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THE DEVELOPMENT OF A MODEL OF SOCIAL WORK INTERVENTION IN MASS CASUALTY SITUATIONS

by

Evan R. Arrindell

A dissertation submitted to the Graduate Faculty in Social Work in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, The City University of New York.

1986

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Abstract

THE DEVELOPMENT OF A MODEL OF
SOCIAL WORK INTERVENTION IN
MASS CASUALITY SITUATIONS

by

Evan R. Arrindell

Advisor: Professor Simon Slavin

The physical and social upheal caused by disaster has been widely discussed in the medical and social science literature. Many victims of disaster experience great emotional stress and disruption of their social systems. The dissertation describes a project designed to provide crisis intervention services offered by social workers as members of a emergency medical response team. The project was developed as part of the National Disaster Medical System (NDMS) which is a program of the federal government. The NDMS program is based of the establishment of 150 emergency medical response teams capable of being moved to different areas of the nation in the event of a major disaster. As part of the planning for the establishment of the 150 teams, the Principal Working Group

on Health, NDMS, asked the U.S. Public Health Service to develop a prototype team that would represent the model for the national program. The development and implementation of the project was incorporated within the design of the prototype unit.

The project report includes a review of the literature on disaster and the use of crisis intervention with victims, a description of the organizational setting in which the model was developed and implemented, and the finding of the evaluation of the project.

The major findings of the study were:

that there is a clear need for crisis intervention services and part of a medical response to disasters;

that the role of the social worker must be clearly defined and understood by the leadership of a emergency medical response team; and

that the social work function cannot be combined with other activities unrelated to the provision of crisis intervention services.

Therefore, the major recommendations for future consideration are that emergency medical response teams established by NDMS should included crisis intervention services for victims and their families and that these services be provided by trained social workers.

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There were a number of people who supported and encouraged me in the preparation of this dissertation. It is therefore fitting that their contribution be acknowledged.

Preparing this document required many hours of researching the topic, developing the project, and analyzing the findings. As a result, the needs of my family were overshadowed by the requirements of the dissertation. Nevertheless, they remained patient and understanding throughout the entire process and for that they have my love and respect. This love and respect is also shared with my parents who shaped my character and who always encouraged me to accomplish whatever goal I set.

The encouragement and support of friends and colleagues were also important to the completion of this manuscript. My appreciation to Rose Dobrof who's faith in my commitment to the field of Social Work was an inspiration in pursuing the completion my doctorate. My sincere gratitude to Drs. Simon Slavin, Erwin Epstein and Barry Lebowitz, the members of my doctoral committee. As teachers, colleagues and friends they counseled and guided me throughout this endeavor. A special thank you to Dr. Edward Martin, Director, Bureau of Health Care Delivery and Assistance, who encouraged me to complete this course of studies.

Finally, to the social workers, team leaders, nurses, and staff of the HRSA, CSU, and especially to Dr. Kenneth Moritsugu, the Unit Commander, I am indebted. Without their cooperation and participation this project would never had been accomplished.

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Introduction

This is a project to develop, implement, and evaluate a model of social work intervention to address the mental health and psychosocial needs of victims of disasters. The overriding conclusion from this project is that a position identified and exclusively devoted to social work functions on the disaster team is necessary to adequately address the mental health and psychosocial needs of disaster victims. Conversely, if these functions are designed to be shared by several on the team or to be only a part of the duties of any particular individual then they cannot be carried out. The model provides the basis for incorporating social work activities, guidelines and standards into the National Disaster Medical System (NDMS). The project focuses on developing a model and implementing a process that can be incorporated within the entire National Disaster Medical System. The project evaluation involved a systematic examination of the roles that social workers can play in the providing crisis intervention services for victims of disaster. The setting in which the project was conducted was a Clearing and Staging Unit (CSU) of the NDMS.

The NDMS is a federal initiative for providing emergency medical services in both natural and industrial related disasters of great magnitude and to augment military medical services in the event of conflict. However, the primary role of the NDMS is to provide acute medical care to civilian populations affected by a disaster.

The NDMS was developed from the Civilian-Military Contingency Hospital System (CMCHS), a program to set aside civilian hospital beds for military casualties in the event of a military conflict. In the NDMS approach, however, hospital services will be augmented with medical personnel and logistical support provided by the U.S. Public Health Service. Prototype Clearing and Staging Units (CSU) are being developed as the models for 150 units planned nationwide to be incorporated within NDMS.

In April of 1984 the first CSU's were established. One hundred and thirty volunteers from the Public Health Service representing several medical and related disciplines, were organized into 3 teams to determine staffing requirements, needed training, necessary logistical support, and cost.

The CSU teams were designed to provide both clearing and staging services. Clearing involves providing direct medical care to

patients at or near a disaster site. Within 72 hours of admission to a clearing team, a patient would be discharged, transported to more definitive care, or diagnosed exspectant (further medical intervention would not improve the outcome). Patient staging is the holding of patients, for a maximum of 3 hours, awaiting transport from the area. Medical staging personnel monitor the condition of the patient during this holding period.

The personnel and training requirements of the prototype CSU were identified during two field exercises, Joint Eagle II and Wounded Eagle III, held during the summer and the fall of 1984. The CSU was developed on a model very similar to the U.S. Army' s Medical Clearing Company (MCC) and the U.S. Air Force's Medical Staging Unit (MSU); neither of the military models incorporated crisis intervention services or social services. According to the MCC model, patients identified as suffering from psychiatric trauma would be treated according to military protocols, under wartime conditions, which involves sedation and a period of 'bed rest' (not to exceed 72 hours) followed by either discharge back to the unit or evacuation to a higher level of care. In the MSU model there is relatively little definitive care provided because the mission of this type of unit is to maintain patients (for a maximum of 3 hours) pending evacuation.

Although the goal of the two exercises was to evaluate the capabilities of the CSU to provide medical care under austere conditions at the scene of a civilian disaster, this goal was displaced by logistical constraints. Specifically, the movement of patients through the medical system (consistent with a military scenario) became the overriding consideration of the exercises. In addition, the types of injuries presented and the characteristics of the patients reflected a military population and not victims that would be encountered in a civilian disaster.

The need to develop a capability to provide social work intervention evolved from the observations of the project evaluators, the CSU leadership, and the CSU personnel who participated in the exercises.

The experience of the two exercises, both of which had a strong military emphasis, indicated design modifications would be necessary. The evaluation, conducted on the basis of a civilian disaster, clearly established that the type of patients in a civilian disaster would significantly differ from those simulated patients seen during the two exercises. The evaluators pointed out that the ages, backgrounds, and groupings (e.g. families) seen in a

civilian disaster presented unique requirements compared to patients from the military services. One of these requirements involved the provision of a qualitatively different form of mental health intervention. As a result of the evaluators' findings and the post exercise discussions with senior staff of the CSU, the decision was made to identify staff within the CSU with the appropriate professional training to provide crisis intervention care and general social services (defined as providing assistance to families of the victims of disaster). Social work was identified as the most appropriate discipline from both a professional and pragmatic standpoint.

Professionally, it was recognized that social work training focuses on intervention techniques and environmental manipulation in behalf of people in crisis and who are under stressful conditions. It was felt that this training would be most appropriate in addressing the needs of disaster victims being brought to a medical unit. Operationally, there were nine social workers participating with the CSU and it was determined that with a minimum of training the social workers could upgrade their clinical skills in a short period of time; therefore, making available the personnel required to meet this need.

The development of a social work intervention model to addressed the diverse psychosocial and emotional problems presented by disaster victims is the objective of this dissertation. The scientific and programatic literature on disaster relief provides considerable information on the reactions of individuals and groups to disasters. The model developed in subsequent chapters draws upon these observations and data. In the next Chapter, the background literature used to arrive at the model is presented and discussed.

CHAPTER I

THE MENTAL HEALTH OF VICTIMS OF DISASTERS

A disaster can also be viewed as an extreme social crisis situation in which individuals and their social system become dysfunctional and disorganized; and where the result is a community of sufferers (Siporin, 1976). The scientific and clinical literature on disaster is very rich and detailed; some significant conclusions can be drawn from this literature to indicate that:

- Disasters occur in sequential stages;
- Reaction by individuals and groups to the stages of a disaster are discernible;
- The degree of emotional impact of a disaster will depend on severity of the disaster, the strength of the individuals and groups, and the resilience of the community; and
- There are specific groups within communities that will be at greater emotional risk than other victims of a disaster.

Nature of Disasters

The capacity of human beings to cope with the effects of disasters has depended upon the strength of the society and the psychological resourcefulness of the individuals within that society. Dating back to 526 A.D. when a major earthquake struck Syria resulting in the death of 250,000 people, societies have had to endure the disruptive effects of major disasters. In more recent history, disasters have struck with devastating effects, great loss of lives and large scale social disruption. In 1976, Tangshan, China, was devastated by an earthquake that caused 650,000 deaths. The largest loss of lives from a natural disaster in recorded history also occurred in China. In 1931, the Hwang-ho River overflowed its banks accounting for 3.7 million deaths. The United States has not escaped the devastation of natural disasters. In 1900, a hurricane struck the coastal city of Galveston, Texas, killing 6,000 people.

Today, the potential for a major industrial accident poses as much concern as natural catastrophes. Nuclear accidents or the escape of chemical toxins are as serious as the destruction caused by earthquakes or hurricanes. The dioxin contamination of Times Beach, Missouri, the PCB poisoning of the Love Canal community in

New York, the near "melt down" of a nuclear reactor at the Three Mile Island power plant in Pennsylvania, and the escape of toxic gas from a chemical plant in Bhopol, India, are all vivid reminders of the role man can play as an agent of disaster.

Disasters have been defined in terms of the effect that these occurrences have had upon societies and, more specifically, upon individuals. Disasters have been described as great, sudden misfortunes resulting in loss of life, serious injury, and property loss (Garb and Eng, 1969). Others have defined disasters as extraordinary events that cause great destruction of property and that may result in death, physical injury, and human suffering (Cohen and Ahearn, 1980). Schulberg (1974) views disasters in terms of a perceived crisis occurring in five stages:

1. A time sequence that unfolds rapidly;
2. Major changes in behavior;
3. Personal sense of helplessness [also a collective feeling of helplessness, depending upon the intensity and duration of the disaster conditions];
4. Tension within one's personal and social system; and
5. Perception of personal [or collective] threat.

The phases of a disaster become clearer when the period of time for each phase is longer. Earthquakes, for example, have a relatively short threat phase or warning phase since they cannot be accurately predicted. Industrial accidents involving explosion, fire, and the release of toxic substances usually occur rapidly and without warning. Nevertheless, the model that Garb and Eng (1969) proposes offers a good framework for identifying the elements of a disaster.

Garb and Eng (1969), in their conceptual model of disaster, describe six phases. Cohen and Ahearn (1980) provide a similar model to describe the mental health aspects of disasters (Exhibit 1). The Cohen and Ahearn model explains the stages of a disaster in behavioral terms - focused on the emotional reactions of victims as the stages of a disaster evolve.

To accurately assess the reactions of individuals and families to disasters, it is important to have information concerning the social and economic environment in which the victims lived prior to the disaster. Knowledge of the social and economic conditions of the community prior to disasters is also critical to the provision of appropriate services.

Major postdisaster change is unlikely unless predisaster trends for change were already operative (Quarantelli and Dynes, 1978). The hypothesis can be offered that a major disaster in an area of industrial decline, high unemployment, and general social reordering would likely result in large-scale population relocation. If social change were occurring prior to the crisis, the disaster will accelerate the process. Conversely, a stable and intact community will likely withstand the social and economic disruption caused by a disaster with relatively little long term social disruption.

Reactions to Disaster

In the United States, when disaster strikes a community, state and local governments and voluntary agencies (e.g. The American Red Cross) are expected to initiate relief efforts. Federal assistance is provided only at the request of a state and after a Presidential Declaration has been issued. Historically, federal involvement in disaster relief has taken the form of monetary assistance through low interest loans, grants, and materials such as temporary living quarters. The commitment of large numbers of federal personnel to provide direct assistance to disaster victims has not been viewed as a role of the federal government.

The attitude, however, of federal officials towards the government's responsibility for providing direct forms of assistance to disaster victims is changing. There has been a executive decision, involving a number of federal agencies, that an emergency medical network be developed using federal, state, and local personnel and funded by the federal government. This change in direction of federal policy makers is difficult of explain. Historically, however, civil defense activities have increased and declined over the past 35 years. In the 1950s to the mid 1960s, there had been a high level of activity associated with the level of international tension. In

the late 1960s and through most of the 1970s there was a deemphasis on civil defense. The decline in civil defense activities during this later period was probably a direct result of the anti-war sentiment prevalent during this period and a reduction in international tension. The resurgence of activity, although not under the rubric of civil defense, may be a result of the concern of government officials and the general public as to the virtual lack of preparedness, on a national basis, to respond to a large scale civilian disaster.

There have been enough examples, within recent memory, of potential disasters that could have caused a mass casualty situation with the civilian population. Industrial accidents and the probability of a major natural disaster occurring in the United States increases a technology advances and as scientist are more accurately able to predict natural phenomena. For example, the probability of a major earthquake in the state of California causing an estimated 100,000 casualties increases 2 to 4 percent every year (Nesbitt, 1982).

Whatever the motivation, there is increased interest in developing a greater federal response to major disasters. Formal relief efforts usually occur with the intervention of police and fire and rescue teams. The response capabilities of these service providers are much greater than other providers, including most health and social

service personnel. Police, fire and rescue personnel have been trained, for the most part, to work together in defined roles under extremely stressful conditions. A major factor in measuring the effectiveness of service providers in a disaster situation, is not only how well they perform their own jobs, but also how well they allow others to do theirs (Garb and Eng, 1969). Service providers who are called upon in a disaster are expected to have a clear understanding of their capabilities and roles and those of others who are providing disaster relief.

Disaster workers must be skilled in the identifying the different emotional responses of victims in the various phases of disasters. Advanced training should be offered to relief workers as a means of assisting victims to avoid or cope effectively with the many potential negative psychological effects of a calamity (Kafrissen et al., 1975). Workers need to be sensitive to different expressions of anxiety, depression and anger that can be exhibited by disaster victims. Hostility may be aimed at a victims spouse (who is also a victim), children, or relief officials (Mitchell and Resnik, 1981). This may appear in the form of chronic irritability, violent outbursts, or constant and severe criticism of relief efforts (Langdon and Parker, 1964). It is important that relief worker provide accurate information to disaster victims. Misinformation

adds to the confusion and anxiety already prevalent among the victims and will tend to hinder the future dissemination of important information (Takuma, 1978).

The threat to life and property posed by any disaster has generated a great deal of interest in preventing, or at least in reducing, the impact of these occurrences. Elaborate plans have been devised by many governments to reduce the effect, such as dangers to life and property, of major natural or industrial disasters. The Republic of China has developed and implemented mass evacuation plans for hundreds of thousands of people in the event of an early warning of an earthquake. Japan, similarly, has instituted a major campaign to make people aware of the safety measure to be taken in the event of an earthquake.

Apart from the loss of life, property, and the immediate social disruption resulting from a disaster, mental health problems, including short and long term psychological trauma, have been documented as consequences of any of these disasters. In fact, the number of lives lost does not always reflect the extent to which psychological problems may exist, since those who survive often experience numerous difficulties that leave turbulence and chaos in their wake (Fredrick, 1977).

The factors affecting the design and implementation of a mental health disaster relief effort are similar to those elements necessary for the development of most human service programs but different from the usual approaches to emergency medicine and disaster relief services. The capability to identify the needs of the target population, knowledge of the client group, and the development of an intervention strategy focused on the strengths of the individual and the group, are necessary components of any human service program and are especially significant in the planning and provision of mental health services in disasters.

Cohen and Ahearn (1980) describe the information requirements involved in the design and implementation of a post disaster mental health service. The provider should be knowledgable about the nature of the calamity and the severity of its consequence; the disaster victims and their probable reactions; and the particular intervention methods for providing assistance.

Emotional Impact of Disaster

A common observation among authorities in the area of disasters is the sudden and disrupted nature and concurrent physical and psychological trauma to both individuals and groups. Sorokin (1943), commenting on the impact of World War II on populations, observed that disaster victims will experience increased degrees of instability, depression, and anxiety not only during the disaster but also for a substantial time afterwards. Individuals with prior histories of emotional instability are likely to suffer from prolonged periods of psychological dysfunction as a result of the stress caused by a disaster. Perlberg's (1979) findings were similar to those of Sorokin. Perlberg administered psychological test to the survivors of the collision of the two jumbo jets in 1977 on a runway on the Canary Islands. The survivors, who were tested up to five months after the accident (580 people died in the collision and ensuing fire), exhibited several symptoms of traumatic neurosis, including anger and rage, sleep disturbance, and repeated nightmares about the event. Findings obtained after the Nicaraguan earthquake of 1972 indicated that areas most severely affected experienced the greater gains in admissions to the Nicaraguan National Psychiatric Hospital (Ahearn, 1981). The largest percentage of these admissions was for individuals with histories of

mental illness. In addition, post disaster admissions for neurosis rose by 46 percent for the year, although the increase was 209 percent for the three months immediately following the earthquake. Erikson (1976) has labeled this the "second disaster" where the impact of disorganization in the aftermath of disaster will increase neurotic behavior.

Similar findings were observed after the Zagreb flood in 1964. There was a sharp increase in the number of workers seeking assistance from the mental health dispensary in the Zagreb factories immediately after the flood. In addition, absenteeism due to neurotic reactions increased as did the relative number of cases of neurotic reaction reported to the factory's mental health clinic (Blazevic et al., 1967).

The degree of emotional trauma following a disaster depends on a number of factors (Cohen and Ahearn, 1980): the type and duration of the disaster; the length of time; the type of prior warning the amount of destruction; the number of persons seriously injured and/or killed; and the perception and interpretation of these factors by victims. All these factors may affect the intensity and

scope of psychological impact (Fritz, 1967). The most commonly observed reaction, immediately following a disaster, is one of shock, confusion and disorientation. These emotional states may persist for several days (Wallace, 1957).

When disasters occur, each individual is confronted with an unfamiliar reality. The tendency is for the individual to shape this new and frightening information in a form they are able to emotionally and intellectually assimilate. This reshaping of the unknown and placing it into a familiar context, especially when the disaster occurs without warning or the warning phase is relatively short, is a particularly important determinant of the mental health consequence of the disaster. This problem of accurately interpreting information is found in numerous reports of researchers who have studied persons who have ignored warnings of danger. This is especially true for individuals who have not experienced a disaster (Kilpatrick, 1957).

McGonagle (1964) identified two disparate emotional responses to disasters, personal invulnerability and illusions of centrality. Personal invulnerability represents a danger during a disaster because victims may react inappropriately to impending danger-risking their lives or those of others. On the other hand, victims experiencing illusions of centrality internalize the crisis

and views the disaster as being aimed directly towards them. The Mount Lamington eruption of 1951 where 4000 deaths occurred gave evidence in support of the centrality hypothesis. Because of the strong influence of the Anglician church in the area, many of the survivors view the destruction as punishment for "their sins" (Belshaw, 1951). These responses can cause difficulty for the victims in adapting and coping with the aftermath of the disaster (Kendrick, 1955). Long after the disaster has passed, the victims may manifest these feelings in inappropriate behaviors (Cohen and Ahearn, 1980).

Perceptual problems are not the only emotional manifestations associated with disaster victims. Psychophysiological factors also affect the behavior of disaster victims during the postimpact phase. While the emotional responses of victims vary, there seems to be general consensus that the dominant emotion expressed by victims is fear (Cohen and Ahearn, 1980). In the more serious cases psychic numbing, hallucinations, and delusions may occur (Fritz, 1966).

Quite frequently disaster victims appear quiet, reserved, and docile when in the presence of disaster workers (Wallace, 1957 and Janis, 1969). This demeanor, however, should not be equated with irresponsibility or helplessness. As Quarantelli (1960) observed,

the dependency image depicted by disaster victims is a false view of their behavior. It is, instead, a manifestation of the psychic numbing phenomenon discussed by Fritz (1966).

Overt expressions of hostility or irritability are generally not associated with disaster victims. When these feelings are exhibited after the disaster, they are usually of wide-spread resentment that existed prior to the crisis (Fritz and Williams, 1957). It has been noted that repressed feelings of hostility, anger, and rage may be expressed as much as weeks or months after the disaster (Glenn, 1979 and Church, 1974).

In some instances, the anger expressed by victims of a disaster is the result of the perceived inadequacy of relief efforts in comparison to the expectations of the victims. The organization and implementation of relief efforts must represent to the victims a sense of confidence and stability that has been disrupted by the disaster (Dalitz, 1979). It is important that the groups involved in a disaster relief effort are clear about their functions and responsibilities and that this is communicated to victims. Along with feelings of anger and confusion are feelings of guilt. This is especially true when there has been great loss of life. Lifton (1972) noted in his description of survivors of Hiroshima that the survivors faced formidable problems as a result of feelings of guilt

because of their having survived the devastation. Survivors become involved in attempts to repay the dead for their survival, relief and joy at being spared became unacceptable. Rosenman (1956) in his study of guilt among disaster victims, tried to account for the "omni-presence of guilt" expressed by victims. He attributed feelings of guilt to the emotional toll victims pay in terms of actual bereavement, terror and loss in which the guilt manifest itself.

In general, the behavior of disaster victims is adaptive and self-protective in nature. Most individuals who find themselves involved in a disaster are able to gather the emotional and, in some cases, the physical strength to withstand the disruptive affects of a crisis. Although most victims of disasters are able to rebound from the calamity and rebuild their lives and their communities, there is a clear sub-group of victims who require additional support.

It is estimated that in disaster situations approximately 15 percent of the victim population will require some form of direct intervention in order to regain their emotional equilibrium (McGonagle, 1964). The majority will exhibit confused and disoriented behavior - evident during the early stages of the postimpact phase. The duration of this maladaptive behavior is

unpredictable but it is safe to assume that the sooner intervention occurs the greater likelihood of a favorable prognosis (Tyhurst, 1951).

Most victims will display transient signs of emotional disturbance immediately after a disaster. For adults, behavior will follow somewhat distinctive patterns depending upon a variety of emotional and experiential factors. For some adults, reactions to the various phases of a disaster range across a spectrum of responses. For example, in the preimpact phase responses are likely to include underactivity, failure to take precautionary measures, denial, fatalistic behavior. In the warning phase, over activity, and a need for information is likely to be observed. During the impact phase 75 percent of the victims will exhibit stunned and bewildered behavior, another 10-25 percent will be confused, paralyzed by anxiety and hysteria and another 12-25 percent will show adaptive behavior. In the postimpact or recoil phase , there will be gradual return to reality, some anger and fear will be shown, feeling of loss of trust, dependency and anxiety will be present. In the post-traumatic phase behaviors will include accelerated activity, frustration, anger, scapegoating, grief and some psychic numbing and guilt (Boyd, 1981). It is important that disaster relief workers understand and are able to address the range and intensity of reactions that will be presented by disaster victims (Mitchell and Resnik, 1981).

There have been a variety of emotional and psychosomatic expressions observed during the postimpact phase of a disaster. Some victims has expressed feelings of loss and loneliness (Tyhurst, 1951). More severe feeling manifestations have been presented such as helpless, aimless, wandering, apathy, and depression. Non-communicative behavior cause by shock has also been cited (Healy, 1969). Physical or somatic reaction have occurred in some form of severe nausea, vomiting, and conversion hysteria (Healy, 1969).

The appearance of somatic problems caused by extreme stress will depend to a large degree upon the relationship between the strength of the adverse force and the emotional stamina of the individual. It would be extremely difficult to try to predict the reactions any particular victim will exhibit. The risk factors of stress induced illness can only be determined if the condition that activate the stress are known (Dohrenwend and Dohrenwend, 1978). Disasters, by definition, are unpredictable in terms of intensity, duration, and cause and the reactions of individuals and groups to the stress produced by disasters. Likewise, the coping ability of disaster victims will depend on the relationship between the degree of stress produced by the external crisis and the emotional strength of the victim. Relief workers need to be aware that early supportive intervention with victims can reduce the emotional damage resulting for a disaster.

Another factor important to the coping ability of victims is the strength of their social support system and the degree to which the system remains functional during the postdisaster period. The level of functional disorganization in which the victims find themselves after the event, and the subsequent recovery and restitution activities will be related to the degree to which the disaster has disrupted the victims social system (Cohen and Ahearn, 1980). If the devastation caused by a disaster is such that those elements comprising the victim's support system are dysfunctional, the victim will experience greater difficulty in returning to the predisaster level of functioning. Conversely, the physical damage resulting from a disaster can be extensive but if the social infrastructure of the community remains relatively intact the degree of social dysfunctioning may remain low.

For example, Taylor (1977) investigated the psychological impact of a tornado that struck the town of Xenia, Ohio, on April 3, 1974, killing thirty three persons and injuring 1200. There was severe damage to the town and the local economic infrastructure. The research team arrived on the site four hours after the tornado struck and spent 18 months observing the residents and the rebuilding of the community. The study documented an extreme low rate of short term and long term mental illness attributable to the

tornado. The researchers inferred that the predisaster strength of the community was a significant element in the relatively low rate of postdisaster emotional illness.

Although there is general agreement that the stress resulting from the onset of a disaster will cause a range of emotional problems, some researchers disagree on the long range negative affects of a calamity. Perry and Lindell (1978) offer a model of the possible long range effects of disasters. The elements of their model fall within three categories: 1) characteristics of the disaster impact; 2) characteristic of the social system; and 3) characteristics of the individual. This model can be readily applied to the time sequence definition of a disaster enabling researchers to observe the reactions of victims as the different phases occur.

Individuals involved in disasters react differently depending upon the strength of their coping ability, the condition of their social support system, and the extent of loss they incur, whether the losses are physical, emotional and/or material. The major increase in the onset of maladaptive behavior has been observed during the recovery phase after the victim has internalized the full impact of disaster. During the impact and rescue phase records have indicated that victims show very little maladaptive behavior, rather, the behavior of victims is rational and of a helping nature.

Panic is one form of behavior that has been rarely observed during a disaster. Most observers of disaster victims have concluded that panic occurs in some victims when there is a belief that escape is impossible. On the other hand, disasters produce a sense of community and group purpose which generally result in a helping behavior. Although under extreme conditions shock may occur accompanied by apathetic and confused behavior, these symptoms are usually transitory and are replaced by what Krebs (1970) characterized as altruistic behavior.

Altruistic behavior incorporates a number elements and activities exhibited by individuals or groups by the ethical and moral nature of their acts, prosocial behavior, empathy, or by the responsiveness and appropriateness of their actions performed during a crisis. The altruistic behavior of disaster victims during the rescue phase of disasters has been widely documented by numerous accounts of survivors reentering a disaster are to assist in rescue operations. Observers have tried to account for this behavior by viewing the impact of the disaster as a cohesive or fusing force as well as a destructive agent. The onset of a disaster forces individuals into experiencing a common situation and, in a general sense, produces an equalization of role and status (Bates, 1963). However, the

altruism demonstrated by victims during the rescue phase of a disaster diminishes as the introduction of formal relief efforts occur.

At-Risk Populations

Within the general victim population, specific groups appear to be more vulnerable than others to the psychological effects of disasters. In addition to individuals with prior histories of mental illness, the elderly also may be more susceptible to psychological trauma resulting from disaster, especially where predisaster support systems have been non-existent or kinships ties have been weak or lacking. Observations on the reactions of elderly victims of the bombings during World War II indicated that:

1. The elderly were less likely to receive warnings, resulting in greater physical and psychological trauma;

2. The elderly were reluctant to evacuate their homes and leave their possessions;

3. The elderly were less likely to engage in behavior oriented towards individuals and groups beyond self and family in rescue and immediate postimpact phases; and

4. The needs of older persons for rehabilitation services was greater than other groups (Friedman, 1962).

Brenton (1975), observed that many aged suffering from the disruption of their social supports systems, exhibited feelings of loneliness and depression and developed somatic or psychosomatic complaints. Bennett (1970) studied the effects of the flooding of Bristol, England, on the population. The flood had damaged 3000 dwellings in the area. The study examined the morbidity rates of individuals who had experienced the disaster and a comparable group who were not affected. The findings indicated that in general the affected group reported a higher incidence of somatic and emotion illness than the comparison group. Gleser, et al., (1978) and Ollendich and Hoffman (1982) also had similar findings in there study of elderly disaster victims.

The literature on the response of elderly victims to disaster contains controversy. Bell, et al., (1978) found that the aged victims of disasters had greater potential for coping with the emotional effects of the disaster than younger victims and concluded, after a study of 200 randomly selected victims of a Nebraska tornado, that the elderly had less self-reported anxiety and stress than other groups. The elderly in Bell's study appeared to be able to resolve tension more quickly than younger victims. Bell attributed his findings to the strength of the informal support system that remained relatively intact during the postdisaster period. This is consistent with the findings among researchers that

the ability of the elderly to rebound successfully from a disaster was dependent upon the existence of an informal support system and the strength of this system.

Children are another group found to have a high rate of psychological trauma resulting from a disaster. The psychological stress caused by a disaster are more profound for this group and the duration of the trauma is longer than for any other group as a whole. Disrupted sleep patterns, loss of appetite, loss of concentration, depression, and hyperactivity are some of the behaviors observed in children who have been the victims of a disaster. In a study conducted by Crawshaw (1963), children were found to demonstrate anxiety, nightmares, and phobic reactions during the postimpact phase of disasters. Children who were victims of the Buffalo Creek flood were found to have a high level of mental impairment and a greater need for prolonged intervention of social work services than adults (Church, 1974).

The vulnerability of children to the effects of a disaster is a characteristic of their dependency upon the stability of the family unit. The quality of familiar relationships in the predisaster setting has a direct bearing upon the degree of psychological trauma and the duration of impairment in the postdisaster phase.

Parent-child interaction prior to impact and the parental response to the child's behavior during the postimpact phase influence the extent and outcome of treatment (Silber 1958).

This chapter has presented a review of the characteristics of disasters, the effects disasters have on people and societies, the range of individual and group responses to disasters, and the vulnerability of certain segments of the population to the disruption disaster can inflict upon them and their social system. It can be surmised from the literature that disasters represent a sudden disruption in a social system, which in its aftermath can lead to the strengthening or undoing of a society.

In the following Chapter there will be a discussion of the strategies for addressing the emotional and social conditions resulting from the onset of a disaster. The strategies will focus on the role social workers can play in providing crisis intervention for victims of disasters.

CHAPTER II

Opportunity for Social Work Intervention

The use of social workers in the provision of crisis intervention and social services for victims of disasters is not a new idea. Community mental health programs have been, for the past 20 years, involved in disaster relief efforts specifically aimed at ameliorating the emotional trauma caused by disasters. Social workers have comprised a significant number of the mental health professional who have participated in disaster relief efforts as part of the community mental health system. However, outside of community mental health programs, social work intervention in disaster relief efforts are limited.

This chapter will explore the potential use of social workers on an emergency medical team. This setting will be unique in that the goal of these teams will be the relief of physical trauma and the movement of victims to facilities where more definitive medical care can be provided. In comparison with the community mental health setting, where social work is an integral part of the service team, on the medical emergency team social work services are adjunct to the overall mission.

Timeliness

The potential for a large scale natural or man made disaster has substantially increased over the past twenty years in the United States and throughout the world. In the United States the increased potential for major loss of life and property, as a result of a disaster, has been directly linked to large shifts in populations away from the industrial areas of the northeast and north central states to the earthquake, hurricane and tornado areas of the "sunbelt." The area with the greatest probability of a serious disaster occurring within the next few years is the western portion of California along the San Andreas Fault.

Geologists, geophysicists, and seismologists have all predicted the occurrence of a major earthquake of devastating magnitude in southern California with the expected epicenter of this earthquake occurring in the Los Angeles area. The seismic signs indicate that pressure is increasing along a series of fault lines throughout southern California.

The consensus of federal and state officials is that a disaster of this magnitude will require the intervention of large numbers of trained health personnel.

Since late 1982, officials of the United States Public Health Service (PHS) have been involved in planning activities aimed at developing a prototype medical Clearing and Staging Unit (CSU). The unit is to be a model for the creation of 150 CSUs throughout the nation under the National Disaster Medical System. These units will consist of volunteer health professionals from communities participating in the NDMS program. These volunteers will be called upon to provide emergency medical assistance in the event of a major disaster. Although these units will be based in communities throughout the country, they will be expected to respond to disasters occurring anywhere within the continental U. S.. The PHS has been assigned responsibility for developing the guidelines and protocols for the staffing, training and equipping the proposed 150 units.

The prototype unit developed by the PHS Health, Resources and Services Administration, was comprised of three teams each with a total strength of 130 health professionals capable of caring for 240 casualties per day over a 12 day period. The design of the CSU is similar to the U.S. Army's Medical Clearing Company (MCC) and the U.S. Air Force Medical Staging Unit (MSU). There is one major difference in this new system, however, in that the MCC and the MSU do not include social workers.

Social work services in the military health care system are provided primarily in hospital settings. The nature of the care delivered at an MCC is acute medical intervention for personnel who are suffering, for the most part, from physical rather than emotional trauma. In those instances when psychological trauma is present, the course of intervention is pharmacological and where necessary evacuation. The MSU functions as a medical holding area where patients are awaiting evacuation for more definitive care. Patients with emotional trauma are, by military evacuation policy, medicated and not amenable to supportive intervention. But the most significant aspect that separates the activities of the two military models from that of the CSU are the characteristics of the victims and the circumstances by which they became victims.

The victim population in a disaster, in contrast to military casualties, spans across all age groups and involves families and communities of victims. When a child or parent, for example, is injured or dies as the result of a disaster, the immediate result may be a family or even a community of victims. The sudden and unexpected trauma of the disaster compounded by injury and death can be devastating to individuals. Likewise the death of a soldier in combat can be traumatic, however, the circumstances under which the tragedy occurred is quite different than in a disaster.

Appropriateness

The staffing pattern of the CSU included physicians, nurses, and other personnel who have different health training backgrounds. Social workers are included in this latter category.

Each of the three CSU teams has a physician as chief; the physician is responsible for providing clinical and administrative direction. During an actual disaster relief effort, the team leader would be heavily involved in providing direct medical care as well as clinical supervision. The purpose of the project was to allow social workers on the team are to provide the crisis intervention services, to identify local resources, and to coordinate the referral of emotionally traumatized victims to community health and mental health providers. This referral function was identified as a specific responsibility of the social workers. In the event that all mental health services are destroyed in the disaster, the social workers would have the responsibility for arranging for evacuating those victims requiring more definitive care.

Proposed Structural Change

The structure of the program is still evolving and roles have yet to be solidified. However, the conditions under which the social worker are to provide services during the course of a disaster will be austere and stressful, similar to wartime conditions. The crisis intervention the social workers will use involves techniques borrowed from 'battle field' psychiatry in addition to traditional skills of support, coordinating services and referrals. Many of the task performed by the social worker in this model are a combination of hospital social work, Red Cross case work activities, and mental health crisis intervention.

The identification of social workers as the professionals most capable of meeting the psychosocial needs of disaster victims was an acknowledgment of the unique skills and training embodied within the profession. The integration of social work services depended upon the identification and synthesis of specific activities related to the provision of crisis intervention care and social services within the structure and function of the CSU.

The development of an implementation plan sensitive to the needs and direction of the CSU leadership required an understanding and

appreciation of the intra-unit politics, since the problems in implementing any program ultimately are problems of politics (Williams and Elmore, 1976). During this evolutionary phase of the CSU, decisions concerning personnel and their functions remained open to change.

At the time of this project, no patient care personnel had been designated to provide services to emotionally traumatized individuals. Neither had there been developed specific guidance on the care of other than physically injured individuals or in linking individuals to community based mental health or social service providers. The lack of social work intervention services had been recognized by the CSU leadership (based on the evaluation of the previous exercises) as a concern and a deficit in the service system.

The CSU leadership has also come to recognize that the military's methodology for providing crisis intervention care was not applicable to civilian disaster relief efforts. The nature of the service population in a military casualty relief setting is such that intervention can occur rapidly. The client population is, for the most part, young, used to functioning within a structured setting, group oriented, and responsive to an authoritative

environment. This approach has been effective for the military but would have questionable application for a civilian population.

In the civilian population emotional trauma will be found within all age groups but are expected to be highest among the young, the elderly, and patients of the mental health system. In some cases, however, the type of disaster may produce a new high risk population vulnerable to increased levels of stress. For example, there were numerous news accounts of the high level of concern expressed by pregnant women and women of child bearing age about the possibility of birth defects as a result of the release of radiation from the Three Mile Island nuclear reactor. The emotional state of disaster victims will vary depending on predisaster characteristics of families and communities. These factors will have an important effect on the type of service provided to the victims. Therefore, the structure of the team and the design of the intervention had to incorporate the flexibility to offer services specific to the needs of victims.

In this chapter the social work role in providing crisis intervention has been discussed. It is reasonable to assume that the greater the disaster the greater the likelihood of emotional trauma which will require professional intervention. The

participation of social workers on emergency medical teams responding to major disasters is an essential component of a relief effort. The development and implementation of a social work intervention model - focused on providing crisis intervention services for disaster victims will be discussed in the following chapter.

CHAPTER III

The Goals, Design and Implementation of a Social Work Intervention Model for Victims of Disaster

This Chapter will be devoted to a discussion of the design and implementation of the social work intervention model-developed for a Clearing and Staging Unit (CSU) of the United States Public Health Service. In discussing the design of the project, there will be a review of the goals and objectives of the model and a discussion of the implementation approach that was used.

Project Goals

The goals of the project were:

1. To develop a social work practice model focused on providing crisis intervention services for disaster victims;

2. To successfully integrate this model of practice into a prototype Clearing and Staging Unit that had as its primary

mission the provision of acute medical care for disaster victims;

3. To demonstrate the value of social work intervention for patients and their families who have been traumatized by a disaster;and

4. To evaluate the effectiveness of the social work model during a simulated disaster exercise.

The objectives of the project were:

a. To identify the social work activities that comprise a crisis intervention model for victims of a disaster;

b. To develop and present to the CSU leadership a plan for including social work intervention as part of the services of a CSU;

c. To identify the social workers who would participate in the project;

d. To provide crisis intervention training to the project social workers;

e. To develop and implement a timetable for the project; and

f. To develop an evaluation methodology that would test the appropriateness of the model.

Program Design

This project was developed in response to a request by the commander of the CSU. The responsibility for designing and implementing the project was given to the author who functioned in the capacity as the Operations Officer. His task was to develop the conceptual basis for the project, identify the different functional elements of a CSU social work service, to establish the criteria for selecting the social workers, to select and train the social workers, to test and evaluate the feasibility of the project, and to prepare findings and recommendations for presentation to the commander and the command staff.

In designing the social work intervention model consideration was given to the structure and staffing of a CSU. The prototype CSU was being developed as a model for possible replication nationwide; therefore, it was important to incorporate a degree of flexibility within the social work model. For example, a CSU is comprised of three teams each with approximately 30 to 35 health care providers responsible for providing acute medical care to severely injured individuals. In addition, a CSU is designed to be operational for 24 hours per day for a period of up to 14 days. The staffing of a team has been kept to a minimum level necessary to provide acute care to 120 patients every 12 hours. This meant that conceptually every member of a CSU will be involved, to some degree, in life - saving activities.

The primary mission, as expressed in the policy document of the CSU, is the provision of acute medical services to disaster victims. Any attempt, to redefine a function other than the direct provision of life saving care would have been met with resistance. The addition of social work services evolved from concerns that surfaced after the annual CSU exercise, Wounded Eagle III. These concerns reflected observations made by two of the five exercise evaluators that in a civilian disaster, there would be a number of patients, and family members, and acquaintances who would need counseling as a

result of the trauma caused by the disaster. The comments of the evaluators did not include a specific recommendation as to who should provide the counseling services. It was the operations officer and a social worker who recommended to the commander of the CSU that social workers be assigned the responsibility for carrying out this service. It was made clear to the operations officer that, if the social workers on the CSU assumed this role, they would have to also satisfy the functions associated with their ward assistant and litter bearing duties.

Therefore, in designing the social work model and in delineating roles - social work activities were present as secondary to the delivery of acute medical care. The successful initiation of this project relied upon the clear acknowledgment of the primary function of a CSU and the unobtrusive integration of social work activities within the host setting.

Development of the Model

The first task was to identify the discrete activities that would comprise the social work intervention model. The activities were divided into two functional areas: the first was crisis intervention for emotionally traumatized victims of a disaster; and

the second was the coordination of services for those individuals requiring follow-up care.

The elements comprising the crisis intervention were seen as consisting of evaluation of the presenting problem(s), diagnosis, and intervention. The evaluation, diagnosis, and intervention would be based on the presenting problem(s) - avoiding, where possible, traditional psychiatric labeling. This is because literature clearly indicates that the majority of individuals who are emotionally traumatized by a disaster are experiencing a transitional stress syndrome and, therefore, psychiatric labels are generally not appropriate.

Service coordination activities were developed in concert with the crisis intervention approach. In general, service coordination was viewed as a logical extension of crisis intervention for victims served by a CSU. The CSU, by definition, is a temporary service and, therefore, victims who require follow-up services would need to be referred to a local program for this care. In recognition of the short-term service provision of a CSU, the training and the protocol developed for the social workers focused on the types of victims that might be encountered and the referrals they would require.

Selection of the Social Workers

Of the 130 people who volunteered for the CSU, 8 were trained social workers with Masters of Social Work Degrees. The 8 social workers who had volunteered to be members of the CSU, were initially assigned to ward attendant positions. There was no expectation that their social work skills would be utilized in any traditional manner. When the social workers volunteered for the CSU, they were informed that the sole mission of the unit was to provide direct medical care to victims of a disaster. Informally, the social workers did express some concern over the lack of recognition of the emotional trauma caused by a stressful situation such as a disaster. Therefore, when the possibility of identifying a social work activity was announced, there was an enthusiastic response by the social workers.

The initial plan was to train all 8 of the social workers, realizing that in an emergency 'call-up' of the CSU some number of them would not be able to respond. Operationally, it was anticipated that a minimum of two social workers would be available for each of the three teams at the point of activation. All of the social workers who had volunteered for the CSU possessed a masters in work and had previous clinical experience in a mental health setting. However, all of them were currently working in administrative positions.

Development of the Treatment Protocol

The use of crisis intervention during periods of extreme stress was first instituted by military psychiatrists during World War II. They found that men suffering from psychological trauma as a result of combat experience had a higher rate of recovery when they were not totally removed from the combat setting. The familiarity of the surroundings, the maintenance of a known structure, and the support of comrades and superiors markedly improved the prognosis for these casualties. Physicians treating soldiers concluded that supportive therapy provided at treatment facilities, close to the front lines, enabled a faster return to duty and prevented the development of more entrenched patterns of psychiatric illness (Hausman and Rioch 1967).

The method used by military physicians focused on the situational crisis; the individual's feelings about what happened, the development of group support, promotion of self confidence, and the avoidance of psychiatric labeling. With minimum interference in a person's routine, and with commitment to returning the individual to functioning, regression was prevented (Lieb, Lipsitch, and Slaby 1973).

The goal of crisis counselling, especially in the short term, is limited to reducing the effect of malevolent external forces while assuring that psychosocial supports are provided to the individual. The immediate manipulation of the individual's environment and the provision of social supports (i.e., family and friends) will reduce the likelihood of further regression and will allow for a more rapid recovery (Parad 1965).

The physical and temporal limitations inherent in disaster situations make the use of short term crisis intervention therapy a necessity. The professional assigned to provide crisis intervention care in the aftermath of a disaster will have to be prepared to address the needs of large numbers of victims who belong to different socioeconomic, ethnic, racial, and age groups and whose psychological and social support are in a state of disruption. Services must, by necessity, be provided rapidly and under less than ideal conditions. Follow-up care, where necessary, has to be provided by community service providers, thus increasing the importance of appropriate diagnoses and referrals.

A major disaster (as the type predicted on the west coast of the United States) involving several thousand people will stretch relief efforts to the limit. Disaster victims with physical trauma will take priority over individuals whose injuries are psychological. Medical personnel will be heavily involved with the saving of lives and the relief of physical suffering. To the extent possible, the relief of emotional suffering will be the responsibility of the social work staff.

General treatment protocols or treatment plans are recommended for providing crisis intervention services (Carlton, 1980). The treatment protocol designed for this demonstration contained five general categories:

1. Time limited treatment contacts.

In most cases the victims of emotional trauma will be experiencing an extreme stress reaction to the disaster situation. These acute and severe reactions are time limited and can be improved through the use of a mild sedative (when appropriate) and support from the worker and someone familiar to the victim (Cohen, 1985). It is

important to stress that the use of the victim's support system is crucial to the recovery process. All efforts should be made to involve the support system in the treatment of the victim.

2. The use of psychotropic medication to relieve symptoms.

In recommending the use of psychotropic medication, standard precautions should be emphasized. The approach should be conservative with victims suffering from anxiety and psychophysiological reactions (Cohen, 1985). In some cases victims may seek psychotropic medication as a means of 'short-circuiting' uncomfortable emotion; counseling, support, and even a change in environment may be a more desirable alternative to the use of medication. It should be remembered that anxiety, anger, and grief are not abnormal reactions for victims of a disaster. Treatment should be focused on the transient nature of the situation.

3. Use of existing social support systems.

Intervention with victims of a disaster is more effective when planned around their natural support system (Solomon,

1985). The mobilization of the victims natural support system helps in reducing stress caused by the sudden disruption in their life situation. Therefore, intervention should be aimed at restoring the victims ability to handle stress and reordering their world through interaction with those individuals who represent stability.

Training of Social Workers in the Treatment Protocol

Training in crisis intervention and agency coordination under disaster conditions was provided to the six social workers who remained with the CSU. The major emphasis of the training was to improve the clinical skills of the social workers and to familiarize them with the organizational structures found in disaster relief efforts. In general, the social workers on the CSU had not been engaged in clinical activities for a number of years. It can be hypothetical that this situation would be a typical for other CSUs that would obtain volunteers from clinical settings. Therefore, the training was be aimed at renewing their clinical skills while providing additional information on crisis intervention services in disaster situations; hence a double training problem.

The agency coordination portion of the training provided information to the social workers on the types of social agencies involved in disaster relief efforts. This portion of the training was reduced from what was originally to be a more extensive presentation on agency coordination and referral approaches. The decision was made to reduce the emphasis on the coordination aspect of the training based on the knowledge on the extensive administrative activities of the social workers which involve daily interaction with other programs and agencies at all governmental levels. It should be recognized, however, that the training was modified to account for the unique skills of this particular group of social workers (e.g., program administration and coordination). If this training model is used with other groups of social workers, it may be necessary to stress the agency coordination aspects of the training as well as crisis intervention.

The training of the six social workers consisted of 16 hours of lecture provided by Jeffrey T. Mitchell, Ph. D, faculty of the Emergency Health Services Department of the University of Maryland. Dr. Mitchell is a consultant to the National Institute of Mental Health on crisis intervention for victims of disasters and to a number of states and local emergency programs. Dr. Mitchell's lectures focused on the effects of disasters on individuals, groups,

and communities. In addition, he described the different programs and activities that might be bounded providing services at the scene of a disaster. Dr. Mitchell used reading material and video tapes of actual disaster relief efforts during his presentations. In addition to lectures and films, time was set-aside at the end of each of the sessions for questions and discussion of the material.

There was not a formal evaluation of the training with respect to a pre and post test of the knowledge and skill levels of the social workers prior to the training and after it was completed. The decision to forego an evaluation was based on the limited amount of time between receiving approval for the training, conducting the sessions, and the actual exercise where the model was to be tested (the training was conducted within a week and a half of the exercise). However, evaluation of the performance of the social workers was conducted during the exercise. The informal response to the training was overwhelmingly positive about the quality of the training and the knowledge of the trainer. In general, it is advisable to conduct an assessment of trainees prior to the training to identify their strengths and weakness, to assist in structuring curricula, and to assess knowledge and skill levels after the training has been conducted.

At the conclusion of the training, the social workers received a protocol developed by the project director based upon the lectures given by Dr. Mitchell and the current literature on crisis intervention in disasters. The protocol stated the purpose of the intervention model and gave specific instructions concerning the type of activities and options the social workers might considered when providing services to victims of a disaster. The protocol was used as the basis for case dispositions and as part of the evaluation. The patient examples described in the protocol were used for patient scenarios during the exercise. It was anticipated that the social workers would have an opportunity to provide services to the simulated patients using the protocol for guidance for both patient management and deposition (Exhibit 2).

Implementation Plan

To paraphrase Williams (1975) the most pressing problem in the implementation of a program is moving from the decision phase to the operational phase while trying to insure that what is being implemented is in someway similar to the initial decision. Implementation, as suggested by Williams is a dynamic and somewhat unpredictable process. The implementation plan (Exhibit 3) for the project had received a series of reviews and approval including the

command staff (the commander and his immediate staff and the team leaders) prior to the selection and training of the social workers. At each phase of the implementation the command staff was kept up-to-date on the progress of the project. They were also provided information on the crisis intervention services and how these services could be provided by the social workers in the CSU. Nevertheless, problems in implementing the project began to occur even prior to the exercise. As Bardach (1977) suggested, it is impossible and impractical to try to plan for every occurrence that may take place during implementation.

The implementation of the model was conducted during Wounded Eagle IV, a three day exercise, at Fort A.P. Hill, in Virginia. As indicated above, prior to the beginning of the exercise problems began to emerge. Originally the plan was to have two social workers for each team, a total of six, and to evaluate their performance in providing care to simulated emotionally disturbed patients. The first problem to surface was the result of a decision made by the CSU commander to change the training schedule by reversing the order in which the teams were to be deployed. This action was taken because the team members were under the impression that team I would always be deployed first. In a real situation, mobilizing all the members of

a particular team is unrealistic because of time constraints and the unavailability of team members. It was felt by the CSU Commander that all three teams should be prepared to be the first to be deployed. As a result, three of the six social workers were unable to participate in the exercise. Fortunately, the three remaining social workers were able to rearrange their schedules so that there was one social worker for each team.

The second problem involved a decision by the exercise commander (the U.S. Air Force was responsible for conducting the exercise) to decrease the number of patients that would have a psychiatric problems in the exercise. His decision was based on a reduced number of Air Force personnel available to act as patients and a need to provide a larger number of physical trauma cases. It was obvious that without additional personnel the project would not be implemented. The U.S. Army commander, who's personnel were providing logistical support, was asked to provide additional patients for the crisis intervention part of the exercise. The Army commander agreed that Army personnel would be used. In addition, he requested that the personnel also be provided training by the project director on handling emotionally traumatized victims; six sessions were conducted for Army personnel.

An additional problem emerged once the exercise began. Up to and until the exercise, the team leaders were supportive of the concept of using the social worker on their teams to evaluate and care for those patients with a initial psychiatric diagnosis. This initial support was evident in the pre-test questionnaire administered to the team leaders to identify their attitudes and knowledge of social work services in disasters. (In the next chapter there will be a discussion of the evaluation that took place during the exercise.) However, when the exercise commenced and the pressure to care for physically injured patients began to increase, the team leaders immediately exercised their option and reassigned the social workers to other patient care activities. It was obvious throughout the exercise that, although the team leaders had expressed an understanding and appreciation for the emotional trauma caused by a disaster, their actions reflected the priorities described in the CSU manual; which placed maximal emphasis on the saving of lives. On the other hand the exercise did not fully represent a civilian disaster scenario. The vast majority of the patients were young unattended males with the exception of the simulated psychiatric patients that were included in the exercise to test the model.

In spite of the difficulties experienced prior to and during the exercise, these were significant findings with respect to the role and functions social workers can perform on a CSU.

In Chapter IV The evaluation and the findings of the project will be discussed. That chapter will examine the type of evaluation used, the reaction of the social workers to the project goals, and the dichotomy between the response of the team leaders to the evaluation questions and their actions during the exercise.

Chapter IV

Evaluation and Findings

This Chapter is devoted to a discussion of the methodology used for the project evaluation; the rationale for selecting this methodology; the implementation of the evaluation; and the evaluation findings. The Chapter will be divided into three sections. The first section will be a discussion of the setting in which the evaluation occurred. This will include the description of the key informants and their involvement in the project. The second will be be an examination of the elements which influenced the evaluation outcomes focused on the consequence or deviation between the anticipated project outcomes and what emerged. The third section will present the finding of the evaluation in a narrative or descriptive format. A purely descriptive format was selected due to the small size of the study sample which involved a total of nine individuals.

To recapitulate, the project was based on the assumption that social work intervention, as a part of medical disaster relief efforts, would reduce long-term emotional trauma for the victims. The setting in which the hypothesis was tested was a prototype unit developed to examine the feasibility of establishing medical

Clearing and Staging Units (CSU) nationwide as a part of the National Disaster Medical System (NDMS). The U.S. Public Health Service was responsible for developing the prototype CSU. The personnel of the CSU were Federal health employees who volunteered to be serve on the prototype unit. The CSU consisted of three teams of 30-35 personnel each. The personnel consisted of physicians, nurses, social workers, and other health professionals. The CSU maintained a total complement of 130 personnel of whom eight were masters level social workers (MSW). The original plan was to train all eight social workers, and select six who would comprise the lead and backup social work for each team. However, before the training occurred two of the eight social workers resigned from the CSU which left six - in effect, subverting the initial selection plan. The training of the remaining six social workers occurred just prior to the exercise in which the model was to be evaluated. The training consisted of 12 hours of didactic lectures on the emotional trauma suffered by victims of disasters, discussions by the group concerning the various treatment modalities used in disaster situations, issues of interagency coordination during disaster relief efforts. Most of the training was focused on strengthening the clinical skills of the social workers in disaster relief. Reviewing clinical interventions was viewed as the most critical aspect of the training as compared to the agency coordination.

In the initial training plan equal emphasis was given to both clinical interventions and agency coordination activities. This approach was later modified due to the high level of administrative experience of the project social workers. The six social workers were involved on a daily basis in coordinating agencies as part of their activities, therefore, training in this area was not considered necessary. If this model is implemented nationwide, training in agency coordination would be important for those social workers with limited experience in this area.

At the completion of the training, a protocol was developed from materials provided during the training and from literature obtained from the National Institutes of Health on crisis intervention services for victims of disaster (Exhibit 2). The protocol was given to the six social workers for use during the exercise, and to be used as part of a secondary analysis of the project model.

The project social workers were asked to review the protocol and to provide comments and suggestions for improving the format and the content. A meeting of the project social workers was scheduled for the purpose of reviewing the protocol and preparing the final document. Copies of the protocol were also distributed to the team leaders who were physicians trained in primary care specialities

(e.g., family medicine, pediatric, etc.), and the chief nurses of each team for review and comment. The team leaders, in turn, were to discuss the protocol and the availability of social work services with the triage/admitting physicians who would be the first to see all patients brought to the unit.

The team leaders and the chief nurses were selected to review the protocol for the following reasons:

- When a team is deployed the team leader has line responsibility for all aspects of the team's performance.

- Modifications of the role and functions of any member of the teams would need the sanction of the team leaders.

- The chief nurse for a team has the responsibility for operating the wards, and without the cooperation of the chief nurse referrals for social work services on the wards would be difficult to obtain.

The team leaders had been aware of the social work project and its purpose. The command-chief nurse of the CSU, who is a member of the command staff representing nursing, who has a disciplinary rather

than a direct administrative relationship with the chief nurses for each team, had participated in the crisis intervention training offered to the social workers. The training experience coupled with the interest of the command-chief nurse surfaced in her enthusiasm for the project and her willingness to discuss the protocol with the chief nurses of the teams, however, time constraints did not permit her to arrange a meeting.

The evaluation focused on two areas, the first, organization and function; and the second, on the degree to which the social work protocol expedited the handling of cases. Organization and function were defined as the degree to which the leadership of the teams (team leaders and chief nurses) understood the role of the social worker vis-a-vis the other members of the team. The social worker (according to the project design) would be asked to fulfill two roles, the first as litter bearer/ medical assistant and the second as team social worker. The organizational issue, therefore, was whether the team leadership and the social worker could effectively manage these competing obligations. In terms of function, the issue was one of understanding the appropriate use of social work services in a mass casualty situation. The protocol was deliberately provided to the team leadership (including discussions about the

purpose of the protocol) so that when a case fitting a description in the protocol was presented, it would signal for the use of the social worker.

Evaluation Plan

The evaluation consisted of four phases, three of which involved survey instruments. Phase one, the pre-exercise survey, focused on identifying whether the leadership of the teams (team leaders and chief nurses) understood the role and function of a social workers and whether they had ever worked in a clinical setting where they had the opportunity to use social work services (Exhibit 4). This phase of the evaluation occurred after the leadership of the teams had an opportunity to review the protocol and just prior to the exercise. Phase two of the evaluation was the observation of the activities of the social workers during the exercise, and their utilization by the team leaders and the chief nurses. It is worth noting that the observation was non-interactive, in that, the observer who was the project director was not an active participant in the exercise, nor was feedback provided during the course of the exercise. Phase three consisted of a post-exercise survey (Exhibit 5). The timing of this phase immediately followed the regularly scheduled debriefing at the end of each exercise, where the survey

was administered. This survey was administered apart from the activities of the rest of the team. The team leader and the chief nurse of the team were surveyed individually and were not given the opportunity to discuss their observations and actions prior to the administration of the survey. The purpose for not allowing discussions of the activities of the social worker by the team leadership prior to the survey was an attempt to obtain their individual impressions of what occurred. Phase four, was the debriefing of the social workers. This phase consisted of two separate research activities, a post-exercise survey of the social workers immediately after the completion of the exercise (Exhibit 6), and a group debriefing session with all the social workers approximately 1 week after the exercise.

Results of the Pre-Exercise Survey

The results of the pre-exercise survey verified what was observed time and again during the exercise; that anticipated behavior can be dramatically altered by circumstances. As the pressure to care for physical injured patients increased there was a decreased emphasis on providing crisis intervention services. This was in contrast to the pre-exercise survey where the team leaders and the chief nurses indicated the following:

a. Both groups claimed an understanding and knowledge of the role of social workers in providing services in a medical setting.

b. All of the respondents confirmed that they had read the social work protocol and indicated that they understood the role of the social worker in a disaster relief effort as defined in the protocol.

c. The one area of knowledge in which the team leaders (physicians) and the chief nurses differed, was in their familiarity with social work services in disaster relief efforts. All of the team leaders answered no to this question, as compared to the three chief nurses who answered yes to this question.

d. In terms of attitudes towards social workers, all of the respondents indicated a favorable response to social work involvement in the management of patients experiencing emotional trauma, this included the entering of notes into the patients medical chart and requesting consultation from the social worker where indicated. The team leaders expressed positive attitudes towards social workers and felt that social work services were "important."

One of the three team leaders wrote on the survey that he did not perceive a need for social work during this particular exercise. The reason he offered was that there would be no request for services such as housing, relocation assistance, or financial assistance, because this exercise had a major focus on caring for military casualties. It should be noted that this team leader did not raise any questions during the review of the protocol, although there were many opportunities to request clarification. The lack of questioning by the team leaders appeared to be related to their belief that they clearly understood the role of social workers in disaster relief efforts. However, it was apparent by the actions of the team leaders during the exercise that if they did understand, they did not apply this knowledge in the practice exercise.

Of particular interest was the fact that the three team leaders did not brief the admitting physicians about the availability of social work protocol. Conversely, all of the chief nurses responded that they did share information about the present of the social workers. When the team leaders were asked to explain why they did not share the information about the availability of social work services with the admitting physicians, their response was that they would be working with the admitting physician and could easily make the referrals.

Results of the Observation During the Exercise

The second phase of the evaluation involved the observation and documentation of a series of anticipated actions to be performed by the team leader, the chief nurse, and the triage/admitting physician. The anticipated activities were based on the team leaders and the chief nurses having an operational knowledge and understanding of the social work protocol, and in turn presenting this information to their respective staff.

The observation of the three categories of personnel was conducted during 3-consecutive days of the actual field exercise. The individuals were observed as they performed the functions and interacted with the social worker on the team. The observer did not participate in the exercise; his role was only to observe the behavior of the team during the exercise.

The overall conclusion from the period of observation was that the pressure to attend to the physically injured overshadowed the emotional considerations of those with less physical trauma. This conclusion was later confirmed by the post-exercise survey of the team leaders, the chief nurses, and the social workers.

During the exercise the social workers who also functioned as litter bearers and ward attendants were observed, asking the admitting physician whether any patients were in need of crisis intervention care. In one case, an identified nonviolent psychiatric patient was sedated and transferred to the ward without the social worker being notified. In another case, the social worker was immediately summoned for consultation for an extremely agitated patient who required four personnel to restrain him (in this case, sedation would have been appropriate). It was the inconsistent and limited use of the social workers which was observed repeatedly throughout the exercise.

The first team to participate in the exercise, assigned the social worker to litter bearing duties. During this time, there were three designated psychiatric cases admitted and only in one instance was the social worker asked by the chief nurse to intervene with the patient. It is important to note two observations, the first is that the chief nurse for this team was involved in triaging patients and requested the social worker because he was one of the litter bearers who had brought the patient to the triage area. In this case, as observed during the entire exercise, the proximity of the social worker to the chief nurse determined his/her utilization. The second observation was that the social worker on this team was

never asked to see patients on the wards. During the exercise this social worker remained as a litter bearer and was never asked to serve on the ward.

In the case of the other two teams, both social workers were assigned to ward duties. These two social workers were observed providing crisis intervention care on the wards where they were assigned. In both cases, the chief nurses ask the social workers to "interview" the psychiatric patients on that ward. Likewise, social work services were not requested on the other wards in the absence of the chief nurse. The conclusion that can be drawn from these observations is that the chief nurses for the teams possessed a more complete understanding of the role of the social worker in disaster relief efforts. It can also be inferred that social workers and nurses have historically worked closer together in health settings, therefore, providing a greater understanding of their professional roles.

It was apparent throughout the exercise that the use of social workers was restricted to those patients with psychiatric diagnosis. Social work intervention was not requested for dying or critically injured patients. It appeared that social work services were defined by the chief nurses and by the team leaders as

psychiatric services. This may be one factor that accounted for the limited utilization of the social workers.

Another observation worth noting relates to the question on the pre-exercise survey administered to the team leaders that asked whether they (the team leaders) shared the information about social services or the protocol with the admitting/triage physicians.

The three team leaders all stated that they had not shared the information; the reason given was that they would be available in the triage area to make the referrals. What was observed was that the team leaders were not able to remain in the triage area, in fact, they spent most of their time monitoring the activities on the wards. Therefore, they had little opportunity to see patients in triage, resulting in only two consultation requests for social work intervention, at triage, ordered by the team leaders from team I and II respectively.

It is unclear whether the team leaders would have asked for greater input from social work if they had been able to spend more time in triage area. What is apparent, however, is that information and understanding of social work intervention needs to be acquired by all staff at all levels. Staff of the CSU need to have an operational understanding of how social work services blend and

complement the medical care provided to disaster victims whether the victims are in an acute psychiatric crisis, seriously injured or dying. It was evident from the observations that there was lack of knowledge as to the psychological effects of sudden physical trauma and social upheaval on patients. This is an area that will require additional education for CSU staff.

Overall, the most commonly observed situation was the minimal utilization of social work intervention. Although the social work protocol was distributed well in advance of the exercise (each team leader and the chief nurses received the protocol at least 48 hours prior to the exercise), and the team leaders and chief nurses were given two opportunities to discuss the protocol as a group and individually; there appeared to be a lack of understanding and an operational knowledge of social work and crisis intervention services.

Post-Survey Results: Team Leaders and Chief Nurses

The third phase of the evaluation was a post-exercise survey of the team leaders and the chief nurses to identify whether there were any changes in their knowledge and their attitudes towards social work and crisis intervention services as a result of the exercise. The pre-exercise survey of this group indicated an apparent

understanding, appreciation, and willingness to use social work services. This was in contrast to what was observed during the exercise. It was important to determine the validity and reliability of the initial survey by asking similar questions and comparing responses. What was indicated by the post-exercise survey was that there was high reliability with the pre-exercise survey instrument but low validity when compared to what was observed.

The results of the post-exercise survey did not indicate a change in the knowledge base of the chief nurses. Their response to the question were consistent with the pre-exercise survey results. This may be a factor of the pre-exercise working relationship that exist between the nursing and social work professions. With respect to the team leaders (in term of knowledge acquisition) two of the three indicate no change in their understanding of social work as a result of the exercise. What was striking were the comments made by the third team leader. Although his responses to the knowledge questions showed no change, his comments about having a greater understanding of social work services in a disaster situation was a significant change. The significance was that this particular team leader was the same person who saw little need for social work services on a CSU, because there would not be any income or housing problems.

The changes in understanding social work intervention by this team leader may be traced to three unrelated incidents. The first, was that this team leader was able to spend all 3 days of the exercise, compared to the other two team leaders who were involved only on the day their teams were deployed, observing the two other teams, and the activities of the social worker (although limited). The second was his participation in all three sessions on crisis intervention services for disaster victims, the other team leaders attend one session conducted by the Public Health Service for Army personnel. Third, was an "accident" in terms of the scheduling of emotionally traumatized patients. Their initial plan was to have five psychiatric patients per team for each days' exercise. On the third day, team three (which this team leader commanded) received nine emotionally disturbed patients all at once. Between the physical and the emotional trauma cases, he was forced to use the social worker. At first, however, the social worker was sent to the most agitated patient, who (according to the scenario) was in the midst of a psychotic episode and could not be helped by counselling while in this condition. The social worker was able to convince the team leader to allow her to attend to the other emotionally traumatized patients who had been transferred to the medical ward.

It appeared that the participation of this team leader during the 3 days of the exercise, his attendance in the training, and his

experience while his team was involved in the exercise, had an impact on his understanding of social work and crisis intervention services. The implications, therefore, are that team leaders need greater exposure to the concepts of social work intervention in disaster situations and more opportunities to observe and to work closely with the problems with which the social workers work in an field situation.

In conversation with all of the team leaders, they were apologetic for not having the "time" to appropriately use the social workers. In every case, the team leaders pointed to the pressure to physically move patients through the system which was viewed by them as the major 'driving' force of the exercise. To some extent the scenario did not totally lend itself to providing patient care (physical or emotional). Patients were delivered by ambulances, trucks, and helicopters and were expected to be discharged and returned to the staging area within 4 hours. However, there were specific opportunities for the team leaders to use social work service with patients who were predesignated to be in need of crisis intervention. Parenthetically, all three teams were over staffed as a result of augmentation by Army personnel, therefore, staffing was not an issue with respect to releasing the social worker from ward or litter bearing duties.

Post-Exercise Survey of the Social Workers

The fourth and final phase of the evaluation consisted of two separate parts. The first was a questionnaire that was administered to each of the social workers immediately after the exercise concluded. The second was a group debriefing meeting with the social workers 1 week after the exercise.

The post survey instrument administered to the social workers had two purposes, the first was to obtain feedback of their impression of the usefulness of the protocol and second to test the validity of the observations of the utilization of social workers during the exercise.

The responses to the post survey were consistent with observational evaluation that: a) social workers were rarely called upon to provide intervention even in the most appropriate cases; b) the chief nurses were more apt to request social work services than either of the team leader of the admitting physician; and c) given the dual role of the social workers (litter bear/ward attendant/social worker), those activities more closely related to the preservation of life took precedent over crisis intervention and other social work services.

The meeting with the social workers, 1 week after the exercise, was aimed at accomplishing two objectives. The first was, again, to confirm or disconfirm observations in a relaxed and informal atmosphere; and second to offer the social workers an opportunity to express any additional responses or ideas they might have about the exercise, the protocol and/or the future of social work on disaster CSU. As with the data obtained during the observation of the exercise, the social workers expressed the same problems of limited use, conflicting responsibilities, and a lack of understanding about the type of services social workers can provide in a disaster relief operation. With respect to the protocol, the social workers were unable to fully test its effectiveness because of their limited access to patients with emotional trauma. They felt that they would want another opportunity to experiment with the protocol in exercise where they would be permitted to actually provide crisis intervention.

General Findings

The evaluation revealed two major findings, the first, was that a theoretical knowledge of social work and a working understanding of social work practice are quite different.

The pre- and post-exercise surveys of the team leaders (physicians) indicated their knowledge of social work and an understanding of when social work and crisis intervention services should be applied. The survey responses of the team leaders also suggested that they had worked with social workers in other settings and understood the types of services they provide. Therefore, the question to be raised is, what was the nature of their previous working relationships with social work?

Did the team leaders participate in a interdisciplinary setting with social workers or was social work a unit to refer patients with income or housing problems. Likewise, were the pressures of the exercise and the nature of the exercise so significantly different from previous situations in which the team leaders had worked with social workers, that they were unable to make the cognitive link between past experiences, and what occurred during the exercise. However, what tends to dispel this possible explanation was the active use of social work by the chief nurses. Although limited to the ward where they were assigned, the chief nurses asked the social workers to provide services to emotionally traumatized patients and, in some cases, to those with traumatic injuries.

In many health setting, nursing and social work have close working relationships (e.g., hospital wards, primary care clinics, local

health department clinics, etc.) and an appreciation and knowledge of the skills of each profession. It is reasonable to assume that as a result of the previous operational understanding of social work by the chief nurses, transferring the application to the exercise setting was able to be accomplished.

An operational understanding of social work and its role and function in an interdisciplinary setting is an issue that will be addressed in the recommendations. It will be important for all members of a CSU to understand the role of social work if appropriate referrals and interventions are to occur. This will require social workers on a priority basis to be available for patients requiring crisis intervention.

This raises the second issue identified during evaluation. If social work and crisis intervention services are to be a viable component of a CSU, these services must be acknowledged by the leadership as a priority. Social workers cannot be expected to bear litters and to be ward attendants and also provide social work services. By definition, a ward attendant is assigned to a single ward (a CSU can have from three to four wards). The social worker will need access to all the wards as well as to engage individuals, families, agencies, and groups as part of his/her social work function.

If the social worker is confined to a ward and is required to provide a service in an another area, replacing the social worker on the ward becomes problematic. Therefore, in order for the social workers to provide care they should not be responsible for any ward activities. Needless to say, in a crisis situation where there is a question of saving lives, all members of the CSU would be expected and required to assist; this would also include social work.

The next Chapter will present the recommendations for including social work intervention as a major element of the services provided by a CSU. The recommendations will also provide a suggested administration structure—identifying the location of social work with the CSU. These recommendations will be presented to the leadership of the CSU for review, discussion and, hopefully, approval.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

In this Chapter, there will be a presentation of the recommendations which emerged as a result of the findings of the project evaluation, including proposed organizational modification for implementing the recommendations. The first part of the Chapter will consist of a series of recommendations, each being followed by a rationale for the recommendation. The second part of the Chapter will present possible organizational alternatives for including social work services within the Clearing and Staging Units (CSU). The third and final section of the Chapter will be a concluding statement on the need for a mechanism to address the emotional trauma caused by disaster. Before presenting the recommendations, however, it is helpful to summarize the findings of the project evaluation.

The intent of the project was to assess the feasibility of including crisis intervention and agency coordination services within a CSU designed to provide emergency medical care to victims of disaster.

The Public Health Service (PHS) CSU was developed as a model or prototype to be replicated nationwide as part of the National

Disaster Medical System (NDMS). The primary goal of the NDMS planners in developing the prototype CSU was to create a system whereby medical support personnel could be rapidly deployed to areas struck by a disaster. The emphasis of the NDMS planners was to reduce the mortality and morbidity caused by physical trauma. This focus was consistent with the scenario used as the basis for their planning; which was a catastrophic disaster occurring in a densely populated area of the Continental United States. The planning scenario was limited, for the most part, to estimates of physical trauma. As such, minor attention was given to the emotional trauma resulting from a disaster and the need to rapidly intervene with disaster victims who have experience major personal and social disruption. Because there was limited consideration given to the emotional aspects of disaster, the staffing of the prototype teams did not reflect any provisions for services for emotionally traumatized victims. Furthermore, the planners did not include in the planning for the CSUs the need to establish linkages at the staff level with other relief programs at the disaster scene.

Based upon these planning assumptions the CSU was designed as an austere medical system for receiving physically injured victims in need of emergency care. Outside of providing direct medical care no attention was given to developing a means of dealing with the

psychosocial problems of disaster victims who may or may not be physically injured. As a result, there exists a significant possibility that in an actual disaster where CSU would be deployed, valuable time of physician, nurses and other health personnel would be used in performing other than life saving activities. This in effect would defeat the purpose of the CSU approach.

It is fortunate that the leadership of the CSU recognized the need to address the emotional trauma resulting from disasters. However, the sanction to conduct the project did not imply a major modification of the existing doctrine and organizational structure of the CSU. The approval to move ahead with the project was given with the understanding that whatever was developed should not require major changes in the current structure of the CSU. The planning and implementation of the project, therefore, was conducted within very specific parameters, which limited the types of organizational options that could be tried.

Another limiting factor of the project were the participants involved in carrying out the exercise scenario in which the project was implemented. The majority of participants involved in the

planning and implementation of the exercise in which the project was conducted were from the military. As a result, the character of the exercise reflected a military rather than civilian disaster perspective. Because of the military characteristics of the exercise, the types of situations found in a civilian disaster were not included; thereby foregoing the opportunity to evaluate certain project assumptions. For example, there was no opportunity to include an activity in the exercise to examine how the social workers would establish linkages with other relief agencies; there were no family members or significant others accompaning patients, leaving the question how these situation would be handled.

Although the exercise presented obstacles to fully testing the model, there were opportunities to implement and examine significant issues and components of the project. This included the use of social work in providing crisis intervention care. Social work training emphasizes the relationship between environmental and pyschosocial factors in the functioning of individuals and groups. Disasters, by definition, are disruptions in the environment which can seriously disturb the emotional equilibrium of individuals and groups. Social workers, through their training, are able to introduce interventions that address psychosocial and environmental factors causing stress to the individual and their social system.

The awareness of the benefits of social work intervention in situations where major social disruption has occurred, was a significant contributing factor in the decision to develop and implement. Furthermore, it was shown to be effective when used during the exercise. The two other significant issues identified during the project implementation were the inability social workers to adequately perform two distinct and separate functions and the limited ability of senior medical staff to appropriately use social workers.

It was evident throughout the exercise that the project social workers could not fulfill the functions of both social worker and ward attendant. The demand for ward duties consistently superseded social work activities. One of the initial premises on which the project was based was that the social workers could preform both duties. This was shown not to be the case. The need to have social work services available to patients at different times throughout the exercise negated the responsibilies to carry out functions.

The findings of the project clearly indicated that, although the senior medical staff had been made aware of the availability of social work services, there was a lack of understanding in how to appropriately use the social worker. It was evident that further education needed to be provided to the senior medical staff on the

emotional impact of disasters on victims and the services that social workers can offer.

It was also evident from the project that even with appropriate training in crisis intervention that organizational constraints presented the most formidable problems in implementation. Training of social workers to provide crisis intervention services in disaster situations is necessary, however, this training by no means is sufficient to assure the delivery of services. It is important that training be provided to social workers focused on ways of integrating their skills within a medical emergency system - unfamiliar with the contribution that social work can offer to the overall provision of care.

Recommendations and Rationale

In this section, specific recommendations and the rationale for the recommendation will be presented. The recommendations will be based upon the findings of the project including a rationale which will be a brief explanation of the basis for making the recommendation. The recommendation will be presented in order of priority, with the understanding that the order of implementation may be quite different. The following are the project's recommendations:

- Social work service, provided by masters level social workers, should be made available to every CSU. These social workers would be responsible for providing crisis intervention care and agency coordination services for victims of disaster.

  The findings of the project clearly showed that social workers cannot function in dual capacities within a CSU. The requirement to provide direct medical care, even in a situation where the patients are stabilized and maintained on the wards, places pressure on the medical and nursing staff to assure adequate staffing. The need to maintain adequate staffing on the wards will always overshadow the need to provide crisis intervention care and agency coordination

services. It was unfortunate that the exercise did not offer an opportunity to demonstrate more closely the type of situation found in a civilian disaster. If a more civilian oriented scenario had been used, it may have created great pressure on the system to more effectively use social work services.

The literature consistently points out that disaster will produce high levels of emotional stress and social disruption of individuals and groups. In a mass casualty situation where there will be thousands of victims who have been abruptly displaced from the homes and communities and where physical trauma and death will be very visible, emotional stress and social disruption will be at extremely high levels.

The planners for the NDMS are involved in developing plans to provide emergency medical care to thousands of civilian disaster victims. The psychiatric cases, according to planning estimates, will represented approximately 10 percent of the total number of casualties. However, the planning estimates represent only the psychiatric cases of those individuals with the most overt symptoms. The patients who maybe

suffering extreme stress but without readily identifiable symptoms and those injured individuals, their family and friends who will be in an increased state of anxiety and stress have not been included in these estimates. The availability of psychiatrist will be limited at best; likewise, there will be pressure to utilize all available medical and nursing personnel in life saving activities; as was clearing demonstrated during the Wounded Eagle IV exercise. Therefore, social workers trained in providing crisis intervention care can relieve the pressure on other direct care providers who will be providing direct medical care.

Furthermore, many of the individuals who will enter the CSU will be seeking information about family and friends who were involved in the disaster. There will be little if any time for medical and nursing personnel to contact and follow-up with relief agencies as to the status of family members or significant others. Social workers can easily

fulfill this role while providing comfort to the inquiring victims. In addition, many of the professionals who staff disaster relief agencies are trained social workers. This professional bridge would be extremely useful in establishing quick linkages between the CSU and other relief agencies.

- A policy and procedure should be develop which clearly identifies the role and function of the CSU team social worker.

  One of the most important finding of the project was that the social workers cannot fulfill dual functions; if one of the functions restricts access to patients requiring social work intervention. Only under conditions where, without the direct intervention of the social worker, the life of a patient would be in jeopardy (e.g., the arrival of large numbers of critically injured patients) should the social worker be ordered to perform other duties.

- Training should be provided to team leaders, physicians, chief nurses, and ward nurses on the emotional trauma resulting from disaster.

In order for the social workers to provide crisis intervention services, key medical staff need to understand the emotional impact of disaster on individuals, families, and communities. Without an appreciation and understanding of the emotional trauma caused by disaster staff may not recognize symptoms requiring immediate intervention. This lack of awareness and sensitivity to emotional trauma could result in increased psychiatric morbidity.

- Training should be offered that focuses on the effects of disaster on CSU personnel.

Although the project did not address the issue of stress among disaster relief workers, this would be a very appropriate area for the CSU team social worker to provide services. The stress of providing care to large numbers of seriously injured individuals can have a devastating affect upon the performance of staff; and in some cases this emotional trauma can have long term consequences. It is important that personnel understand that they to can become victims and that the stress associated with providing emergency care to large number of seriously injured and dying patients will

traumatize workers in a very short period of time. Therefore, it is important to the maintenance of the CSU team members to be aware of their limitations and for the team leadership to know when a staff person should be removed from the "line." The social worker can be valuable in assisting the team leader in identifying staff who are experiencing undue stress and need counseling as a result of the situation.

- The leadership of the CSU should consider planning a series of exercises focused more on a civilian disaster scenario.

  One of the major difficulties faced in implementing the project was the lack of an appropriate scenario. The exercise was limited in time, in scopes and, more importantly, in the types of patient setting. This did not allow for an adequate examination of the performance of the social workers or the CSU staff in general. As indicated in the findings, the exercise was "driven" by requirements to quickly process patients and transport them. Furthermore, the types of

patients reflected injures and condition found more in military conflict rather than what would result from a civilian disaster. Therefore, the training needs of both the medical personnel as well as providing greater opportunity for assessing the use of social workers continues to be a major issue.

These recommendations represent the major areas requiring consideration by the leadership of the CSU. It is important to recognize that implementing these recommendation will require a change in the planning assumptions that have been the basis for the development of the prototype CSU and in the organizational structure. As with any organization, it will be difficult to change existing philosophy and structure. However, if CSUs are to be responsive to the emotional as well as the physical needs of disaster victims, changes will be necessary.

Proposed Organizational Alternative for Including Social Work Services

This part of the Chapter will present three proposals to include social work services as part of the care provided to disaster victims by the CSU. The presentation will include a statement describing where the social work services should be located and the benefits and problems associated with each approach.

Proposal I

Each CSU team should include one masters level trained social worker who will be responsible for providing crisis intervention care and agency coordination services for disaster victims. The social worker would be administratively under the direct supervision of the team leader and, only under emergency condition, would be directed to assist in medical or other CSU duties.

Benefits

By clearly identifying the social worker duties and functions on the CSU team and by placing the social work administratively, under the team leader this would reduce the possibility of having the social

worker assigned to other activities. The clear delineation and elevation of the social work position provides sanction for social work to conduct activities within the CSU, and to establish linkages with other disaster relief programs in behalf of the CSU. Furthermore, in this position, the social worker can intervene and provide consultation to the team leader concerning the level of stress on team personnel. Although stress among team members was not included as part of the elements of the project, it is an important and crucial area to be considered.

Problems

In assigning a social worker for each CSU team it would require an increase in the proposed number of personnel. The number of personnel is currently fixed at a maximum of 35 per team. Adding the social work position would require an additional position.

Another potential problem would involve the other health professionals on the team who may raise the issue of identifying social work as a required service. For example, there are dentist and pharmacist on the teams who are not functioning in their profession roles. They could site examples of the need for their services as part of the activities of a medical emergency team. For instance, in a mass casualty situation a dentist could be useful in

aiding victims with facial trauma. Another example would be assigning a pharmacist to the CSU to manage and administer to large supply of medications, required for a civilian population.

Finally, there is the problem that has been repeatedly discussed, which is assuring that the social worker is used by the team leader in accordance with the policies and procedures of the organization. One of the recommendations that was offered was training for team leaders to sensitize them concerning the emotional impact of disasters on individuals and groups, the recognition of the need for crisis intervention. and the potential contribution of social professionals.

Proposal 2

In the absence of having a social worker assigned to each team, a social work consultant group would be attached to the command unit of the CSU. The group would number no more the four masters level social workers and they would be deployed when requested by the team leader(s).

Benefit

The visibility of social work services would be raised to the command level - potentially giving greater sanction to social work activities. As part of the command structure social workers could advise the leadership of the CSU on issues such as the emotional readiness of personnel, training needs in the psychosocial area, and they could assist in planning exercises that include emotional as well as physical trauma. In addition, functioning at the command level would present less of a problem in maintaining the integrity of social work services at the team level. If the social work consultants were deployed, they would carry the sanction of the Commander.

Problems

Having a social work consultant group at the command level increases the size of the administrative group and moves a direct service away from the environment and group in which it is expected to function. It would place the social worker outside of the team—possibly causing friction between the team members and what maybe perceived as an imposition from the "top-down." This in affect would negate the opportunity for social workers to provide intervention for

members of the team. Likewise, moving the social workers from the team level does not allow the type of informal networking to develop which is important to groups in accomplishing a task.

Placement at the command level may increase visibility but it may also raise even greater controversy about singling out social work as a particular service. It is possible that other health professions would request having their group identified as consultants and raised to the command level thus creating a "top-heavy" command structure. Team leaders would, therefore, lose control of the teams operation as more and more consultants are identified under the Commander.

The other major problem will be deployment. The three teams within the CSU can be deployed together or separately and, even if deployed together, there may be wide distances between teams. There would be a problem in moving the social work consultants from one team to another—given that transportation at the disaster scene will be aimed at transporting patients not staff. In addition, there is no way of predicting the need for social work service before arrival at the scene. It may evolve that the greatest need for social work intervention may occur within the first 24 hours. The time between the consultants arrival and the need for social work service may not be congruent.

Proposal 3

This proposal would incorporate the elements of the first proposal which was to assign a masters level social worker to each team, under the direction of the team leader. In addition to specifically identifying a team social work, a chief social worker would be designated at the command level. The chief social worker would be responsible for providing psychosocial consultation to the command staff concerning overall patient services and staff readiness.

Benefits

Maintaining a social work presence at the team level offers on-the-scene availability and accessibility of crisis intervention care for victims and personnel, agency coordination, and consultation to the team leader. The social worker would be viewed as part of the team and can more readily integrate the social work services into the total care giving apparatus of the team.

The chief social worker at the command level can offer professional support to the team social workers and provide a locus of authority for the activities of the social workers. The chief social worker can also provide consultation to the CSU commander and the command

staff on psychosocial issues concerning patient care and personnel readiness. In the area of professional guidance, the chief social worker can develop training programs for the team social workers, the team personnel, and the team leadership. The introduction of training on the emotional impact of disaster was conducted during Wounded Eagle IV and received a good evaluation. With the designation of a chief social worker, this training can be incorporated into the overall training program for CSUs personnel.

As the focal point for professional guidance, the chief social worker can be the conduit to the command section for information concerning the emotional readiness of personnel. As the profession focal point, the chief social worker can address problems or issues raised by the team social workers.

Problems

At present there are two disciplines represented at the command level; there are medicine and nursing. By designating a chief social worker the commander may be asked to have representation by other health professions. The designation of other chief professional officers at the command level is not as problematic as it may appear. Currently, the command group has other professionals, however, they are functioning in their discipline.

For example, there are two pharmacist; one is the executive officer, and the other is the supply officer. There is also a medical engineer, a sanitarian, and a health administrator, as well as a social worker who is the operations officer. A possible solution would be to establish dual roles for the current members of the command group.

For example, the executive officer could also function as the chief pharmacist, the communications officer (the medical engineer) could be designated to represent his discipline, and so on. However, the problem that may arise is at the team level. There are no corresponding positions identified on the teams—as being proposed for social work. The question arises whether these other professions will seek disciplinary presence at the team level, or whether they will be satisfied with a consultative role within the command group.

Although there are benefits and problems associated with each of the proposals, the third approach would appear to be the one of choice. Proposal 3 provides for integration at the team level for social work and for a locus of responsibility within the command group. A chief social worker provides liaison for the teams, as well as a vehicle for establishing and maintaining a psychosocial emphasis at

the command level of the CSU. In respect to other disciplines, it would be advantageous for the command group to call upon the professional expertise of its members to improve and maintain a high quality of service even though the disciplines are not represented at the team level.

In conclusion, the social work model that was implemented still requires further refinement. The exercise in which the model was executed did not provide optimal conditions to effectively assess the efficacy of crisis intervention and agency coordination in a disaster relief effort. There remains a considerable number of areas that require attention; for example, training of CSU personnel including sensitizing team leaders, establishing a locus of professional support at the command level, and the planning and development of training exercises that reflect the conditions under which the CSU will be asked to provide services.

Traditionally, social workers have not played a major role in providing services as members of a medical emergency unit. However, given the opportunity, social workers and the services they have been trained to provide, they could be vital in the providing care to emotionally traumatized victims of disaster.

If the National Disaster Medical System continues to grow, social

work services could become an integral part of the array of services offered as a part of medical disaster relief. The implications for the social work profession are far reaching. Schools of social work can begin to design curricula focused on crisis intervention care for disaster victims.* Furthermore, there will be a need to identify and develop appropriate field placement for social work students who are being trained in this area of practice. Finally, continuing education courses and programs will need to be developed for social workers who are currently in practice and who wish to training in this field. This field of practice has the potential to be a new and exciting area for the involvement of social workers.

* Howard University School of Social Work, Washington D.C., is proposing to introduce curriculum that will focus on social work services for displaced populations. Although this project examined social work intervention for victims of disaster, there are similarities between the problems faced by displaced groups and victims of disaster who, as a result of a disaster, become displaced.

Appendix A

Exhibit 1

Comparison of Phases of Disaster and Victim's Reaction

Carb and Eng: Phases of A Disaster	Cohen and Ahearn: Mental Health Aspects of Disaster
1. The Threat Phase - in most disasters there is an accompanying threat which may last for minutes or weeks (e.g. severe weather reports)	1. Preimpact Phase -Degree of existing stress in the individual -Prior disaster experience and the nature of that experience -Coping ability
2. The Warning Phase - implies a high probability that disaster will strike (e.g., a tornado warning)	
3. The Impact Phase - is the time during which the disaster is actually present in a particular area	2. Impact Phase -Type and severity of disaster -Duration of the disaster -Role of the victim -Coping skills -Existence and strength of social support system
4. The Inventory Phase - follows the impact, when the victims, their neighbors, and the general community assess what has occurred and determine their situation	3. Postimpact Phase -Degree and duration of social disorganization -Nature and degree of continued loss -Role of victim -Presence of social support system
5. The Rescue Phase - the transition or distinction between the inventory phase and the rescue phase is not clearly drawn. Some victims will still be involved in assessing their situation while others will be actively involved in rescue activities	
6. The Recovery Phase - the time needed for victims to return to a relatively stable and balanced condition	4. Behavior Outcome Phase -An array of behaviors in coping with aftermath of the disaster

Appendix B

Exhibit 2

Social Work Protocol

HRSA/Clearing and Staging Unit

Purpose: To provide guidance to clearing and staging unit (CSU) social workers who are providing crisis intervention services. The foremost responsibility of CSU members is to save lives and reduce the suffering of disaster victims. The responsibilities of the team's social worker are:

to provide care and comfort to emotionally traumatized victims;

to assist medical staff in the management of victims suffering from physical and emotional injuries;

to assist families in obtaining information on members who are patients in the CSU;

to assist in the referral of victims who are returning to the community or who are being transported away from the area to more definitive care; and

to be the liaison between the CSU and other social services providing disaster relief assistance.

Structure: A lead social worker is assigned to each CSU. The social worker will work in conjunction with the chief nurse of the unit and the medical records staff. The social worker will be directly responsible to the team leader and will report on a daily basis to the team leader in accordance with CSU reporting protocols.

Procedure: Introduction

The success of crisis intervention with victims of disaster will depend, for the most part, on the workers skill in communicating with the victims. Workers should be aware that the victim(s) may be disoriented, angry, confused, frustrated, and, in some cases, hysterical. It is important to remember that the victims have just experienced a major disruption in their lives and are attempting to regain some form of mental equalibrium. Questions

and responses to the victims should be clear, simple, and reality based. Avoid confrontations and speculative discussions and respond to only concrete request that are within your capabilities. If the victim(s) appears to be severely agitated or deeply withdrawn, attempt to transport immediately. Consult with CSU physician concerning medication when transporting agitated patients; some sedatives may cause paradoxical reaction.

Upon arrival in the disaster area, the following actions should be taken:

identify and contact key individuals at the disaster control center (DCC) or the incident command center (ICC) and advise them of your role on the CSU;

contact DCC or ICC to obtain name and location of social services and mental health program in area;

establish contact with local mental health providers and inform them of the activities of the CSU and your role ;

identify liaison person in social services agencies and inform them of the activities of the CSU and your role; and

identify individual(s) of responsible for coordinating information on missing persons.

All patient activities should be documented in medical records under heading, "Social Work Notes". If information is to be released to any group or individual other than receiving or evacuation hospital, obtain signed release of information form prior to transmittal.

Prior to taking action with a patient, the social worker should review the medical record to identify or rule-out a medical condition that may cause a temporary emotional problem. If there is doubt as to the etiology of a problem, medical consultation should be sought immediately. Furthermore, always ask the patient whether he/she had sustained any injuries during the disaster; a medical consultation should be sought if the patient received a recent blow to the head. In some cases there will not be outward physical signs.

Glossary:

A&D	Admitting and Discharge
CSU	Clearing and Staging Unit
DCC	Disaster Control Center
F/SO	Family or Significant Other
ICC	Incident Command Center

Patient Characteristics	Protocol		Action	
I.	Adult; agitate, confused, no apparent physical trauma; attended by F/SO	I.P.1	Ask patient and F/SO about any recent injury to head area, history of neurological or psychiatric problems, or substance abuse.	I.A.1	If patient has sustained recent head injury, has history of neurological or psychiatric problems, immediately consult physician. Patient may have subdural injury, require mediation, or is withdrawl
		I.P.2	Attempt to identify what the patient concerns. Has the patient sustained personal loss (family, significant other, property, etc.). Attempt to focus the patient on the transient nature of the situation. Provide information to patient on where assistance can be obtained. Try to provide any immediate and reasonable request. Be supportive but reality oriented; attempt to channel the patients frustration and anger into constructive activities (e.g. contacting other assistance programs). Facilitate all contacts with other groups.	I.A.2	If medical or psychiatric problems have been ruled out, assist patient in identifying immediate needs, contact appropiate agency or program, complete necessary release of information and referral form, and explain, to both the F/SO, in clear terms the type of agency they are being referred to and who they will see (if name is available). Give patient half referral form to patient and discharge according to CSU protocol.
				I.A.3	If patient continues to be agitated provide quiet area and request observation. When patient behavior has become more rational, follow procedure in I.A.2.
				I.A.4	If patient's behavior continues to be agitated, consult with physician, medication may be required (note: some sedatives may cause paradoxical reaction). Alert ward staff to continue observation. If behavior continues, prepare to evacuate the patient. Arrange, if possible, for F/SO to accompany patient.

-II-

Patient Characteristics	Protocol		Action	
II. Adult; agitate, confused, no apparent physical trauma; unattended	II.P.1	Ask patient about any recent injury to head area, history of neurological or psychiatric problems, or substance abuse.	II.A.1	If patient has sustained recent head injury, has history of neurological or psychiatric problems, immediately consult physician. Patient may have subdural injury, require medication, or is withdrawl
	I.P.2	Attempt to identify what the patient concerns. Has the patient sustained personal loss (family, significant other, property, etc.). Attempt to focus the patient on the transient nature of the situation. Provide information to patient on where assistance can be obtained. Try to provide any immediate and reasonable request. Be supportive but reality oriented; attempt to channel the patients frustration and anger into constructive activities (e.g. contacting other assistance programs). Facilitate all contacts with other groups.	II.A.2	If medical or psychiatric problems have been ruled out, assist patient in identifying immediate needs, contact appropiate agency or program, complete necessary release of information and referral form, and explain, repeat if required, in clear terms the type of agency they are being referred to and who they will see (if name is available). Give patient half referral form to patient and discharge according to CSU protocol.
			II.A.3	If patient continues to be agitated provide quiet area and request observation. When patient behavior has become more rational, follow procedure in I.A.2.
			II.A.4	If patient's behavior continues to be agitated, consult with physician, medication may be required (note: some sedatives may cause paradoxical reaction). Alert ward staff to continue observation. If behavior continues, prepare to evacuate the patient. Arrange, if possible, for escort to accompany patient.

-II-

Patient Characteristics	Protocol		Action	
II.	Adult; agitate, confused, no apparent physical trauma; unattended	II.P.1	Ask patient about any recent injury to head area, history of neurological or psychiatric problems, or substance abuse.	II.A.1	If patient has sustained recent head injury, has history of neurological or psychiatric problems, immediately consult physician. Patient may have subdural injury, require medication, or in withdrawl
		I.P.2	Attempt to identify what the patient concerns. Has the patient sustained personal loss (family, significant other, property, etc.). Attempt to focus the patient on the transient nature of the situation. Provide information to patient on where assistance can be obtained. Try to provide any immediate and reasonable request. Be supportive but reality oriented; attempt to channel the patients frustration and anger into constructive activities (e.g. contacting other assistance programs). Facilitate all contacts with other groups.	II.A.2	If medical or psychiatric problems have been ruled out, assist patient in identifying immediate needs, contact appropiate agency or program, complete necessary release of information and referral form, and explain, repeat if required, in clear terms the type of agency they are being referred to and who they will see (if name is available). Give patient half referral form to patient and discharge according to CSU protocol.
				II.A.3	If patient continues to be agitated provide quiet area and request observation. When patient behavior has become more rational, follow procedure in I.A.2.
				II.A.4	If patient's behavior continues to be agitated, consult with physician, medication may be required (note: some sedatives may cause paradoxical reaction). Alert ward staff to continue observation. If behavior continues, prepare to evacuate the patient. Arrange, if possible, for escort to accompany patient.

Patient Characteristics	Protocol		Action	
III. Adult; no apparent physical injuries; found wandering; non-communicative; no identification and is alone	III.P.1	Assure patient has been seen by admitting and discharge physician (A&D); assure behavior is not due to reaction to medication, pre-existing medical problem or injury.	III.A.1	If patient is responsive (presence of good affect) and has family/significant other (F/SO) in community; notify of patient's condition (be aware that release of information form must be signed by patient prior to releasing information). Verify whether they have capability to care for patient, if yes, discharge and transport.
	III.P.2	Verify with rescue personnel and admitting staff that no identification was found.		
	III.P.3	Observe and document physical characteristics and general appearance (e.g. is patient in business suit, work clothes, etc.) Contact local missing persons unit	III.A.2	If patient is responsive but no F/SO, prepare patient for transport nearest shelter. Inform shelter staff of patient's status and need for additional observation. Provide escort and referral form.
	III.P.4	Attempt to communicate with patient; ask questions about: Family, wife, children, "There may be someone who is search-for you and would be relieved to know that you are O K." If work day, ask about job; was the patient at work when the disaster occured. "Where do you work?"	III.A.3.	If patient is unresponsive arrange for immediate transport to more definitive care. Assure that copy of social work notes are transported with patient. Inform missing persons unit of location receiving hospital where patient will be transferred.
	III.P.5	Communicate temporary nature of situation. Does the patient have an immediate request (e.g. a glass of water, something to eat, etc.).		

Patient Characteristics	Protocol	Action
IV. Child; alone, no apparent physical injuries, rescue workers found child wandering, non-communicative, no identification	IV.P.1 Immediately provide description to disaster control center (DCC). Compare description of of missing children with patient.	IV.A.1 If child is non-responsive, arrange for immediate evacuation. Contact DCC, notify them of location of evacuation center and verify no inquiries about patient. If possible, arrange for escort to accompany patient. Be aware that emotionally traumatize patients must be strapped to litter and medicated if using military aircraft. In these cases rule may be waived if escort is available.
	IV.P.2 Assure patient has been seen by admitting and discharge physician (A&D); assure behavior is not due to reaction to medication or pre-existing medical problem.	IV.A.2 If child is responsive, contact DCC check on inquiries. If parents or relatives have been located, informed them of child's condition, assess capability for care of child if discharged; if community situation is stabilizing, arrange for transport and discharge. If situation is unstable, arrange for discharge to nearest shelter; inform parents/relatives, inform shelter staff, transport to shelter.
	II.P.3 Verify with rescue personnel and admitting staff that no identification was found.	IV.A.3 If responsive and parents/relatives cannot be located, discharge to nearest shelter. Inform shelter supervisor of child's condition and request additional observation while at shelter. Provide escort and referral form
	IV.P.4 Observe and document physical characteristics and general appearance (e.g. is patient in sportswear, monogram shirt, etc.)	
	IV.P.5 Attempt to communicate by asking questions about parents, siblings school, age, sports, etc.. Attempt to find out what child was doing when disaster occurred. Be comforting and supportive, do not pressure patient for answers.	

	Patient Characteristics		Protocol		Action
V.	Adult with major physical trauma and inemotional difficulty; physical conditionis relatively stable; unattended by P/SOwill require transport from area to more definitive care; patient is communicative	V.P.1	Inform patient of plans to transport; why he/she is being moved (avoid detail medical explanations); be supportive; and where they are being moved. Ascertain name and location of nearest P/SO and inquirier as to whether the patient want P/SO notified	V.A.1	If P/SO cannot be located prior to transport, obtain signed release of information form. If possible, obtain names of specific individual for which information is to be given. Reassure patient before transport.
		V.P.2	Obtain all patient data not obtained at admission, especially names and addresses of P/SO. Check with patient to identify any special request (e.g. mailing letter, assuring that eyeglasses are sent with the patient, etc.).	V.A.2	If P/SO have been located prior to transport, inform patient, obtain signature on release of information form, and inform P/SO.

Patient Characteristics		Protocol		Action	
VI.	Children with major physical trauma and in emotional difficulty; physical condition is relatively stable; unattended by P/SO will require transport from area to more definitive care; patient is communicative	VI.P.1	Attempt to identify P/SO; explain (in simple terms) why he/she must be moved; where they are being moved, and, if known, for how long. Child will require a great deal of support; there may be fear of the unknown be reassuring but creditable.	VI.A.1	Attempt to transport child accompanied be P/SO. If not possible, attempt to identify ambulatory (preferably female) patient to accompany child during transport. Notify military/civilian transport supervisor of escort arrangement; document for record.
		VI.P.2	Assure that DCC has been notified. Patients condition during transport can be enhanced if accompanied by P/SO.	VI.A.2	If no escort is available, notify military/civilian transport supervisor of patient's condition and special needs during transport; document for record
		VI.P.3	In the event that military transport will be used, make arrangements for adult escort (if possible) if P/SO cannot located or unable to accompany child.		

Patient Characteristics	Protocol	Action
VII. Expectant (dying) patient; conscious; unattended;	VII.P.1 Provide comfort but reality focused. Assist medical staff in caring for the emotional needs of the patient. Attempt to locate F/SO, be in contact with DCC. Be attentive to simple and reasonable request.	VII.A.1 In conjunction with medical records, arrange for notification of F/SO. Coordinate activity with DCC. Document any last request in record.
	VII.P.2 Provide emotional support to staff and be aware of emotion effects on staff and be prepare to request supervisor to relieve affected personnel.	VII.A.2 If F/SO are located, assist in disposition of body and personal effects.

Patient Characteristics	Protocol	Action
VIII. Expectant; attended by F/SO	VIII.P.1 Provide support to F/SO where appropriate. Arrange, wherepossible for F/SO to be present with patient. Be aware of emotional condition of F/SO and be pre- to provide crisis intervention.	VIII.A.1 When patient expires, assist family in arranging for the disposition of body and personal affects, act as facilitator.
	VIII.P.2 Observe staff reactions and be prepared to intervene to provide support or to advise removal from ward.	VIII.A.2 Provide mental health information to F/SO (location of nearest MH program) and make referral if re- quested.

Appendix C

Exhibit 3

Implementation Timetable

Activity	Participants	Dates		Comments
		Start	Complete	
Presentation of Plan to Command Group	Commander, Deputy Commander, Executive Officer, Training Officer, Chief Nurse	01/29/85	01/29/85	Commander and Deputy have received preliminary briefing; no problems anticipated
Presentation of Plan to Team Leaders	3 Team Leaders	02/13/85	02/13/85	No anticipated problems
Meeting with CSU social workers to discuss project	6 Social Workers	03/29/95	03/29/85	No anticipated problems with concept, however, time commitments will have to be negotiated with individual supervisors. Some supervisors will be reluctant to permit release time for training
Development of training Schedule	Red Cross and NIMH	02/25/85	03/04/85	Funds will not be a problem, the scheduling of trainers may present some difficulty depending upon previous commitments and availability of trainees
Presentation of training schedule to Commander	Commander and Executive Officer	03/25/85	03/25/85	No anticipated problems
Initiate Training	6 Social Workers	04/15/85	05/10/85	Attendance of social workers may be less than expected. Full attendance will be required to be considered for the social work position.

Selection of lead social workers and backup	Commander, Executive Officer, and Administrative Officer	05/13/85	05/13/85	Selection criteria will be a major factor. Clinical experience, final test, and attendance will be important considerations
Preparation of Social Work Guidelines for CSU	Administrative Officer	04/30/85	05/06/85	Synthesis of information from Red Cross and NIMH
Presentation of Social Work Guidelines	Commander and Team Leaders	05/15/85	05/15/85	Questions may arise concerning dual roll of social workers in providing crisis intervention care as well as direct emergency medical care. Social workers can be use when medical crises arise but their use in this situation will be monitored
Wounded Eagle IV: Evaluation of Social Workers	All 3 Teams	05/19/85	05/26/85	The provision of crisis intervention services and the patterns of use of social workers will be evaluated
Report on Social Work Intervention	Administrative Officer	06/01/85	06/30/85	

Appendix D

Exhibit 4

(RESPONSES)

Pre-Exercise Survey

(Knowledge, Attitude, and Practice)

(Key informants: Team Leader and Chief Nurse) Team #____

Knowledge:

Have you worked with social workers before in a medical care setting?
yes 3 no____

Do you understand the role of social work in a medical care setting?
yes 2 no 1

How would you rate your professional relationship with social workers?
excellent 2 good 1 fair____ poor____ na____

Are you familiar with the emotional problems caused by disasters?
yes 3 no____

Has the role of the social worker on the clearing and staging unit (CSU) been explained to you?
yes 3 no____

Have you read the social work protocol for the CSU?
yes 3 no____

Do you have any questions about the role and function of the social worker as discussed in the protocol?
yes____ no 3

If yes, what are your questions?

Attitudes:

Do you consider emotional problems a serious by-product of disaster?
yes 3 no____

Do you consider social workers as an appropriated group to intervene with emotionally traumatized victims of disaster?
yes 3 no____

If no, what other professional would you recommend?

Would you accept consultation from the social worker on issues related to the psychosocial care of a patient?
yes 3 no_____

If no, why?

Would you permit the social worker to enter patient information into the medical record under the heading of "Social Work Notes"?
yes 3 no_____

Do you feel that identifying a social worker in the CSU to provide intervention for emotionally traumatized patients and social services for both the patients and their families is positive addition to the unit?
yes 3 no_____

If no, why?

Practice:
(Key informant: Team Leader)

Did you inform the admitting physician of the social workers role on the CSU, according to the protocol?
yes_____ no 3

Did you explain to the admitting physician the type of patients that could benefit from social work services?
yes_____ no 3

In explaining the social workers role to the admitting physician, were there any questions or concerns raised?
yes_____ no 3

If yes, explain.

Comment:

One of the team leaders stated the "social work services would not be appropriate in this exercise because most of the cases would be mostly physical trauma and theat pateints would be young not requiring housing, family support or income assistance."

Practice:
(Key informant: Chief Nurse)

Did you inform the ward staff of the role of the social worker on the CSU?
yes_____ no_____

Did the staff raise any questions or concerns?
yes_____ no_____

If yes, explain.

(RESPONSES)

Pre-Exercise Survey

(Knowledge, Attitude, and Practice)

(Key informants: Team Leader and Chief Nurse) Team #____

Knowledge:

Have you worked with social workers before in a medical care setting?
yes 3 no____

Do you understand the role of social work in a medical care setting?
yes 3 no____

How would you rate your professional relationship with social workers?
excellent 2 good 1 fair____ poor____ na____

Are you familiar with the role social workers in disaster relief efforts?
yes 3 no____

Are you familiar with the emotional problems caused by disasters?
yes 3 no____

Has the role of the social worker on the clearing and staging unit (CSU) been explained to you?
yes 3 no____

Have you read the social work protocol for the CSU?
yes 3 no____

Do you have any questions about the role and function of the social worker as discussed in the protocol?
yes____ no 3

If yes, what are your questions?

Attitudes:

Do you consider emotional problems a serious by-product of disaster?
yes 3 no____

Do you consider social workers as an appropriated group to intervene with emotionally traumatized victims of disaster?
yes 3 no____

If no, what other professional would you recommend?

Would you accept consultation from the social worker on issues related to the psychosocial care of a patient?
yes 3 no_____

If no, why?

Would you permit the social worker to enter patient information into the medical record under the heading of "Social Work Notes"?
yes 3 no_____

Do you feel that identifying a social worker in the CSU to provide intervention for emotionally traumatized patients and social services for both the patients and their families is positive addition to the unit?
yes 3 no_____

If no, why?

Practice:
(Key informant: Team Leader)

Did you inform the admitting physician of the social workers role on the CSU, according to the protocol?
yes_____ no_____

Did you explain to the admitting physician the type of patients that could benefit from social work services?
yes_____ no_____

In explaining the social workers role to the admitting physician, were there any questions or concerns raised?
yes_____ no_____

If yes, explain.

Practice:
(Key informant: Chief Nurse)

Did you inform the ward staff of the role of the social worker on the CSU?
yes 3 no ____

Did the staff raise any questions or concerns?
yes 2 no 1

If yes, explain.

1) Who would refer patients on the ward to the social worker?
2) Would the social worker also be responsible for ward duties?

Appendix E

Exhibit 5

(RESPONSES)

Post-Exercise Survey

(Key informants: Team Leader and Chief Nurse) Team #____

Knowledge:

Has your understanding of the social worker's role in a disaster relief effort changed as a result of the exercise?
yes 2 no 1

Do you have a clearer understanding of the social work protocol now that you have been involved with its implementation?
yes 2 no 1

Have the other members of the unit expressed any questions or concerns the activities of the social worker during the exercise?
yes____ no 3

If yes, explain.

Attitudes:

Was the social worker's performance during the exercise in accordance with your understanding of the protocol?
yes 1 no 2

If no, explain.

"There were not many opportunities to use social work services."
"During the exercise, there was only one psychiatric patient who was referred to the social worker."

Did you feel that the social worker provided a needed services for the patients during the excercise?
yes 1 no 2

Were the activities of the social worker considered valuable in the management of emotionally traumatized patients?
yes 1 no 2

Now that you have worked with a social worker in a CSU setting, would you considered social work services an essential aspect of this type of activity?
yes 3 no____ ["But not is this type of exercise"]

Do you have any comments that you would like to share about the social work role in the CSU or about the implementation of the protocol?

(RESPONSES)

Post-Exercise Survey

(Key informants: Team Leader and Chief Nurse) Team #____

Knowledge:

Has your understanding of the social worker's role in a disaster relief effort changed as a result of the exercise?
yes 2 no 1

Do you have a clearer understanding to the social work protocol now that you have been involved with its implementation?
yes 2 no 1

Have the other members of the unit expressed any questions or concerns the activities of the social worker during the exercise?
yes____ no 3

If yes, explain.

Attitudes:

Was the social worker's performance during the exercise in accordance with your understanding of the protocol?
yes 2 no 1

If no, explain.

"The exercise did not offer an opportunity to use the social worker appropriately."

Did you feel that the social worker provided a needed services for the patients during the excercise?
yes 3 no____

Were the activities of the social worker considered valuable in the management of emotionally traumatized patients?
yes 3 no____ ("limited")

Now that you have worked with a social worker in a CSU setting, would you considered social work services an essential aspect of this type of activity?
yes 3 no____

Do you have any comments that you would like to share about the social work role in the CSU or about the implementation of the protocol?

litter bearer/ward assistant. There was total agreement among the social workers that they could not satisfy the expectation inherent in the two roles.

Appendix F

Exhibit 6
(RESPONSES)

Survey of CSU Social Workers
(Post)

Team #:_____

Did you read the protocol prior to the exercise?
yes 3 **no**_____

Did the protocol clearly explain the procedures and the process for managing certain types of emotionally traumatized patients?
yes 3 **no**_____

Did the protocol provide you with a method for managing emotionally traumatized patients?
yes 3 **no**_____

If no, why?

Were there patients that did not fit the types described in the protocol?
yes_____ **no** 3

Were patients referred to you by the admitting physician?
yes_____ **no** 3

Were all of the patients referred to you by the admitting physician psychiatric patients?
yes_____ **no**_____ **na** 3

Did the team leader refer patients for social work services?
yes 1 **no** 2

Did the chief nurse refer patients for social work services?
yes 3 **no**_____

Did the staff on the wards request social work consultation for patients?
yes_____ **no** 3

If yes, what category of patient?
psychiatric only _____
medical only _____
both categories _____

Comment:
The social workers all commented on the limited use of the crisis intervention skills and, when call upon to provide service, they pointed out that it was limited to the location to which they were assigned. However, the strongest comments focused on the inability to function as a social worker and

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