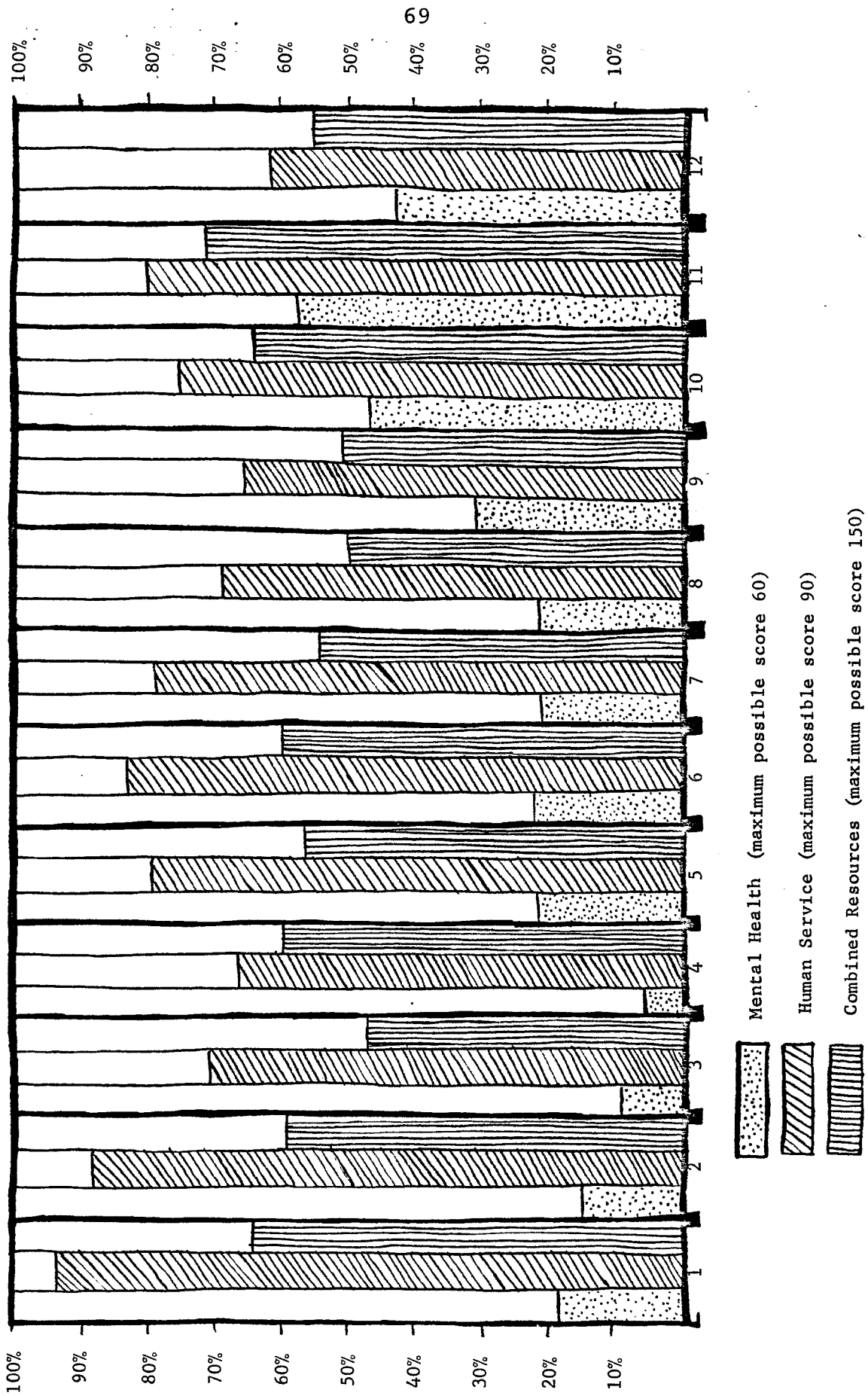
When we compared assessment levels for mental health services in disaster as opposed to control towns, we found ratings generally were lower where disasters had occurred. The same pattern emerges for social services. Again, it is members of the mental health profession who most drastically revised their opinions downward. However, although overall ratings of social

services decreased in disaster communities, they did not decrease as much as did mental health services. Whereas informants in control towns ranked mental health services slightly higher than social services, informants in disaster towns reversed that order. If, as we supposed earlier, differences in assessment between the two sets of communities are partially a result of how well agencies rise to the occasion of disaster, then social services apparently met the test a little better than did mental health services.

This is not to say that social services are better than mental health services. Most interviewees, including mental health professionals, simply seem to feel that in the aftermath of a disaster, the most immediate and pressing needs--certainly the most easily identified--stem from the widespread disruption of everyday living patterns. In the words of informants: "...after the tornado, people were concerned with their most basic needs: food, clothing, shelter..." with "getting things back in shape." Problems such as these bring people to social service agencies, thus these agencies were given relatively more opportunity to help than were mental health agencies. This finding resembles that of Wright (forthcoming), who found that after disasters, social service agencies and other organizations active in the later phases of disaster response experience an increase in community prestige. Regarding emotional problems that might have otherwise taken people to mental health services, a respondent remarked that, "...there was a lot of esprit de corps in the community. The community provided a lot of support that in other times the mental health center would be providing."

For whatever reasons, the public seems to be considerably more aware of social as opposed to mental health services. Over 60% of all informants saw community residents as having a "moderate" to "widespread" knowledge of social services. Human service professionals ventured the highest assessments of awareness levels. Sizeable percentages of all informants, especially mental health professionals, nevertheless, feel more could be done to publicize or otherwise bring services within reach of people who need them.

Our hypothesis stated that as need arises, the system adjusts to meet it, and someone steps in to fill the gaps. We have posited that because in rural areas designated mental health resources are relatively scarce--more precisely relatively inaccessible and understaffed--human service resources might well be meeting much of the need for day-to-day counseling of a mental health nature. This does seem to be the case, particularly when we compare levels of service within each community. Table 5.4 suggests an inverse relationship between these two components of the care-giving system. Those communities that have lower scores for mental health tend to rate more highly on human services. As human service scores fall relative to maximum possible, mental health scores rise. Levels on mental health and human service scores tend to balance each other out. When scores in each community are combined for an overall rating, all communities fall in the middle range.



The Distribution of Mental Health and Human Service Resources in Twelve Communities

Table 5.4

This is a rather important finding, since it enhances the potential for wider applicability of any emergency mental health program that has been found to be effective. We have and continue to endorse the notion that there is sufficient, indeed, extensive variety in rural communities, and strongly recommend that each one tailor a program to its own particular case. Each community must assess its own needs in terms of its own typical problems, its own high-risk groups, its own configurations of resources and patterns of service delivery, and on the many other factors we have discussed throughout this report. Yet it does seem, in light of this finding, that certain basic strategies will work in most communities, obviating the need for program planners to start from rock bottom.

As for the problem of the variance that does exist in rural communities, as reflected in combined scores from one town to another and in disparate mental health and human service scores within towns, some light might be shed by analyzing certain of the social and economic characteristics of the communities we studied. We related the following items on each community to its mental health, human service and combined resource scores:

Population 1975
 Population Change 1960-75
 Percent non-white population
 Median family income
 Economic base

Though recognizing that some of these characteristics are related to each other, we decided to limit ourselves to comparing individually each characteristic to community scores, commenting on possible relationships were possible.

Table 5.5

Size of Community Population and Resources Scores

<u>Population Class</u>	<u>Average Mental Health Score</u>	<u>Average Human Service Score</u>	<u>Average Combined Score</u>
0-10,000	13.8%	70.8%	47.8%
10-20,000	18.3%	86.0%	59.3%
20-30,000			
30-40,000	44.3%	71.0%	60.3%

Without doubt, size of community is related to higher mental health scores. The larger the population, the better the supply of mental health resources and services. Middle-sized communities--those in the 10-20,000 class--tend to have the fullest array of human service resources and services, while the largest and smallest communities score almost equally. As we noted earlier, where mental health scores are highest, human service scores are lowest, explaining why the latter scores are lower in the largest communities. The smallest communities score lower on human services simply because they tend to have an overall poorer supply of both kinds of resources.

Combined resources scores show only a partial relationship to size of community. The very smallest towns score lowest. Once beyond the 10,000 mark, scores are nearly equal.

Percentage of Population Change and Resource Scores

It was difficult to assess the impact of population increase or decrease on resource scores. For one thing, our population data is reliable only up to 1970, and on-site observation and data collection led us to suspect that the situation may have changed in some communities in recent years. In making what comparisons we could, only a few very general patterns emerged. Towns that are small and are losing population tend to have rather lower overall supplies of resources. Expanding towns, with "new" money to spend tend to favor the construction and staffing of mental health facilities over human services agencies. This might be due to the fact that most of the expanding communities in our study are located in regions (North Dakota and Florida) that have been among the earliest supporters of mental health programming, at least at the state planning level. On the other hand, this finding may point to a trend of general growth of mental health resources.

Table 5.6

Percentage of Non-White Population and Resources Scores

Percentage of <u>Non-Whites</u>	Average Mental Health <u>Score</u>	Average Human Service <u>Score</u>	Average Combined <u>Score</u>
50-100% (majority non-white)	21.0%	82.7%	58.0%
10- 49% (significant non- white minority)	22.0%	72.6%	52.4%
0- 9% (small non-white minority)	32.0%	75.0%	58.0%

Mental health scores are clearly highest in communities with few non-white citizens, while towns whose residents are largely non-white have a greater supply of human services resources. Communities having definite racial majorities, either white or non-white, tend to have a better overall supply of resources than do towns that are largely mixed.

Table 5.7

Median Family Income and Resources Scores

<u>Income Class</u>	<u>Average Mental Health Score</u>	<u>Average Human Service Score</u>	<u>Average Combined Score</u>
Upper Third (8,700-9,800)	32.5%	73.5%	58.3%
Middle Third (5,800-7,300)	31.8%	77.0%	58.8%
Lower Third (4,300-5,800)	12.0%	75.8%	50.3%

As with community size, which is related to medium income, there appears to be a definite relationship between higher income levels and presence of mental health resources. In our sample, the cut-off point falls around \$6,000.00. Towns with low income levels scored relatively high on human service resources, but in general, there is a slight tendency of combined resource levels to rise with income.

Economic Base and Resources Scores

We found no significant relationships in comparing resources scores to leading economic activity, be it manufacturing, retailing, education or agriculture. What is interesting is that our findings contradict earlier ones linking agriculturally-based economies to low levels of resources. Not all agricultural areas are small or impoverished, and, as we have seen, resource levels are related to size and income.

Informal Caregivers as Mental Health and Human Services Resources

In the course of designing our research format, we took some pains to insure that sufficient information was gathered to comment rather definitively on the supply of formal resources in rural communities, on the capacity for providing services in general crisis counseling in particular, and on actual patterns of formal service delivery. Program planning is, or should be, a logical process, predicated on a need/supply ratio. The first step, generally, perhaps because its relatively objective nature makes it easier, is the determination of supply. For purposes of comprehensive yet non-specific research, which this study attempted to

conduct, this is an acceptable procedure. However, we should point out, beginning with what one has and then proceeding to what one has not may not be the best way to plan a program, since problems or needs all too often tend to be defined in terms of what one can easily or immediately do about the, not what should be done.

At any rate, we have already assessed the supply of mental health and human service resources in rural areas and will shortly address the matter of needs, both actual and perceived, in these same areas. Now is an opportune time to interject a third factor in the planning ratio-demand. Need does not directly cause movement toward supply. Simply because an individual has a problem, particularly a mental health problem, does not mean that it will be vocalized. And if it is vocalized, this does not automatically mean that the individual will vocalize it to a formal agency simply because such agencies are supposed to be community care-givers.

The value placed on self reliance in rural areas is widely recognized by social scientists and by rural people themselves. "They tend to be really rugged individualists," is the case as summed up by one resident. Stigma is attached to asking for formal services of any kind, but particularly for mental health problems. Going to a mental health agency is not only socially difficult..."bad for your public image"...it is also a blow to one's self image..."a real admission of weakness." "Mental illness has been looked down upon," said one professional..."you're supposed to have a stiff upper lip and get through it."

Suspecting some degree of reluctance on the part of rural residents to avail themselves of formal services, we asked all informants to rank the prevalence of various kinds of need in their communities. We then gave examples of some stress-producing situations and asked them to tell us where, in their opinion, people generally went for help in such cases. (See Tables 5.8 and 5.9.)

It is clear that, while community acceptance and utilization of formal care-givers, including mental health agencies, is growing, a large number of people do not avail themselves of such services. "The whole lifestyle in these small towns is such that people are just not as prone to go to something like this (mental health center)...it's not a normal part of their patterns of life."

We heard numerous references to the stronger religious orientation in rural communities and to the amount of pastoral counseling being done. As the table shows, nearly one quarter (22.5% overall) prefer to take their troubles to a minister.

In my estimation, they do not go to agencies for help-- they are afraid--what will people think--So often they are reluctant to talk it over even with...(their) pastor: "If I told him all my problems I wouldn't be able to face him in church." People therefore often go to some other pastor.

Table 5.8

Choice of Care-giver by Community

	<u>Disaster Communities</u>	<u>Control Communities</u>	<u>All Communities</u>
Clergy	24.3%	20.0%	22.5%
Mental Health Centers	21.0%	13.8%	17.4%
Physicians	16.2%	16.6%	16.4%
Social Service Agencies	15.5%	15.9%	15.7%
Friends & Relatives	6.1%	12.5%	9.2%
Legal--Public Safety Orgs.	4.1%	6.9%	5.4%
Psychiatrist	2.0%	4.8%	3.4%
School Personnel	3.4%	3.4%	3.4%
Hotlines	5.4%	1.4%	3.4%
Hospital Emergency Room	3.4%	2.1%	2.7%
Psychologist	1.4%	2.1%	1.7%

Table 5.9

Choice of Care-giver by Occupation

	<u>Mental Health Professionals</u>	<u>Human Service Professionals</u>	<u>Community Leaders</u>
Clergy	25.3%	19.8%	23.8%
Mental Health Centers	17.9%	15.6%	14.6%
Physicians	16.4%	11.5%	20.0%
Social Service Agencies	9.0%	21.9%	12.3%
Friends & Relatives	25.4%	17.7%	14.6%
Legal--Public Safety Orgs.	1.5%	4.2%	8.5%
Psychiatrist	4.5%	2.1%	4.6%
School Personnel	6.0%	3.1%	2.3%
Hotlines	1.5%	5.2%	3.1%
Hospital Emergency Room	.0%	4.2%	3.1%
Psychologist	3.0%	.0%	2.3%

What is encouraging for members of the mental health professions is that mental health centers were cited as often as they were (17.4% overall) as the place people go for help in dealing with stressful situations. We note that there is a slight tendency for mental health professionals to assume more than other groups that people do come to them first, just as human service professionals assume regarding their own agencies. Utilization of mental health services seems to be a function of familiarity, particularly among those who have traditionally attached most stigma to mental illness---the lower income and minorities.

I think they are gradually getting to use the Center more and more. When we first opened, some in the black community would walk across the other block. They wouldn't want to go by the "Crazy Place."

Still the tables show that the majority of people in rural areas continue to seek help from a wide variety of resources other than mental health. Sometimes those are formal human service resources, such as Social Service agencies (16.4%), legal aid and the law enforcement officials (5.4%), and quite frequently the most informal of care-givers--family, friends and the local bartender (9.2%).

Perhaps the entire pattern of help seeking, as present here, is best illustrated by the statement of a Legal Aid professional in one community:

Most family counseling, unfortunately, is done by a neighbor or a friend who may or may not have gone through a similar experience...it's like legal advice... some people get more legal advice in a tavern or a barber shop than they ever ask for in a law office. And they probably believe it more.

The direction that mental health agencies and those planning emergency mental health services might take is suggested by a veteran welfare worker in another community: "People stick with their families. They'll go to the outside resources once in a while. In order for him to do that, someone close to him or a worker of that agency would have to give him the right approach and make him see the need of it..."

Disaster Related Agencies

As various data were compared, it became evident that disaster communities are slightly better endowed with help-giving resources of all kinds. While the numbers of resource agencies was about the same for both sets of towns, communities that have experienced large scale emergencies tend to be organizationally richer, with their agencies offering more types of service more frequently, as measured by resource scores.

Table 5.10

Resource Scores for Disaster & Control Towns			
	<u>Avg. Mental Health Scores</u>	<u>Avg. Human Service Scores</u>	<u>Avg. Combined Scores</u>
Disaster	25.7%	77.5%	56.8%
Control	25.2%	74.3%	54.7%

The difference is not striking, but it is consistent. Whether this will always be the case is a question for further study. However, this finding is consistent with the hypothesis advanced by many disaster researchers (Quarantelli & Dynes, 1976; Fritz, 1961) that disasters produce positive as well as negative consequences--in this case, an increase in the supply and complexity of human service resources.

A more salient question for our immediate purpose is whether such variance has practical significance for planning and subsequent operations of disaster relief efforts. Using the rationale that any prior knowledge is useful, it is well to look more closely at what happens to organizations in disaster.

We know that disasters generate problems that are qualitatively and quantitatively different from those of the pre-disaster period. One simply expects that there will be new needs and demands calling for new tasks to be performed. As we have said, systems adapt in various ways to deal with changing situations. Adaptation within care-giving systems follows certain patterns, three of which are commonly found in smaller communities and are, therefore, important to recognize. Mental health and human service organizations in rural towns tend to either extend, expand or emerge in response to disaster (Dynes & Quarantelli, 1965).

Extending organizations are those that have the greatest continuity with their pre-disaster status. Typical examples of these are the mental health and social service agencies which currently exist and function on a daily basis. While their helping behavior in disaster may be unplanned or even unanticipated, they enter the emergency system pretty much as they are. Mobilizing from their own base of inter-relationships, they direct their "old" activities toward new disaster-related tasks.

We found that mental health and human service agency activity was affected by disaster in the six towns that we studied. Human service agencies appeared to be significantly more affected (76.2%) than were mental health agencies (46.6%). The ways in which agencies were

affected had to do with the types of client problems they encountered as a result of disaster and the efforts they made to deal with such problems. Human service personnel mentioned heavier workloads during and after the emergency period, increased stress in clients months afterwards, the formation of new relationships with other agencies, new referral patterns, and the lack of proper programs for dealing with disaster victims. Mental health professionals also commented on seeing new kinds of client problems and new interagency relationship and referral patterns. Two mental health agencies set up hotlines as a result of the disaster. At the time, both types of resources provided varying amounts of outreach, volunteer/paraprofessional and particularly information and referral service.

Years later, both mental health and human service resources continue to have a richer supply of services than do similar resources in control towns. Mental health resources, for example, consistently offer more outpatient care, emergency service and consultation and education. While we cannot say with certainty that such programs are a direct or an immediate response to disaster, they do seem to be an outgrowth of the experience, indicating that towns that have gone through a large-scale emergency are more likely to perceive a need for these types of mental health services.

Expanding organizations are best represented by the Red Cross, which in normal times tends to be a rather small agency in rural communities. Such organizations have a latent emergency function which is quite apart from their manifest activity in day-to-day life. When disaster occurs, groups like the Red Cross provide the well-known name and regular employees as the core for a large influx of material and manpower from within and outside the disaster affected area. The tasks they perform are ones for which they are trained and ready, but the structure in which they work is new and somewhat unwieldy, which may make for difficulties in coordinating their mandated disaster responsibilities with other organizations involved in the relief effort, particularly with emergent groups.

Emergent organizations are those that are totally new in both structure and task. They arise in situations where obvious needs develop that do not become the immediate focus of attention of some existing organized effort. For example, in recent years, communities suffering a disaster were increasingly likely to see the emergence of a type of interdenominational church-related group commonly named Interfaith Council or Interfaith Disaster Task Force, devoting itself to launching local disaster relief efforts. Such groups perceive themselves as "gap fillers," commencing their work with an assessment of need and then addressing themselves to the provision of a broad variety of human services to those whom they feel are not receiving sufficient or appropriate help from the existing system. In another example, a group in Xenia perceived a need for mental health counseling for victims of the 1974 tornado. In the months following the disaster, the existing mental health care-givers were unable to mobilize any kind of relief program. Consequently, this group, calling itself Disaster Follow-up, organized an outreach effort, taking services door to door in an effort to insure that all possible victims and affected persons would be reached.

The totality of disaster-related effort coalesces into an emergent sub-system arising to meet the variety of community needs and demands that can no longer be met through the care-giving system as it operated prior to disaster. This sub-system is comprised not only of emergent groups, but of existing agencies which extend or expand to adapt to the situation as it develops. New relationships form between agencies, work is shared, new tasks are performed by veterans, old tasks oft-times by newcomers. Changes must be expected and, if incorporated into the long-range planning process, can be advantageous. Coordination and cooperation among all parts of the system can help to avoid wasteful duplication, insure that needs are adequately met, and circumvent the creation of ill will that can work to the disadvantage of the entire community for years to come.

Actual and Potential Crisis Needs in Sample Communities

It is obvious that disasters create community needs by virtue of their occurrence. Few communities experience an intense need for community protection and security, for massive debris removal, or for wholesale business redevelopment on an everyday basis. However, disasters also do a great deal of their damage by intensifying or making more prevalent problems that were already present in the community during the pre-disaster period. Examples of these kinds of problems might include the need for low-cost legal services and the need for consumer protection. This intensification of needs occurs in many areas of individual and community functioning, including the mental health area. Therefore, just as plans for the development of resources for launching a mental health disaster response must depend somewhat on the features of already existing resources, disaster-generated mental health needs can be seen as related to needs for services that already exist in the community. For this reason, we thought it imperative to gather data on needs for communities which had not experienced disasters, as well as for those which had. Our intention was to demonstrate both how disaster and non-disaster communities might differ in terms of prevalent needs for services and how these small towns are similar in the needs of their residents.

The issue of community needs was approached in three ways in this study. First, in both disaster and control communities, all informants--mental health professionals, human service professionals and community leaders--were asked to select from a list of over twenty problems (or problem areas) those they believed were most common or severe in their communities, those which were next most severe, and those which were least severe. The list was comprised of a wide variety of difficulties, ranging from problems in living and the need for "hard" services through disturbances in interpersonal relations, deviance, and symptoms of emotional disorder, to actual symptoms of mental illness.

Second, all informants in the twelve towns were asked to attempt to rank the need for material and/or financial support, the need for broad human or social services and the need for mental health services in terms of their relative significance for community residents. Third, in an attempt to discover what types of potential target groups exist in the designated areas, we asked informants to discuss whether there were groups or individuals living in their communities needing either social services or mental health services but not receiving them. Additionally, an attempt was made to determine whether informants believe that disasters generate a need for mental health services and, if so, what kinds of services they think should be provided and by whom. Finally, in disaster communities informants were asked whether the disaster either created or intensified or, perhaps, even ameliorated community problems.

Prevalent Community Needs

Housing, drinking, transportation and family problems are seen by informants as presenting the most serious problems in all communities studied. These are followed in importance by the need for legal aid, medical problems, depression, loneliness, emotional problems and finances. All problems in the last-mentioned group were chosen relatively infrequently (5% of the time or less) as among the "most serious" community problems.

Housing is noted as the most serious problem in all communities, receiving a 14.8% share of the total responses in the "most serious" category. This is consistent with the research on non-metropolitan and rural areas, cited above, which stresses the shortage of quality housing and the high proportion of substandard housing in these areas even in non-disaster times. Housing seems to be a highly salient problem for informants. It is likely to be among the very first problems mentioned and almost always appears among the group of problems labeled "most serious." Interestingly, informants in disaster communities seem no more likely to cite housing as a problem than do those in control communities.

Transportation, another need often categorized as a problem in living, is cited as among the five most serious problems in both disaster and control communities. When not mentioned among the "most serious" problems, it is commonly placed in the next highest category. Like housing, transportation is mentioned as a particularly serious problem by informants, who are likely to add that the need for adequate transportation is felt most acutely by the elderly and the poor and by those living in remote areas. Disaster community informants are only slightly more likely to mention transportation as a need than are their counterparts in control communities.

Drinking and family problems are two personal and interpersonal stress situations that receive ranking as "most serious" in all sample communities. Overall, drinking receives the second highest ranking as a problem (11.6% of the "most serious" rankings) and family problems

the fifth. Many informants note that drinking constitutes a major community problem despite laws declaring their communities "dry." Such laws, they state, merely reduce the incidence of public drunkenness and have no effect on residents' private behavior. The high ranking accorded to drinking and family problems by community informants in the sample towns seems indicative of a significant need for some form of crisis intervention or emergency mental health service in these communities.

Unemployment is cited as a very serious problem in a number of cases and is ranked overall among the "most serious" problems (9.9%). However, informants also tend to state that unemployment is not a serious problem in their communities, and, thus, unemployment appears on both the "most serious" and the "least serious" lists. This is probably due to two factors. One factor is that unemployment is more chronic and widespread in some sample communities than in others. Informants in some communities, therefore, rank unemployment very high, while those in others do not. Another factor appears to be the tendency to view unemployment as a relatively minor problem because of the existence of services to reduce its effects; e.g., unemployment compensation.

Disaster and control communities do not appear to differ markedly in terms of the problems judged to be most serious. However, the need for legal aid is cited as among the most serious needs in disaster communities, while it is not mentioned at all in control communities. Additionally, while drinking averages overall among the "most serious" problems, it is not among the problems judged "most serious" in disaster communities.

Symptoms of emotional disorder and examples of deviant behavior begin to appear more frequently in the ranking of the "next most serious" problems in all communities. Seen as serious in the community, although perhaps not so widespread or severe as others previously mentioned, are such problems as drugs, loneliness, depression and emotional problems in general. While disaster and control communities do not differ greatly in terms of the problems placed in this category, it should perhaps be noted that depression is explicitly named as a problem in disaster-stricken communities, but not in others. Living conditions also appear with greater frequency in the "next most serious" category in disaster communities, as opposed to control towns.

Although, in general, failure to take note of a problem mentioned on the list given to informants can be interpreted as a judgment that the problem is not salient, the data indicate some needs and problems that are explicitly mentioned as not serious or not important in the communities studied. These include the need for the most basic necessities of life--food and clothing--as well as one problem usually associated with severe personal crises, suicide. Regarding the lack of a need for food and clothing, many informants express the opinion that these needs are not pressing because public agencies such as welfare, together with private charities and social service organizations, furnish aid to the most destitute community members. Thus, they indicate, no one goes without such basic life requirements. (See Tables 5-11, 5-12 and 5-13 for lists of community problems and the percentage of informants selecting them.)

Table 5.11

Disaster Communities

Problems Receiving Most Frequent
Mention as "Most Serious"

	<u>% of Total Responses</u>
Housing	14.8
Unemployment	11.3
Transportation	8.3
Family Problems	8.3
Legal Aid	5.2

Problems Receiving Most Frequent
Mention as "Next Most Serious"

	<u>% of Total Responses</u>
Transportation	10
Legal Aid	9
Drinking	8
Depression	7
Living Conditions	6
Family Problems	6

Problems Receiving Most Frequent
Mention as "Least Serious"

	<u>% of Total Responses</u>
Clothing	17.9
Food	16.6
Unemployment	11.5
Insurance	8.9
Suicide	7.6

Table 5.12

Control Communities

Problems Receiving Most Frequent
Mention as "Most Serious"

	<u>% of Total Responses</u>
Housing	14.8
Drinking	11.9
Unemployment	8.6
Transportation	7.4
Medical Problems	6.6

Problems Receiving Most Frequent
Mention as "Next Most Serious"

	<u>% of Total Responses</u>
Drugs	9.3
Loneliness	7.9
Emotional Problems	7.9
Transportation	7.1
Family Problems	7.1

Problems Receiving Most Frequent
Mention as "Least Serious"

	<u>% of Total Responses</u>
Clothing	20
Food	11.6
Unemployment	8.4
Living conditions	8.4
Suicide	7.4

Table 5.13

All Communities

Problems Receiving Most Frequent
Mention as "Most Serious"

	<u>% of Total Responses</u>
Housing	14.8
Drinking	11.6
Unemployment	9.9
Transportation	7.8
Family Problems	6.8

Problems Receiving Most Frequent
Mention as "Next Most Serious"

	<u>% of Total Responses</u>
Transportation	8.3
Drugs	7.1
Family Problems	6.7
Legal Aid	6.3
Loneliness	6.3
Emotional Problems	6.3
Drinking	6.3

Problems Receiving Most Frequent
Mention as "Least Serious"

	<u>% of Total Responses</u>
Clothing	19.2
Food	14.0
Unemployment	10.5
Insurance	7.0
Suicide	7.0

We expected the data to indicate differences among mental health professionals, human service agency professionals and community leaders where the ranking of problems was concerned. In other words, we expected that there might be a tendency for professionals in different fields to view community problems in terms of their particular areas of expertise and perhaps to deemphasize the importance of needs outside their own realms of responsibility. Similarly, we expected professionals and community influentials to "see the world" differently. No such differences appear in the data, however. There is, in fact, no marked tendency for any one group of informants to ignore, or even to downplay, needs believed to be important by another group. For example, mental health professionals rank housing, drinking, unemployment and transportation as the most serious community problems; this is consistent with the overall ranking of these problems for all communities. Human service agency personnel are as likely as others to cite mental health-related problems as important in their communities. Moreover, another encouraging finding is that community leaders seem quite sensitive to the emotional needs of residents and quite willing to offer opinions on these needs. Drinking, drugs, emotional problems, and family problems are all mentioned as problem areas as frequently--and sometimes more frequently--by community leaders as they are by professionals in mental health and human service agencies. This agreement by professionals and community influentials indicates that, in general, the worst problems are probably more visible and well-known in small towns. It also seems to indicate that there is more homogeneity in attitudes about what kinds of services or programs these small towns need than exists in larger communities.

One positive consequence of this common identification of problems and this consensus on their ranking may be that the planning and development of social service and mental health programs will be easier in these kinds of communities than in larger areas, where citizens and professionals may not see eye to eye on what problems are most severe and may not share common priorities about solving them.

Relative Importance of Three Types of Needs

Interviewees were asked to rank material/financial, mental health and social or human service needs in terms of the seriousness or urgency of these needs in their own communities. As was the case with the identification of community problems, there was a marked degree of agreement among informants on this ranking. The most commonly chosen ranking of these needs, chosen by 30.7% of our informants, places material/financial needs first, followed by social service and mental health needs. Altogether, responses ranking material needs first, followed by either mental health or social service needs, comprise 37.6% of the responses. Informants in disaster communities, are more likely than those in control communities to rank residents' material needs first in importance. Configurations in which material needs are ranked first are chosen by 43.8% of informants in disaster communities, as compared with 30.1% of informants in control communities. (See Table 5-14 for a complete listing of informant's choices.)

Table 5.14

Percentage of Informants Choosing
Rankings of Social Services, Mental Health
and Material/Financial Needs

	<u>Disaster Communities</u>	<u>Control Communities</u>	<u>All Communities</u>
Social Service			
Material/Financial	8.3	7.5	7.9
Mental Health			
Social Service			
Mental Health	12.5	15.0	9.9
Material/Financial			
Mental Health			
Social Service	12.5	16.9	11.9
Material/Financial			
Mental Health			
Material/Financial	10.4	3.8	9.9
Social Service			
Material/Financial			
Mental Health	4.2	9.4	6.9
Social Service			
Material/Financial			
Social Service	39.6	20.7	30.7
Mental Health			
Unable to separate problems or unable to rank	18.7	26.4	22.8

21.8% of informants in all communities rate mental health as a serious community need. Those selecting mental health as most significant are slightly more likely to then emphasize social services as a need than they are to emphasize material and financial needs.

Interview data indicates that, in general, informants feel that community social service organizations are sufficient in number and quality to meet community needs. This feeling probably accounts for the relative lack of emphasis on social and human service needs, chosen as primary only by 17.8% of the informants.

Do professionals perceive needs to be greatest in their own areas of expertise? Again, the data indicates that this is not the case. Mental health professionals are very likely to cite a need for material or social service aid as crucial and human service agency professionals seem just as likely as the other two groups to recognize the need for mental health services in their communities.

As was the case with the ranking of community problems, community influentials and agency professionals appear to have approximately the same priorities. However, the data do indicate that community leaders seem to make mental health needs a top community priority more often than do either mental health or human service professionals.

The tendency to rank material/financial needs of residents first in disaster communities has already been mentioned. This ranking is particularly marked among agency professionals: in disaster communities, 42.9% of the mental health professionals and 50% of the human service agency professionals rank material needs first, followed by mental health and then social service needs; this ranking is selected by 0% and 28% of their professional counterparts in control communities.

It seems paradoxical that informants asked to rank material, mental health and social service needs rank material needs first, but, when asked the question a different way (as in the section above), rate problems associated with the need for food and clothing as not serious in their communities. This apparent inconsistency seems due to several facts. One, of course, is the stress placed by informants on housing, which is a material need and which, as such, is logically included among material/financial needs. Another involves the interviewees' tendency to see material needs as very pressing when they do occur, however infrequently. A third factor may be the informants' tendency to equate the presence of agencies of a mental health or social service nature with the satisfaction of most needs for these services.

However, another characteristic of informants' responses to this question should perhaps be noted; namely, their tendency to be unable to distinguish the three kinds of needs sufficiently to be able to then rank them in importance. In fact, 22.8% of the informants in all communities could not distinguish the problems sufficiently to rank them. This tendency is, we believe, at the root of the choice to place material needs before all others. Informants frequently describe the three kinds of needs as closely interrelated and often designate the lack of material and financial resources as the basic

source of other needs, such as the need for mental health services. One interviewee, for example, expressed the notion that, so long as many clients must return to the same poor living conditions, the efforts of mental health agencies will be largely ineffective. Another stated that the various types of difficulties are interrelated, and that family problems and drinking frequently stem from unemployment and financial need. Still another located the cause of depression in material factors such as poor housing and financial worries. Informants generally define material and financial needs as most pressing because they see these as the source of many other problems.

Groups Needing Social and Mental Health Services

In this portion of the interview, informants were asked open-ended, general questions about whether or not there were groups or individuals in the community needing social and mental health services and not receiving them. By means of these questions, we were attempting to probe for the existence both of potential target groups and of barriers to effective service delivery. We believe that groups such as the elderly and minorities would be mentioned frequently in answers to these questions, since both groups are often seen as receiving fewer services than they actually require.

With regard to the need for social services, the two groups mentioned above were designated as having unmet needs, but there was a great deal of variation in the responses made to the question, and neither group was the most frequently mentioned. Instead, many categories of individuals were specified, such as the poor, newcomers to the community, the uninformed, persons in physically isolated areas, and persons unable to afford transportation. It seemed clear that informants, in their comments, were raising the issue of accessibility of services. Informants were indicating that many persons, rather than being members of an identifiable social class or ethnic group, have in common the fact that they are, for some reason, inaccessible relative to the services being offered in the community.

This category, which we termed the "socially and geographically inaccessible," is cited by 39.2% of the informants as needing social services and not receiving them. The elderly are the next most frequently mentioned group (22.5% of the informants), followed by children (9.8%) and minorities (7.8%). Other groups mentioned as needing social services are the unemployed, those needing legal aid, alcoholics, and those who are too proud or too concerned about possible stigma to ask for help.

It should be noted that, while the social service needs of minority group members are not among the most frequently mentioned needs in all communities, there are communities in the sample with relatively large non-white populations, and in these communities, the needs of minority group members are emphasized. Additionally, interviewees in some community agencies stressed the needs of minority group members very strongly.

Informants in disaster-impacted and control communities do not differ markedly in terms of the groups they single out as needing social services. In both sets of towns, the socially and geographically inaccessible and the elderly are singled out as the groups most needing such services. However, disaster community informants mentioned more needy groups and included those requiring legal aid, single parent families, drug users, alcoholics and those afraid of stigma among those needing and not receiving social and human services.

When the question of the need for mental health services is addressed the socially and geographically inaccessible is again the most frequently cited group, mentioned by 29.3% of all informants. Additionally, the interview data indicate that "the uninformed," which we included as part of the more general "inaccessible" category in later analysis, are mentioned quite frequently in response to this question.

Minorities is the group mentioned next most frequently as needing and not receiving mental health services, having been cited by 22.4% of the informants. This represents a much higher percentage than those judging minority group members as requiring more extensive social services. With regard to the mental health needs of minority group members, the notion is expressed in interviews that minority group persons not only may not feel comfortable using such services, but also may not be as aware of their availability as others in the community.

Another group whose representation increases when the question of mental health needs is discussed is the group comprised of those too proud or too afraid of stigma to ask for help; 17.2% of all informants mention pride and fear of stigma as barriers to use of mental health services by those needing them. Statements such as the following, made by both professionals and by lay persons, were common in the interviews conducted:

There is a stigma against going to a mental health agency, more than in metropolitan areas. In this community, it's bad for your public image.

Some people think, if we changed our name to counseling center, anything except mental health, we might have more. Because of the stigma.

Stigma is attached to using mental health services. You can send them to any specialist...except a psychiatrist. They put the brakes on then.

Clearly, in the communities we studied, reluctance to incur the stigma of mental illness is a factor which acts to reduce utilization of mental health resources.

The elderly and children are also mentioned by informants (13.8% and 6.9% respectively) as needing mental health services. In neither case, however, do informants judge this need to be as great as their need for social and human services. Drug users, alcoholics, the unemployed and single parent families are also designated by some informants as groups needing more or better mental health services than they are currently receiving.

In summary, with regard to the mental health needs of particular target groups, informants displayed a great degree of variety in their opinions. Most did not single out socially identifiable groupings--blacks, Mexican-Americans, Indians, children, the elderly, lower-class individuals, and the like--but rather focused on problem areas and/or various categories of individuals for which programs might be tailored. This may mean that needy sociocultural groups are not present in the areas studied; or--and this is more likely--it may mean that such groups are either ignored or are socially invisible by virtue of their lack of community influence.

Impact of Disaster on Community Needs

Most informants in disaster communities indicate that disaster both exacerbate existing community needs and create new ones. Problems associated with housing are, of course, mentioned most often as both generated and intensified by disaster. The need for food and clothing are also mentioned as needs that were created by the disaster. Unemployment, transportation problems and medical problems are also mentioned frequently as having been generated or made more intense by the disaster. Financial and insurance problems are likewise noted as having been evident during disaster times. Finally, some informants state that the disaster intensified emotional problems and depression in the community. As one interviewee remarked:

It's had the effect on the emotional part of the community. They do have anxieties about these things now.

Most did not view disasters as creating emotional problems in and of themselves, however. The disaster was seen more as adding to existing stress:

I think you get some surfacing of problems that are already there. I'm not sure that the tornado itself created new problems.

Approximately one-half of the informants in disaster communities report either believing or hearing that mental health problems would increase after the disaster, citing depression, emotional upset, sleep disturbances and childrens' anxieties as among the symptoms which were anticipated. Some informants expressed disagreement with this notion, however; one declared himself "amazed that anyone would ever have suggested that mental health problems could possibly be related to a disaster situation."

Not all our informants share the view that disasters are wholly negative in their effects, or even the view that they have significant effects. Some apparently felt that the disaster impact was so slight that it did little to increase community problems or that relief efforts solved them quickly, since some informants could not cite any

specific problems they found to be more pressing after the disaster. Additionally, we did ask whether anyone in the community may have been better off in some respects as a result of the disaster, and about one-half of the interviewees answered affirmatively. Several mentioned the spirit of cooperation and togetherness that emerged after the disaster as a positive community force. One said simply, "Crisis brings people closer to one another." Those who were furnished with new housing were also viewed as better off in many cases.

In general, then, disasters are seen as having mixed effects. They are viewed as both creating and increasing community problems and as affecting psychological as well as physical well-being. They are also seen as generating a sense of esprit de corps in the community which may have salutary effects for some.

Perceived Need for Mental Health Counseling in the Disaster Setting

Informants in all communities were asked whether they consider natural disaster to be a crisis situation requiring the provision of counseling services to victims. We hoped to learn from noting the responses to this question whether people had ever thought about this kind of need and whether disaster experience affected the attitudes of informants in disaster towns, making the issue of counseling services in disaster more clear or salient.

Interviewees in disaster communities do appear to have considered this question more than have their counterparts in control communities. About one-half the informants in control towns had not thought about the question previously and would not venture their opinions, but this was not found in disaster communities.

In both disaster and control communities, however, among those who had considered the question sufficiently to feel able to express an opinion, the responses indicate a strong belief that some sort of counseling effort should be directed towards disaster victims. Overall, less than 10% of our informants stated that an effort of this nature is not necessary.

Of all groups interviewed, mental health and human service agency professionals in disaster communities seem to endorse the notion of counseling for disaster victims most strongly. Apparently, witnessing the effects of disaster on their clients created in them the impression that these clients might have benefitted from psychological support, at least at some point in the disaster experience. Community leaders in control towns were most likely to see a need for disaster-related counseling services. Community leaders in disaster communities, while still endorsing the notion of counseling, do not support it as strongly as do community professionals.

When asked what forms of assistance would provide the most psychological support for disaster victims, the great majority of informants

in control communities did not venture a reply and indicated substantial confusion on this point. In disaster-stricken communities, however, while many informants mentioned that traditional kinds of mental health services might have a place in disasters, there was much more support expressed for the use of non-traditional, informal or innovative forms of counseling. In most cases, informants in disaster communities stressed the notion that informal counseling, together with the provision of material aid, would be most helpful to disaster victims.

When informants were asked who should provide mental health services to disaster victims---traditional disaster relief agencies, mental health professionals, mental health volunteers, and so on---responses dwindled to a thread. It is apparent that even in communities with recent disaster experience, few individuals feel able to offer opinions or suggestions on this important point. However, some isolated informants did have thoughts on this question; among those thoughts are the following:

- that after a disaster people will turn to those with whom they have already established a relationship, and they will not want to accept help offered from outside the community;
- that mental health should be a formal part of any disaster relief effort and should be a part of community-wide planning;
- that the most useful role of mental health professionals after disasters is the provision of information and referral;
- that whoever becomes involved in providing emergency mental health services should seek and receive legitimation from members of local government and from influential individuals in the community;
- that after disaster, ministers, social workers, friends and "anyone willing to listen" might play a very large mental health role;
- that the swiftness of the move to help people in disaster is perhaps essential.

Conclusion

A few points need to be highlighted before leaving the discussion on mental health needs in the communities studied and moving on to the discussion of strategies for meeting disaster-related needs. First, the data indicate substantial agreement among informants in all communities on the need for better housing and transportation. There is also apparent agreement that disturbed interpersonal relations--evidenced by problem drinking and family difficulties--are quite common. Similarly, all informants seem aware that various other problems associated with emotional stress are present in their communities.

When asked to identify groups needing and not receiving services-- in other words, when asked to speculate on the characteristics of potential target groups for mental health and social services--informants show less agreement, and the consensus which was evident earlier among professionals and community influentials is not as apparent. There appear to be two different sets of criteria influencing the informants' responses: on the one hand, there is the tendency to conceptualize those needing services as identifiable, visible sociocultural groupings; on the other, there is the more pronounced tendency to think of target groups in terms of specific problems that may be manifested or in terms of programs which already exist. We have suggested that, due to their low community influence, some sociocultural groups may have been ignored in these communities.

It has been noted previously that, little solid evidence exists to indicate that groups, such as children and the elderly, do, in fact, become worse off psychologically after disasters. Some researchers argue, for example, that older individuals, having experienced and coped with hard times in the past, are better equipped than many others to withstand disaster-related stresses. This is what Huerta, Horton, and Winters conclude in their study of the elderly victims of the 1976 Grand Teton Dam break:

It does not appear that the more elderly victims express higher levels of alienation, feelings of depression or hardship than others. Although the elderly suffered high losses, in this disaster, this would not be their first major hardship or adversity. (1977,8)

On the other hand, however, if the concept of disaster as a stressful life event is kept in mind, it also seems reasonable to assume that an unequal share of the negative psychological effects of disasters may be borne by those members of the community already bearing life-stresses, e.g., the poor, non-whites, and both young and old who must live on fixed incomes. This was found to be the case among the victims of the Rapid City flash flood studied by Hall and Landreth, who state that social and psychological stress was "felt primarily among a segment of the lower socio-economic categories." (1975,59) In the population studied, this category, which included transients in the community, minorities, and persons relocated in trailer camps, evidenced a higher level of stress and a higher rate of maladaptive behavior than did other groups. Thus, we believe that while efforts on behalf of children and the elderly are certainly wise, a special effort needs to be put forth to insure that groups such as the poor are not overlooked in the disaster-recovery period.

Regarding disaster and its impact on community needs, we observed a marked tendency for disaster community informants to focus on disaster-related needs which are both dramatic and relatively short-lived. For

example, many emphasized the creation of the need for food and clothing as an important disaster effect; however, these are the kinds of needs which are almost always ameliorated within days after the disaster event. Few mentioned subtle, long-lasting disaster effects. While informants stated that there had been an expectation that the disaster might result in psychological problems for some victims, and while disaster was seen as leading to an increase in some symptoms of disturbance, including depression, almost no one expressed the notion that disasters might place more stress on some segments of the community than on others.

The idea that disaster itself is a stressful life event that calls for supportive actions to sustain the coping abilities of victims seems reasonable to most people we interviewed; they appear more than willing to support the notion that disaster victims need mental health counseling of some sort--but only in the abstract. Other than to stress the therapeutic effects of the provision of tangible aid and informal counseling, few seem to have ideas on what kinds of supportive services might work best or on what groups in the community might be best suited to provide such services. Even among agency professionals in disaster-stricken communities, disaster experience apparently has not resulted in increased emphasis on disaster mental health or increased interest in the psychological effects of disasters.

Clearly, a need exists for public education in these areas. Before meaningful planning can occur, community residents must cease viewing disasters as events so uncommon--indeed, so nearly unique--that planning is useless. Many rationales are commonly expressed by community members in an effort to minimize perceptions of hazards and to justify their failure to plan. The notion that "lightning never strikes the same place twice"; the idea that disasters come in cycles--the erroneous belief expressed by residents of flood-prone localities that "one-hundred year floods" actually occur no more than once in one hundred years, and that having experienced one renders a community immune to serious flooding for at least ninety-nine years; and the notion that mortals cannot and should not attempt to intervene in the workings of "God's Will" are but a few examples of such thinking. All ideas of this nature are patently false, as has been repeatedly and tragically demonstrated, and it is this fact that community residents must recognize.

If we had surveyed disaster victims themselves rather than the community informants, they may have mentioned other sets of needs, and a more comprehensive picture might have been obtained. However, this is exactly what we are urging those who become involved in the delivery of mental health services to disaster victims to do as soon as possible: assess the material and mental health related needs of victims in the stricken community and identify relevant target groups, so that appropriate resources can be provided to those who need them most.

More information on how to match needs and resources in the rural disaster-stricken community will be provided in the chapter that follows.

MATCHING NEEDS AND RESOURCESSTRATEGIES FOR PLANNING AND IMPLEMENTING
A MENTAL HEALTH DISASTER RESPONSE IN THE
SMALLER COMMUNITY

So far, we have discussed a number of topics. Special characteristics of the rural and small town setting, as treated in the literature on mental health needs of rural populations, have been highlighted. We stated, in general, that, while rural and urban lifestyles and problems should be thought of as on a continuum rather than as contrasting with one another, and while the attitudes of small town residents may increasingly resemble those of urban dwellers, nevertheless, there are features of small town life that are distinctive. And, even more important for this discussion, we have suggested that the mental health needs of people in the non-urban setting may differ in some respects from those commonly associated with urban living and have also expressed the notion that, for their solution, such problems may require different modes of service delivery than are employed in the traditional clinic-centered urban arrangement.

Turning to the question of mental health needs following disasters, we noted that evidence indicates that disasters, in and of themselves, do not appear to eventuate in severe, long-lasting psychological disturbances in victims. However, disasters can be viewed as stressful life events which, by their occurrence, can create acute problems in living, emotional upset, and transient symptoms of psychological disturbance in some of the individuals who experience their impact. This fact and the fact that disasters may also result in mental health problems of somewhat longer duration for a somewhat smaller percentage of victims, has led us to emphasize the importance of psychological first aid for disaster victims. We have reported the findings of some research and the conclusions reached by mental health practitioners involved in disaster response, which support the use of crisis intervention methods to reduce symptoms of stress in victims and to quickly restore them to positive social functioning so that the long-run consequences of continued stress can be avoided.

Following the discussion of mental health needs in disasters, we again turned to a discussion of the small town setting, this time to describe the research we conducted on emergency mental health needs and capabilities in small U. S. towns and to report our findings, paying close attention to how the resources in smaller communities might contain the potential for being mobilized to launch a crisis intervention response to disaster.

As might be anticipated, we found that the need for emergency mental health resources is by no means confined to urban settings. According to informants, some portion of the residents of the small towns we studied experience problems in living on a day-to-day basis, exhibit behaviors which are indicative of disturbed interpersonal relations, and manifest symptoms

of stress--all of which indicate that a need for crisis intervention services exists, even outside the disaster context. Informants in disaster-stricken towns believe that disaster generally increases stress and adds to community problems. Additionally, informants endorse the notion that counseling assistance of some sort should be given to disaster victims to mitigate the stress they experience. However, beyond stating that such counseling should be informal, short term, and oriented to solving concrete problems, few had any specific observations about how a disaster mental health program should be carried out. In sum, we found a low degree of awareness about issues of disaster.

Happily, we also found that smaller communities are not so resource-poor as they are sometimes depicted. While services can undoubtedly be upgraded in each of the areas we studied, there is apparently not as great a shortage of mental health and human service resources in these communities as may have been anticipated, given such factors as population size and distance from large urban centers. We were able to locate a number of both formal and informal resources which typically function in response to demands for psychological first aid. Communities were found to vary in terms of the extent to which such demands are routinely met by formally designated mental health agencies. In fact, those communities rich in mental health resources tended to be poorer in human services resources, and vice versa.

Regardless of the picture on the agency level, in every town we studied, we identified a sector of informal care-givers who are also engaged in performing crisis intervention functions. These traditional sources of psychological support--the family physician, the pastor, the friend--are perhaps more significant in smaller communities than in today's big city.

On the basis of our research, we concluded that those interested in planning and carrying out a mental health program to meet the needs of disaster victims already have available on the local level resources sufficient to at least begin that work. This chapter, then, will discuss those factors which need to be considered by mental health planners and practitioners on both the local and the state level. The recommendations for program planning and implementation will follow in chronological order: the pre-disaster period, the immediate post-impact period, and the post-disaster recovery period will each be discussed. Discussion will focus on the steps organizations may take to insure disaster readiness and effective response, the relatively simple principles which should be followed, approaches to avoid, and sources of various technical information and assistance which are available to mental health and human service practitioners.

PRE-IMPACT PHASE: Planning for Service Delivery

The Role of the State

Although disaster planning should originate and be carried out on the local level, there are several things that mental health personnel on the state and regional level can do to provide impetus for local planning efforts and to support efforts that are already underway:

1. Create an awareness among local mental health professionals that the delivery of disaster-related mental health services is primarily a local responsibility. Make available to local organizations information on resources from federal, state and regional sources to be used in training and planning for mental health disaster service delivery.
2. Provide information about how communities and individuals respond to disasters, with specific emphasis on problems of mental health in disasters. Take appropriate steps to ensure that local personnel are aware of the procedures for applying for federal funds under Section 413 of the Disaster Assistance Act, as well as for other funds for which their communities might be eligible.
3. Set disaster preparedness standards for mental health-delivery systems on the local level. Appoint a coordinator of Disaster Mental Health, who will work with local personnel in disaster planning and operations and who will act as liaison among various levels of government and disaster-relevant agencies.
4. Sponsor legislation specifying the rights and responsibilities of local mental health systems in the disaster response.
5. Establish criteria for the monitoring and expenditure of disaster-related funds.

Local personnel can be sensitized to issues of disaster mental health by a variety of means, including sponsoring seminars, workshops, and meetings; attending conferences devoted to disasters and disaster mental health; distributing books, pamphlets, and manuals; and setting formal requirements for local agencies wishing to apply for funding for disaster-related programs.

The Role of Personnel at the Local Level

As stated, disaster planning in the mental health area should be conducted primarily by local personnel, taking into account needs and resources which exist in the community. The following are the kinds of activities which, if performed, will insure that a state of disaster preparedness is achieved on the local level:

1. Be aware of disaster-relevant legislation on both the federal and the state levels and of sources of information and assistance which are available to the local community. As noted earlier, the Disaster Relief Act of 1974, Public Law 93-288, includes provisions for the granting of aid and assistance to disaster-stricken states. Section 413 of the law states that the President, through the National Institute of Mental Health (NIMH), is authorized to provide counseling services to victims experiencing disaster-induced mental health problems by giving financial aid and assistance to state or local agencies and groups, including both public and private mental health agencies. Such funds may be used for training personnel to render counseling services as well as for the actual delivery of

services. This means that, in large-scale, federally-declared disasters, resources are available from national agencies to assist local efforts in the event that local resources are judged inadequate to meet increased demands for mental health-related services. (See Appendix I for the text of Section 413 of the Disaster Relief Act of 1974).

Many states now have in effect legislation specifying the rights and obligations of various local agencies and jurisdictions during times of disaster. Local mental health personnel need to be aware of such laws.

The Disaster Assistance and Emergency Mental Health Section is a special subsection of the National Institute of Mental Health (NIMH) which is specifically responsible for problems relating to disaster mental health. This Section disburses funds made available through the Federal Disaster Assistance Administration (FDAA) in the form of grants-in-aid to local communities where there is a need for the provision of disaster-related emergency mental health programs. Financial aid is given to local organizations in federally-declared disaster areas following a visit to the stricken area by a representative of the Disaster Assistance and Emergency Mental Health Section, which includes an assessment of the extent of local needs, and contingent upon an application for funds by some group, agency, or organization engaged in the delivery of emergency mental health services. As is the case with any grant, documentation providing the existence of needs for services is required, and, thus, every local mental health agency should have knowledge of the regulations which apply in the disaster assistance area. (See Appendix II for the outlines of National Institute of Mental Health disaster assistance regulations).

2. Become involved in local disaster-planning activities. Many communities have community-wide committees devoted to problems of disaster preparedness. Such committees typically include representatives from such organizations as the Red Cross, the police, the fire department, city and county government, Civil Defense, and the local general hospital. Mental health personnel will find it very difficult to integrate their efforts with those of other disaster-relevant organizations following disaster if they do not work with these organizations during the planning phase. Thus, the mental health sector of the community should also have its representative on this committee. Mental health should be a formal part of the local disaster plan if the efforts of mental health professionals are to be effective. In communities where disaster planning has not yet begun, mental health personnel have an opportunity to initiate these kinds of efforts. In fact, this activity--originating and participating in local disaster planning--can help the local mental health organization even outside disaster times by publicizing the important role of mental health in the community. Here, then, is an unanticipated benefit of mental health involvement in disaster planning.

3. Develop a mental health disaster plan. This plan should include provisions for the services the organization will deliver, as well as when, where, how, and by whom these services will be provided. A division of labor and lines of authority and responsibility should be clearly specified and understood during the planning phase, so they can operate effectively in the disaster context. Planning should occur not merely within organizations, but also among organizations; inter-organizational planning and working agreements will contribute immeasurably to efficient disaster operations.

4. Know your community. Communities are not static entities, and, as is the case with many other local organizations and institutional sectors--business, educational, and others--the organizational picture in the health and welfare realm is an ever-changing one. For any number of reasons, social service organizations frequently expand and contract their task domains, offering new services or cutting back old ones. At the same time, various kinds of voluntary organizations, some having specialized functions or target clientele, may expand, or disappear.

Because of the dynamic nature of interorganizational activities and relationships, in order to be prepared to mount a crisis intervention response to disaster, the mental health professional needs to have complete, accurate, up-to-date knowledge about local social and human service resources. This knowledge should include information about organizations which become very important following disasters--the Red Cross, for example--as well as information about local agencies which offer material and financial aid. Additionally, the mental health professional should have a thorough understanding of what informal networks exist in the community that routinely meet the urgent needs of residents. The composition of these informal networks will vary from community to community, but may include local neighborhood organizations or friendship groups, clubs, church groups, clergy, and labor union organizations. Finally, the mental health practitioner should be aware of the identity and location of high-risk groups in the population, since these are groups upon which disasters might have a particularly marked impact. In short, one's knowledge of the community should be such that it will be possible to function very effectively in providing immediate psychological support and information and referral during the emergency period as well as in performing fast, accurate needs assessment following disaster impact.

5. Educate mental health personnel about human behavior in disaster and about disaster mental health. Before mental health professionals can act effectively in the disaster setting, they must learn what to expect, that is, they must be encouraged to understand how people typically react. Contained in the annotated bibliography of the report are a number of publications on various aspects of disaster response; local mental health agencies may wish to obtain some of these devise workshops, seminars, or programs based on their findings.

Some of the notions that can be stressed in staff training for disaster operations include the fact that many organizations, including mental health organizations, may be performing activities which they do not perform on an everyday basis and also that they themselves may not be called upon to provide services in the same fashion that they provide them during routine times. Mental health personnel should also be prepared to work with new agencies and groups from both outside and within the community, some of which may be performing an implicit mental health function. In general, then, flexibility and sensitivity to new organizational arrangements and tasks should be emphasized.

Mental health and other crisis response organizations and groups in several communities have recognized the advantage of receiving technical assistance in training workers in the delivery of disaster-related crisis intervention and emergency mental health services. Resources now exist for organizing this kind of training program which would insure that communities will have a trained cadre of workers ready to commence activities as soon as disaster strikes. Recently, a comprehensive training manual has been prepared by the Los Angeles Suicide Prevention Center, under contract with the NIMH, specifically to use in the training of mental health professionals, paraprofessionals and volunteers in disaster mental health techniques. The manual, which focuses on training individuals in the rudiments of crisis intervention as performed in the disaster setting, may be particularly helpful in a rural area or small town because the programs for which it serves as a basis may be conducted on any scale, large or small, and do not require a large supply of highly trained personnel. (See Appendix III for the table of contents of this manual and for information on how to obtain copies.) Low-budget training programs can be devised using such resources as the manual on crisis intervention in disasters, some of the publications contained in the annotated bibliography of this report, and films on community-wide disasters available from local Red Cross chapters and Civil Defense organizations.

6. Assign responsibility for agency disaster planning to specific individuals.

Disaster planning and response are frequently given low priority in organizations. It is essential to good disaster planning that mental health organizations have disaster committees and formal disaster plans similar to those that function in hospitals and other community organizations. In short, disaster preparedness should be a formal organizational priority. (The chairperson of the mental health disaster committee may be the representative to the community planning body. This person should have the authority to commit the resources of the organization in the overall community response.)

7. Exercise crisis intervention and psychological first aid skills in small localized emergencies.

What is being advocated here is nothing more than a mental health disaster drill. Local personnel do not have to wait for the occurrence of a massive community-wide disaster to exercise their newly-learned skills. A mass casualty event, such as a large automobile crash, a train collision, or a nursing home fire may provide a setting in which mental health personnel can deliver supportive services on a limited basis to a few victims. When events such as these occur, a mental health organization should activate its disaster plan, dispatching personnel to the site or to the local hospital emergency department, thus providing these workers with experience that may prove invaluable at some later time when a community-wide disaster strikes.

8. Upgrade agency record-keeping procedures.

It was noted in Chapter IV that our researchers experienced considerable difficulty in obtaining statistics in the communities studied and that this difficulty was quite marked in the case of agency statistics of various kinds. Post-disaster needs assessment, as well as the application for funding from the federal or state level, will be based, in part, on statistical data, including baseline data on mental health problems, number and nature of cases treated and the like. Thus, we wish to stress the importance of keeping accurate, comprehensive and current records on a day-to-day basis. Like involvement in community-wide planning, this is an aspect of disaster mental health preparedness that will benefit the local agency even if disaster never occurs.

In summary, the goals of state and local pre-disaster planning are: to insure that existing resources can be mobilized quickly, efficiently and effectively should disaster strike; to integrate mental health related efforts with overall community efforts; to see to it that mental health personnel will be prepared to act in a manner designed to enhance the morale of community residents; and to institute methods of record keeping and evaluation capable of providing useful feedback to organizations that become involved in the post-disaster delivery of mental health services.

IMPACT AND EMERGENCY PERIOD: The Provision of Psychological First Aid

State and local agencies that have engaged in pre-disaster planning will not be overwhelmed when disaster strikes. The benefits of planning will be apparent immediately as organizations activate their disaster plans and begin emergency operations. However, even if planning has not occurred, it is still not too late for organizations to mount an effective response in the immediate post-impact period.

The Role of the State

1. Become involved in the local response.

Should a request for assistance come from local individuals, state level personnel should be prepared to offer needed resources and personnel. Even in the absence of a formal request, a state official should initiate contact with local personnel to begin a joint assessment of the need for services.

2. Assure that information on laws, regulations and programs of relevance to local mental health organizations will be quickly disseminated.

3. Urge official disaster declaration so that support can be made available on the local level.

4. In cases where need has been established, make emergency funding available to whatever local group is engaging in needs assessment or the delivery of counseling services to disaster victims.

5. Act as a liaison between the federal and the local levels of government, as well as between different catchment areas, if more than one is involved in disaster response.

The Role of Personnel at the Local Level

At the community level, three main tasks must be performed simultaneously when disaster strikes: integration with the emergent community system delivering services during the emergency period; delivery of direct and indirect services to victims; and post-disaster needs-assessment. All phases of these tasks will have been made immeasurably easier if pre-disaster planning has occurred. Where there has been prior planning, the responsible individual needs only to activate the disaster plan to put the mental health response in motion. If there has been no pre-disaster planning, local personnel will have to engage in swift planning as soon as possible after impact, focusing on the most immediate things that can be done to alleviate victims' distress. The recommendations below are intended to be applicable both in situations where preplanning has occurred and those where it has not.

1. Conduct an initial meeting with other deliverers of emergency health care services.

If preplanning has occurred, this meeting will be routine. If not, it will be even more necessary. At this time, groups and organizations involved in providing supportive services to victims should devise a clear division of labor so that task responsibilities are well understood and so that duplication of effort is avoided.

Information about such topics as the severity of the disaster, damage and injury reports, the number and location of the injured, the location of the emergency operations center and the availability of resources should be exchanged. Organizations may also decide to exchange personnel, share resources, or merge their efforts. Some briefing or training of volunteers or paraprofessional staff may also be necessary at this time.

2. Integrate with the emergent care-giving system.

The emergency period will be marked by changes in the everyday operations of a number of organizations and by the emergence of new groups; it may also see the arrival on the local scene of representatives of state and local disaster-relevant organizations. Part of the task of the providers of emergency mental health services during this period will be to coordinate mental health efforts with the efforts of these and other groups involved in the emergency response. The new community system will consist of agencies such as the Red Cross and the Salvation Army, city and county officials, a well-fortified police and fire department, the Civil Defense organization and personnel from the community's health-care subsystem--public health officials, doctors, nurses, paramedics, emergency medical technicians--as well as emergent groups, some of which may already be engaged in providing counseling to disaster victims. If there is a federal disaster declaration, these local care-givers may also be joined within hours or days by representatives of state and federal agencies such as state departments of health and mental health, the Federal Disaster Assistance Administration (FDAA), the Small Business Administration (SBA), the Department of Housing and Urban Development (HUD), the National Institute of Mental Health (NIMH), the National Guard, and the Army Corps of Engineers. It is important that local mental health personnel be aware of the function of these agencies, and that representatives of mental health and human service organizations participate in their co-ordinating meetings.

In disasters where there has been a federal declaration, a "one-stop center" is usually set up to aid victims. Organizations involved in disaster recovery station representatives at the one-stop center so that victims can file for all types of available aid in a single visit. This kind of center makes integration and coordination of agency efforts easier.

3. Provide direct services to disaster victims.

As has been previously noted, there is evidence that the most common kinds of services that will be required following disaster will be those of a crisis intervention nature, rather than more traditional forms of therapy. The authors are not clinicians, and therefore we do not consider ourselves qualified to give instruction in how to provide good crisis intervention services. We can, however,

discuss how crisis intervention has come to be defined and what kinds of techniques are usually employed in crisis intervention in the disaster setting.

Crisis intervention, as discussed by Caplan (1964), is an innovative technique for dealing with psychological disturbance which is characterized by: 1) frequent contacts with the person being aided over a short period of time; 2) emphasis on the present problem or crisis rather than on the earlier causes of disturbance; 3) rapid problem-assessment rather than long-range diagnosis; 4) use of trained paraprofessionals instead of exclusive use of highly trained professionals; and 5) emphasis on helping persons receiving services to deal positively with the current situation rather than on seeking complete personality reorganization. This problem-solving model contrasts markedly with the medical model, which emphasizes "treatment" of the "patient" by a qualified professional, usually by means of long-term psychotherapy. The object of crisis intervention is not personality change, but rather the reduction of the state of crisis, so that the individual can once again deal with his or her environment, and the prevent of future maladaptive behavior.

Assuming that the overall mental health emphasis will be on the provision of crisis intervention services, of what should these services consist? The focus should be on providing broad human services. In terms of the meeting of needs, the mental health worker should begin where the victim is; frequently the provision of tangible aid is the best and only way to reduce the symptoms of emotional disturbance. As one mental health professional who provided services to victims of the Xenia tornado stated,

Sometimes maybe giving them a stove, or giving them a week's worth of food was the best way to handle the emotional problems. Sometimes being overwhelmed by a financial problem or a material assistance-kind of problem puts you over the limit and things get blown out of proportion...a lot of times if you go on to meet the material assistance kind of problem or the information kinds of problems, you solve what's bothering them. If you go in with the attitude that everybody needs counseling or everybody has a defect in decision-making or coping, I think it will take too long to get at what they really need. (Taylor, Ross and Quarantelli, 1976, 74)

Information and referral services are among the most valuable services that can be given during the immediate post-impact period. Workers should be knowledgeable enough about the emergent care-giving system to be able to assist victims in solving their practical problems, even to the point of actually taking them to the appropriate agency. Providing information and referral services may seem simple at first glance; many mental health centers do this routinely. However, it is important to note a number of ways in

which the care-giving system in the post-impact period may differ from the system as it exists on an everyday basis. Agencies may be located in new quarters due to destruction of their facilities. They may have new and different telephone numbers. They may even be offering new, different or expanded services. Additionally, as has been noted repeatedly, disaster-relevant organizations, outside agencies and emergent groups may all be on the scene to offer various forms of needed aid. All these things mean that a large amount of effort in the post-impact period may be devoted simply to gathering complete and accurate information on the capabilities of the emergent care-giving system. When such information is obtained, it should be made available to victims as quickly as possible. One of the most important services that can be rendered by a mental health organization is to provide a master list of who is providing what services and where within the first twenty-four to forty-eight hours after disaster.

A second point is that services given should not carry the mental health label. Disaster victims are normal individuals reacting in a normal fashion to a trying situation. These individuals need and deserve psychological support, but there is a possibility that they will not avail themselves of it if doing so means accepting the mentally ill label. This is particularly true in the smaller community, where little, if any, distinction is made between "mental health" and "mental illness."

Another characteristic of disaster-related mental health service delivery is that it should focus on the prevention of further problems, rather than on the treatment of symptoms. Of course, this is not to say that treatment should be abandoned entirely. Agencies may be called upon to practice traditional psychotherapy following disaster, especially with those individuals who are already agency clients. And the occurrence of disaster should not lead to the neglect of the mental health needs of those in the community not affected by disaster.

How should services be provided to victims? Crisis intervention can be performed through any number of imaginative means. In the disaster setting, simply sitting with someone in the hospital and listening to the story of the disaster or helping a person with clean-up may be therapeutic--although the same individuals who gratefully accept this kind of help may never have accepted "therapy." An outreaching stance should be adopted: help should be offered on the mere evidence that a need exists and not only on the basis of a formal request from a victim.

It is difficult to predict in advance where services will be given following a disaster. In general, however, we recommend extensive community outreach efforts. Workers should go to where the people are who may be experiencing problems. We advise that workers become active in shelters set up for disaster victims; but it must be remembered that relatively few people use official shelters even one night after disaster, since most stay with relatives or friends. Thus, persons in shelters constitute only a small portion of those

a mental health program should be attempting to reach. Other sites where victims may gather include temporary morgues (when large numbers of deaths have occurred), hospital emergency rooms, sections of the community which have been destroyed or badly damaged, food canteens, first aid stations, and one-stop centers. The hospital, the shelter(s), the morgue and the one-stop center are worthwhile sites for beginning the counseling effort, since many of the hardest-hit victims will be found in these locations. It is possible to be both unobtrusive and effective in these kinds of settings. For example, following a recent disaster in a rural Appalachian community, personnel from the local Community Mental Health Center volunteered to staff the exit desk at the one-stop center. In the course of helping victims see that applications for possible forms of aid had been filled out correctly and completely, these workers were able to assess victims' psychological states, listen to complaints, give reassurances and encouragement, offer information, and keep a record of cases appearing to need follow-up. Similarly, a mental health paraprofessional can volunteer in a Red Cross shelter and dispense blankets, food and toys while talking with mothers about the reactions of their children.

After the few few days, service can and should be delivered in victims' homes, in the schools and in other places where people typically go as part of their daily routine. These may even include such settings as bars, beauty shops, church functions, and neighborhood and community gatherings.

By whom should services be provided? We have tended to speak of mental health service delivery in disasters as a function of designated mental health organizations, and this is accurate, particularly where planning, training and supervision are concerned. However, most communities--particularly smaller communities--will probably not contain a sufficient number of trained professionals to launch a mental health response. Moreover, such persons are undoubtedly already needed by their regular clients and are, in any case, overtrained for most of the activities involved in post-disaster counseling. For these reasons, we have emphasized human service resources and informal care-giving networks in the communities we studied as resources that can be built upon. Agencies that already perform outreach and informal counseling--the agricultural extension office, the public health service, the school home visiting program--can provide both material resources and personnel during disaster times. Agency personnel who typically play helping roles in the community, together with traditionally recognized community care-givers can be used in a paraprofessional capacity in disaster outreach and counseling work. While some older, established groups with prestige in the community should be responsible for the leadership and supervision of the mental health recovery effort, it is conceivable that the majority of those involved in service delivery might be community volunteers.

More important than the level of training of the person delivering counseling services is the fact that services should be delivered

by people from within the community, rather than from the outside. Virtually every mental health professional who has been involved in the provision of disaster-related mental health services stresses the benefits that can be obtained from the use of indigenous personnel: they are familiar with the local scene and can offer information about where different services can be obtained; they know the local neighborhoods and the people who inhabit them; they are knowledgeable about local problems; they are known by the people. In short, they are perceived as belonging. Use of local personnel is particularly important in the immediate post-disaster period because this is a time that is often marked not only by increased community morale, but also by its obverse--hostility to the outsider.

For whom should services be provided? This question can be ultimately answered only by the individual community and only after a thorough needs-assessment. (See 4 below.) The latter will provide useful information about which individuals and groups were most severely impacted and which persons are experiencing the most practical difficulty. In the immediate post-impact period, however, the best strategy is to assume that all the people in the stricken area are potential clients and to begin to identify and to make contact with persons who logically can be assumed to be most in need of psychological support--persons who have lost one or more family members, persons whose homes have been destroyed, the seriously injured, the institutionalized, and those who are or have been under psychiatric care. A priority should be placed on delivering services to neglected segments of the population (the poor, racial and cultural minorities), as well as to those who are geographically isolated and/or without transportation.

The question of when services should be delivered can be divided in two parts: the question of how soon services should commence and the question of how long they should continue. Obviously, the provision of services should begin as soon as possible after disaster impact. The sooner psychological first aid is provided, the less total stress victims will experience, and the greater the probability that long-term emotional problems will be avoided. The swift provision of supportive services can also contribute to improved community morale, essential for successful disaster recovery.

How long services should continue depends upon the number, nature and duration of the problems encountered by the population during the post-disaster period. This is one reason why we encourage needs assessment as a part of effective mental health service delivery. Although federal funding for disaster mental health programs is intended to extend for a six-month period, the ideal length of a given program cannot be known in advance, because each disaster and each community are different. Because of the importance of continuity of client care, we urge that those involved in planning for and for delivering disaster-related counseling services be mindful of the time dimension as it relates to their programs.

4. Offer services to the community in addition to those provided directly to victims.

Besides offering counseling to victims on a face-to-face basis, disaster-related mental health programs can engage in community education, even during the immediate post-impact period. These educational efforts should be designed to reach as many people as possible in the stricken area and should express a few simple themes relating to problems of disaster mental health. The notion should be conveyed, for example, that it is normal to feel upset, discouraged and emotionally drained after a disaster experience. Forms of catharsis, such as the expression of grief over loss and the retelling of upsetting experiences, should be encouraged. Information about available sources of mental health counseling should be provided and should include specific directions on how to go about finding someone to listen or to help with concrete problems. The idea that it is quite common for normal people experiencing stress to utilize such services should be emphasized.

A number of means can be employed for disseminating this information. Mental health professionals can take part in discussions devoted to the topic of psychological reactions to disasters on radio or television talk shows; commercial time can be purchased on local media for the purpose of publicizing the availability of helping services, again playing down any possible connotations of mental illness or breakdown. A series of articles or advertisements can be run in the local newspaper. Pamphlets can be printed quickly and distributed at the one-stop-center and at other places where people gather. Eye-catching posters can be printed and placed in hospitals, shelters, first-aid stations, and similar locations, as well as in informal neighborhood gathering places.

Mental health-oriented groups should see to it that their existence is widely known and that their services are outlined in directories listing and describing disaster-related agencies. Workers should be present at assemblies and planning meetings attended by local officials and community residents to offer support, information and suggestions.

5. Engage in needs assessment in order to obtain information for use in planning and future service delivery.

Effective services are always those which are delivered on the basis of known needs, rather than on the basis of anticipated or predicted needs or on the basis of visible demands. Thus, those involved in mental health service delivery following disaster must begin to employ various needs assessment procedures as soon as possible after impact.

The assessment of the mental health needs of a population is often performed by means of surveys on members of that population. In the

period following disaster, however, population surveys are not the most appropriate method of needs assessment for several reasons. First of all, they take time to devise and analyze, and the actual delivery of emergency mental health services must begin as soon as possible after disaster strikes. Moreover, surveys are usually quite expensive to undertake. Third, common needs assessment instruments, such as the Health Opinion Survey (HOS), while excellent for a number of purposes, are not comprehensive enough to be applicable in the disaster situation. Of equal importance, of course, is that those making up the population whose needs are to be gauged; i.e., those who were in the community at the time of the disaster, may be scattered throughout the region in new and different locations, having left the area entirely or having moved to places in the community other than their pre-disaster residences.

For these reasons, methods of needs-assessment other than surveys should be employed in the immediate post-disaster period; this does not, however, rule out the use of surveys for a variety of purposes in the long-term disaster period. Nor does it mean that other forms of quantitative data cannot be gathered in the days immediately preceding the disaster event. Three methods of assessing victims' disaster-related mental health needs will be discussed briefly: the use of indirect indicators of emotional stress; the use of informants; and the use of clinical evaluation.

Indirect indicators include official statistics or records which, taken singly or together, provide data on the incidence of what can logically be construed to be stressful life events for those experiencing them. The indicators listed below have in common that they point to the prevalence of disaster-generated situations which can be very stressful events in peoples' lives: death, injury, loss, change of residence, and the like. The following are some examples of indirect indicators that can supply information concerning the nature, range and extensiveness of the community's post-disaster mental health-related problems, as well as information on potential target groups for services.

From health care organizations:	Number of dead (hospitals) Number of disaster-related admissions (hospitals) Number evacuated (hospitals) Number receiving first aid (first aid stations)
From mental hospitals:	Number of persons currently institutionalized Number evacuated or relocated (where applicable)
From mental health facilities:	Number of persons currently receiving a service who experienced disaster losses

From nursing homes:	Number of persons in residence Number evacuated or re-located (where applicable)
From disaster relief organizations:	Families receiving financial subsidies (Red Cross) Residences destroyed (Red Cross) Residences with major damage (Red Cross) Number of persons sheltered (Red Cross)
From disaster relief organizations:	Average length of stay in shelters Number of persons applying for low-interest loans (SBA) Number of families requesting housing assistance (HUD) Number of applications for individual and family grants (FDAA) Number of applications for rural housing disaster loans (FHA) Number of applications for crop loss assistance (U.S. Department of Agriculture)
From social welfare organizations:	Number new food stamp applications Number new applications for Aid to Families with Dependent Children Agricultural and livestock losses Number of applications for unemployment assistance
From other community groups assessing needs:	Number and nature of cases found

Other information on the number, identity and location of high-risk groups can be obtained in a variety of ways. For example, workers may overhear people in shelters discussing problems that are known to them, or serious cases of need may be reported in the local newspaper. Workers should get out and circulate in the community during the emergency period. Visits to low-income areas or to nursing homes may reveal the existence of unrecognized and unreported needs. In short, mental health personnel may be able to obtain a great deal of useful data on the mental health status of community members by passing through the

stricken area, listening and observing carefully, and noting the problems that become apparent.

Going about actively in the impacted area also provides an opportunity for contacting community informants capable of supplying information on the mental health needs of the victim population. Volunteers who work in search and rescue operations, hospital emergency department personnel, community officials, religious leaders and persons who staff both official agencies and emergent groups may all prove to be valuable sources of data about victims' emergency mental health needs. Contacts with informal care-givers in the community will also provide useful inputs into post-disaster needs assessment efforts. Such contacts are encouraged to insure that the information obtained is complete and representative of the needs of all community sectors, including those not usually tied into formal care-giving networks.

Needs assessment can also be performed through the use of clinical evaluation techniques. In this case, trained personnel judge the prevalence of stress on the basis of contacts with members of the victim population. Although not performed until many months after the disaster, this was the method employed to estimate the prevalence of symptoms of psychological disturbance among the survivors of the Buffalo Creek flood. Lengthy interviews were conducted with victims by individuals possessing expertise in the diagnosis of psychological complaints, primarily psychiatrists.

Clinical evaluation is frequently conducted on at least an implicit basis by mental health professionals working in the disaster setting. Such persons are typically highly sensitive to symptoms of emotional turmoil exhibited by persons with whom they come in contact. What is required for valid needs assessment is that this kind of evaluation be performed self-consciously, uniformly and systematically by mental health care-givers. Additionally, evaluation should be performed as quickly as possible. Because highly-trained personnel will be in relatively short supply in the emergency period, and because their skills may be needed for other tasks, it is advisable that all mental health personnel, including volunteers, be trained in simple methods of clinical assessment, based on gross categories and visible symptoms, which can be employed in the course of delivering supportive services. Examples of these types of evaluation, together with recommendations for various referral options, are contained in the disaster training manual written by the staff of the Los Angeles Suicide Prevention Center (See Appendix III).

Use of any combination of the three methods of needs assessment discussed above--and ideally, of course, all three should be used together--should result in relatively accurate and complete information on the incidence of mental health-related community needs, at least as these manifest themselves in the first few days. Needs assessment in the emergency period should lead to knowledge of the approximate number of potential clients in the stricken area; what groups in the community are most heavily represented; how pronounced the need is for various kinds of services; e.g., help with transportation, assistance

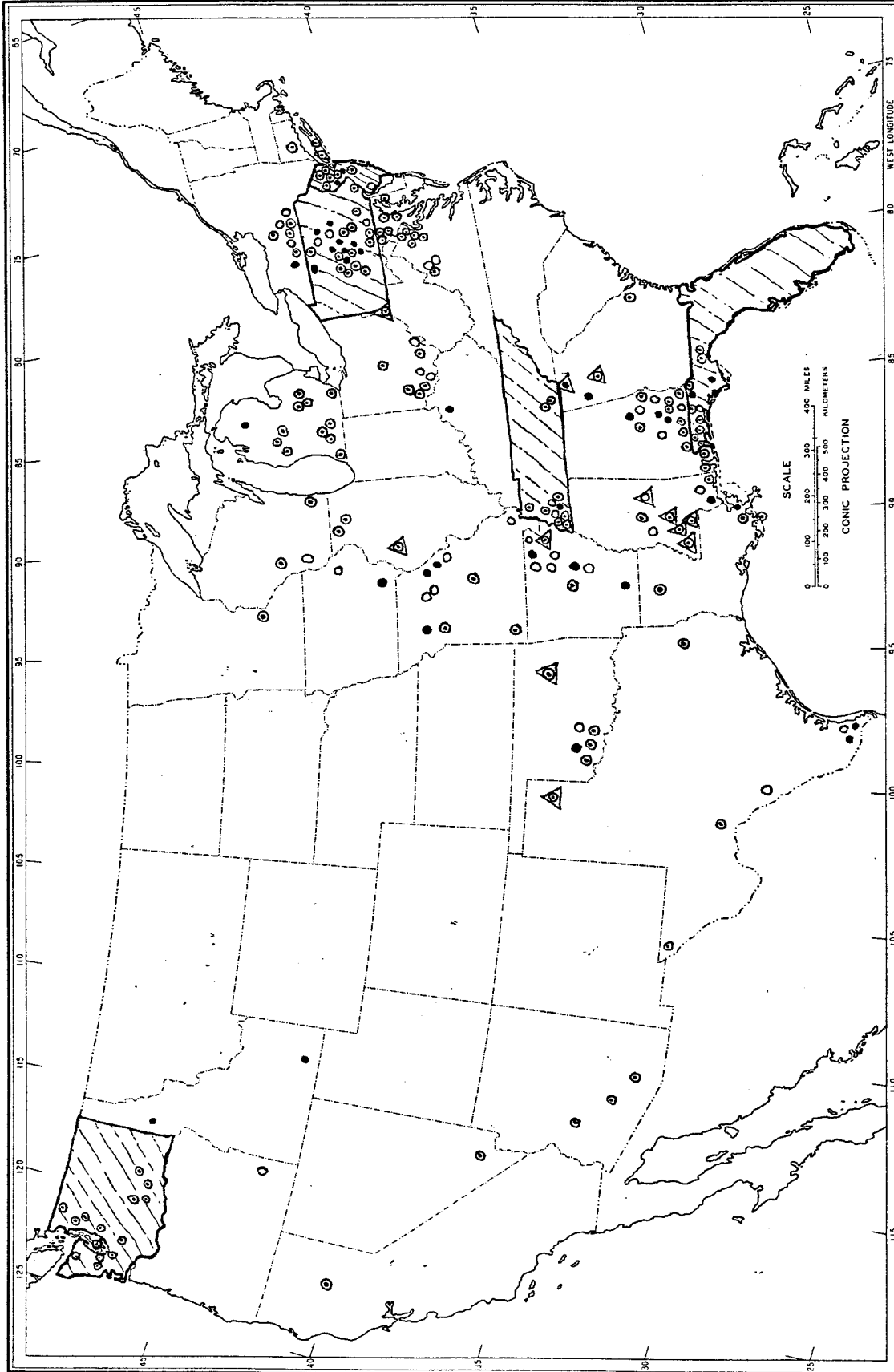
with family decision making, information and referral; and how many staff persons will be required to meet disaster-generated needs during the next few months.

At this point--say, ten days to two weeks after the disaster, although the time period will vary from community to community--local personnel should be in a position to determine whether the magnitude of the community's need for disaster-related mental health services is great enough to necessitate either the creation of new services or the expansion of existing services by some local care-giving group. If a decision is made to begin delivering new or expanded services, this group may decide to apply for supplementary funding from either state, local or federal sources. Data from the initial needs-assessment will be needed to serve as a basis for this request, as will certain state and federal disaster declarations.

In order for a local community to qualify for federal funding, the community must be within a federally declared disaster area. Most severe community-wide disasters do become subject to federal declarations, often within a day or two after impact. In such cases, no barriers exist to requests for federal assistance in delivering mental health services. However, some disasters, even those resulting in relatively large amounts of loss, are not federally declared. This may be particularly true in rural areas, where losses may seem small on an absolute scale, but may be great relative to the local resources.

Table 6.1 illustrates the frequency of this type of situation; it shows the incidence of disasters in the Continental United States in which the Red Cross gave aid to stricken families during the year 1975. Disaster events are further classified in terms of population size of the largest community in the impacted county and in terms of whether a federal state of disaster was subsequently declared. Of the total of 218 disaster events, 83, or less than 40%, were federally declared disasters. Of those 39 disasters occurring in counties in which the largest town has a population of 15,000 or less, only 17 were subject to federal declaration; of the 44 disasters striking counties in which the largest city has a population of 15,000 to 25,000, 12 were officially declared. (The map on the following page illustrates the geographical distribution of 1975 disaster events.) Thus, local mental health personnel should be mindful of the fact that, while it is almost certain that various forms of federal aid will be made available to communities experiencing dire need, "borderline" cases can also exist, which may be considered disasters from the local perspective, but not from the federal perspective. In such cases, local mental health programs may have to practice considerable budgetary flexibility in program planning and implementation, using existing capabilities as efficiently and effectively as possible and seeking financial assistance from a variety of local, state and regional sources.

No. 10



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Federal Disaster Declaration
 [Hatched box symbol] all cities/counties statewide
 [Triangle with dot symbol] selected cities/counties within state

Size of largest Community in County:
 ● under 15,000
 ○ 15,000-25,000
 ⊙ over 25,000

GOODE'S SERIES OF BASE MAPS
 HENRY M. LEPPARD, EDITOR

Counties in the Continental U.S. Impacted by Natural Disaster Agents in 1975

Table 6.1

1975 incidence of federally declared and non-declared disasters in the continental U.S., by size of largest community in impacted area.

<u>Population</u>	<u>Declared</u>	<u>Non-Declared</u>	<u>Total</u>
25,000 and over	54	81	135
15,000 to 25,000	12	32	44
Under 15,000	17	22	39

THE POST-DISASTER PERIOD:
Long-Run Program Options

The length of the emergency period will vary from disaster to disaster, depending on the severity of the impact, the extensiveness of the disruption experienced by various community sectors, and the community's capability for coping with disaster. For discussion purposes, however, we will assume that the post-disaster period begins approximately two weeks after the disaster event. Instead of discussing the role of agencies on the state and local levels, as we did in the previous two sections, we will simply note that the role of the state during this time remains what it has been previously--that of resource, sponsor and facilitator--and will move directly to a discussion of disaster-related mental health activities on the local level.

Within a relatively short period of time, then, the initial period of emergency is over. Operations at the one-stop-center may be gearing down, as one by one various disaster-related agencies begin to see their tasks as nearing completion. Crisis intervention, in the form of immediate material assistance and psychological first aid, has been given to those who are known to have needed it, usually as they were encountered in the hospital, the morgue, the One-Stop Center or any other disaster relief center their community may have operated.

Search and rescue is over, the major traffic routes have been cleared of debris, communications systems--telephone service and radio and television--are once again functioning. People are gone from emergency shelters, having been placed in temporary housing by some governmental agency of having placed themselves with relatives or friends. Planning alternatives have been explored by local authorities, and the long, slow process of rebuilding has begun.

Now is the time to reassess the situation. If the disaster suffered by the community was relatively minor, mental health workers may feel that all of the crisis intervention work that really needed to be done has been already performed and it may seem that the community's main task revolves around problems of physical reconstruction. However, individuals affected by the disaster may still be experiencing

subtle life changes having a potential for leading to emotional crisis. Those who have been faced with a life-threatening situation, loss of property, or interruptions of everyday social support mechanisms--family life, work, the neighborhood--and who have not resolved the attending stress in a positive manner may still be feeling stress which could result in mental health problems of a more serious nature.

At the One-Stop or Disaster Center, for example, volunteers may have noted that relatively few people experienced severe emotional discomfort. Those who were upset seemed to benefit from the intervention of crisis workers sufficiently to be able to cope with their own rebuilding tasks. What should be remembered now is that much of the emotional strain on victims and affected people may not surface immediately because people do not have the time or ability to feel their losses. They may be rationally aware of what they and others have suffered, but--usually through hard work, sometimes through withdrawing--many people may also be insulating themselves from feeling very much until they are ready to recognize and deal with the problem of loss, anger, etc. It may take anywhere from a few weeks to several months after the disaster to reach this point. Indeed, as studies have shown (Penick, Larcen & Powell, 1974), it is not only the experience of the disaster agent itself, but the frustrations ensuing from the snarl of red tape and delay surrounding the procuring of assistance, that are conducive to poor mental health.

In light of this knowledge, and based on needs assessment conducted in the impact-emergency period, local personnel involved in the mental health effort may wish to provide the community with a long-range disaster mental health program. Funding, of course, would optimize any such program.

Groups or organizations in a federally declared disaster area may wish to apply to the Regional Director of the Federal Disaster Assistance Administration (FDAA) for operating money, if initial needs assessment (see above: Impact/Emergency Period) indicates that a program would be beneficial. There are nearly 100 federal programs, covering a wide range of disaster-related economic, health and physical reconstruction problems, available to supplement state and local efforts. The FDAA has published a digest, here included in the bibliography, which details programs that require a Presidential declaration of major disaster and those that do not. Of interest here are the provisions for assistance to provide crisis counseling to victims of major disaster to relieve mental health problems caused or aggravated by disaster or its aftermath. This assistance may include funds for the training of disaster workers. Although a proposal for this funding must be submitted within sixty days after the Presidential Disaster Declaration, preparing this kind of document is not as onerous a task as it may seem. Typically, the National Institute of Mental Health will provide technical assistance in the preparation of the proposal, if so requested. The funding process, of course, is considerably facilitated if communities have worked on local coordination and contingency planning before disaster occurs and if they make contact with state and federal agencies during the emergency period.

Where there has been a formal disaster declaration on the state level, other funding options might be available. Hopefully, local groups will have familiarized themselves with these at an earlier planning stage. If neither federal nor state funds are available, there are a number of strategies that can be employed with expertise and manpower voluntarily contributed from the community or perhaps from nearby towns.

One final note before going to specific strategies. The literature mentions frequently that disaster mental health programs are unique in that they deal with essentially "normal" or "healthy" populations that are undergoing severe but understandable stress. Manifestations of tension, worry, depression, etc. are seen as normal, acceptable responses to personal and community catastrophe. The majority of such people do not feel they need counseling, do not want to identify their problems as mental illness, and do not want to be identified as clients. If this is typical for general populations in disaster, it is still more so for rural populations that, even in normal times, have a tendency to resist mental health labeling as applied to either agencies or problems. What is really quite fortuitous is that methods found to be effective for reaching disaster victims should be especially effective in reaching rural disaster victims. In fact, if a good mental health and human service delivery system is currently functioning in the smaller, relatively isolated community, chances are excellent that at least the basic elements of good disaster mental health service delivery exist.

Below are some recommended program options that can be tailored to local needs and available personnel and financial resources. Ideally, all of these options should operate in conjunction with each other. If this is impossible, presence of even one or two will go far toward meeting acute and chronic mental health needs, contributing to the prevention of further need, and facilitating the overall recovery effort.

1. Perform Needs Assessment

This has been stressed before in the discussion of the pre-planning stage and again in the treatment of the post-impact period. We cannot emphasize too strongly that this should be an ongoing process. Particularly in a situation as fluid as that following disaster, an evaluation of what is needed at a given time is no indication of what may be needed later. At the very outset, program personnel should realize and keep in mind that a disaster mental health program is intended to be temporary. The length of the post-disaster period will vary from place to place, depending on the degree of severity of the disaster, and there is nothing magic in the six months to one year time spans stipulated by some funding agencies; however, there will inevitably come an end point for any disaster program. This must be taken into account from program inception---no "empire building" allowed. A periodic assessment of disaster related mental health needs, as they change over time, will help in the phasing out of components of the program as they outlive their usefulness, and in the incorporating of other components that have continued value for community mental health into the existing system of care-giving resources.

The same four methods of needs assessment outlined above (see Impact/Emergency period) can be utilized at this time. Clinical assessments made by professionals and other crisis intervenors in working with individuals can give an idea of the specific types of problems being encountered. Statistical information from agency caseloads and various kinds of public records can objectively indicate the extent of community social and economic disruption and can indirectly suggest the nature, range and scope of problems that have bearing on mental health needs. A number of these indirect indicators were listed earlier. Others that can be collected over a longer time period are: police records on family disputes; child abuse and neglect; juvenile delinquency; school attendance records; marriage and divorce records; number of days closed for schools, hospitals, churches, workplaces; hospital admissions; welfare assistance applications, including food stamps; unemployment numbers and costs; housing losses, including minor and major damage as well as complete loss; and disruption of public transportation service. Data gathered by helping organizations--the Information and Referral Center, the Red Cross, Interfaith, etc.--can provide leads on particular neighborhoods and population groups that have been hardest hit and seem to be most affected.

Of particular worth in long run needs assessment, and more feasible than during the immediate post-impact period because there is more time in which to do so, is the gathering of direct indicators of needs through survey data. This simply means going straight to the people of the community, to the victims themselves, and asking them about what they need and want. If groups such as a local Interfaith organization or any other social agency plan to do any kind of survey, they might be asked to include some questions relating to mental health on their questionnaire. Another possibility might be to recruit the services of a nearby college sociology or psychology or community medicine department to conduct such a survey. One other means for gathering direct indicators would be to conduct a survey in conjunction with performing outreach, since this would spare victims too many knocks on the door and improve chances for gaining entry.

2. Offer Crisis Intervention and Information and Referral Services

We have defined crisis intervention and information and referral and their rationale as service tactics elsewhere and have particularly endorsed their use during the post-impact phase. While the need for such services is not as pronounced once the initial period is over, it still exists. Crisis is an individual as well as a community experience. As stated above, many people do not allow themselves to feel loss, tension or any other kind of emotional disturbance right away and, thus, put off coming to a One-Stop or Disaster Center. If such a problem is felt and it becomes more than the person can deal with, crisis can occur.

When a crisis of this nature occurs, disaster victims generally, and small town disaster victims especially, will probably be reluctant to identify it as an emotional problem. A basic tenet in crisis intervention is that it emphasizes strengths and coping mechanisms for addressing specific immediate difficulties, providing support and information that will help people help themselves. To be useful, crisis intervention must offer practical, as well as emotional, assistance, hence the tie-in with information and referral. To be truly helpful on a practical level, one must know what resources are available from day to day in a disaster stricken community and must be prepared to help people secure the aid they need. Information and referral involves coordination with other agencies to insure that the work is shared and distributed, rather than duplicated, and to keep abreast of who is doing what during the somewhat confused recovery period. A limited number of information and referral points are desirable, rather than many, in order to facilitate coordination and the exchange of information. Information and referral that becomes too specialized loses its effectiveness as a disaster strategy; crisis workers must be capable of providing assistance with all kinds of problems. Service is not complete merely when information is conveyed verbally. It may also be necessary to provide transportation, an interpreter or advocate, child care and other services in order to insure that the victim actually gains access to the resources to which he or she has been referred. Finally, follow-up on referrals is essential.

Such aid, which helps meet material needs, is good not only in itself but also in that it opens doors for disclosure of psychological needs as well. If, in the course of giving help on practical matters, a crisis worker finds evidence of, or is taken into confidence regarding emotional problems, the worker is then in a position to better exercise skills of a more direct mental health nature. For most disaster victims a few sessions emphasizing what the victim can do to cope are more effective than extended therapy, which may reinforce the victim's feeling of helplessness. For the relatively few cases where a pre-existing emotional problem is exacerbated by disaster, it is better for the crisis worker personally to get the victim involved with a regular community mental health agency. Such an agency is more appropriate and has the required skills for long-term counseling, and continuity of care of the victim does not become a problem when the disaster mental health program is phased out.

In the case of children who are experiencing adverse effects from the disaster, crisis workers can best intervene through the parents, instructing them to give their children the opportunity to ventilate and to make a special attempt to give little ones more time and attention, even though the adults may be busy rebuilding and reorganizing their lives. Again, for more severe problems, parents should be assisted in seeking help from a regular mental health or child welfare agency.

3. Conduct Outreach and Casefinding Activities

A basic question in disaster mental health generally and in rural mental health, disaster or otherwise, is not so much what to deliver, but

how, when and where to deliver it. A disaster mental health program certainly needs a home base from which to operate, yet those who have experience in these matters say it is a mistake to assume that people will come to a stationary facility in great numbers, requesting counseling. Disaster victims have been found to welcome the opportunity to ventilate, to share their experiences and feelings, and to exchange information, but they will not necessarily seek such opportunity out. As the post-disaster period lengthens and patterns of life settle back to normal, people may become increasingly reluctant to go to formal caregivers for help with disaster-related problems. A strategy that has been found to be effective during this phase is that of outreach. Some things to consider in establishing an outreach program are personnel selection, training and program goals and philosophy.

Outreach personnel can be quite diverse--professionals from outside the community or from local agencies, trained paraprofessionals, indigenous volunteers. The selection of outreach workers merits considerable attention. One program (Hefron, 1975) used the criteria that workers be indigenous to the disaster affected area and/or be directly, personally affected by the disaster and/or have experience in the delivery of human services to disaster victims. Usually workers who are in some way known to victims have the greatest chance of acceptance by them. Familiarity alone is not enough, however. Effectiveness of outreach workers is dependent as well on possession of a number of personal traits which Collins and Pancoast (1976) summarized in the concept of "freedom from drain." The person who undertakes to help others in times of trouble must possess sufficient emotional and physical resources and must be receiving sufficient personal rewards to be truly capable of helping. Some specific qualities required in an outreach worker would be a high level of energy in order to remain active and resourceful in the face of shared stresses, a strong personality capable of showing a wide range of emotions, and experience in living, manifested by the capacity to negotiate with others and the ability to establish rapport with outside sources of power (other agencies), as well as with victims.

In one community that mounted an outreach effort (Bowman, 1975), it was felt that selection of workers was critical to the success of the program. Since only about 15-20 people were needed, about the number most smaller towns would find adequate, they decided not to advertise widely or go through a lengthy and perhaps faulty screening process, but to directly recruit "natural helpers"--typically women and some men from the community who were known to one or another of the program committee as "good with people."

Training in generic disaster relief and crisis intervention techniques is necessary where volunteers are used and is recommended even for professionals. Money for training is available from the FDAA in federally declared disasters, but there are a number of tested programs that local mental health agencies could obtain and conduct for very little money even prior to a disaster or in disasters where federal funds are

not available. Several of these are cited in the bibliography. Generally, for most outreach programs, training has been given in two phases. The first is usually a one to two week intensive workshop which orients workers to the disaster context and provides information on specific problem areas and specific resources for dealing with them. After workers are already functioning in assigned roles, they attend a series of meetings designed to enhance natural helping skills and to help them respond to changing needs of community and client.

Another factor which has been found to relate to the success of outreach programs concerns how the workers see themselves and their jobs. The professional specialist who is accustomed to sitting in an office dispensing service for a relatively narrow range of problems may have trouble stepping into the role of outreach worker. Actually, mental health professionals in small town agencies tend not to be as narrowly based as their counterparts in urban centers, seeing the mental health center more as a social agency (Jones, Wagenfeld, Robin, 1976) and would therefore probably work well in an outreach capacity. Shortages of professional expertise and a need to keep the regular care-giving system functioning at an adequate level for non-disaster victims, however, precludes professionals providing much more than supervision to a disaster outreach effort.

A role that we find particularly appropriate to rural mental health and disaster mental health programs is that of the Service Guide (Raft, Coley, Miller, 1976). The term itself is a good one, implying as it does a level of expertise somewhere between that of the professional and the typical volunteer. It is also neutral with regard to the mental health label. The Service Guide visits people in their own homes, even those in isolated areas, and is prepared intellectually and attitudinally to provide help on all problems, material, physical and emotional. While trained in crisis intervention techniques, they are ready to provide needed information and referral to the point of transporting and accompanying individuals to needed resources and following up on the case by providing support and encouragement to continue necessary treatment or help-seeking. In a study where Service Guides worked for a year and were then discontinued (Raft, Coley and Miller, 1976), it was found that the percentages of blacks, nursing home residents, the elderly and children under twelve who had previously utilized formal mental health services significantly--seriously--decreased. A truism often heard in small towns and elsewhere is that "those who need most, don't get." The use of Service Guides to reach out to people appears to help overcome the imbalance of need and service in rural communities.

One problem frequently mentioned in connection with outreach is that people sometimes resent "agency" people knocking on their doors offering help; i.e., "charity." Workers themselves have a normal fear of rejection. Yet it is clear that a community mental health program, as a disaster mental health program so emphatically is, must be a real part of the community. Workers cannot simply sit behind desks at a center and expect to help a town that has been torn apart.

In some Nebraska communities (Omaha Tornado Report, 1976), this dilemma was resolved as workers developed and expressed a sincere interest in how people coped with disaster. Going from house to house, asking not how badly people were doing, but how well, and stressing that what victims had to say would be helpful to others, workers overcame resistance in themselves and the people they visited. One method for opening doors that the Nebraska workers used, which, as we suggested earlier would be an invaluable tool for needs assessment, was to take a survey. In the process of gaining direct information on community needs, workers used the survey as a tool for emotional support, providing those they visited with an opportunity to vent feelings and to be reassured as to the normality of those feelings.

4. Provide Consultation and Education Services to the Entire Community

As an alternative to direct service methods such as outreach or as a supplement that serves the community as a whole while outreach and crisis intervention deal with individuals, consultation and education is a way of fortifying existing helping resources to meet mental health needs. Paralleling the crisis intervention framework of focusing on strengths rather than on weaknesses, consultation and education emphasizes what the community can do and reinforces the feeling that the collective citizenry is already doing well to meet the challenge of disaster.

The strategy is simply one of investing scarce mental health resources into areas where the returns will be greatest. In one noteworthy application of community-wide consultation and education (Hollister, et al., 1973), the phrase "effective parsimony" was coined to describe how limited funds and relatively few clinicians can be committed to an extensive program of consultations, agency staff training and citizen education to meet the needs of people who seek help for their emotional problems somewhere other than formal mental health agencies.

To do as efficiently and effectively as possible, mental health consultation and education programs must be coordinated with other existing resources, both formal and informal. This coordination must be done in a way that: requires the least disruption of the individual victim's life; uses the least effort that is reasonably effective; and employs the least expenditure of time and effort. This is achieved by meeting with people where they are--on the job, in schools and in neighborhoods. The use of other agencies that most nearly fit in with normal living patterns is encouraged, as is the use of services that require the least time and training first, such as crisis intervention, saving highly educated professionals and sophisticated clinical procedures for more difficult cases (Hollister, et. al., 1973).

As we have often noted, a number of human service agencies and formal care-givers have a pre-eminent mental health role in smaller and rural communities. Since these are the resources to which people

typically turn for help, local mental health professionals can strengthen them in their roles by conducting workshops and training sessions with informal community care-givers such as: general practitioners and other physicians; ministers; public health nurses; local hospital nurses; and the staffs of residential facilities such as nursing homes and childrens' villages.

Lay people who are motivated to learn more about mental health may be reached through meetings at churches, schools and the waiting rooms of agencies. Groups of parents and teachers are primary targets for consultation and education, since they would be the first to notice any manifestations of disaster-related emotional problems in children and are in an excellent position to help such children. Even if nothing is done in terms of mental health programming in a town experiencing disaster, adults involved in recovery efforts have at least some opportunity to tell their stories and share their feelings with others. Children may not, since schools are often closed and play groups disrupted in the disaster's aftermath. Moreover, parents often feel that it is beneficial for their children to "try to forget it" and, therefore, avoid talking about the disaster when the children are present. This attitude, while well intentioned, has been found to hinder rather than help the child in dealing with his fears. Several disaster programs have been concerned with the effects that tornadoes, floods and earthquakes, etc. have had on children. The Omaha Tornado Project (1976), among others, developed excellent techniques for alleviating fear, confusion and discomfort, including a coloring book for children and fliers for parents and teachers explaining what children may be feeling and what action to take.

Consultation and education can reach the general public via radio and tv spots and longer programs, fliers, pamphlets, displays at shopping centers and grocery stores, and newspaper articles. Mental health is not hard to sell, even to those who traditionally resist the label and formal services, if it is couched in terms that can be easily understood and applied to daily life and that show that everybody has a part to play. A positive, self-help approach, rather than a sickness-focused, psychiatry-centered one, seems tailor-made for communities and people who value self reliance.

A program of this scope does not spring up full blown. Leadership is required to win community support, to share joint planning with other agencies, to share decision making with other disciplines, and to work toward inter-agency participation in the implementation of the consultation and education strategy. In disaster, leadership tends to be emergent, often falling to whomever is willing to assume it. The result of the mental health profession taking an active role in coordinating a program designed to spread mental health knowledge and skills throughout the community is increased visibility of the whole field, which can have positive ramifications long after recovery.

The assumption of a leadership role, however, requires an increased sensitivity to the needs of those led. In any community, particularly a close-knit one, the rise of one segment, such as the mental health profession, into a position of relative power or centrality can result in conflict and/or ineffectiveness without the guidance of an operating philosophy that is truly community oriented.

Eisdorfer, Altrocchi and Young (1968), in years of experience with establishing consultation and education programs in rural communities, have elucidated certain principles that seem highly operative. Certain of these have relevance to the post-disaster context.

- The support of community leaders is crucial for the development of a mental health program. While a key individual may play the central role in starting a program, he must depend upon the support of other community figures for long-range development.
- An accurate appraisal of community needs, supported by data, is extremely helpful in approaching community agencies, especially those with fiscal responsibilities.
- Flexibility in meeting needs is extremely important. Although a consultation and education program needs protection against inundation by clinical services, it should, nevertheless, be recognized that in selected instances, direct clinical intervention may be very valuable to program development.
- A new consultation and education program will increase the community's awareness of mental health problems, and the demand for clinical services will rise. Plans should be made for meeting such demands.
- In dealing with different professionals, it should be understood that each profession has its own ways of doing things, and such patterns should be respected.
- Existence over time is most helpful for consultation and education. Offering aid a little at a time over a year is far more effective than an intensive effort lasting a few weeks.
- One of the foremost functions of consultation and education is to help the community recognize widespread mental health problems and assist the proper agents in the community in dealing with them.
- The most appropriate attitude of consultants, especially those from outside the community, is one of eagerness to learn from the community.

5. Maintain the Existing Care-giving System

Although we have been primarily concerned here with developing new strategies for meeting disaster-related mental health needs, we in no way mean to imply that the existing care-giving system is unimportant or should be neglected. We are emphatic about the notion that a disaster service delivery system is not an entity that will replace the existing system, but is rather one to be built into and integrally linked with what has gone before. Those care-givers who have long been active in the community can be an invaluable source of support in terms of manpower and administrative structure, and can lend credibility and acceptance to disaster programs. They are, moreover, important in and of themselves.

Even in a major catastrophe, a significant number, perhaps a majority, of people will be either unaffected or only marginally affected. They will continue to need the services they have been accustomed to receiving. As the post-disaster period lengthens and disaster-related needs are met, some of those who have been victims will reassume status as normal agency consumers. In addition, it is highly likely that, as an outcome of receiving mental health services from disaster crisis workers, many previous victims who had not before been consumers of mental health services will be more aware of ongoing mental health needs and will, thus, increase the demand for such services.

One of the basic rationales for crisis intervention, used here in the generic rather than the technical sense, is that those who are given both practical and emotional support at a time when their own coping mechanisms are inadequate, can come through the crisis stronger than before---better able to handle whatever emergencies present themselves in the future. As this applies to individuals, it likewise applies to systems as a whole. If the existing care-giving system is linked with the disaster response effort and at the same time is given the necessary community support to keep its non-disaster services at a high level, it can emerge at the end of the recovery period more comprehensive and more effective than before. Such enhanced capabilities are important in relation to the final strategy to be considered.

6. Make All Necessary Arrangements for Phase-Out and Evaluation of the Work

As a part of the overall disaster recovery effort, the purpose of a disaster mental health program is to "work itself out of business." Funding, if it has been obtained, will run out at a specified time. Those programs mounted with local resources have more flexibility as to termination date, but eventually it will become apparent that disaster-related needs have largely been satisfied, and the program itself will have reached a point of diminishing returns. The primary object of the phase-out period is continuity of care for those whose needs are still manifest. Here is where a strong, on-going care-giving system becomes essential, since services to these people will have to be absorbed by local community resources. This process will be facilitated

if victims recognized as having need for long-term care are referred to other agencies as early as possible. In the case of people who are having an unusually difficult time resolving disaster-related problems, there should be discussions with and referrals to the appropriate ongoing organizations.

Finally, communities which have received state or federal funds for disaster mental health programs are required to submit a final evaluation to their funding sources. Even where a final report is not mandatory, a program will benefit tremendously by virtue of ongoing evaluation, conducted in conjunction with needs assessment. Program planners need to assess the strengths and weaknesses, the accomplishments and failures of their programs in order to upgrade ongoing services. Once this has been done, they should consider disseminating their experiences and program assessments by means of seminars, conferences, media reports, or published articles. Experiences and recommendations shared in this fashion would be of positive value to other communities which may suffer a disaster, as well as to the whole field of disaster research.

Throughout the foregoing chapter, we have attempted to provide those interested in planning for and delivering emergency mental health services in disasters with a series of practical, detailed suggestions for developing programs suitable for use at the local level. In addition to attempting to convey a sense of what it is like to try to conduct mental health work in the turbulent physical and social environment of the post-disaster setting, we have sought to make a number of points that should probably be briefly reiterated. In general, these are some of the more important ideas expressed in this very important chapter on strategies for disaster mental health programs.

1. It is possible to organize an efficient and effective mental health-oriented response to disaster even in areas which are relatively lacking in resources. In order to do this, however, pre-planning is necessary. Sources of information and expertise exist to help with this planning.
2. Planning for the delivery of counseling services in disasters, as well as for the actual provision of services, is, in the last analysis, a local responsibility. Nevertheless, the states bear a large share of the responsibility for stimulating, coordinating and assisting local communities in developing mental health disaster plans.
3. In the event of a community-wide disaster, logistic and financial assistance is available from federal sources and, in many cases, from the state level, explicitly designated for use in the provision of counseling and other needed services to disaster victims.
4. Individuals who have experienced disaster impact are, in the main, normal, healthy individuals who may be experiencing an unprecedented

degree of stress. The therapeutic stance that should be taken toward most victims, at least in the short run, is one that offers counseling and broad human services that de-emphasize the intensive psychotherapeutic and treatment aspects of mental health care.

5. Programs work best that deliver services "where the client is."

This is the case both with reference to the client's physical location (in a hospital, in a shelter, at a work-site) and to client's wants and needs.

6. In the event that an expanded mental health program is judged to be necessary, the use of volunteers and para-professionals is highly appropriate in the post-disaster situation, particularly in such important areas as outreach and information and referral. Those organizing a post-disaster mental health program should recruit volunteers from among traditional, informal community care-givers.
7. Needs assessment is an integral part of the delivery of disaster-related mental health services at all phases of operation.
8. In order to insure continuity of care for all community members requiring mental health services, it is important to a) maintain pre-disaster levels of service for clients already receiving mental health services; and b) work throughout the period with the regular agencies to arrange for the phasing out of special disaster mental health programs at the end of the post-disaster period.

APPENDIX I

TITLE IV—FEDERAL DISASTER ASSISTANCE
PROGRAMS

FEDERAL FACILITIES

- 42 USC 5171. SEC. 401. (a) The President may authorize any Federal agency to repair, reconstruct, restore, or replace any facility owned by the United States and under the jurisdiction of such agency which is damaged or destroyed by any major disaster if he determines that such repair, reconstruction, restoration, or replacement is of such importance and urgency that it cannot reasonably be deferred pending the enactment of specific authorizing legislation or the making of an appropriation for such purposes, or the obtaining of congressional committee approval.
- (b) In order to carry out the provisions of this section, such repair, reconstruction, restoration, or replacement may be begun notwithstanding a lack or an insufficiency of funds appropriated for such purpose, where such lack or insufficiency can be remedied by the transfer, in accordance with law, of funds appropriated to that agency for another purpose.
- (c) In implementing this section, Federal agencies shall evaluate the natural hazards to which these facilities are exposed and shall take appropriate action to mitigate such hazards, including safe land-use and construction practices, in accordance with standards prescribed by the President.

REPAIR AND RESTORATION OF DAMAGED FACILITIES

- 42 USC 5172. SEC. 402. (a) The President is authorized to make contributions to State or local governments to help repair, restore, reconstruct, or replace public facilities belonging to such State or local governments which were damaged or destroyed by a major disaster.
- (b) The President is also authorized to make grants to help repair, restore, reconstruct, or replace private nonprofit educational, utility, emergency, medical, and custodial care facilities, including those for the aged or disabled, and facilities on Indian reservations as defined by the President, which were damaged or destroyed by a major disaster.
- (c) For those facilities eligible under this section which were in the process of construction when damaged or destroyed by a major disaster, the grant shall be based on the net costs of restoring such facilities substantially to their predisaster condition.
- "Public facility."
Limitation. (d) For the purposes of this section, "public facility" includes any publicly owned flood control, navigation, irrigation, reclamation, public power, sewage treatment and collection, water supply and distribution, watershed development, or airport facility, any non-Federal-aid street, road, or highway, any other public building, structure, or system including those used for educational or recreational purposes, and any park.
- (e) The Federal contribution for grants made under this section shall not exceed 100 per centum of the net cost of repairing, restoring, reconstructing, or replacing any such facility on the basis of the

May 22, 1974

- 11 -

Pub. Law 93-288

88 STAT. 154

design of such facility as it existed immediately prior to such disaster and in conformity with current applicable codes, specifications, and standards.

(f) In those cases where a State or local government determines that public welfare would not be best served by repairing, restoring, reconstructing, or replacing particular public facilities owned or controlled by that State or that local government which have been damaged or destroyed in a major disaster, it may elect to receive, in lieu of the contribution described in subsection (e) of this section, a contribution based on 90 per centum of the Federal estimate of the total cost of repairing, restoring, reconstructing, or replacing all damaged facilities owned by it within its jurisdiction. The cost of repairing, restoring, reconstructing, or replacing damaged or destroyed public facilities shall be estimated on the basis of the design of each such facility as it existed immediately prior to such disaster and in conformity with current applicable codes, specifications and standards. Funds contributed under this subsection may be expended either to repair or restore certain selected damaged public facilities or to construct new public facilities which the State or local government determines to be necessary to meet its needs for governmental services and functions in the disaster-affected area.

DEBRIS REMOVAL

SEC. 403. (a) The President, whenever he determines it to be in the public interest, is authorized— 42 USC 5173.

(1) through the use of Federal departments, agencies, and instrumentalities, to clear debris and wreckage resulting from a major disaster from publicly and privately owned lands and waters; and

(2) to make grants to any State or local government for the purpose of removing debris or wreckage resulting from a major disaster from publicly or privately owned lands and waters.

(b) No authority under this section shall be exercised unless the affected State or local government shall first arrange an unconditional authorization for removal of such debris or wreckage from public and private property, and, in the case of removal of debris or wreckage from private property, shall first agree to indemnify the Federal Government against any claim arising from such removal.

TEMPORARY HOUSING ASSISTANCE

SEC. 404. (a) The President is authorized to provide, either by purchase or lease, temporary housing, including, but not limited to, unoccupied habitable dwellings, suitable rental housing, mobile homes or other readily fabricated dwellings for those who, as a result of a major disaster, require temporary housing. During the first twelve months of occupancy no rentals shall be established for any such accommodations, and thereafter rentals shall be established, based upon fair market value of the accommodations being furnished, adjusted to take into consideration the financial ability of the occupant. Any mobile home or readily fabricated dwelling shall be placed on a site complete with utilities provided either by the State or local government, or by the owner or occupant of the site who was displaced by the major disaster, without charge to the United States. The President may authorize installation of essential utilities at Federal expense and he may elect to provide other more economical or accessible sites when he determines such action to be in the public interest. 42 USC 5174.

88 STAT. 155

(b) The President is authorized to provide assistance on a temporary basis in the form of mortgage or rental payments to or on behalf of individuals and families who, as a result of financial hardship caused by a major disaster, have received written notice of dispossession or eviction from a residence by reason of foreclosure of any mortgage or lien, cancellation of any contract of sale, or termination of any lease, entered into prior to such disaster. Such assistance shall be provided for a period of not to exceed one year or for the duration of the period of financial hardship, whichever is the lesser.

(c) In lieu of providing other types of temporary housing after a major disaster, the President is authorized to make expenditures for the purpose of repairing or restoring to a habitable condition owner-occupied private residential structures made uninhabitable by a major disaster which are capable of being restored quickly to a habitable condition with minimal repairs. No assistance provided under this section may be used for major reconstruction or rehabilitation of damaged property.

(d) (1) Notwithstanding any other provision of law, any temporary housing acquired by purchase may be sold directly to individuals and families who are occupants of temporary housing at prices that are fair and equitable, as determined by the President.

Nondiscrimi-
nation.

(2) The President may sell or otherwise make available temporary housing units directly to States, other governmental entities, and voluntary organizations. The President shall impose as a condition of transfer under this paragraph a covenant to comply with the provisions of section 311 of this Act requiring nondiscrimination in occupancy of such temporary housing units. Such disposition shall be limited to units purchased under the provisions of subsection (a) of this section and to the purposes of providing temporary housing for disaster victims in emergencies or in major disasters.

PROTECTION OF ENVIRONMENT

42 USC 5175.

Sec. 405. No action taken or assistance provided pursuant to sections 305, 306, or 403 of this Act, or any assistance provided pursuant to section 402 or 419 of this Act that has the effect of restoring facilities substantially as they existed prior to the disaster, shall be deemed a major Federal action significantly affecting the quality of the human environment within the meaning of the National Environmental Policy Act of 1969 (83 Stat. 852). Nothing in this section shall alter or affect the applicability of the National Environmental Policy Act of 1969 (83 Stat. 852) to other Federal actions taken under this Act or under any other provision of law.

43 USC 4321
note.

MINIMUM STANDARDS FOR PUBLIC AND PRIVATE STRUCTURES

42 USC 5176.

Sec. 406. As a condition of any disaster loan or grant made under the provisions of this Act, the recipient shall agree that any repair or construction to be financed therewith shall be in accordance with applicable standards of safety, decency, and sanitation and in conformity with applicable codes, specifications, and standards, and shall furnish such evidence of compliance with this section as may be required by regulation. As a further condition of any loan or grant made under the provisions of this Act, the State or local government shall agree that the natural hazards in the areas in which the proceeds of the grants or loans are to be used shall be evaluated and appropriate action shall be taken to mitigate such hazards, including safe land-use and construction practices, in accordance with standards prescribed or

Natural ha-
zards, eval-
uation.

May 22, 1974

- 13 -

Pub. Law 93-288

88 STAT. 156

approved by the President after adequate consultation with the appropriate elected officials of general purpose local governments, and the State shall furnish such evidence of compliance with this section as may be required by regulation.

UNEMPLOYMENT ASSISTANCE

SEC. 407. (a) The President is authorized to provide to any individual unemployed as a result of a major disaster such benefit assistance as he deems appropriate while such individual is unemployed. Such assistance as the President shall provide shall be available to an individual as long as the individual's unemployment caused by the major disaster continues or until the individual is reemployed in a suitable position, but no longer than one year after the major disaster is declared. Such assistance for a week of unemployment shall not exceed the maximum weekly amount authorized under the unemployment compensation law of the State in which the disaster occurred, and the amount of assistance under this section to any such individual for a week of unemployment shall be reduced by any amount of unemployment compensation or of private income protection insurance compensation available to such individual for such week of unemployment. The President is directed to provide such assistance through agreements with States which, in his judgment, have an adequate system for administering such assistance through existing State agencies.

42 USC 5177.

Time limitation.

(b) The President is further authorized for the purposes of this Act to provide reemployment assistance services under other laws to individuals who are unemployed as a result of a major disaster.

Agreement with State agencies.

Reemployment assistance services.

INDIVIDUAL AND FAMILY GRANT PROGRAMS

SEC. 408. (a) The President is authorized to make a grant to a State for the purpose of such State making grants to meet disaster-related necessary expenses or serious needs of individuals or families adversely affected by a major disaster in those cases where such individuals or families are unable to meet such expenses or needs through assistance under other provisions of this Act, or from other means. The Governor of a State shall administer the grant program authorized by this section.

42 USC 5178.

(b) The Federal share of a grant to an individual or a family under this section shall be equal to 75 per centum of the actual cost of meeting such an expense or need and shall be made only on condition that the remaining 25 per centum of such cost is paid to such individual or family from funds made available by a State. Where a State is unable immediately to pay its share, the President is authorized to advance to such State such 25 per centum share, and any such advance is to be repaid to the United States when such State is able to do so. No individual and no family shall receive any grant or grants under this section aggregating more than \$5,000 with respect to any one major disaster.

Federal share.

Advances.

Limitation.

(c) The President shall promulgate regulations to carry out this section and such regulations shall include national criteria, standards, and procedures for the determination of eligibility for grants and the administration of grants made under this section.

Regulations.

(d) A State may expend not to exceed 3 per centum of any grant made by the President to it under subsection (a) of this section for expenses of administering grants to individuals and families under this section.

Administration expenses, limitation.

(e) This section shall take effect as of April 20, 1973.

Effective date.

88 STAT. 157

Pub. Law 93-288

- 14 -

May 22, 1974

FOOD COUPONS AND DISTRIBUTION

- 42 USC 5179. SEC. 409. (a) Whenever the President determines that, as a result of a major disaster, low-income households are unable to purchase adequate amounts of nutritious food, he is authorized, under such terms and conditions as he may prescribe, to distribute through the Secretary of Agriculture or other appropriate agencies coupon allotments to such households pursuant to the provisions of the Food Stamp Act of 1964 (P.L. 91-671; 84 Stat. 2048) and to make surplus commodities available pursuant to the provisions of this Act.
- 78 Stat. 703.
7 USC 2011
note. (b) The President, through the Secretary of Agriculture or other appropriate agencies, is authorized to continue to make such coupon allotments and surplus commodities available to such households for so long as he determines necessary, taking into consideration such factors as he deems appropriate, including the consequences of the major disaster on the earning power of the households, to which assistance is made available under this section.
- (c) Nothing in this section shall be construed as amending or otherwise changing the provisions of the Food Stamp Act of 1964 except as they relate to the availability of food stamps in an area affected by a major disaster.

FOOD COMMODITIES

- Emergency mass
feeding.
42 USC 5180. SEC. 410. (a) The President is authorized and directed to assure that adequate stocks of food will be ready and conveniently available for emergency mass feeding or distribution in any area of the United States which suffers a major disaster or emergency.
- 49 Stat. 774. (b) The Secretary of Agriculture shall utilize funds appropriated under section 32 of the Act of August 24, 1935 (7 U.S.C. 612c), to purchase food commodities necessary to provide adequate supplies for use in any area of the United States in the event of a major disaster or emergency in such area.

RELOCATION ASSISTANCE

- 42 USC 5181. SEC. 411. Notwithstanding any other provision of law, no person otherwise eligible for any kind of replacement housing payment under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) shall be denied such eligibility as a result of his being unable, because of a major disaster as determined by the President, to meet the occupancy requirements set by such Act.
- 84 Stat. 1894.
42 USC 4601
note.

LEGAL SERVICES

- 42 USC 5182. SEC. 412. Whenever the President determines that low-income individuals are unable to secure legal services adequate to meet their needs as a consequence of a major disaster, consistent with the goals of the programs authorized by this Act, the President shall assure that such programs are conducted with the advice and assistance of appropriate Federal agencies and State and local bar associations.

CRISIS COUNSELING ASSISTANCE AND TRAINING

- 42 USC 5183. SEC. 413. The President is authorized (through the National Institute of Mental Health) to provide professional counseling services, including financial assistance to State or local agencies or private mental health organizations to provide such services or training of disaster workers, to victims of major disasters in order to relieve mental health problems caused or aggravated by such major disaster or its aftermath.

May 22, 1974

- 15 -

Pub. Law 93-288

88 STAT. 158

COMMUNITY DISASTER LOANS

SEC. 414. (a) The President is authorized to make loans to any local government which may suffer a substantial loss of tax and other revenues as a result of a major disaster, and has demonstrated a need for financial assistance in order to perform its governmental functions. The amount of any such loan shall be based on need, and shall not exceed 25 per centum of the annual operating budget of that local government for the fiscal year in which the major disaster occurs. Repayment of all or any part of such loan to the extent that revenues of the local government during the three full fiscal year period following the major disaster are insufficient to meet the operating budget of the local government, including additional disaster-related expenses of a municipal operation character shall be cancelled.

Loans to local governments.
42 USC 5184.

Repayment.

(b) Any loans made under this section shall not reduce or otherwise affect any grants or other assistance under this Act.

(c) (1) Subtitle C of title I of the State and Local Fiscal Assistance Act of 1972 (P.L. 92-512; 86 Stat. 919) is amended by adding at the end thereof the following new section:

31 USC 1261
and note.

"SEC. 145. ENTITLEMENT FACTORS AFFECTED BY MAJOR DISASTERS.

"In the administration of this title the Secretary shall disregard any change in data used in determining the entitlement of a State government or a unit of local government for a period of 60 months if that change—

"(1) results from a major disaster determined by the President under section 301 of the Disaster Relief Act of 1974, and

"(2) reduces the amount of the entitlement of that State government or unit of local government."

(2) The amendment made by this section takes effect on April 1, 1974. Effective date.

EMERGENCY COMMUNICATIONS

SEC. 415. The President is authorized during, or in anticipation of, an emergency or major disaster to establish temporary communications systems and to make such communications available to State and local government officials and other persons as he deems appropriate.

42 USC 5185.

EMERGENCY PUBLIC TRANSPORTATION

SEC. 416. The President is authorized to provide temporary public transportation service in an area affected by a major disaster to meet emergency needs and to provide transportation to governmental offices, supply centers, stores, post offices, schools, major employment centers, and such other places as may be necessary in order to enable the community to resume its normal pattern of life as soon as possible.

42 USC 5186.

FIRE SUPPRESSION GRANTS

SEC. 417. The President is authorized to provide assistance, including grants, equipment, supplies, and personnel, to any State for the suppression of any fire on publicly or privately owned forest or grassland which threatens such destruction as would constitute a major disaster.

42 USC 5187.

TIMBER SALE CONTRACTS

SEC. 418. (a) Where an existing timber sale contract between the Secretary of Agriculture or the Secretary of the Interior and a timber

Cost-sharing.
42 USC 5188.

purchaser does not provide relief from major physical change not due to negligence of the purchaser prior to approval of construction of any section of specified road or of any other specified development facility and, as a result of a major disaster, a major physical change results in additional construction work in connection with such road or facility by such purchaser with an estimated cost, as determined by the appropriate Secretary, (1) of more than \$1,000 for sales under one million board feet, (2) of more than \$1 per thousand board feet for sales of one to three million board feet, or (3) of more than \$3,000 for sales over three million board feet, such increased construction cost shall be borne by the United States.

Contract cancellation.

(b) If the appropriate Secretary determines that damages are so great that restoration, reconstruction, or construction is not practical under the cost-sharing arrangement authorized by subsection (a) of this section, he may allow cancellation of a contract entered into by his Department notwithstanding contrary provisions therein.

Sale of timber, notices,
30 Stat. 35.

(c) The Secretary of Agriculture is authorized to reduce to seven days the minimum period of advance public notice required by the first section of the Act of June 4, 1897 (16 U.S.C. 476), in connection with the sale of timber from national forests, whenever the Secretary determines that (1) the sale of such timber will assist in the construction of any area of a State damaged by a major disaster, (2) the sale of such timber will assist in sustaining the economy of such area, or (3) the sale of such timber is necessary to salvage the value of timber damaged in such major disaster or to protect undamaged timber.

(d) The President, when he determines it to be in the public interest, is authorized to make grants to any State or local government for the purpose of removing from privately owned lands timber damaged as a result of a major disaster, and such State or local government is authorized upon application, to make payments out of such grants to any person for reimbursement of expenses actually incurred by such person in the removal of the damaged timber, not to exceed the amount that such expenses exceed the salvage value of such timber.

IN-LIEU CONTRIBUTION

42 USC 5189.

Sec. 419. In any case in which the Federal estimate of the total cost of (1) repairing, restoring, reconstructing, or replacing, under section 402, all damaged or destroyed public facilities owned by a State or local government within its jurisdiction, and (2) emergency assistance under section 306 and debris removed under section 403, is less than \$25,000, then on application of a State or local government, the President is authorized to make a contribution to such State or local government under the provisions of this section in lieu of any contribution to such State or local government under section 306, 402, or 403. Such contribution shall be based on 100 per centum of such total estimated cost, which may be expended either to repair, restore, reconstruct, or replace all such damaged or destroyed public facilities, to repair, restore, reconstruct, or replace certain selected damaged or destroyed public facilities, to construct new public facilities which the State or local government determines to be necessary to meet its needs for governmental services and functions in the disaster-affected area, or to undertake disaster work as authorized in section 306 or 403. The cost of repairing, restoring, reconstructing, or replacing damaged or destroyed public facilities shall be estimated on the basis of the design of each such facility as it existed immediately prior to such disaster and in conformity with current applicable codes, specifications and standards.

APPENDIX II

Rules and regulations for implementation of Section 413 of the Disaster Relief Act of 1974, as taken from the Federal Register, Vol. 41, no. 229, November 26, 1976.

Title 42--Public Health

Chapter 1 -- Public Health Service, Department of Health, Education, and Welfare

Part 38 -- Disaster Assistance for Crisis Counseling and Training

On April 16, 1976, there was published in the Federal Register (41 FR 16169) a notice of proposed rulemaking setting forth procedures to implement section 413 of Pub. L. 93-288, the Disaster Relief Act of 1974 (42 U.S.C. 5183), which authorizes the President, through the National Institute of Mental Health, "to provide professional counseling services, including financial assistance to States or local agencies or private mental health organizations to provide such services or training of disaster workers, to victims of major disasters in order to alleviate mental health problems caused or aggravated by major disasters or their aftermath."

On July 11, 1974, the President delegated his authority under Section 413 and other provisions of the Disaster Relief Act of 1974 to the Secretary of Housing and Urban Development (Executive Order No. 11795, 39 FR 25939, as amended by Executive Order No. 11910, 41 FR 15681). The authority to promulgate regulations for the implementation of Section 413 of Pub. L. 93-288 was delegated to the Secretary of Health, Education, and Welfare by the Secretary of Housing and Urban Development on March 7, 1975 (40 FR 10705). The citation of authority in the regulations has been amended to include these delegations.

In addition, 38.3(d) has been amended to clarify that the recommendation of the Secretary of Health, Education, and Welfare is a prerequisite to an extension of the 180 day time limitation on grants and contracts by either the Regional Director or the Administrator.

As set forth in 38.1(b), the activities to be carried out under the regulations are subject to all applicable provisions of the Disaster Relief Act of 1974 and the implementing regulations, 24 CFR Part 2205, promulgated by the Administrator of the Federal Disaster Assistance Administration and are subject to the general policy guidance and coordination of the Administrator. The regulations do not change the existing Federal Disaster Assistance Administration (FDAA) and Department of Health, Education, and Welfare (HEW) policies which provide for the involvement and assistance of FDAA and HEW regional health officers in the implementation of the crisis counseling and training program.

Ten responses were received within the thirty day period following publication of the notice of proposed rulemaking in the Federal Register. All comments with respect to the proposed revision were given due consideration. Six of the respondents suggested an extension of the program to encompass pre-disaster or pre-crisis training; one asked that public notices be provided by way of newspaper advertisements to alert communities to available services; one emphasized the need for program accountability, requesting the State agencies be designated to conduct ongoing monitoring of programs; one suggested that

training take place through mental health programs in the community to meet local needs and provide continuity of care; and another stated complete support for the program. These comments have not required any changes in the proposed rules for the reasons set forth below.

1. With respect to pre-crisis training, it has been determined that priority must be given to the adequate operation of essential disaster and post-disaster programs. If experience indicates that available funds exceed the needs of these programs, this determination will be reconsidered.

2. Contained within some of the comments which stressed the need for pre-crisis training were statements regarding the engagement of experienced professionals and the use of universities to provide a continuing base of qualified counsellors. The regulations do encompass the utilization of such skills. Public agencies and private mental health organizations which receive assistance under the regulations for the provision of the professional mental health counseling services or mental health training of disaster workers needed as a result of a major disaster may enlist and employ experienced community and university professionals to supplement their staff as necessary to meet the needs resulting from the major disaster.

3. Similarly, the substance of the comment suggesting the use of local mental health programs for training and service delivery is already incorporated within the terms of 38.4(b) and 38.5(c) of the regulations. It is a long-standing policy of the Federal Disaster Assistance Administration (FDAA) that preference be given to the extent feasible and practicable to the use of local agencies and organizations in providing disaster relief, including the provision of training and service delivery.

4. With regard to the comment about public notices, the Department of Health, Education, and Welfare will follow the policy of the Federal Disaster Assistance Administration by using paid advertising as needed for disaster situations, while reserving the right to determine its frequency. The need for paid advertising varies according to the type of disaster, geographic area, duration, and cultural population; thus, it has been determined not to promulgate a specific regulation on this point.

5. With respect to the suggestion for State supervision, adequate provision for program accountability is made by the regulations. See in particular 38.4, 38.5, and 38.9.

Characteristically, this program involves the expenditure of relatively small amounts of money over short time periods. It does not involve the additional employment of large numbers of persons for its implementation.

Accordingly, with the addition of the foregoing minor technical and clarifying changes, the regulations proposing to amend Subchapter C, Chapter I of Title 42 Code of Federal Regulations by adding a new Part 38 are hereby adopted and are set forth below.

Effective date. This amendment becomes effective on November 26, 1976.

If is hereby certified that this proposal has been screened pursuant to Executive Order No. 11821, and does not require an inflation impact evaluation.

Dated: October 6, 1976.

James F. Dickson,
Acting Assistant Secretary
for Health.

Approved: November 12, 1976.

Majorie Lynch,
Acting Secretary.

Sec.

- 38.1 Purpose; coordination.
- 38.2 Definitions.
- 38.3 Assistance; procedures, limitations.
- 38.4 Contracts.
- 38.5 Grant assistance.
- 38.6 Nondiscrimination.
- 38.7 Nonliability.
- 38.8 Criminal and civil penalties.
- 38.9 Federal audits.

Authority: Sec. 413, Pub. L. 93-288. The Disaster Relief Act of 1974, 88 Stat. 157, 42 U.S.C. 5183, EO 11795, 39 FR 25939, as amended by EO 11910, 41 FR 15681.

38.1 Purpose; coordination.

(a) Purpose. This part establishes standards and procedures for the implementation of Section 413 of Pub. L. 93-288, the Disaster Relief Act of 1974 (42 U.S.C. 5183) which authorizes the provision, either directly or through financial assistance to State or local agencies or private mental health organizations, of:

(1) Professional counseling services to victims of a major disaster in order to relieve mental health problems caused or aggravated by such a major disaster or its aftermath; and

(2) Training of disaster workers to provide or assist in providing those professional counseling services.

(b) Coordination. The Secretary, acting through the National Institute of Mental Health, will, as provided in 24 CFR 2205.51, carry out Section 413 of the Act and this part in coordination with, and under the general policy guidance of the Administrator of the Federal Disaster Assistance Administration. Contracts and grants awarded under this part are subject to all applicable provisions of the Act and the implementing regulations promulgated by the Administrator (24 CFR Part 2205).

38.2 Definitions.

All terms not defined herein shall have the same meaning as given them in the Act. As used in this part:

(a) "Act" means the Disaster Relief Act of 1974 (42 U.S.C. 5121 et seq.).

(b) "Administrator" means the Administrator, Federal Disaster Assistance Administration (FDAA), Department of Housing and Urban Development, and any other person to whom he delegates the authority.

(c) "Contractor" means any public agency or private mental health organization which, pursuant to this part, contracts with the Secretary to provide professional mental health crisis counseling services or to provide mental health training for disaster workers.

(d) "Crisis" means the existence of any life situation resulting from a major disaster or its aftermath which so effects the emotional and mental equilibrium of a disaster victim that professional mental health counseling services should be provided to help preclude possible damaging physical or psychological effects.

(e) "Disaster workers" means mental health specialists such as psychiatrists, psychologists, psychiatric nurses, social workers, or qualified agents thereof.

(f) "Federal Coordinating Officer" means the person appointed by the Administrator to coordinate Federal assistance in a major disaster.

(g) "Governor" means the chief executive of a State.

(h) "Grantee" means any public agency or private nonprofit mental health organization which, pursuant to this part, is awarded a grant for the purpose of providing professional mental health crisis counseling services or mental health training for disaster workers.

(i) "Major disaster" means any hurricane, tornado, storm, flood, high-water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, drought, fire, explosion, or other catastrophe in any part of the United States which, in the determination of the President, causes damage of sufficient severity and magnitude to warrant major disaster assistance under the Act above and beyond emergency services by the Federal Government, to supplement the efforts and available resources of the States, local governments, and disaster relief organizations, in alleviating the damage, loss, hardship, or suffering caused thereby.

(j) "Regional Director" means a director of a regional office of the Federal Disaster Assistance Administration (FDAA).

(k) "Secretary" means the Secretary of Health, Education, and Welfare and any other officer or employee of the Department of Health, Education, and Welfare to whom the authority involved has been delegated.

(l) "State" means any of the fifty States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Canal Zone, or the Trust Territory of the Pacific Islands.

(m) "State Coordinating Officer" means the person appointed by the Governor to act in cooperation with the appointed Federal Coordinating Officer.

(n) "Training" means the specific instruction which may be required to enable disaster workers to provide professional mental health crisis counseling to victims of a major disaster or its aftermath.

38.3 Assistance; procedures, limitations.

(a) Application. In order to obtain assistance under this part, the Governor or his State Coordinating Officer must, not later than 60 days following a major disaster declaration by the President, file with the appropriate Regional Director a request which includes:

(1) An estimate of the number of disaster victims who may need professional mental health crisis counseling services and of the number of disaster workers who may need training in the provision of such services;

(2) Identification of the geographical areas in which the need exists;

(3) An estimate of the period during which assistance under this part will be required and of the total funds which will be required to provide such assistance;

(4) A description of the types of mental health problems caused or aggravated by the major disaster or its aftermath; and

(5) Identification of the State and local agencies and private mental health organizations capable of providing professional mental health crisis counseling to disaster victims or training of disaster workers.

(b) Review, approval. The Secretary, upon notification by the Administrator of a State request for assistance under this part, will conduct a review to determine the extent to which such assistance is needed to

supplement assistance programs provided by State and local governments and private organizations and, on the basis of that review, prepare and submit a recommendation and report for consideration by the Administrator. Upon approval by the Administrator and his advancement of funds for carrying out the approved assistance, the Secretary may, within the limits of the funds advanced, provide the approved services either directly or through a grant or contract.

(c) Eligibility for services. (1) In order to be eligible for the professional mental health crisis counseling services available under this part an individual must:

(i) Have been located within the designated major disaster area or have been a resident of such area at the time of the major disaster or its aftermath; and

(ii) Have a mental health problem which was caused or aggravated by the major disaster or its aftermath.

(2) Disaster workers who are available on short notice to provide professional mental health crisis counseling services in a major disaster area are eligible for training under this part.

(d) Time Limitation. Contracts and grants awarded under this part will not continue beyond 180 days after the first day services are provided pursuant to such contracts and grants, except that upon the recommendation of the Secretary (1) the Regional Director may extend the 180 day period for up to 30 days or (2) the Administrator may extend the 180 day period for more than 30 days.

38.4 Contracts

(a) Eligibility. Public agencies and private mental health organizations which are determined by the Secretary to be capable of providing the professional mental health crisis counseling services or mental health training of disaster workers needed as a result of a major disaster are eligible for the award of a contract under this part.

(b) Use of local agencies. Preference will be given to the extent feasible and practicable, to those agencies and organizations which are located or do business primarily in the area affected by the major disaster.

(c) General Requirements. Contracts under this part shall be entered into and carried out in accordance with the provisions of Chapters 1 and 3 of Title 41 of the Code of Federal Regulations and all other applicable laws and regulations.

(d) Payments. The Secretary shall from time to time make payments to the contractor of all or a portion of the contract award, either by way of reimbursement for expenses incurred or in advance for expenses to be incurred, to the extent he determines such payments are necessary to promote prompt initiation and advancement of the services to be provided under the contract. All payments not expended by the contractor within the period of the contract shall be returned to the Secretary.

(e) Reports. Contractors shall submit the following reports to the Secretary:

(1) Progress reports, to be submitted at the end of the first 30 days of the contract period and every 30 days thereafter;

(2) A final report to be submitted within 60 days of the date upon which the contract terminates; and

(3) Such additional reports as the Secretary may prescribe including those which may be required to enable the Federal Coordinating Officer to carry out his functions.

38.5 Grant Assistance

(a) Eligibility. Public agencies and private nonprofit mental health organizations which are determined by the Secretary to be capable of providing the professional mental health crisis counseling services or mental health training of disaster workers needed as a result of a major disaster are eligible for a grant award under this part.

(b) Application.

(1) In order to receive a grant award under this part an eligible entity must submit an application in such form and at such time as the Secretary may prescribe.

(2) The application shall be executed by an individual authorized to act for the applicant and to assume on behalf of the applicant the obligations imposed by the Act, the regulations of this part, and the terms and conditions of any grant award.

(3) The application shall contain:

(i) A proposed plan for the provision of the services for which grant assistance is requested;

(ii) A proposed budget for the expenditure of the requested grant funds; and

(iii) Such other pertinent information and assurances as the Secretary may require.

(c) Grant awards.

(1) Within the limits of the funds advanced by the Administrator, the Secretary may award grants to cover all or part of the cost of the project to those applicants whose projects will in his judgment best promote the purposes of section 413 of the Act and the regulations of this part. Preference will be given, to the extent feasible and practicable, to those public and private nonprofit agencies and organizations which are located or do business primarily in the area affected by the major disaster.

(2) A grant award under this part shall be in writing and shall specify the amount of the award, the period of support, and the approved budget for that period.

(3) A grant award shall not commit or obligate the United States in any way to make any additional, supplemental, continuation, or other grant award.

(4) Within the limits of the funds advanced by the Administrator, the amount of any grant award shall be determined by the Secretary on the basis of his estimate of the sum necessary to carry out the grant purpose.

(d) Applicability of 45 CFR Part 74.

(1) The provisions of 45 CFR Part 74, establishing uniform administrative requirements and cost principles, shall apply to all grants under this part to State and local governments as those terms are defined in Subpart A of that Part 74. The relevant provisions of the following subparts of Part 74 shall also apply to grants to all other grantee organizations under this part;

45 CFR Part 74

Subpart

A -- General.

B -- Cash Depositories.

C -- Bonding and Insurance.

D -- Retention and Custodial Requirements for Records.

F -- Grant-Related Income.

- G -- Matching and Cost Sharing.
- K -- Grant Payment Requirements.
- L -- Budget Revision Procedures.
- M -- Grant Closeout, Suspension, and Termination.
- O -- Property.
- Q -- Cost Principles.

(2) Additional conditions. The Secretary may at the time of any grant award impose such conditions as in his judgment are necessary to assure or protect advancement of the supported activity, the interests of the public health, or the conservation of grant funds.

(e) Payment. The Secretary shall from time to time make payments to a grantee of all or a portion of any grant award, either in advance or by way of reimbursement for expenses incurred or to be incurred in accordance with the terms and conditions of the grant award.

(f) Grantee accountability. All payments made by the Secretary shall be recorded by the grantee in accounting records separate from the records of all other grant funds, including funds derived from other grant awards. With respect to each approved project the grantee shall account for the sum total of all amounts paid by presenting or otherwise making available to the Secretary, satisfactory evidence of expenditures for direct and indirect costs meeting the requirements of this part.

(g) Expenditure of grant funds.

(1) Any funds awarded pursuant to this part shall be expended solely for the purposes for which the funds were granted in accordance with the approved budget, the regulations of this part, the terms and conditions of the grant award, and the applicable cost principles prescribed by Subpart Q of 45 CFR Part 74.

(2) At the end of the period of support any unobligated grant funds remaining in the grant account must be refunded to the United States.

(h) Reports. Grantees shall submit the following reports to the Secretary:

(1) Quarterly progress reports, to be submitted within 30 days of the end of each quarterly period within the grant period;

(2) A final report to be submitted within 90 days of the date upon which the grant period ends; and

(3) Such additional reports as the Secretary may prescribe including those which may be required to enable the Federal Coordinating Officer to carry out his functions.

38.6 Nondiscrimination.

Attention is called to the requirements of 24 CFR 2205.13 relating to nondiscrimination on the grounds of race, religion, sex, color, age, economic status, or national origin in the provision of disaster assistance.

38.7 Nonliability.

Attention is called to section 308 of the Act (42 U.S.C. 5148) which provides that the Federal Government shall not be liable for any claim based upon the exercise or performance of or the failure to exercise or perform a discretionary function or duty on the part of a Federal agency or an employee of the Federal Government in carrying out the provisions of the Act.

38.8 Criminal and Civil Penalties.

Attention is called to section 317 of the Act (42 U.S.C. 5157) which provides:

(a) Any individual who fraudulently or willfully misstates any fact in connection with a request for assistance under this Act shall be fined not more than \$10,000 or imprisoned for not more than one year or both for each violation.

(b) Any individual who knowingly violates any order or regulation under this Act shall be subject to a civil penalty of not more than \$5,000 for each violation.

(c) Whoever knowingly misapplies the proceeds of a loan or other cash benefit obtained under any section of this Act shall be subject to a fine in an amount equal to one and one half times the original principal amount of the loan or cash benefit.

38.9 Federal Audits.

The Secretary, the Administrator, and the Comptroller General of the United States, or their duly authorized representatives shall have access to any books, documents, papers, and records that pertain to Federal funds, equipment, and supplies received under this part for the purpose of audit and examination.

Appendix III

Training Manual for Human Service Workers in Major Disasters

This manual was prepared by the Institute for the Studies of Destructive Behaviors and the Los Angeles Suicide Prevention Center, under contract No. 278-75-0018 (SM) from the National Institute of Mental Health.

It is accompanied by an audio-visual component containing 72 slides and an audio cassette.

The manual and slide presentation can be obtained from:

The Dept. of Health, Education & Welfare
Public Health Service
ADAMHA -
5600 Fishers Lane
Rockville, Md. 20852

TABLE OF CONTENTS

	<u>Page</u>
PRE FACE	i
SECTION I. INTRODUCTION	1
I. Background	1
II. Need for Intervention	2
III. Phases of Disaster	3
A. Heroic phase	
B. Honeymoon phase	
C. Disillusionment phase	
D. Reconstruction phase	
IV. Key Concepts	5
A. The target population is primarily normal	
B. Avoid mental health labels	
C. Be innovative in offering help	
D. Fit the program into the community	
V. Manual	7
A. When?	
B. Who?	
C. What?	
SECTION II. BEFORE THE TRAINING BEGINS	9
I. Community Acceptance	9
A. Gaining entry and sanction	
II. Initial Entry	10
A. Civic leaders	
B. Disaster intervention agencies	
III. Appraisal of the Community	12
A. Resources for human services	
B. Locations for observing the relief efforts	
C. Sources for selecting Trainers and Trainees	
D. Community organizations as recipients of human service support	

IV.	Selection of Personnel	14
	A. Director	
	B. Assistant director	
	C. Secretary	
	D. Trainers	
	E. Selecting Trainees	
V.	Establishment of Headquarters and Field Sites	18
	A. Headquarters	
VI.	Information and Rumor Control	20
VII.	Summary	21
SECTION III.	TRAINING THE TRAINERS	22
	Outline	22
I.	Preparation	23
	A. Selection of Trainers	
	B. Information	
	C. Insurance	
II.	Program	24
	A. First day	
	B. Second day	
	C. Debriefing	
SECTION IV.	TRAINING THE HUMAN SERVICE WORKERS	27
	Outline	27-28
I.	Introduction	29
	A. Suggested 5-day curriculum	
II.	Introduction of Training Program to Trainees	31
	A. Distribution of materials	
	B. Introduction of Staff and Trainees	
	C. Director opens program	
III.	Course Content	33
	A. Sharing of personal disaster experiences	
	B. Information on the status of the disaster	
	C. Background phases of disaster and accompanying behavior	
	D. Task concept--definition of the role of the Trainee	
	E. The helping process	
	F. Empathy	
	G. Problems of living	
	H. Help and seek-help behaviors	
	I. Types of mental health problems following disasters	
	J. Role playing	
	K. Tapping strengths in the individual and the community	
	L. Groups--therapy and community	
	M. Reports and debriefing	
	N. Governmental and non-governmental disaster relief agencies	
SECTION V.	SPECIAL RISK GROUPS	65
	Outline	65
I.	Introduction	66
	A. Common needs and reactions	
	B. Special needs groups	

II.	Age Groups	67
	A. Pre-school (1-5)	
	B. Early childhood (ages 5-11)	
	C. Preadolescent (ages 11-14)	
	D. Adolescent (ages 14-18)	
	E. Middle age	
	F. Older adults	
III.	Socio-economic Classes	78
IV.	Cultural and Racial Differences	78
V.	Institutionalized Persons	79
VI.	People in Emotional Crises	80
VII.	People Requiring Emergency Medical Care	81
VIII.	Human Services and Disaster Relief Workers	82
	A. Symptoms	
	B. Management	
SECTION VI.	SELF-AWARENESS SESSION	84
I.	Overview	84
II.	General Format	84
	A. Exploring motivations for helping	
	B. Helping self to help others	
	C. Exploring self	
	D. Where do we go from here?	
	E. Evaluations	
SECTION VII.	APPENDICES	
	Appendix	
	A. Health Service Worker Information Form	91
	B. Training Program Evaluation Form	92
	C. Client Information Form	94
	D. Examples of Disaster-Related Emotional Problems	95
	1. Depression	
	2. Grief	
	3. Anger	
	4. Guilt	
	5. Apathy	
	6. Fears	
	7. The "burn-out" syndrome	
	8. Bizarre behavior	
	9. Suicide	

Selected Annotated Bibliography

Introduction

This bibliography is designed to supply persons interested in the planning and delivery of disaster-related crisis intervention services with up-to-date, useful information on three general topics: individual and organizational behavior in disasters; identification and treatment of mental illness in small communities; and disaster mental health. It would be a monumental task to assemble and annotate all the material relating to these three topics. Thus, we were somewhat selective in our judgment of what works to include.

Section I, on human reactions in disaster, is intended to introduce the reader to some general works mainly of a social-scientific nature, on various types of individual and community responses to a variety of disaster agents.

Section II, "Recent Literature on Rural Mental Health and Selected Works in Community Mental Health and Crisis Intervention", contains references on current and recent research findings concerning the incidence of mental illness in rural areas and innovative rural mental health programs. Works having a more general scope are also included in this section, as are some widely recognized writings on crisis intervention practice.

In Section III, we attempt to be somewhat more comprehensive and include references for a large proportion of what has been written about mental health consequences of disasters, as well as for writings dealing with the delivery of mental health services to victims.

I. General Social-Scientific Writings on Disaster and Disaster Planning

Barton, Allen H. Communities in Disasters: A Sociological Analysis of Collective Stress Situations (Garden City, New York: Doubleday, Anchor Books). 1970.

A theoretical discussion and abstract summary of much of the disaster literature. Barton discusses individual behavior in emergencies, the coordination of organization behavior and the altruistic responses that develop in disasters. Some attention is also given to factors influencing long-run recovery.

Bates, F. L., et al. The Social and Psychological Consequences of a Natural Disaster (Washington, D. C.: National Academy of Sciences - National Research Council, Publication 1081). 1963.

This is a longitudinal study of Hurricane Audrey. Most of the description and analysis is about the rehabilitation and recovery activities after the disaster, and long-run social changes.

Chapman, Dwight (ed.), "Human Behavior in Disaster: A New Field of Social Research," Special issue, Journal of Social Issues 10, no. 3, 1954.

This collection of articles includes a description of the work of the Committee on Disaster Studies of the National Research Council and of the NORC Studies in disaster. Among the papers are "Problems of Theory in the Analysis of Stress Behavior" by Irving Janis and "Some Accomplishments and Some Needs in Disaster Study" by Lewis Killian.

- Drabek, Thomas E., "Social Processes in Disaster: Family Evacuation," Social Problems 16, no. 3 (Winter): 336-349. 1969.
A study of family response to disaster warnings. Analysis of interviews with families who were suddenly evacuated prior to a major flood revealed a series of distinct processes through which warning, confirmation, and evacuation occurred. Evacuation behavior followed four patterns: by default, by invitation, by compromise, and by decision.
- Dynes, Russell R., The Functioning of Expanding Organizations in Community Disasters, (Columbus: The Ohio State University, The Disaster Research Center Report Series No. 2). 1968.
Expanding organizations are those which have latent disaster responsibilities but must develop a new group structure to achieve them. Case studies are presented of three kinds of expanding organizations--Red Cross, Salvation Army, and local civil defense.
- Dynes, Russell R., Organized Behavior in Disaster, (Columbus: The Ohio State University, The Disaster Research Center Book and Monograph Series No. 3). 1973 new paperback printing.
This book focuses on a theoretical discussion of community organizations and their activities in meeting problems created by disaster. Dynes draws on the existing literature and the work of the Disaster Research Center. The different meanings of "disaster" and the social implications of various types of disaster agents are discussed, and four types of organized behavior are isolated.
- Dynes, Russell R., E. L. Quarantelli and Gary A. Kreps, A Perspective on Disaster Planning, (Columbus: The Ohio State University, The Disaster Research Center Report Series No. 11). 1972.
This report presents the characteristics of disaster agents and the kinds of demands they generate. A contrast is made between community activities in normal times and during emergencies. The basic elements involved in organized response of a community to disaster are set forth. The report concludes with a systematic discussion of disaster planning, including weaknesses in typical disaster plans and strategies for planning.
- Form, William H. and Sigmund Nosow, Community in Disaster, (New York: Harper). 1958.
An older study about the community response to a Michigan tornado. The major focus is on the rescue behavior by small groups after the disaster, and problems of organizations in mobilizing for the emergency. There is also a discussion on planning for disasters.
- Fritz, Charles E., "Disaster," Contemporary Social Problems, Merton and Nisbet, eds., (New York: Harcourt, Brace & World, Inc.). 1961.
A classic apologia for the study of disasters, including the issues of definition and misconceptions. Discusses the many problems communities have in responding to the event as well as some of the adaptive or positive outcomes.

Fritz, Charles E. and J. H. Mathewson, Convergence Behavior in Disasters: A Problem in Social Control, (Washington, D. C.: National Academy of Sciences - National Research Council Publication 476). 1957.

This report looks at the convergence, or the informal, spontaneous movement of people, messages and supplies toward the disaster area. Methods and techniques for controlling such convergence behavior are detailed.

Laffoon, Polk IV, Tornado, (New York: Harper & Row). 1975.

A reporter's account of the 1974 Xenia tornado. Social, psychological and economic consequences are presented through eye-witness accounts. Essentially descriptive and mostly accurate, it could be a useful supplement to more analytical treatments of the topic.

Marks, Eli S., et al., Human Reactions in Disaster Situations, (Chicago: The University of Chicago, National Opinion Research Center; available on microfile AD #107-594 from the Clearinghouse for Federal Scientific and Technical Information, National Bureau of Standards, Springfield, Virginia, 22151). 1954.

This report summarizes a series of field studies conducted by the National Opinion Research Center in the early 1950's. The major study in the set is about a series of tornadoes in Arkansas. One of the few quantitative studies in the literature.

Quarantelli, E. L., Russell R. Dynes eds., "Organizational and Group Behavior in Disasters," American Behavioral Scientist 13, no. 3 (January-February). 1970.

This special issue focuses on disaster as a social disruption within communities. The pattern of social disruption is closely related to the various characteristics of the disaster agent; these determine the nature of disaster tasks to which emergency organizations have to respond.

Quarantelli, E. L. and Russell R. Dynes, "Images of Disaster Behavior: Myths and Consequences." (Columbus: The Ohio State University, The Disaster Research Center Preliminary Paper No. 5). 1972.

The authors argue that what are generally believed to be problems in the disaster setting are not the real ones organizations have to face. Erroneous beliefs about human behavior in disasters are compared with what is known through empirical research to actually occur in disasters. Planners are urged to base their preparations for disasters on a realistic picture of disaster behavior, rather than on myths.

Quarantelli, E. L. and Russell R. Dynes, "Different Types of Organizations in Disaster Responses and their Operational Problems," (Columbus: The Ohio State University, The Disaster Research Center Preliminary Paper No. 41). 1977.

Four different types of organized efforts to cope with community emergencies, especially natural disasters, are described. Some consequences of a disaster event for these organizations are delineated, including the problems of uncertainty, urgency, and lost authority. Problems of task assignment, communication, authority and decision making are also reviewed.

Taylor, James B., Louis A. Zurcher and William H. Key, Tornado, (Seattle: University of Washington Press). 1970.

Using personalistic, case-centered data, the authors take a systematic, interdisciplinary look at the Topeka tornado. The focus moves from the individual response, through mid-levels of group and mass behavior and organizational response, to placement in the historical context, with comparisons and contrasts made between this and other disasters.

Warheit, George and Russell R. Dynes, The Functioning of Established Organizations in Community Disasters, (Columbus: The Ohio State University, The Disaster Research Center Report Series No. 1). 1968. Established organizations are defined as those which respond to disaster with their regular personnel engaged in familiar tasks. A theoretical framework is presented viewing established organizations' pre-disaster operations as a situation where capabilities exceed demands. Operational problems in disaster and adaptations to these are discussed.

Wenger, Dennis E. and Arnold Parr, Community Functions Under Disaster Conditions, (Columbus: The Ohio State University, The Disaster Research Center Report Series No. 4). 1969.

This report examines disaster-activated tasks at the community level of analysis. After theoretically describing the community in pre-disaster periods, the authors undertake an in-depth analysis of community tasks and activities corresponding to the disaster stages from warning to rehabilitation. Specific inter- and intraorganizational problems are described.

II. Recent Literature on Rural Mental Health Needs and Programs and Selected Works on Community Mental Health and Crisis Intervention

A. Rural Mental Health

Allerton, William S., "Rural Mental Health in Virginia," Virginia Medical Monthly, 99:1 (January): 72-73. 1972.

Use of para-medicals and psychiatric nurses increases service coverage to remote areas. Allerton calls for more collaboration between nurses, mental health clinics and hospitals, and for training programs for "mental health technicians."

Bloom, Joseph and William Richards, "Mental Health Program Development in Rural Alaska," Alaska Medicine, 18:3 (May): 25-28. 1976.

While dealing specifically with the unique character of service delivery in Alaska, this paper may be suggestive to those concerned with providing MH services to extremely "backwoods" rural areas. It includes a useful scale for measuring the development and organization of such services and a discussion of the roles suitable to either the public or private practitioner.

Bowden, Charles L. and Arvil E. Reeb, "Community Psychiatry: Scott County Evaluation," Journal of the Kentucky State Medical Association, 70:2 (February): 106-108. 1972.

Bowden evaluates one once-weekly community psychiatric program as adequate for rural catchment areas. He finds distance less important a factor than convenience, and attributes program success to its location within the familiar health department building and to close liason between the center and local medical personnel.

Clemente, Frank (ed.), "The New Rural America," Special issue, The Annals, eds. Lambert and Heston, Vol. 429 (January). 1977.

This issue of The Annals is devoted to the concerns and characteristics of today's rural America. Titles of interest include: "Rural-Urban Differences in Attitudes and Behavior in the United States," "Political Structure of Rural America," "The Rural Aged," "The Rural Church and Rural Religion," and "The Quality of Life in Rural America."

Cohen, Julius, "The Effect of Distance on the Use of Outpatient Services In a Rural Mental Health Center," Hospital and Community Psychiatry, 23:1 (March): 27-28. 1972.

To offset the deterring effects of distance and adverse local attitudes on service utilization, the author recommends various outreach and consultation programs for greater visibility.

Daniels, David N., "The Community Mental Health Center in the Rural Area: Is the Present Model Appropriate?," American Journal of Psychiatry, 124:4 (April): 32-36. 1967.

Daniels believes that the direct clinical service CMHC model does not meet the needs of people in the large Western states. He proposes an alternative indirect service model emphasizing consultation and education, preventive psychiatry, and community psychiatry as community organization.

Gertz, Boris, Jill Meider, and Margaret L. Pluckhan, "A Survey of Rural Mental Health Needs and Resources," Hospital and Community Psychiatry, 26:12 (December): 816-819. 1975.

The authors surveyed rural CMHC's across the country to come up with the composite presented in this article. Description focuses on services offered, skills required, and problems in the delivery of care and of evaluation. Also analyzed were the extent of inservice training available, the support systems needed, and the functions a proposed national task force on rural mental health could perform.

Guillozet, Noel, "Community Mental Health--New Approaches for Rural Areas Using Psychiatric Social Workers," Medical Care, 13:1 (January): 59-67. 1975.

Dealing with the problems of scarce resources, high need but low demand and/or acceptance for mental health services, the author recommends, and cites his experiences with recruiting social workers into a medical group practice.

Hofstatter, L. et al., "A Modern Psychiatric Delivery System for Urban and Rural Areas," Southern Medical Journal, 65:7 (July): 875-881. 1972. Residency training programs within CMHC's have both short and long term

advantages. Continuity of care in a CMHC is best achieved through the use of an inter-disciplinary team. Working through existing networks helps workers gain better entry into tightly knit communities.

Hollister, William G., et al., Experiences in Rural Mental Health, (Chapel Hill, North Carolina: University of North Carolina, School of Medicine, Division of Community Psychiatry of the Department of Psychiatry.) 1973. A series of 8 booklets describing what the authors did and learned about developing flexible, workable patterns for providing comprehensive mental health services to rural people. The approach includes: living within the realities of low funding capabilities, coping with the problems of scarce mental health personnel, and avoiding the imposition of urban-type services by outside professionals through local citizen involvement. Included in these booklets is a demography of the rural areas served. Recommended.

Huessy, Hans R., "Tactic and Targets in the Rural Setting," Handbook of Community Mental Health, pp. 699-710, eds. Golann and Eisdorfer, (New York: Appleton-Century-Crofts). 1972.

Huessy is concerned here with the aspects of mental health programming which are peculiar to rural settings. Disadvantages--under-estimates of mental health problems, scarcity of trained personnel, social visibility of the professional, state imposition of programs more suitable to the city, and financing--are weighed against advantages--the need for reevaluation resulting in better methods, ease of interagency relations, research opportunities, feasibility of first level management leading to better continuity of care, and others. Strategies designed to take advantage of the resources of each community are presented.

Dohrenwend, Bruce P. and Barbara S. Dohrenwend, "Psychiatric Disorders in Urban Settings," American Handbook of Psychiatry, Vol. II, pp. 424-447. ed. Arieti, (New York: Basic Books). 1974.

An important analysis of epidemiologic data on mental illness. Included here because it is one of the few such analyses to have comparable data for both urban and rural segments of the populations studied, and is thus able to make some definitive statements about rural mental illness rates as opposed to urban.

Edgerton, J. Wilbert and W. Kenneth Bentz, "Attitudes and Opinions of Rural People about Mental Illness and Program Services," American Journal of Public Health, 59:3 (March): 470-477. 1969.

The authors report results of a survey conducted in two counties. Findings showed an expressed need for mental health services, especially a clinic, yet low awareness of existing services. The CMHC concept was nearly unknown. Attitudes toward the mentally ill was more positive than in the past, but still ambivalent. Respondents saw the role of psychiatrist as unique, but felt non-psychiatrists have important role as well.

Edgerton, J. Wilbert, et al., "Demographic Factors and Responses to Stress Among Rural People," American Journal of Public Health, 60:6 (June): 1065-1071. 1970.

An application of the Health Opinion Survey (HOS) is documented to show its usefulness as a tool for initially assessing prevalence of mental

disorder in rural populations. Referring to a previous study which reported that mental health clinics in the survey area were not used by the low-income and poorly educated, they call for special programming to meet the needs of these key target groups.

Eisdorfer, Carl, John Altrocchi, and Robert F. Young, "Principles of Community Mental Health in a Rural Setting: The Halifax County Program," Community Mental Health Journal, 4:3 (March): 211-220. 1968.

The authors endorse the consultation and education approach as a temporary solution to the problems of scarce mental health resources in rural areas. Based upon a history of operating such a program, 20 principles, focusing on community sanction, consultation techniques, clinical services and other aspects of CMH programming are proposed.

Garett, Mary Louise, David L. Miles and Allan G. LeBaron, "Rural Areas Pose Special Problems for Providing Social Services," Hospitals, 50:22 (November): 77-79. 1976.

Like other writers, the authors endorse the notion that many of the problems of introducing and providing social and mental health services to rural communities are offset by using some established local institution as a base. Two cases where this has been tried are discussed--unsuccessfully through a doctor's office, and successfully through a hospital. Both advantages and disadvantages of using indigenous paraprofessionals are described.

Hunter, William F. and Allen W. Ratcliffe, "The Range Mental Health Center: Evaluation of a Community-Oriented MH Consultation Program in Northern Minnesota," Community Mental Health Journal, 4:3: 260-267. 1968.

The basic content of this paper is described in its' title. Initial findings suggest that consultation services assist community caretakers in managing emotionally disturbed clients, thus broadening significantly the impact of the MH center staff over a large geographic area.

Janzen, Sharon Ann, "Psychiatric Day Care in a Rural Area," American Journal of Nursing, 74:12 (December): 2216-2217. 1974.

The author describes a successful lay mental health care group, nearly devoid of professional intervention. Such a volunteer group is necessarily limited in scope, and depends upon the dedication of its members for its success.

Johnson, Robert Jr. and William F. Gandy, "Rural Mental Health Care: A Fourth Year Report," Journal of the Oklahoma State Medical Association, 65:8 (August): 336-338. 1972.

A description of the growth and development of a CMHC in rural Oklahoma. Equitable financing and staff compensation are credited for operational efficiency.

Jones, James D., Morton Wagenfeld and Stanley S. Robin, "A Profile of the Rural Community Mental Health Center," Community Mental Health Journal, 12:2: 176-181. 1976.

Jones, et al., compared rural CMHC's with their counterparts in cities. Findings were that rural workers were most likely to view their centers

as like social agencies, and evidenced a significantly higher endorsement of CMH ideology. Rural workers also perceived their role as one of higher organizational and personal activism, with less discrepancy between the two than did urban workers.

Lee, Soong H., et al., "Community Mental Health Center Accessibility--A Survey of the Rural Poor," Archives of General Psychiatry, 31:(September): 335-339. 1974.

A statement of familiar findings: ignorance of available services and stigma are as effective barriers as distance to the provision of mental health services. Recommendations include community education, use of indigenous workers to gain entry, and the provision of backup MH services to local physicians.

Leighton, D. C., A. H. Leighton and R. A. Armstrong, "Community Psychiatry in a Rural Area: A Social Psychiatric Approach," Handbook of Community Psychiatry and Community Mental Health, pp. 166-176. (New York: Grune and Stratton). 1967.

A classic and oft-cited work. Leighton, et al., see overall community integration as well as socioeconomic status as causal factors in individual mental health.

Muhlberger, Esther V., "Collaboration for Community Mental Health," Social Work, 20:6 (November): 445-447. 1975.

Muhlberger sees collaboration as potentially more productive than consultation in the smaller community. The use of volunteers, part-time staff, and the strong interagency linkages often found in rural areas are ways of extending traditional resources. Group workshops between the CMHC and other agency staffs are mutually beneficial.

Naftulin, Donald, Frank Donnelly, and Patricia O'Halloran, "Mental Health Courses as a Facilitator for Change in a Rural Community," Community Mental Health Journal, 10:3: 359-365. 1974.

This study documents a university effort to assist a rural community in developing a mental health educational program for primary interveners within the community, which resulted in significant positive change in groups taking the courses.

Phillips, Donald F., "Reaching Out to Rural Communities," Hospitals, 46 (June): 53-57. 1972.

An interesting and provocative discussion of the potential for hospital involvement in community mental health.

Raft, David, Silas B. Coley and Francis T. Miller, "Using a Service Guide to Provide Comprehensive Care in a Rural Mental Health Clinic," Hospital and Community Psychiatry, 27:8 (August): 553 plus. 1976.

The Service Guide (SG), a type of non-professional linking person between a rural mental health center and the less affluent community, was found to be highly effective in maintaining continuity of care. The SG participated in all levels of MH care delivery and especially kept close contact with the poor and elderly. When the SG program was discontinued it was found that clinic use decreased and referrals dropped among these segments of the population, while better off clients were relatively unaffected.

Riggs, R. Thomas and Linda F. Kugel, "Transition from Urban to Rural Mental Health Practice," Social Casework, (November): 562-567. 1976.

This article discusses the culture shock facing MH professionals who move to smaller towns as they realize that they are professionally more isolated, that urban-oriented models of psycho-therapy don't apply in rural settings, and that the clinician-client relationship is less private, more visible and subject to public evaluation. Some of the skills and personal qualities necessary to make the transition are described, as are the stages professionals new to rural communities commonly experience--euphoria, through depression, to adaptation.

Roemer, Milton I., "Health Needs and Services of the Rural Poor," Rural Poverty in the United States, pp. 311-332. (Washington, D. C.: U. S. National Advisory Commission on Rural Poverty, USGPO). 1968.

Specific health needs of the rural poor are cited: susceptibility to various chronic diseases; inadequacies of rural physicians, both in numbers and specializations; deficiencies of and in treatment facilities, public non-support for hospitalization costs; and social adjustment problems particular to the rural poor. State hospital use is a last resort for many, which leads to energetic building programs by some low-income states, though the result may still be understaffed and substandard facilities.

Saltzman, Ben N., "Mental Health and the Rural Aging," Arkansas Medical Society Journal, 68:4 (September): 131-135. 1971.

The isolated lifestyle of many older persons, coupled with the isolation of the rural setting, make the elderly a high risk group for mental health problems. Saltzman suggests that psychiatrists may tend to ignore MH problems in the elderly, and states that rates for mental illness are highest in older age groups.

Segal, Julius, ed., The Mental Health of Rural America: The Rural Programs of the National Institute of Mental Health, (Rockville, Maryland: Program Analysis and Reports Branch, Office of Program Planning and Evaluation, Alcohol, Drug Abuse, and Mental Health Administration, 5600 Fishers Lane, 20852, DHEW (HSM) 73-9035). 1973.

This book is a primer of sorts, coming from the viewpoint that mental health problems in rural areas are often proportionately worse than in urban settings, exacerbated by poverty and scarce resources. It provides a basic overview of epidemiologic, demographic, and attitudinal studies, and goes into considerable descriptive detail on how NIMH has helped various communities deal with different issues in mental health delivery.

Shore, James H., et al., "A Suicide Prevention Center on an Indian Reservation," American Journal of Psychiatry, 128:9 (March): 76-81. 1972.

The authors emphasize the importance of community involvement in a suicide prevention service, especially that of the reservation power structure. Characteristics of the patient population are analyzed, including attitudes relating to the development of the CMHC. Indigenous counselor-attendants were considered extremely helpful. The author states suicide attempts may be related to a learned pattern of destructive behavior.

Shupe, Anson Jr., "Development of Mental Health Services Among Existing Community Institutions in Rural Areas: The Case of the Japanese Kumiai," Community Mental Health Journal, 10:3: 351-358. 1974.

The Japanese Kumiai, essentially highly developed community service centers are presented as an example of the use of an established community focal point and familiar personnel to introduce new ideas to a rural community. It is suggested that U. S. farmer's cooperatives might be similarly used by community mental health programmers, as a bridge to the populace. Special problems encountered by mental health program developers in rural areas are mentioned, as well as the need for a "preventive perspective" in rural communities undergoing disintegrative social change, as well as lacking mental health facilities.

Thomas, Captane P. and Norman W. Bell, "Evaluation of a Rural Community Mental Health Program," Archives of General Psychiatry, 20: 448-456, (April). 1969.

The CMHC examined here operates not on a walk-in basis, but as a source of specialist evaluation and treatment of the more seriously ill. Screening and referral are mandatory, which brings into question the label of "CMHC." Community response to this policy gave rise to several volunteer crisis intervention groups.

Veverka, Joseph F. and James Goldman, "Rural Family Counseling," Journal of the Iowa Medical Society, 63:8 (August): 395-398. 1973.

Description of a small-scale experiment wherein a social worker in a rural area worked with the local physician in an attempt to provide family counseling. Continuity of care resulted, plus satisfaction with the teamwork approach.

Wedel, Harold L., "Characteristics of Community Mental Health Center Operations in Small Communities," Community Mental Health Journal, 5:6: 437-444. 1969.

The author discusses the peculiar aspects of rural communities as opposed to urban in some detail, stating among other things, that human needs are different in areas of low population density. He discusses the fact that a community mental health program must adapt to these differentiations, and outlines specific recommendations to MH personnel as to modes of conduct in the community, and variations in patient-therapist relations.

Williams, Michael, "A Rural Mental Health Delivery System," Hospital and Community Psychiatry, 26:10 (October): 671-674. 1975.

This CMHC, in an extremely rural area of Utah, serves its geographically scattered and multi-ethnic population through the use of indigenous outreach workers and programs tailored to various ethnic needs.

Willie, Charles V., "Health Care Needs of the Disadvantaged in a Rural-Urban Area," HSMHA Health Reports, 87:1 (January): 82-86. 1972.

A survey conducted with both professionals and consumers showed basic health care needs for both urban and rural areas. Needs were identical but ranked differently in the two settings. Recommendations are made in each category, including the general one that program planners should be fed information from consumers themselves.

Wethersty, David T., "Psychiatric Residents Provide Extra Manpower for Rural Community Agencies," Hospital and Community Psychiatry, 26:5 (May): 270-271. 1975.

Second year residents from a nearby medical center were used as full-time workers for periods of 3 to 6 months, providing both direct and indirect service.

B. Community Mental Health

Bellin, Seymour S., Ben Z. Locke and Mary New, "One Neighborhood Health Center as a Mental Health Diagnostic Service," Public Health Reports, 91:5 (September/October): 446-451. 1976.

Discusses the potential of a neighborhood health center as a case-finding and treatment service for a socially and economically disadvantaged area. The authors conclude that being a comprehensive--physical and mental-care center encourages service utilization. Attention is paid to the epidemiology and demographics of the area.

Cobb, Sidney, "Social Support as a Moderator of Life Stress," Psychosomatic Medicine, 38:5 (September/October): 300-314. 1976.

This article contains an overview of significant research on the role of social support for the individual undergoing crisis. The belief that one is cared for and esteemed is seen as having a potential for protecting those in crisis from a variety of pathological conditions. A number of situations where social support can result in more positive psychosocial functioning are noted. The author urges further investigation on the effects of social support on the outcome of medical treatment and on individuals in chronic stress situations.

Collins, Alice H. and Diane L. Pancoast, Natural Helping Networks: A Strategy for Prevention, (Washington, D. C.: NASW Pub. # CBC-070-C). 1976.

The authors argue strongly that "natural helpers" have a uniquely valuable role to play in the delivery of mental health and human services. The issues of identifying, recruiting and coordinating the best possible indigenous workers are treated in depth.

Fann, William E. and Charles E. Goshen, The Language of Mental Health, (St. Louis: The C. V. Mosby Co.). 1973.

A comprehensive easily usable guide to the vocabulary of the mental health and behavioral sciences. Includes categorical glossaries of diagnostic, treatment, and administrative and legal terminology.

Feild, Hubert S. and Robert Gatewood, "The Paraprofessional and the Organization: Some Problems of Mutual Adjustment," Personnel and Guidance Journal, 55:4 (December): 181-185. 1976.

The authors detail some of the problems that can arise when paraprofessionals are employed by social service agencies. From the paraprofessionals' viewpoint these are the nature of their work, opportunities for advancement,

relationships with professional staff, and dealing with agency policies; from the agency perspective, the paraprofessional can overidentify with either the client or the agency, may lack certain work skills, and may require more attention than the agency wants to give.

Gill, Merton M. "The Two Models of the Mental Health Disciplines," Paper presented at the graduation exercises of the Menninger School of Psychiatry, June 19, 1976.

Gill attempts to clarify what is meant by the "medical" and the "psychological" or community mental health model. He re-terms these two the "reactive" and the "proactive", and maintains that the essential difference is how they view and utilize the concept of responsibility.

Giordano, Joseph, "Community Mental Health in a Pluralistic Society," International Journal of Mental Health 5: 5-15. 1976.

Problems of professionalism, ideological conflict, inequality and inflexibility are discussed as factors which account for dissatisfaction with the community mental health movement. The author calls for a revision of the philosophy of community mental health to one which recognizes the ethnic and subcultural differences which exist in American society.

Golann, Stuart E. and Carl Eisdorfer, "Mental Health and the Community-- The Development of Issues," in Handbook of Community Mental Health (New York: Appleton-Century-Crofts). 1972.

Golann and Eisdorfer discuss developing the role of the community in mental health clinic operations, in terms of location and availability of services, outreach to clients, and involvement with an increased variety of caregivers.

Gomez, Angel Gregorio, "Some Considerations in Structuring Human Services for the Spanish-Speaking Population of the United States," International Journal of Mental Health, 5:2: 60-68. 1976.

Gomez argues that few social action programs exist that actually meet the needs of Hispanic Americans, and that those which do exist are token efforts. Several problems of social and mental health service delivery to these groups are noted, and recommendations are made for their amelioration.

Herbert, George K. "Factors Contributing to the Successful Use of Indigenous Mental Health Workers," Hospital and Community Psychiatry 25:5 (May): 308-310. 1974.

In recognition of the unique contributions indigenous workers can make, one program allowed them flexibility in developing job skills, supplementing this with ongoing inservice training. Workers' feelings of satisfaction and of being of worth to the center stemmed from the respect the agency accorded them.

Hesse, Katherine F. "The Paraprofessional as a Referral Link in the Mental Health Delivery System," Community Mental Health Journal 12:3: 252-258. 1976.

There are differing expectations on the part of clients, agency people and the paraprofessionals themselves regarding qualifications, knowledge and activities of the paraprofessional referral worker. This study suggests that as long as paraprofessional roles are ambiguously defined the workers will not be able to satisfy everyone involved.

Howe, Louisa P. "The Concept of the Community: Some Implications for the Development of Community Psychiatry," Handbook of Community Psychiatry and Community Mental Health, pp. 16-46, (New York: Grune & Stratton). 1964.

The author discusses a number of theoretical conceptions of the "community", citing as most salient one which deals with symbolic interactions between people in terms of common destiny and a shared history, and which sees crisis as the fulcrum upon which sense of community is either heightened or diminished. Recommendations are made to the psychiatrist who would work at the community as well as the individual patient level, including respect for the autonomy of people regardless of their status, a soft pedal approach to power structures, and the study of crisis and coping reactions so a crisis situation can be capitalized on to effect constructive change.

Kaplan, Howard M. and Ronald H. Bohr, "Change in the Mental Health Field?" Community Mental Health Journal 12:3: 244-251. 1976.

Reasons for non-utilization of community mental health centers are discussed, as are several social, political, economic, and ideological factors which the authors consider to be barriers to change in the field of community mental health. Trends acting to promote needed changes are also noted.

Lorion, Raymond P. "Ethnicity and Mental Health: An Empirical Obstacle Course," International Journal of Mental Health 5:2: 16-25. 1976.

Lorion argues that innovative approaches to providing care, advocated in the community mental health movement, have not produced intervention strategies suitable for use with those in our society who are part of ethnic-group subcultures. Noting that there are formidable methodological problems in assessing the relationship between ethnicity and mental health, the author argues for an inductive, pragmatic approach to the delivery of mental health services to members of ethnic subcultures. He concludes that the treatment of members of ethnic groups and other subcultures may have to be accompanied by a redefinition of role and a change in attitude on the part of the mental health professional.

Manis, Jerome G., et al., "Estimating the Prevalence of Mental Illness," American Sociological Review 29:1 (February): 84-89. 1964.

This article discusses methods of locating and identifying cases of mental illness. Using a 22 item Mental Health Scale, the study found little variation in treated prevalence rates in three communities. The largest variation was found to occur in the rates of untreated cases, leading the authors to conclude, among other things, that differences in reported rates of untreated mental illness may arise from a lack of agreement in criteria used to establish mental health and mental illness categories.

Mechanic, David "Community Psychiatry: Some Sociological Perspectives and Implications," Community Psychiatry, pp. 201-222, (Madison, Wisconsin: University of Wisconsin Press, Symposium on Community Psychiatry). 1966. The author discusses trends and issues in community psychiatry from a sociological point of view. The notions of mental health and mental illness are discussed from a variety of perspectives: definitional, conceptual, practical, and ethical. Throughout his discussion, Mechanic focuses on the linkages, both obvious and subtle, between the field of mental health and the larger society.

Norris, Eleanor and Judith K. Larsen, "Critical Issues in Mental Health Service Delivery: What are the Priorities?" Hospital and Community Psychiatry 27:8 (August): 561-566. 1976. When caregivers were asked to rate 57 mental health issues in terms of present and future (5 year) importance, ratings varied considerably by professional role and educational attainment. The author is concerned that such difference be acknowledged if future MH programs are to be planned effectively.

Penn, Nolan E., Frank Baker and Herbert C. Schulberg, "Community Mental Health Ideology Scale: Social Work Norms," Community Mental Health Journal 12:2: 211-214. 1976. Using the 1967 CMH Ideology Scale, the authors surveyed social work professionals and graduate students to measure individual commitment to the tenets of community mental health. High scores, particularly on items relevant to treatment goals and total community involvement, argue for an integral role for the profession in community psychiatry.

Rabkin, Judith and Elmer L. Struening, "Life Events, Stress and Illness," Science 194:426 (December): 1013-1020. 1976. A review of the literature on stressful life events and their relation to illness. In addition to delineating research trends and critiquing methodological approaches, the authors consider: definitions of social stressors, stress and the onset of illness, and mediating factors, such as the various social support systems to which an individual might belong. Noting the complexity of the relationships between life stress, events and illness, they maintain that care must be taken to select life events relevant to the topic and population under study.

Rabkin, Judith "Public Attitudes Toward Mental Illness: A Review of the Literature," Schizophrenia Bulletin 10 (Fall): 9-33. 1974. The author concludes, after reviewing the literature, that despite community education efforts, the label of mental illness continues to lead to irreversibly diminished community standing. Rabkin notes that the public seems to be more influenced by the social visibility of symptoms than by their actual severity and discusses various characteristics of the mentally ill that influence public acceptance. The author believes more research is needed in order to understand what conditions foster both positive and negative attitudes toward the mentally ill.

Reed, Katherine, Mental Health and Social Services for Mexican-Americans: An Essay and Annotated Bibliography, (Monticello, Illinois: Council of Planning Librarians Exchange Bibliography # 1023, ed. Mary Vance, P. O. Box 229). 1976.

Reissman, Frank "A Neighborhood-Based Mental Health Approach," Emergent Approaches to Mental Health Problems, pp. 162-184, eds. Cowan, Gardner, and Zax, (New York: Appleton-Century-Crofts). 1967.
Presents a service strategy for reaching low income populations, and by implication, those who are otherwise isolated, geographically, socially, or emotionally. Reissman outlines goals, objectives and some of the reasons why traditional service programs often fail with these groups. A strong community action stance is advocated.

Rome, Howard P. "Barriers to the Establishment of Comprehensive Community Mental Health Centers," Community Psychiatry, pp. 31-55, (Madison, Wisconsin: University of Wisconsin Press, Symposium on Community Psychiatry). 1966.

Rome views the "frontier psychology", i.e., rugged individualism and resistance to governmental control, as being a significant barrier to community MH programs, since today's technology and complex operational structures make dealing with government agencies a realistic necessity. A number of organizational conflicts within and between agencies are outlined, as well as social conflicts between professionals and clients, and professionals and the general public. Problems related to the ambiguous standing of psychiatry and to distance between professional and client are also discussed. A list of 15 specific barriers to the establishment of CMHC's is furnished.

See, Joel J. and R. David Mustian, "The Emerging Role of Sociological Consultation in the Field of Community Mental Health," Community Mental Health Journal 12:3: 267-274. 1976.

The authors discuss the use of sociologists both as researchers and as consultants in mental health planning and the design of services. Sociologists are seen as having skills which would aid in statewide planning; needs assessment; the setting of goals for community mental health centers; and the establishment of efficient and effective organizational operating principles. Possible sources of role strain between the sociologist and the community mental health practitioner are also noted.

Sheeley, William F. "The General Practitioners' Contribution to Community Psychiatry," Handbook of Community Psychiatry and Community Mental Health, pp. 269-279, (New York: Grune & Stratton). 1964.

Because he knows and is known to so many people, Sheeley sees the GP as a potential casefinder and community educator regarding mental health problems. This position is made more advantageous if the GP is willing to improve his own psychiatric skills, and cultivate ongoing relationships with referring colleagues and other suitable resources, such as the local clergy. By the same token the GP who is ignorant or fearful of the mental health milieu is viewed as a hazard.

Snow, David L. and Peter M. Newton, "The Task, Social Structure and Social Process in the Community Mental Health Center Movement," American Psychologist, 31:8 (August): 582-594. 1976.

A discussion of the CMHC movement's historical emphasis on direct (treatment) over indirect (preventive, social-action) services. The need for indirect services is cited, in terms of dealing with mental health needs in a social rather than medical framework. Suggested improvements are specified.

Snyder, James D. and Robert M. Engleman, "Ten Social Service Programs That Really Work," Geriatrics 31:10 (October): 119-125. 1976.

Ten social service programs geared to the needs of the elderly are described in detail, including federal nutrition and volunteer programs, discount merchandising, health activation, legal counsel, and job and program fairs.

Sundel, Martin "Establishing a Needs Assessment Program in a Human Service Organization: A Case Study," Louisville, Kentucky: Paper presented at the National Conference on Needs Assessment in Health and Human Services, March 10, 1976.

Needs assessment is becoming increasingly important as a result of pressures on service organizations to be truly responsive to the community. Sundel here discusses the approach taken by one CMH program in assessing needs relevant to program planning and evaluation. As a case study on a program serving rural, suburban and urban populations with varying levels of income and diverse ethnic backgrounds, this paper is descriptive, analytic and somewhat prescriptive and should therefore be of value to other organizations who are considering undertaking their own needs assessment programs.

Vaughn, Warren T. "Local Mental Health Program Administration," Handbook of Community Psychiatry and Community Mental Health, pp. 388-408, (New York: Grune & Stratton). 1964.

Vaughn deals with the complexities of community mental health administration. He furnishes an administrative job description, in terms of qualifications, responsibilities and expectations, and extensively discusses the need for communication and coordination with community groups, focusing particularly on various "partnership" axes: state-local, public-private, professional-lay, interagency and interdisciplinary. An appendix provides source materials relative to organizations involved in CMHC research, organizations of program administrators, and a general reference guide to community mental health and social psychiatry.

Warheit, George I., Charles E. Holzer, and John J. Schwab, "An Analysis of Social Class and Racial Differences in Depressive Symptomatology: A Community Study," Journal of Health and Social Rehabilitation 14:4 (December): 291-299. 1973.

This paper reports data from a random sample of adults in a Southeastern county, analyzing scores on a depression scale according to age, race, sex, annual family income, education and a general socioeconomic status score. SES was found to be the most significant variable, with age and race not significant at the level studied.

C. Crisis Intervention

Caplan, Gerald, Principles of Preventive Psychiatry, (New York: Basic Books). 1964.

One of the earlier and clearest statements of the CMH ideology. Many of the terms found in the literature--primary, secondary and tertiary prevention, crisis intervention, high risk populations--are defined, illustrated, and placed in a context of community organization and planning. Central to Caplan's conceptualization is the significance of crises in the life and mental health of an individual, hence his basic model for treatment and prevention is based on intervention at these times.

Jacobson, Gerald F., "Emergency Services in Community Mental Health," American Journal of Public Health, 64:2:- 124-128. 1974.

Reporting on the inadequacies of emergency MH services in CMHC's, the author states that there is promise in this area that could be realized if clear definitions were developed for emergency services, coupled with the application of a consistent theoretical framework. A classification is proposed, differentiating between suicide prevention, emergency and referral, and crisis intervention. Crisis intervention is discussed in further detail in regard to theoretical framework and techniques.

Kaslow, Florence, "Crisis Intervention Theory and Technique," Intellect Magazine, (January) 1976.

A succinct explanation of the significance and potential of crisis for the individual, the theory behind crisis intervention, and the techniques for strengthening a person's capacity to cope with stress.

Litman, Robert E. and Carl I. Wold, "Beyond Crisis Intervention," Psychiatric Annals, 6:11: 119-121. 1976.

The authors see standard crisis intervention techniques as being ineffectual with some high suicide risks. They have developed a reaching out service called "continuing relationships", provided by volunteers. The service is not considered therapy, clients are encouraged to utilize other appropriate resources, and the emphasis is on rehabilitation rather than crisis.

McGee, Richard K., Crisis Intervention in the Community, (Baltimore: University Park Press): 1974.

A basic text for those concerned with planning crisis intervention programs. McGee provides the historical and conceptual context of crisis intervention, describes characteristics of 10 actual programs, and develops a model for service delivery. Some of the topics discussed are, among others, crisis center staffing, record keeping and statistics, planning guidelines, evaluation, and the use of non-professional volunteers.

McGee, Thomas F., "Some Basic Considerations in Crisis Intervention," Community Mental Health Journal, 4:4: 319-325. 1968.

To increase understanding of the concept of crisis intervention, it is proposed that emotional crises be placed on a continuum ranging from normal developmental crises to psychiatric emergencies. This clarifies the reasons behind using crisis intervention, as it does the roles of direct treatment and consultation. McGee also suggests that a variety of viewpoints be considered in assessing a crisis, resulting in a more pragmatic orientation for the CMHC.

Parad, Howard J., ed., Crisis Intervention: Selected Readings, (New York: Family Service Association of America, 44 East 23rd Street, 10010). 1965. The papers presented here delineate the range of formulations of crisis theory, the varieties of practical applications, and some of the research done on the subject. The underlying philosophy is that short term treatment can be a matter of choice, not merely of expediency. Long a Social Work text, the book is treatment oriented, and thus has considerable value for those who deliver as well as those who plan services.

Smith, Larry L., "Crisis Intervention Theory and Practice," Community Mental Health Review, 2:1. 1977.

Smith reviews current and basic literature on crisis intervention, dealing particularly with the formulations of Caplan, Parad, and Rapoport. He concludes that while crisis intervention is a popular model, it is still conceptually unclear because it is not operationalized into clear treatment plans. An extensive bibliography is included.

Spitz, Norris, "The Evolution of a Psychiatric Emergency Crisis Intervention Service in a Medical Emergency Room Setting," Comprehensive Psychiatry, 17:1 (January/February): 99-113. 1976.

This article describes the emergency room at Cincinnati General Hospital, where a new type of psychiatric team has been implemented to provide better psychiatric emergency care.

Yano, Brian, et al., "Crisis Intervention: A Guide for Nurses," Journal of Rehabilitation, 42:5 (September/October): 23-26. 1976.

Three broad aspects of crisis intervention are examined in the context of one case study. Stages of crisis are identified, definitions of crisis are offered, and the effects of an individual's (victim or caregiver) psychological conditioning on crisis response are discussed.

III. Mental Health Consequences of Disaster and the Delivery of Services to Victims

Bates, F. L., et. al., The Social and Psychological Consequences of a Natural Disaster: A Longitudinal Study of Hurricane Audrey, (Washington, D. C.: National Academy of Sciences - National Research Council). 1963.

Part of this book's value is that it analyzes social and psychological changes in a disaster stricken community over a long run period. Noteworthy chapters are "Role Stress Associated with Rehabilitation," "Mental Health Effects of Hurricane Audrey," and "Social Change in Response to Hurricane Audrey." The authors conducted a number of interviews, surveys, and analyses of records to determine lasting changes in community and individual functioning. Regarding mental health they found only minimal reporting of mental illness or emotional disturbance but considerable evidence of "nervousness, somatic complaints and behavioral disturbance" that were not likely to be identified as emotionally related. Findings are supplemented with a discussion of various types of stress, attenuating factors and behavioral responses within a temporal context.

Birnbaum, Freda, Jennifer Coplon, and Ira Scharff, "Crisis Intervention after a Natural Disaster," Social Casework 54, (November): 545-551. 1973.

A descriptive account of social work crisis intervention services to the Jewish community affected by the 1972 Agnes flood. The authors explain the structures used and some of the strategies employed. Groupwork and outreach were particularly effective, while discontinuity of care and resentment of "outside interference" were cited as serious problems.

Block, Donald A., Earle Silber and Stewart Perry, Some Factors in the Emotional Reaction of Children to Disaster, (Bethesda, Maryland: Laboratory of Child Research, National Institute of Mental Health). 1953.

This 1953 study, investigating the results of a tornado that particularly affected a theatre filled with children, explored two general areas of interest: the relationship between a child's emotional disturbance and 1) the extent of his actual involvement in the disaster, and 2) the way in which parents handled the experience with the child.

Bowman, Sue, "Disaster Intervention: from the Inside," Paper presented at the Annual Meeting of the American Psychological Association, Chicago, Illinois, August 31, 1975.

Written by the coordinator of the Monticello Neighbor-to-Neighbor Team, this paper describes the organization of a mental health outreach effort for tornado victims in a community previously without formally designated mental health agencies. Use of paraprofessionals indigenous to the community under the leadership of outside professionals is discussed, and the importance of gaining legitimacy in the community is stressed. Other topics include: criteria for choice of mental health workers; the training of workers; problems posed by funding questions; and program evaluation.

Brownstone, Jane, et. al., "Disaster-Relief Training and Mental Health," Hospital and Community Psychiatry 28:1 (January). 1977.

Following a Mississippi River flood in 1973, a task force was created to merge mental health and disaster relief services. Recommendations were: short term emotional support to victims, ideally coupled with material aid, and the use of MH professionals as "back-up" to front line workers. A self-contained videotape/workshop was developed to help workers improve listening skills, learn problems solving techniques, become aware of behavioral clues to emotional disturbance, and familiarize them with the work of other relief agencies.

Church, June, "The Buffalo Creek Disaster: Extent and Range of Emotional and/or Behavioral Problems," Paper for APA Symposium on Picking up the Pieces: Disaster Intervention and Human Ecology, Montreal, Canada, 1973.

Church gives examples of the emotional disturbance found and the treatment provided. Based on her experience she suggests that such emotional stress could be alleviated if natural social groupings of evacuees were preserved, if there was someone with a clearly defined ombudsman/advocate role, and if in-service mental health training was provided to members of disaster relief organizations.

Cohen, Raquel E., "Post-Disaster Mobilization of a Crisis Intervention Team: The Managua Experience," Paper presented at the National Institute of Mental Health Continuing Education Seminar on Emergency Mental Health Services, Washington, D. C., June 22-24, 1973.

In this account of mental health activities following a major earthquake, Cohen focuses on 1) the multilevel areas of activities of the team--direct services plus consultation and education within existing services; 2) the dislocation of socio-economic structures, community services and its impact on the population; and 3) a description of a series of crisis intervention projects, paying special attention to procedures for entering and integrating with the existing system, defining objectives, detailing activities of workers and the outcomes, and suggesting future techniques and procedures.

Drabek, Thomas E. and Keith S. Boggs, "Families in Disaster: Reactions and Relatives," Journal of Marriage and the Family, Volume XXX (August): 443-451. 1968.

In studying the response of families to disaster warnings, the authors interviewed a sample of the over 3,700 families who were evacuated when a flood struck metropolitan Denver. They found initial response to be marked disbelief regardless of warning source, and a strong tendency for families to take refuge with relatives rather than centers. This tendency was significantly affected by social class, and by the degree of interaction between relatives during the warning period.

Drayer, Calvin S., Dale C. Cameron, Walter D. Woodward, and Albert J. Glass, "Psychological First Aid in Community Disasters," Journal of the American Medical Association, Volume 156, No. 1 (September): 36-41. 1954.

This article, which makes reference to both natural disasters and combat situations, discusses five kinds of psychological reactions to disaster: "normal" reactions, panic, "depressed" reactions, "overly active" responses, and bodily reactions. Four principles for effective psychological first aid are outlined, most of which focus on the need for conveying acceptance of the kinds of feelings victims are experiencing. Strategies for dealing with each of the five types of reactions are also advanced.

Farber, Irving J., "Psychological Aspects of Mass Disasters," Journal of the National Medical Association 59:5: 340-345. 1967.

A psychoanalytically oriented discussion of what Farber terms the "disaster syndrome." Drawn mostly from studies of war neuroses and from Freud, it would be of limited value to those concerned with community wide disasters, requiring systematic intervention strategies.

Frederick, Calvin J. "Psychological First Aid: Emergency Mental Health and Disaster Assistance," The Psychotherapy Bulletin, Volume 10, No. 1 (Winter): 15-20. 1977.

Recent findings on the negative psychological effects of disaster are reviewed briefly by the author, a NIMH official who recommends the use of crisis intervention techniques to reduce disaster-related psychological problems. The legal basis for the delivery of mental health services to disaster victims is reviewed, and the means by which funds may be obtained are outlined.

Glass, Albert J. "Psychological Aspects of Disaster," Journal of the American Medical Association, (September): 188-191. 1959.

This author assumes that the experiences of individuals in combat are analogous to those of individuals in disasters, and he makes generalizations concerning behavior in both settings. The emphasis is on individual psychological processes and individual behavior during various phases in crisis situations. The article focuses on strategies for training individuals to perform effectively under "traumatic" conditions.

Grossman, Leona, "Train Crash: Social Work and Disaster Services," Social Work 18 (September): 38-44. 1973.

The patterns of response in victims, their friends and relatives, and the social workers who served them are described and analyzed. Of note are the author's observations that people in stress are oriented to mutual help, particularly if positive models are provided; that urgent needs for comfort and help require suspension of the mechanisms that usually separate professionals from clients; and that opportunities for talking things out is paramount in the process of recovery.

Hall, Philip S. and Patrick W. Landreth, "Assessing Some Long Term Consequences of a Natural Disaster," Mass Emergencies 1:1 (October): 55-62. 1975.

In an attempt to determine long term consequences of a flash flood, the authors analyzed routinely collected public records--police blotters, school attendance, divorce statistics, etc. They found that as a whole the community did not experience a major mental health crisis, but that there were several indicators of social stress. However, they believe the stress was felt mainly by a small segment of the population and that the Federal disaster relief program, more than the flood itself, had the greater impact on social dysfunction.

Harshbarger, Dwight, "An Ecological Perspective on Disastrous and Facilitative Disaster Intervention Based on the Buffalo Creek Disaster," Paper presented at the NIMH Continuing Education Seminar on Emergency Mental Health Services, Washington, D. C., June 22-24, 1973.

Discusses how intervention efforts can aggravate as well as aid the recovery process. The paper outlines how attempts to speedily remove debris and find shelter for victims produced a situation that heightened stress and created a potential for emotional disturbance. On the positive side the author notes the development of mental health programming that was helpful, and present a conceptual framework for looking at the nature of intervention, the problems of groups at risk, characteristics of intervenors. An ecological model for the organization of emergency mental health services is proposed.

Heffron, Edward, Project Outreach, Final Report, (Nanticoke, Pennsylvania: NIMH Contract 1-MH-4-0008, Hazleton-Nanticoke MH/MR Center). June, 1975.

Heffron provides a comprehensive overview of the first organized mental health effort to be made in direct response to a disaster. One outcome of this project, which pioneered in the use of specially trained indigenous paraprofessionals, was its influence on the inclusion of Section 413 (the provision of mental health services to disaster victims) in the Disaster Relief Act of 1974.

Howard, Stephen J. and Norma S. Gordon, "Final Progress Report: Mental Health Intervention in a Major Disaster," (Van Nuys, California: Small Research Grant, MH21649-01, San Fernando Valley Child Guidance Clinic, 7335 Van Nuys Boulevard). 1972.

Following an earthquake, a clinic offered crisis services to children and families. They found that disaster services were utilized by a higher socio-economic group than those ordinarily using the clinic, and that children using clinic services showed an overall higher level of symptomatology than a control group, with fears and sleep disturbances still present a year afterwards.

Heurta, F. C., R. L. Horton, and H. T. Winters, "Coping with Disaster Among the Elderly," Paper presented at the Annual Meeting of the Western Social Science Association, Denver, Colorado, April 21-23, 1977.

This report on research conducted among victims of the 1976 Teton Dam break and flood, finds that, contrary to what many mental health researchers and practitioners claim, older individuals cope well with the effects of disaster. A sample of 372 elderly people in the victim population were interviewed and were found to be relatively low in alienation and feelings of deprivation and hardship. Rural values and a strong church-orientation are seen as possible sources of strength for these elderly disaster victims.

Kirn, Steven P., "Community Mental Health Centers and Disaster: Considerations Regarding Response During the Post-Impact Period," Paper presented at the meetings of the Southeastern Psychological Association, Atlanta, Georgia, March 28, 1975.

This paper recounts the author's first-hand experience as a mental health professional in the Brandenburg, Kentucky tornado of 1974. Two approaches--special training of crisis intervention workers and a "participation response" by local professionals--are contrasted. Activities engaged in by mental health workers in Brandenburg as part of their response to the tornado are discussed, and a community-oriented program, without explicit mental health overtones, is advocated.

Kliman, Ann S., "The Corning Flood Project: Psychological First Aid Following a Natural Disaster," in *Emergency and Disaster Management: A Mental Health Sourcebook*, Howard J. Parad, H. L. P. Resnik and Libbie G. Parad, eds., (Bowie, Maryland: Charles Press Publishers, Inc.): 325-335. 1976.

This article describes a program utilizing local professionals and paraprofessionals, which was developed to provide crisis intervention and related mental health services to victims of the 1972 Corning, New York flood. Beginning with the assumption that all residents of a disaster-stricken community are either direct or indirect victims in a psychological sense, the program consisted of several elements, including victim discussion groups, an emergency mental health phone-in service, and public education programs. Kliman is among the first to highlight the mental health needs of the "hidden victims," the caregivers in the disaster setting.

Lifton, Robert Jay and Eric Olson, "The Human Meaning of Total Disaster," *Psychiatry*, 39, (February): 1-18. 1976.

The authors discuss how, in Buffalo Creek, the simultaneous occurrence of five characteristics of disaster: suddenness, human callousness in causation, continuing relationship of survivors to the disaster, isolation

of the community, and totality of destruction, produced a situation unique in its potential for producing emotional pathology. They state that everyone exposed to the disaster experienced some or all manifestations of death imprinting, death guilt, psychic numbing, unfocused rage and the struggle to explain and integrate the disaster to themselves so as to allow resolution of inner conflicts.

Lindemann, Erich, "Symptomatology and Management of Acute Grief," American Journal of Psychiatry 101, (September): 141-148. 1944.

Acute grief is recognized to be a consequence of loss of significant others and even of important possessions. Based on observations of, among others, bereaved disaster victims, Lindemann concludes that acute grief is a definite syndrome that may appear at any time after a crisis, may be normal or distorted, may even appear to be absent. He describes the symptomatology of both normal and morbid grief reactions, the course of the reaction, and discusses how proper management techniques can help people resolve the crisis.

Marnocha, Mark and Thomas H. Zarle, "Disaster Intervention: An Investigation of the Correlates of Helping in a Naturalistic Setting," (West Lafayette, Indiana, Department of Psychological Sciences, Purdue University). 1974. This study attempted to determine how three groups of individuals--Helpers, Nonhelping visitors, and Nonhelping-nonvisiting controls--in a post-disaster recovery period differed on selected personality, attitudinal and experience variables. The results are discussed in terms of their implications for altruism research and of the possibility of visitor defensiveness.

McGee, Richard K., The Role of Crisis Intervention Services in Disaster Recovery Center for Crisis Intervention Research, (Gainesville, Florida, University of Florida). 1973.

Beginning with the rationale for applying crisis intervention methodology to disaster recovery, McGee proceeds to discuss the training provided for paraprofessionals in two project areas. Capsule summaries are used to illustrate the eight types of problems that, at the minimum, crisis workers must be prepared to handle. Issues related to how this type of human service delivery system can most efficiently be developed are considered briefly.

Moore, Harry Estill, "Some Emotional Concomitants of Disaster," Mental Hygiene, Volume 42 (January): 45-50. 1958.

This article is based on survey and interview data collected following a tornado and a severe storm and tornado threat which struck San Angelo, Texas in two consecutive years, 1953 and 1954. Some objective measures and a variety of self-reported data on individuals' psychological states are cited in support of the author's contention that the disasters had a lasting effect on victims' psychological adjustment.

Omaha Tornado Project, Final Report, (Omaha, Nebraska). 1976.

Report of the activities of a mental health task force set up to deliver services to victims of the May 6, 1975 tornado which struck Omaha. Topics discussed include: individual and community reactions to disaster; nature and types of problems displayed by individuals who were recipients of direct services; and various programs designed to reach target groups in the community. Lengthy appendices detail the approaches used with victims, and recommendations are made for improved future service delivery.

Parad, Howard, H. L. P. Resnik and Libbie Parad, eds., Emergency and Disaster Management: A Mental Health Sourcebook, (Bowie, Maryland: The Charles Press Publishers, Inc.). 1976.

Defining a mental health emergency as one resulting from an unforeseen incident which, if not responded to, will result in psychologically damaging consequences, this is the first major book to focus on the management of such emergencies. Its format is a series of case histories (many of which are cited separately in this bibliography) which have been contributed from several disciplines. Typically, intervention follows a conceptual model grounded in crisis theory, which sets goals and localizes treatment within the community.

Penick, Elizabeth C., Steven W. Larcen, and Barbara J. Powell, Final Report of the Lieutenant Governor's Task Force for Mental Health Delivery Systems in Time of Disaster, (St. Louis, Missouri, Department of Psychological Services, Malcolm Bliss Mental Health Center). 1974.

This report is based on a study of the need for, and delivery of, mental health and other human services following the 1973 Mississippi River floods in Missouri. The report contains 1) a discussion of a needs-assessment survey (interview type) performed by the Task Force; 2) a set of recommendations for the development of a more adequate disaster response on the part of the mental health sector; 3) a series of appendices containing program outlines, media treatments of disaster mental health problems, task force meeting minutes, and other materials, including a copy of the survey instrument.

Poulshock, S. Walter and Elias S. Cohen, "The Elderly in the Aftermath of a Disaster," The Gerontologist, 15 (August): 357-361. 1975.

Survey data obtained from a sample of elderly flood victims one year after impact indicate their perceived need for "hard" services such as housing, increased income and transportation. Implications for normal circumstances center on the stigma that seems to hold for services proffered by Public Assistance and mental health agencies.

Schulberg, Herbert, "Disaster, Crisis Theory, and Intervention Strategies," Omega, 5:1: 77-87. 1974.

Schulberg discusses the proliferation of definitions and usages of the concept of crisis, depending on whether it is viewed as a clinical syndrome, a prototype of the interaction between the individual and his environment, a normative experience, or a change tactic. Pointing out as well those features of crisis which are central to most viewpoints, he suggests a probability formulation of whether or not individuals or groups will experience crisis and discusses both anticipatory and participatory strategies of disaster intervention.

Sundel, Martin, "Problems Facing a Community Mental Health Center in Delivery of Mental Health Services to a Disaster Area," Paper based on a presentation made at the Annual Meeting of the National Council of CMHCs, Washington, D. C., February 25, 1975.

Sundel presents a detailed account of a regional CMHC program's response to a tornado. At the time of impact services were mainly ad hoc consultation and education. In following months various direct and indirect services

were provided to both victims and caregivers; concurrently, planning was done for a formal disaster plan incorporating CMHC services with those of other agencies. Several attachments are included, covering training, crisis intervention techniques, and a proposal for CMHC roles in pre-, during, and post-disaster intervention.

Taylor, Verta A., et. al., Delivery of Mental Health Services in Disasters: The Xenia Tornado and Some Implications, (Columbus, Ohio: The Ohio State University, The Disaster Research Center Book and Monograph Series No. 11). 1976.

The first attempt to survey the overall delivery of mental health services in a community after disaster, this work is aimed at ascertaining the characteristics of the organized response. The questions asked center around the who, what, for whom, how, why, and where of service delivery. Secondary attention is paid to the conditions for and the consequences resulting from the overall response.

Titchener, James L. and Frederic T. Kapp, "Family and Character Change at Buffalo Creek," American Journal of Psychiatry, 133:3 (March): 295-299. 1976.

Two years after the 1972 flood which wiped out an entire valley, psychoanalytically oriented evaluation teams studied psychological after effects. They found traumatic neurotic reactions in 80% of the survivors, characterized by a definite symptom complex of unresolved grief, survivor shame and feelings of impotent rage and hopelessness. The authors posit that the very means used by survivors to cope with their feelings actually preserved symptoms, and suggest that professional services aimed at helping victims work through personal crisis would be of value.

Tuckman, Alan J., "Disaster and Mental Health Intervention," Community Mental Health Journal, 9:2: 151-157. 1973.

Tuckman sees disaster relief as a proper arena for community mental health practice, but one that requires reaching out to victims and departing from traditional professional roles. The paper explores the psychological reactions to a major school bus accident and the intervention technique that were utilized.

Tyhurst, J. S., "Psychological and Social Aspects of Civilian Disaster," Canadian Medical Association Journal, 76, (March): 385-393. 1957.

Tyhurst was one of the first to note consistent patterns in individual response to disaster. He outlines the characteristics, the duration, and the psychological phenomena associated with three phases: the period of impact, of recoil, and the post-traumatic period. Some of his observations, relating to the extent of emotional disturbance and the degree of helplessness in populations, have not withstood the test of time. However, his central premise, that disaster is essentially a social phenomenon is compatible with current thinking on disaster mental health.

Wolfenstein, Martha, Disaster: A Psychological Essay, (Glencoe, California: Free Press). 1957.

This book is based on data collected for the Committee on Disaster Studies of the National Academy of Sciences--National Research Council. It focuses primarily on peacetime disasters in the U. S. The analysis is at the individual level, and various psychological processes thought to operate

during the threat, impact, and post-impact periods are discussed. Psychoanalytical concepts are used in the explanation of phenomena such as the denial of threat, "the disaster syndrome" and post-disaster altruism and utopian feelings.

Zarle, Thomas H., Don M. Hartsough and Donald R. Ottinger, "Tornado Recovery: The Development of a Professional-Paraprofessional Response to a Disaster," Journal of Community Psychology, 2:4 (October): 311-320. 1974.

When formal mental health agencies did not involve themselves in the recovery operations, mental health resources from a nearby university, coupled with indigenous paraprofessionals formulated a response. The authors report on the eight phases of the project, describe the training manual and schedule used, and spell out the specific goals of what came to be known as the Neighbor to Neighbor Team. With both immediate and long term objectives in mind, the project shifted over time from a referral based crisis intervention response to a coordinated outreach program grounded in both crisis intervention and social systems theory.

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