# Disaster Behavioral Health Family Reunification – ESF#8- Fatality Management Annex

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| **Category** | **Maine Disaster Behavioral Health Program** | **Number** | Maine CDC –ESF#8 |
| **Applicability** | **Family and Friend Reunification Center** | **Effective Date** | June 2015<br><br>Revision: January 2018 |
| | **Family Assistance Center** | **Approved by:** | Maine CDC Executive Director |

**Subject:** The Family and Friend Reunification Center (FFRC) and the Family Assistance Center (FAC) are both safe, secure and supportive environments established to serve as a centralized location to provide information and assistance about missing or unaccounted for persons and deceased; and support the family and friend's reunification with missing or deceased loved ones. This plan addresses Disaster Behavioral Health capabilities exercised in Mass Care Incidents, and to support Fatality Management and Medical Surge during Public Health emergencies.

**Purpose:** The purpose of providing Behavioral Health Services resources in a Family and Friend Reunification Center and the Family Assistance Center is to provide short term emotional support, spiritual and pastoral care, and assessments and referral services for individuals and families impacted by disasters and public health emergencies, and for Center staff/volunteers deployed to assist the individuals and families.

Key assumptions underlying a Family Reunification and Family Assistance Center include:
Activation:

- The activation of a Family Center may be a result of many different types of incidents. For example, it may be due to a chemical spill, train derailment, airline accident or active shooter incidents.
- The Center should open within 24 hours of the decision to activate.
- The Center will be part of a larger emergency response, requiring coordination and information sharing among multiple organizations and agencies.
- Coordination among responding agencies about family member welfare inquiries, missing persons reports and patient tracking will be necessary.
- Family Assistance Centers may be virtual via a call center or online, in person or both
- The National Transportation Safety Board (NTSB) will be the lead agency for coordinating family assistance operations following an air carrier and passenger rail accidents resulting in a major loss of life.

- FBI Office of Victim Assistance will participate in family assistance services for federal crimes, e.g. terrorism.

Family Care:

- On average 3-6 family members for each potential victim will interface with family assistance operations.
- Not all family members will come to the Family Centers. Services may need to be available virtually to support and provide information to those who are not physically on site at the Centers.
- A short term Family Reunification Center may be established to give families a place to convene until a Family Assistance Center is established. This may occur at a hospital, airport, or other community site and should be established within two hours of the incident.
- After an incident, family members will immediately call or self-report to many agencies/locations seeking information about their loved ones. This could include the incident site, 911, hospitals, clinics, 2-1-1, fire departments, police stations, or public health offices.
- Depending on the populations affected by the incident, translations and interpreters may be needed for all aspects of the Center operations.
- Ethnic and cultural practices will be important factors in how families communicate about the incident, manage stress and express grieving.

Logistics:

- When selecting a Family Center site, whenever possible, it will be apart from and not within viewing distance of the incident site.
- The Centers may need to operate 24 hours/day during the initial hours/days/weeks after an incident.
- Family dynamics may pose different challenges and needs, especially regarding security and staff work load. It will be important to ensure only those receiving services at the Centers are allowed access, especially with respect to media.
- The Family Assistance Centers may be long term, depending on the nature of the incidents.

**Procedures:**

Qualified Disaster Behavioral Health Response Team members will:

a) Provide families with a safe, private and comfortable place to give and receive verified information concerning injured or missing family members.
b) Allow critical medical staff to focus on patient care needs.
c) Provide accurate and up to date information concerning the disaster and recovery process via information provided by reputable authorities, such as medical staff and law enforcement.
d) Triage mental health needs of family members and friends to identify “at risk” individuals.

e) Provide Psychological First Aid (PFA), crisis intervention, mediation, and management of "at risk" family members, including children and the elderly.
f) Provide spiritual support and interdenominational pastoral counseling for people of all faiths who request it; conduct religious services and provide worship opportunities; and offer a bridge to faith resources.
g) Facilitate family reunification by collecting limited information from visitors on the person they are looking for and by sharing lists of identified admitted patients with Public Health and other disaster organizations.
h) Collect information about unidentified patients or children.
i) Coordinate messaging with local hospitals, law enforcement, and the Family Assistance Center via incident command structures.
j) Provide assistance in completing Victim Information Profile forms in coordination with the Medical Examiner's Office.

This plan will be used when activating a Maine Disaster Behavioral Health response within a Family and Friends Reunification Center, or a Family Assistance Center in coordination with other organizations activated to respond.

**References:**

State of Maine Disaster Behavioral Health Response Plan (2016)
*Mass Fatality and Family Assistance Operations Response Plan (*2013) Public Health Department of Seattle & King Counties, Washington State
*Transportation Disaster Assistance Point Paper* (2016) the National Transportation Safety Board, Transportation Disaster Assistance Division
*Disaster Behavioral Health: Critical Response* (2009), Author: Jack Hermann
*Psychological First Aid Field Operations* Guide (2011) National Center for PTSD/the National Child Traumatic Stress Network

## Family and Friend Reunification Centers

In the hours and days after a mass-casualty or mass-fatality incident occurs, families and friends will anxiously seek assistance in accessing information about the event and locating their loved one(s) through many different avenues. As they search for information, they will frequently go to places where they assume it will be found. This often leads to a surge of individuals arriving at the incident site, or calling or showing up at local hospitals, churches and schools. In addition to the physical presence at these key locations, an influx of calls with information-seeking inquiries will be made to 9-1-1, hospitals, law enforcement and fire departments, or the Medical Examiner/Coroner's (ME/C) Office, creating a significant burden on the agencies already busy with other aspects of the response.

In this environment of uncertainty, confusion, fear and anxious need for information, Family and Friend Reunification Centers become an important resource for helping a community meet the needs of family and friends, and supporting the overall incident response. Those family

members may be best served by providing them with a separate place to wait for word of their loved ones. They offer an immediate, temporary centralized location for providing updates and information to family members as verified information becomes available; offer interagency collaboration and communications; media management; and basic services including Psychological First Aid and Spiritual Care supports; and help to facilitate family reunifications. In larger operations, a Joint Family Support Operations Center can be established and will involve healthcare, community behavioral health partners, and disaster response organizations, such as the American Red Cross and Salvation Army.

### Family Assistance Centers

Additionally, following a large mass fatality situation, a Family Assistance Center may be opened for more long term assistance to family members to help coordinate all service providers in one central location; and for collecting information that will be pertinent to a medical examiner or coroner in facilitating the identification of the victims; and to provide family, survivor and victim services, e.g. funeral home information, grief and bereavement services, transportation. The DBHRT may be requested to set up a FAC in coordination with interagency and community-based healthcare providers.

### Federally Legislated Family Assistance Centers

The National Transportation Safety Board (NTSB) is an independent federal agency charged with investigating and determining the probable cause of all civil aviation accidents in the United States, and selected accidents in rail, highway, marine and pipeline operations. The NTSB Transportation Disaster Assistance Division (TDA) coordinates the resources of federal, state and local agencies, transportation operators, and the American Red Cross, in order to meet the needs of family members and survivors. TDA also serves as the primary resource to provide investigative information for family members and survivors.

Three federal laws provided the legal mandates under which the TDA operates and outlined the responsibilities of the NTSB, the transportation carrier, the American Red Cross and supporting federal agencies:

- Aviation Disaster Family Assistance Act of 1996
- Foreign Air Carrier Family Support Act of 1997
- Rail Passenger Disaster Family Assistance Act of 2008

The **Air/Rail Transportation Carrier's responsibilities** outlined in the federal legislation are to:

- Notify the family members of the accident
- Organize the family assistance center

- Arrange for travel, lodging, and other logistics for family members traveling to the accident
- Manage the recovery and return of personal effects
- Assume reasonable costs for the recovery, identification, and repatriation of fatalities.

The **TDA's responsibilities** outlined in the federal legislation are to:

- Coordinate and provide oversight of family assistance operations
- Ensure the provision of disaster mental health services that includes family care, crisis intervention, and spiritual care in coordination with the American Red Cross
- Facilitate victim recovery and identification processes in coordination with the local medical examiner or coroner
- Provision of information to the families about NTSB investigations once the information is publically released
- Coordinate with federal, state, and local agencies

The Department of Health and Human Services, Assistant Secretary for Preparedness and Response, **Disaster Mortuary Operational Response Team (DMORT)** responsibilities outlined in the federal legislation:

- Assists local medical examiner or coroner by providing technical assistance and personnel to support the victim recovery and identification process

The **Department of Defense (DOD)** responsibilities outlined in the federal legislation:

- Assists the local medical examiner or coroner in victim identification process with services from the Armed Forces Medical Examiner System and the Armed Forces DNA Identification Laboratory

Federal, state and local agencies, transportation operators and the American Red Cross will work together within the guidance of TDA to ensure that the needs of family members and survivors are being addressed after a transportation accident. Typical family assistance operations required under the federal laws involve the following:

- **The Family Assistance Center** (FAC): is a secure meeting place ***established by the transportation carrier*** for family members, survivors, and friends to obtain services and receive information about the investigation. The FAC remains open throughout the on-scene work.
- **Daily Family Briefings:** While on-scene, the TDA coordinates briefings for family members at the FAC. These briefings provide information on the progress of the investigation, local agency responsibilities (such as victim identification) and available

family assistance services. Following the on-scene phase, the TDA remains in contact with family members and survivors during the NTSB investigative process.

- **Personal Effects:** the collection, processing, and return of person effects are the responsibility of the transportation carrier and the local medical examiner or coroner.
- **Emotional Support Services:** the American Red Cross provides crisis and emotional support services for family members, survivors, and friends while at the FAC and after they return home.
- **Victim Recovery and Identification:** Victim recovery, identification, and death certificates are the responsibilities of the local medical examiner or coroner. TDA can coordinate technical expertise to assist this process.
- **Assisting Families of Foreign Citizens:** The Department of State secures translation and communication services, provides official notification to foreign governments, assists with visa services, and facilitates consular and customs services.

In general, the primary goals of a Joint Family Support Operations Center involving multiple agency responders and services are to:

1. Provide a private and secure place for families to gather and receive information about the response and their loved ones, community resources and to process grief and loss.
2. Protect families from the media and curiosity seekers.
3. Address family's informational, psychological, spiritual, medical, and logistical needs.
4. Conduct family interviews with multiple family members in order to collect sufficient information to assist with the reunification or victim identification.
5. Ensure interagency collaboration and communications within the Joint Family Support Operations Center (JFSOC).
6. Provide supportive services and psychological interventions. Family members may need to travel to the Center and may need assistance with basic resources such as lodging, meals, personal hygiene products, clothes and medical prescriptions, etc.
7. Facilitate information exchange between the Medical Examiner/Coroner's Office and families so that the medical examiners and coroners can obtain information needed to identify the missing or mass fatality victims.
8. Provide a private space for family notifications on victims and facilitate the processing of death certificates and the release of human remains for final disposition.

**DISASTER BEHAVIORAL HEALTH RESPONSE TEAM NOTIFICATION**

## 1. HAN Alert

The Health Alert Network (HAN) will be used to notify team members of a pending or immediate activation. If specified, the Family and Friends Reception Center /Family Assistance Center Plan will be activated. Three groups may be activated simultaneously or sequentially.

- Group 1 – Key representatives from organizations involved in the operation of a Center (FAC), e.g., Medical Examiner Office, Red Cross, DHHS and other representatives.
- Group 2 – Team members and others trained to staff and operate a FAC.
- Group 3 – Untrained individuals who have volunteered to support the operation of the FAC and who will need to complete just-in-time-training and background checks.

Each agency operating within the FAC is responsible to notify and oversee its own staff. ESF-8, Health and Medical Services and ESF-6, Mass Care and Sheltering will be activated and regular updates with DHHS will begin. The activation of county and possibly state Emergency Operations Centers (EOCs) will inform the activation guidelines and alert level. MEMA would recommend activation of the Federal family assistance centers in coordination with the transportation carriers, either air or rail providers.

**Alert Levels**

The following are the HAN activation levels that would indicate need for the Family Reunification/ Assistance (FAC) Center Plan:

- **Low** – informational, operations normal
- **Medium** – monitoring, event-triggered, could lead to activation
- **High** – activation indicated, information for partial or full activation

High level activation may be triggered by (a) a real-time unexpected event resulting in severe threat and/or multi- fatalities, or (b) a mass casualty event that overwhelms the local jurisdiction. If the Plan is to be activated immediately, the DHHS Commissioner (or designee) will establish a liaison for departmental collaboration and information exchange. Upon activation of the Plan, a location will be identified and alert notification for complete staffing will be issued.

If an air or rail carrier that is subject to Federal family assistance legislation is involved in the accident that warrants a FFRC or FAC operation, there must be close coordination between the local or state agencies and the affected carrier for activation, location, services, transportation of family members, etc.

## 2. Deployment of DBHRT

Any request to activate a Disaster Behavioral Health Response Family and Friend Reunification Center will be coordinated through MEMA, Public Health Emergency Preparedness and County EMA's; Regional Healthcare Coalition Directors, or directly with the Disaster Behavioral Health Director. A Family and Friends Reunification Center and Family Assistance Centers can be set up within a healthcare facility, community facility or school following a mass fatality incident. Disaster Behavioral Health Team Leaders will be notified, whether deployed or not to ensure complete coverage of all shifts. The DBH Director will maintain a roster of available Team Leaders for activation.

During an air and rail transportation accident subject to the Federal family assistance legislation, the deployment of DBHRT would come from a request by the American Red Cross or ESF#6 Mass Care Officer.

**Team Briefings**

In non-emergent situations when a FFRC or FAC is proactively being established before actually needed, team members will be briefed and updated through the HAN about activation status and projected needs. In emergency situations, team members may be requested to drive to the site of the FAC (or staging area) for an initial briefing. Preliminary organizations will identify a Liaison Officer who may conduct briefings and communicate with the Family and Friends Reunification Center or Family Assistance Center Director and DBH Director.

Information dissemination and staff briefings following a federal transportation accident will be managed by the transportation carrier and the carrier will conduct briefings in coordination with the NTSB, Healthcare Liaison Officers, Public Safety, Medical Examiners or coroners, and the American Red Cross.

**Hours of Operation and Work Shifts**

The Centers may operate on a 24/7 basis as long as needed. Some branches within the Centers may have restricted hours of operation based on need and availability of resources. An operational period is 12 hours. Each participating agency is expected to ensure its presence/representation until no longer needed and to set up its own staff requirements. Common work shifts are four 6-hour shifts; three 8-hour shifts; and two 12-hour shifts. Agency staff requirements will be registered with the Center Director and overseen by each respective agency.

**Command Staff:** **Center Director role must always be filled and may assume or assign responsibilities to any other staff member.

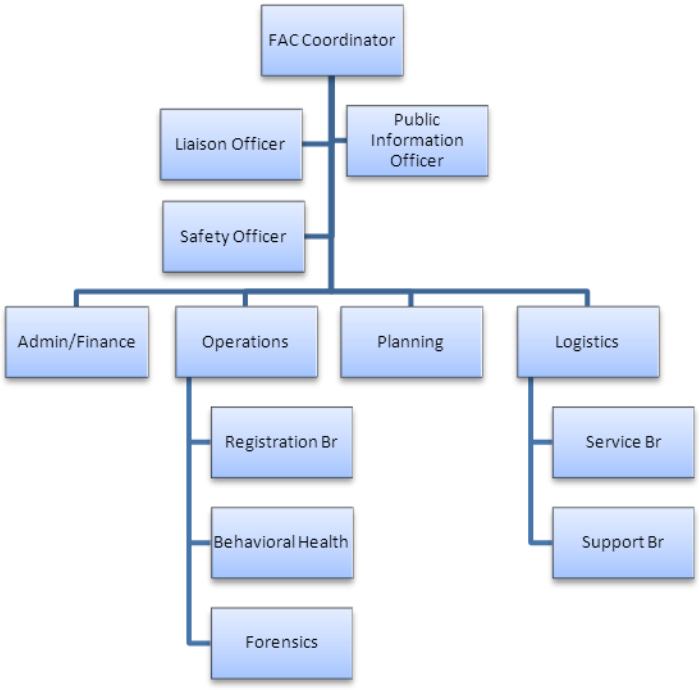
- ****Center Director –** overall responsibility for a center, designates personnel to assume leadership roles, sets objectives for each operational period, strategies and priorities, and to develop demobilization plans and budgets. Approves Incident Action Plan for future shifts, coordinates with local, state and federal level command entities.

- **Public Information Officer (PIO)** - interacts with media, develops public information materials, organizes press briefings; coordinates media tours
- **Liaison Officer (LNO) –** primary contact between responding agencies and the Centers; provides initial briefings to arriving staff; maintains resource information for response agencies and command entities
- **Safety Officer (SO) –** ensures safety of staff and families by identifying and mitigating hazards

**General Staff**

In accordance with ICS structure, the Center will include four sections (Logistics, Operations, Planning, Administration/Finance), headed by a Section Chief who reports directly to the Director. The general organization chart and general areas of responsibility are depicted. A more detailed organizational chart presenting expanded areas of responsibility, such as multi-agencies to support FAC or FFRC may be developed.

When a Family Center is established in response to a transportation accident involving a carrier subject to Federal family assistance legislation, all aspects of the family assistance operations; staffing should be closely coordinated with the affected carrier.




**Administration/Finance Section** – Tracks and oversees the financial management specifically related to the center operations including staff work hours, injury claims, vendor contracts, fiscal agreements. The Section negotiates all purchases, leases, contracts, etc. and provides cost-analysis services.

**Operations Section** – Tactical operations are conducted including registration of victims' families, arranging children services and/or guardianship services, psychological first aid and bereavement supportive services, assisting families with the Victim Identification Profile, language translation services, support of Medical Examiner's Office staff members, maintain communication with Red Cross's "Safe and Well" program, organization of post-event memorial services, security for center and morgue, and credentialling/badging of volunteers.

**Planning Section –** Conducts check-in activities of staff; collects and analyzes FAC data to share with various command entities; develops Incident Action Plan (IAP) every 12 hours; creates situation reports; develops maps, layouts, etc.; prepares demobilization plan; maintains documentation of activities for incident records; tracks resources assigned to the center. Subject matter experts who can provide knowledge and expertise to the on-scene Center leadership are assigned to this section.

**Logistics Section** – Supports staff in setting up and maintaining the FFRC or FAC. Oversees lodging, food services, transportation, credentialing, medical needs, office supplies, communications, sanitaton, security, etc. All requests for resources are processed through this section which then works with the Finance Section to fufill requests. Oversight is included here for IT support, inventory support and food protection.

## GENERAL AREAS OF RESPONSIBILITY

| Logistics | Planning | Finance/Admin | Operations | | |
|---|---|---|---|---|---|
| | | | Family Care | Med. Exam. | Security |
| Site Acquisition | Briefings | Records Mgt. | Registration | Victim ID | FAC Security |
| Feeding/Hydration | Action Plan | Procurement | Patient Tracking | Decedent Info | Morgue |
| IT Support | Scheduling | | Medical Care | Personal Effects | Credentialing |
| Communications | Memorials | | Behavioral Health | Notification | |
| Transportation | Demobilization | | Family Liaison | Morgue Ops | |
| Lodging | Planning | | | DMORT | |
| Sanitation | Resource Plan | | | | |
| Site Visits** | | | | | |

Site Visits**
Site visits become the responsibilities of the NTSB, and affected carrier; FBI OVA, American Red Cross, and other public safety agencies following an air or rail transportation accident involving carriers subject to Federal family assistance legislation.

### Volunteer Staffing

Disaster Behavioral Health (DBH) volunteers will respond in a two-tiered system, under the DBH Director's oversight. Job Action Sheets for Team Leader and Team Member positions indicate the requisite skills and training. All volunteers should be comfortable working in community-based settings in non-clinical roles. Completion of the Crisis Counseling Core Content training, FEMA ICS-100 and ICS-700, and a criminal background check has been successfully completed and a Maine Responds ID badge issued is required before responding. Unity of command will be observed at all times, requiring each Team Member to report to only one supervisor/Team

Leader. Under NIMS, an appropriate span of control is a ratio of 3:1 and a maximum of 7:1 (Team Members to Team Leader).

The disaster incident level will affect resource needs, including number of staff both paid and volunteers to fulfill all roles. For example, fewer staff will be needed if the number of injured or causalities is fewer than 20 people. Also, fewer staff may be required if the remains of the deceased are intact and not severely traumatized; or if it is a closed population, e.g. airplane accident with a passenger manifest. The daily capacity for critical services and family interviewers to number of family members may need to be higher, if you need special considerations for children, the frail elderly and estranged family members.

**Disaster Levels**

| Incident Level | Size | Expected Family and Community Members | Daily Capacity for Critical Services |
|---|---|---|---|
| **Level 4: Small** | Fewer than 20 injured or fatalities | Fewer than 120 | 3-5 interviewers/12 hours per day=12-20 interviews per day |
| **Level 3: Medium** | 20-100 injured or fatalities | 120-600 | 5-10 interviewers/12 hour per day=20-40 interviews per day |
| **Level 2: Large** | 101-500 injured or fatalities | 600-1000 | 10-30 interviewers/12 hours a day=40-100 interviews per day |
| **Level 1: Catastrophic** | More than 500 injured or fatalities | More than 1000 | 30-50 interviewers/12 Hours a day=120 interviews per day |

Team Members will be requested to deploy with an issued photo Maine Responds badge. Identification from employees representing other entities, jurisdictions and/or volunteer agencies (e.g., DHHS, Carrier employees) can be credentialed pending appropriate authorization during the event. Volunteers who are not trained in the DBH curriculum, are not familiar with ICS and NIMS, and for whom background checks have not been completed will not be serving in the role as a disaster behavioral health responder. Depending upon the magnitude of the event, just-in-time training may be developed and made available to non-DBH volunteers at the discretion of the Public Health Emergency Preparedness office.

In addition, *Maine Responds* registered healthcare volunteers have valid credentials and may, at the discretion of the Director, be admitted as non-DBH responders within the center to support family members or survivors. Such volunteers will be assigned oversight by a DBH Team Leader who will screen candidates for skills appropriate to the team response. Maine

VOAD and American Red Cross have signed MOA's with DBH, so are able to work side-by-side within a Family Assistance Center.

Following a transportation accident involving a carrier, subject to the Federal family assistance legislation, the American Red Cross and the transportation carrier will manage both paid and volunteer staffing. The transportation carrier may issue temporary identification cards to volunteers and family members.

**Team Assignments**

Following the DBH Annex to the Maine CDC Emergency Operations Plan, all responders will be assigned a Team Leader. Team Leaders may be given an area of activity oversight, e.g., family support, hotline operations, etc. Expanded or multi-agency operations within a Joint Family Support Operations Center may include support teams for broad categories of responsibility, e.g., donations management, forensic support, etc. The DBHRT Operating Procedures delineate the team activation/ deployment process. Responders will be given information on where, when and to whom (team leader identification) to report. All records (e.g., Deployment Check-in Form, Disaster Action Log) will be maintained by Team Leaders and submitted to the Center Financial Chief for surveillance and follow-up action.

In accordance with Operations Section activities, responders may be assigned any tactical operations necessary to carry out the FAC Incident Action Plan, including registration, providing initial psychological first aid, loss and bereavement support to family members and first responders, conducting on-going situation updates for family members, Victim Identification Profile (VIP) data compilation, supporting the Medical Examiner's office, offering messaging services, providing children services; and organizing post-event memorial services,

**Working with People impacted by a Traumatic Event**

Mass trauma that affects communities covers a broad range of emergency events that erode the sense of safety within a given community. Resilience can be defined as the capability of individuals and systems to cope and maintain positive functioning in the face of significant adversity or risk. Resiliency can be enhanced by building in protective factors and interventions that enable people to help themselves and one another during crises. Nevertheless, the majority of the public are amazingly resilient and most of their trauma-related symptoms will resolve in a matter of months.

*Psychological First Aid* was developed by the National Child Traumatic Stress Center and the Center for PTSD for all individuals affected by a disaster and involves psychoeducation and supportive services to accelerate the natural healing process and promote effective resilience strategies. PFA is an evidence-informed modular intervention used by mental health and disaster response workers to help children, adolescents, adults and families in the immediate aftermath of disaster and terrorism. Psychological First Aid includes basic information-gathering techniques for providers to complete rapid assessments on survivor's immediate

concerns and needs, and to implement supportive activities in a flexible manner. PFA emphasizes developmentally and culturally appropriate approaches to work with survivors of various ages and backgrounds; and includes handouts that provide important information for youth, adults and families over the course of their recovery.

Psychological First Aid is designed to reduce the initial distress caused by traumatic events and to foster short-and long-term adaptive functioning and coping. PFA does not assume that all survivors will develop mental health problems or long-term difficulties in recovery. Instead, it is based on an understanding that disaster survivors and others affected by such events will experience a broad range of early reactions e.g., physical, psychological, emotional, behavioral, and spiritual. Some of these reactions will cause enough distress to interfere with adaptive coping, and recovery may be helped by support from compassionate and caring disaster responders and trained community members. PFA during the first days and weeks after a traumatic event strive to create safe conditions by working with responders who remain calm and friendly and help to make connections to larger social support networks and community programs.

## Family & Friends Reception/Family Assistance Center overview

**Hours of Operation**

The Centers will operate on a 24/7 basis as needed. Some sections within the Center may have reduced hours of operation depending upon availability of resources. All agencies participating are expected to ensure the presence/representation of service providers until no longer needed and implement a work schedule that is comfortable for its staff.

**Family Briefing/Information Updates**

The Family Assistance Liaison Officer (LNO) or Incident Command designee may conduct an initial briefing based on information available. Briefing times should be posted and held on a regular schedule for families at the Family Reception Center to provide accurate information on the event, the status of patients, and the recovery process. Briefings on event information and the identification process can be done with all survivor families. Non-patient information for these briefings should come from law enforcement and/or medical authorities. Individual briefings for families on the status of patients should be held in a quiet private location.

During a mass fatality event involving NTSB or FBI OVA, these federal agencies may facilitate the initial briefing. A schedule for follow-up briefings should be announced for relaying updated information. The LNO will ensure that incoming Center staff are briefed and directed to appropriate registration processes.

**Patient Identification/Family Reunification**

Information about unaccounted for and injured persons will be gathered to aid in the identification of patients or deceased individuals. If possible families should be reunified with their family members when survivors are medically cleared.

**Behavioral Health**
Family members will call or show up at hospitals to inquire about a family member that might be injured or missing. Family members may be confused and anxious if they are unable to immediately locate their family member. Behavioral Health services at healthcare facilities can provide Psychological First Aid, mental health care and spiritual care to families and friends at the Family Reception Services areas. Behavioral Health staff should be available during family briefings, and to support family members during patient identification notifications with spiritual and counseling services.

## Space and Facility Requirements

As family members seek information on their injured or missing loved ones, 3 to 6 family per potential victim may show up and require services. Using an estimate of 210-250 sq. ft. per staff person, a space should be able to accommodate as many of the desired characteristics listed below as possible. If one large area is to be used, it must be divided to include a labeled registration area, messaging area, interview rooms, staff work stations and family rooms (including a secured children's area).

It is important that a hospital-based reunification centers not be within visual distance of an Emergency Department or the Intensive Care Unit, but close enough to facilitate communications about patient status.

NTSB general guidelines for setting up a Family and Friends Reunification Center and/or Family Assistance Centers, is that it is easier to decrease the size of the facility, if necessary, than to increase the size of the facility after operations have begun. Some transportation carriers use a multiplier of 10 and many base their estimated guidelines for minimum space needs on the total number of passengers involved, not just the number of deceased.

NTSB recommends that notifications are done in private, and to expect 6-10 family members for each victim. The NTSB guidelines may not account for incidents that yield a small number of fatalities but includes a large number of injured. Social media can also challenge the notification process with unverified information before family members and next of kin have been officially notified.

NTSB Estimated guidelines for minimum space:
Number of fatalities X with 6 family members
= amount of space needed

NTSB Estimated guidelines for maximum space:
Number of fatalities X with 10 family members
=Amount of space required

**Desired characteristics of space:**
The desired space can be a high school gymnasium, community centers, hospital cafeteria or staff training rooms, hotel conference centers, or rented spaces. It is important to choose

facilities that are a safe proximity from scene (out of sight and sound of response/recovery efforts); are easily accessible for family members; and can accommodate the necessary security measures to monitor access. Other special considerations for family members are to have access to a television and computer/phone bank, charging station for cell phones and computers; some tables and enough chairs for all family members and rooms should be kept private and quiet.

**Initial Facility Set-Up**

- The Family Reunification Services should be activated immediately following a notification of a disaster involving fatalities, and at the direction of the Incident Command, ideally in consultation with Public Health Operations and MEMA.
- Staff should be assigned to designated roles within the Center prior to an incident happening to allow them to become familiar with the plan and process. In hospitals, consider calling up staff currently not on shift or staff from other non-clinical departments; HR, Patient Relations, Volunteers.
- Resources should be allocated to the Center area, and any resource needs should be assessed.
- In hospitals, job action sheets identify HICS Family Assistance Director, Social Services Leader, and Family Reunification Leader to manage the Family Centers.
- Following an air or rail accident, close coordination needs to be established with the affected Carrier, NTSB and the American Red Cross
- Layout is decided upon taking into consideration facility layout and resource requirements
- Perimeter security is established
- Staging area for staff is identified
- Extraneous service areas are defined and identified, e.g., family parking, off site food services, etc.
- Volunteer and staff Credentialing system is set up
- Collaboration with Maine American Red Cross and VOAD is established
- Section Chiefs commence activities within scope of responsibilities

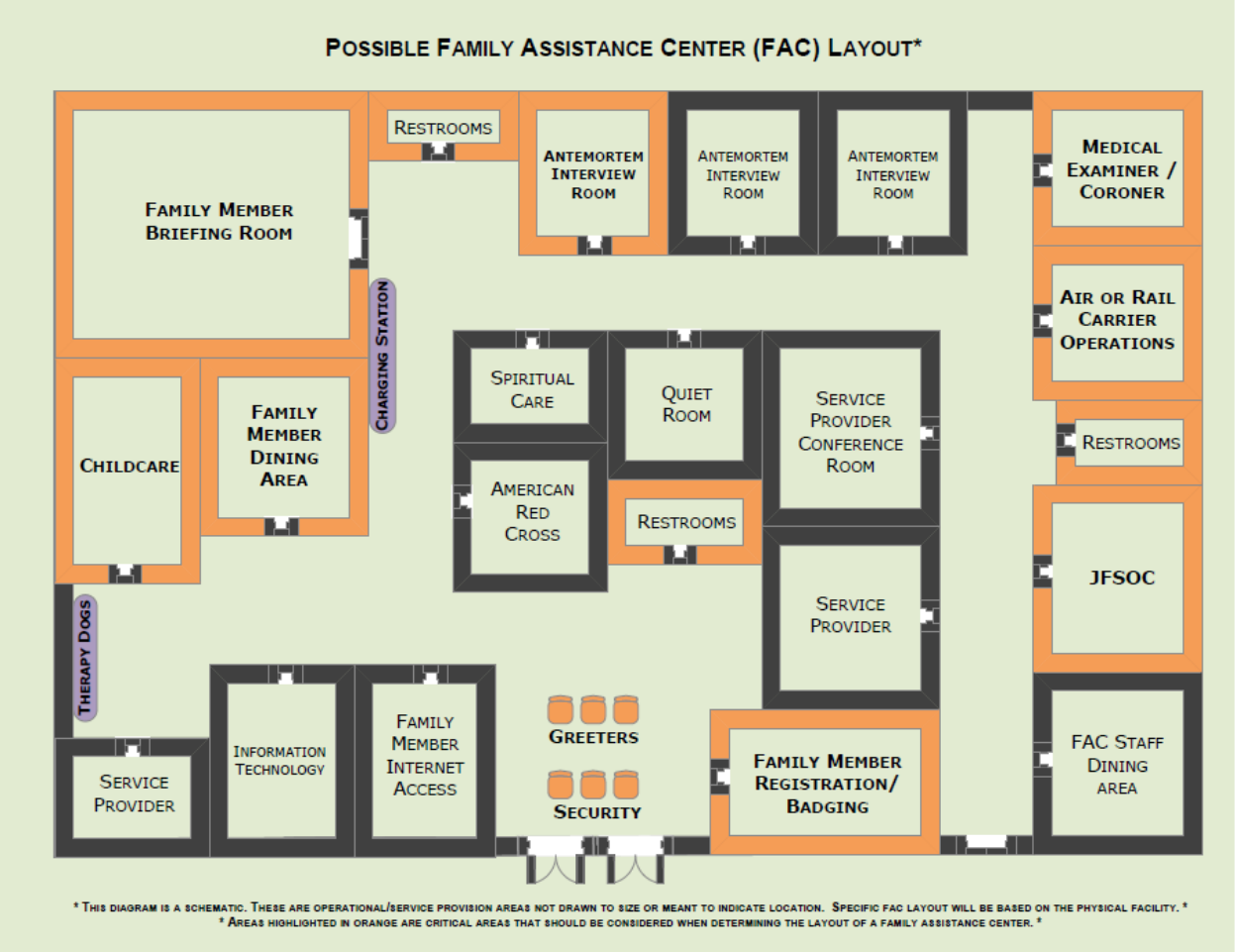
**ADA Considerations**

Facilities used for a Center should be assessed for functional needs accessibility. The Americans with Disabilities Act (ADA) specifies how buildings and facilities must be designed or can be modified to be accessible by following the guidelines known as ADA Standards. Some considerations follow:

- Safe proximity, yet out of sight and sound of scene and/or recovery efforts
- ADA compliant
- Sufficient security manpower
- Entrances/exits that can be secured
- Sufficient private areas for emotional and spiritual support
- At least one large room for briefings
- Sufficient bathrooms and sanitary facilities, including diaper change stations

- Heat and/or air conditioning
- In proximity of a hotel
- Ability to service food and space for overnight stays, if necessary
- Alternate backup power source
- High capacity telephone service; TTY capability
- Internet access, Wi-Fi
- Break/rest area for workers that is out of sight and sound of family members
- Site is registered with PHEP and MEMA Director
- Command Staff may be designated by local/state EOC as needed
- Team Leader(s) coordinate with responders to set up facility using the general layout and flow
- Perimeter security is identified including parking areas
- Staging area and parking for Center staff is identified
- Accessible parking for victims' families is ADA compliant
- Credential verification system is set up
- Media center (off site) is identified and staffed
- Automated External Defibrillator (AED) should be within center, if possible

**NTSB Federal Family Assistance Center Layout**




**Security and Safety**

A representative from local law enforcement should verify the safety and security of the facility, including the following considerations:

- Entrances and exits
- Parking area
- Presence of auxiliary power
- Traffic situation leading to the site
- Proximity to a medical facility
- Availability of additional law enforcement resources
- Availability and source of security equipment
- Personnel requirements (Officer-in-Charge)
- Any requirements for crowd management/internal traffic flow

**Credentialing**

All Center staff must be Federal, State or local employees or members of an established volunteer team. Center staff will receive event badges unless a badge from a permanent affiliation is visible. Photo Identification badges will be worn and required within the FAC. The DHHS *Maine Responds* may assume responsibility for credentialing of new staff. Following transportation accidents, carriers legislated under the Federal family assistance laws, will assume responsibility for credentialing of any Center staff and family members in the Center.

**Operational Security**

All Center staff must adopt operational security measures as part of daily activities. Examples include:

- Caution about what information is disclosed on cell phone and two-way radios that operate on frequencies that can be monitored.
- Using a "need to know" basis in disclosing information to authorized or unauthorized personnel
- Maintaining caution about eavesdropping
- Ensuring that information is approved by proper authority prior to release
- Labeling client information/notes "Confidential" and keeping them in a secure location
- Labeling emails "Confidential" in the subject line and including the following footnote in the email itself:

*This email and any files transmitted with it are confidential and are intended solely for the use of the individual or entity to which they are addressed. This communication may contain material protected by law. If you are not the in- tended recipient, be advised that you have received this email in error and that any us, dissemination, forwarding, printing or copying of this email is strictly prohibited and may be subject to criminal prosecution. If you have received this email in error, please immediately notify sender by telephone or immediate email response indicating the error.*

**Family and Friends Reunification Center and Family Assistance Center Registration**

American Red Cross and Maine's Disaster Behavioral Health volunteers may work collaboratively to address registration and intake needs through a system designed explicitly to register persons fleeing from a disaster or public health emergency and assisting them in reuniting with family and loved ones. Initial information is used to identify those individuals who are present in the Center, and includes information about separation from victims. A more detailed Victim Identification Program may be used later by the Medical Examiner's office and should be pre-populated with registration data to prevent families from being asked for the same information repeatedly and may lead to "form fatigue".

The air or rail transportation carrier that falls under the Federal family assistance center legislation should have a plan for creating identification badges for FAC workers and family

members. The American Red Cross may be called upon to assist the carrier with the family registration process.

**Communication Strategies**

There may be a need for translation services and other means of responding with individuals with limited English proficiency or impairments of vision or hearing. Preliminary identification of resources to meet these needs is important. Once identified, resource information should be made accessible to all staff of the Center. Greeters are the first representatives of the Centers to meet family members. Greeters should be alert to identify individual needs as they arrive and can use "language cards" or other universal symbols to determine how best to communicate. Signage should be in languages common in the impacted area and identification of an area near registration where interpreter services can be provided should be available.

DHHS maintains a list of staff language translators and uses various interpreter services. See http://www.maine.gov/dhhs/policies/us.

For U.S. citizens living abroad, family members are directed to call the U.S. State Department at 1-888-407-4747 to request information on the victim, investigation and interpretative services.

Following a federal transportation accident, the NTSB and Department of State will identify and provide pre-approved language services through their identified national vendors. For foreign nationals, the U.S. State Department recommends contacting the country Embassy. Foreign embassies are located in New York City, Washington D.C., Los Angeles, and San Francisco.

**Cultural Sensitivity**

Family decision responsibility varies among cultures and organizations. To better understand a group's perception of suffering, illness, loss, pain, healing and to gain acceptance; local social services, faith-based and community resources should be utilized to educate Center staff. If local resources are not available, care should be taken to inquire and/or research the necessary information prior to engaging with families and first responders.

**Messaging**

An internal messaging system may be utilized to appropriate purpose within the Center. Liaison should be established with the "Safe and Well" Program and maintained by the American Red Cross, and collaborative registration efforts established as soon as possible.

## Family Interview Process

The purpose of the family interview during a mass fatality event is to gather personal ante mortem information about the unidentified or missing victim(s) to assist the approved medical examiner using the Victim Identification Program (VIP). This information/form will enable a trained medical examiner or coroner to efficiently identify victims' remains. The forms will be provided by the Medical Examiner's office. It is desirable to have the web-based application of the VIP for efficiency, but forms may be filled out by hand and transported to the Medical Examiner's operation center. In all cases, every effort should be made to transfer information already collected at the Center's registration rather than repeat the request for basic information, such as demographics at multiple stages in the process.

Family interviews may be conducted by two-person teams comprised of:

- Medical personnel
- Coroner or Medical Examiner staff
- Clergy or Military Casualty Officers/Chaplains
- Law Enforcement
- Funeral Directors
- VIP trained personnel

Two person teams are organized with one Primary Person conducting the interview and one Support Person acting as a scribe, monitoring behavioral and emotional reactions and managing scene safety. In some cases, a victim advocate or DBHRT specialist may be added to the team to support the family member's emotional and psychological needs. This is particularly valuable when there is a large family or an interviewee with functional needs and/or extreme emotional reactions.

The following persons may participate in the VIP interview process:

- Next-of-kin (meets legal definition)
- Spouse
- Family representative
- Partner
- Those who know the victim(s)' personal identifying features (e.g., scars, tattoos, birthmarks, medical history)

The FAC Director, working in coordination with the Medical Examiner, will address the following points with family VIP teams to enable clear process to proceed:

- The purpose of the VIP process to family members
- Which family members will be selected for the interview process
- Possible necessity of DNA test and hence request for personal effects of the victim(s)' belongings (e.g., tooth or hair brush)

VIP interview teams should maintain awareness of special circumstances which require a unique approach during the process. In the event FAC staff is made aware of a perpetrator(s) or their family member's presence, similar services will be provided at a different location.

Examples of special circumstances may include:

- Presence of children, elderly, individuals with disabilities or language barriers
- Mass casualty incidents
- Active social media messaging
- Estranged family of victim(s)
- Multiple family unit's presence
- Possibility of presence of family perpetrator(s)

**Family Member Concerns**

The Federal Bureau of Investigations (FBI) and Penn State have developed a death notification training for safety officers, victim advocates, medical examiners and coroners, and healthcare professionals. They have identified the following concerns may be expressed by family members:

**Short Term**

- How do you know it is my loved one?
- What happened?
- Where did injury/death occur?
- Where is my loved one now?
- Who is in charge?
- Where can I get accurate, immediate information?
- Where do I get (specific) services?
- Where are my/their belongings?
- Can I visit the accident site?

**Long Term**

- How and where will I get continued information?
- What happens next?
- What is an autopsy and why is it necessary?
- How can this be prevented from happening again?
- Memorial preparations, transportation of body?
- Where do I get (specific) services?

VIP interview teams should focus on the VIP interview process and complete all documentation to help expedite the identification notification with family members. Other trained FAC volunteers should anticipate requests about the family assistance center operations and be as prepared as possible with acceptable responses. Daily staff and family briefings should provide information that allows for accurate and compassionate responses.

**Personal Effects**

One of the questions that family members undoubtedly will ask staff is the status of personal effects of their loved one(s) and how they can regain custody of them. VIP Interview staff should be briefed on the procedures or process to ensure consistency of information being given to families.

The quantity of personal effects that may result from a public transportation crash, for example, is staggering. The transportation accident may involve a carrier subject to the Federal family assistance legislation will have specific requirements regarding specific aspects of the recovery, processing and disposition of personal effects. Additionally, personal effects may be found on human remains or unassociated with a victim. It is therefore difficult to address specific family concerns without daily briefings that include information from the Medical Examiner's Office and/or leading response authority (e.g., NTSB). In general, items are processed as follows:

- Documented on-scene by medical examiner, law enforcement or first responders
- Collected
- Made safe and clear
- Catalogued (e.g., photographed, computer database entered)
- Restored and cleaned
- Returned to legal owner

**DNA Sampling**

The common source of DNA is blood and soft tissue samples, but it can be obtained from personal effects. In cases where DNA sampling is required, family members may be asked to provide personal effects such as:

- Toothbrush
- Hairbrush
- Glasses
- Locks of hair
- Clothing

Collected sources should be stored in a provided "sample kit" if available, or in a stapled and labeled paper bag.

**Victim Confidentiality**

All information affiliated with victims of the incident is considered sensitive and kept confidential. Any information released to those outside direct involvement in the incident must have prior approval by the Unified Command structure at the EOC. Center staff will receive a briefing on confidentiality and reporting procedures when they arrive at work and demobilize after every shift. The DHHS Authorization form to release confidential information will be completed with each survivor family to ensure that the victim information is maintained and

safeguarded during the operation. This form is located at [www.maine.gov](http://www.maine.gov)

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor  Richard Hamilton, Commissioner

**Authorization to Release Information**

**We are committed to the privacy of your information.**
**Please read this form carefully.**

**Which DHHS office(s) should help you?** Please check.

| | |
|---|---|
| ❒Office of MaineCare Services | ❒ Substance Abuse and Mental Health Services |
| ❒Office for Family Independence and Medical Review Team | ❒ Office of Child and Family Services |
| ❒ Maine Center for Disease Control and Prevention | ❒ Office of Aging and Disability Services |
| ❒ Dorothea Dix Psychiatric Center | ❒ Office of Administrative Hearings |
| ❒ Riverview Psychiatric Center | ❒ Other: |

**Whose information is being released?** Please print clearly.

| | | | |
|---|---|---|---|
| Individual's Name | | Date of Birth | Social Security # |
| Home Address | Town/City | State | Zip Code |
| Telephone<br>( ) - | Email address<br>@ | | |

**What information should DHHS release?** Please check all that apply.

| | |
|---|---|
| **General permission:**<br><br>❒All health information from the DHHS office(s) checked above<br>❒Claims or encounter data (information about visits to health care providers)<br>❒Billing, payment, income, banking, tax, asset, or data needed to see if you qualify for DHHS program benefits<br>❒Limit to the following date(s) or type(s) of information: (for example "Lab test dated June 2, 2017" or "Claims from 2015-2017")<br>_____<br>❒Other:_____ | **Special permission: Drug/Alcohol Referral or Services**<br><br>❒Include all drug/alcohol information in the release<br>❒Include only the specific drug/alcohol records checked:<br><br>❒Diagnosis and treatment<br>❒Clinical notes and discharge summaries<br>❒ Drug/Alcohol history or summary<br>❒Payment or claims information<br>❒Living situation and social supports<br>❒Medication, dosages or supplies<br>❒Lab results<br>❒Other: _____ |
| **Special permission: Mental/Behavioral Health Services**<br><br>❒Include this information in the release<br><br>❒I want to review my mental health/behavioral health record before release. I understand that the review will be supervised.<br><br>**Please note**: Maine law allows us to share this information with other health care providers and health plans to coordinate your care (to help take care of you) so long as we make a reasonable effort to notify you of the release. | **Special permission: HIV/AIDS Status/Test Results**<br><br>❒Include this information in the release<br><br>**Please note**: Maine law requires us to tell you of possible effects of releasing HIV/AIDS information. For example, you may receive more complete care if you release this information, but you could experience discrimination if your data is misused. **DHHS** will protect your HIV data, and all your information, as the law requires. |

**Are you asking DHHS to send your information by EMAIL?** ❒ **Yes.**

| |
|---|
| Although DHHS has privacy and security protections for my information, I understand that email and the internet have risks that DHHS cannot control. It is possible that my emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask DHHS to send my information by email. **INITIAL HERE** _____ |
| **Where should DHHS send your information by email? Please print the email address clearly:** |

DHHS Authorization Form 1/18
Page 1 of 2

## Team Self Care

The intensity of working with people with trauma-related symptoms adds to the risk of secondary traumatization. Secondary traumatization is a trauma-related stress reaction and set of symptoms resulting from exposure to another individual's traumatic experiences rather than from exposure directly to a traumatic event. DBHRT members have received training on developing personal and professional boundaries unique to disaster work and how to identify the signs of secondary traumatization in themselves, and how to develop a comprehensive personal and professional self-care plan to prevent and/or ameliorate the secondary trauma-related effects.

Experienced Clinical Team Leaders will manage the interactions that each team member has to trauma-impacted individuals. Clear guidance and supervision will help members understand secondary traumatization and their own personal risks; and the importance of their own self-care. Each interviewer will receive an initial briefing regarding the process and their role prior to accepting an assignment. No interview team should conduct more than five family interviews during a work shift, and a minimum of 30 minutes between interviews should be observed. Each team member will receive a debriefing and brief personal assessment upon completion of a shift.

**Medical Examiner and Law Enforcement Family Notifications**

Representatives from the Medical Examiner's Office, law enforcement, and clergy will conduct and notify family members about the incident fatalities; with family member support being provided by behavioral health professionals, victim advocates, or other trained volunteers. DBHRT Volunteers will not make family notifications, but will assist family members in managing their emotional responses, grief and loss; and assist with practical matters, e.g. supplying information on funeral arrangements, transportation and memorial services.

A minimum of two members of the family notification team must be present. The maximum number of team members may depend upon the size of the family unit among other circumstances. Notifications should be done in as private an area as possible with adequate seating for family and team. Food, water, tissues and information regarding grief support and coping techniques should be available. Make sure children are not present during the initial notification; and do not use children as language translators. If children are to be notified other Next of Kin or caregivers should be present, use age-appropriate language, and have direct eye contact (sitting on ground or low seating to be equal with child's height); and use developmentally appropriate resources. Expect to repeat the death notification information several times, since individual cognitive (thinking) skills may be impacted by the stress of the disaster or potentially traumatic event.

**Notification Procedure**

- The family notification team should be made aware of all known details of the event as it relates to the deceased and how further arrangements can be made. If the family requests to see the deceased, all information about the process should be known before the meeting. The team should also know all procedures to be followed for claiming and transferring the deceased.
- Any written materials that may be helpful to the family should be prepared in advance and made available. These may include lists of funeral homes, phone numbers of the medical examiner's office, transportation carrier 1-800 family support phone number, information on support systems and spiritual care resources, and grief and bereavement services.

- Center staff will identify and escort family members to the family notification team.
- The Primary representative of the family notification team (identified ahead of meeting) will confirm family identity and inform the family of the death in a direct, concise manner.
    - The Primary family notification team member may be asked about how scene and identification were processed; include details of forensic investigation; and avoid telephone notifications, when possible.
    - The Support family notification team member/s will be monitoring scene safety issues and the next of kin's emotional and behavioral responses.
    - Other members of the team can provide emotional support to the family, assure the needs of children are addressed, assist the family with connecting to other relatives and support networks, provide resource information and materials.
- The privacy of the family will be protected during notification and a member of DBH team may remain with the family, if indicated or requested by the family members.
- If notification needs to take place outside the Center, the Director will be notified.
- The team will review the process to ensure lessons learned are used to improve the process. They will also use the review process to support self-care.

**EMOTIONAL and SPIRITUAL SUPPORT**

The primary work of the Disaster Response Team Volunteers is to provide emotional and psychological, and spiritual support to survivors, patients, impacted family members and community members, center workers and first responders. Other responders who may become active during a disaster in a support capacity include Trauma Intervention (TIP) Teams and Crisis Agencies under DHHS contracts. While each entity has a response mission, there may be a need for DBHRT to collaborate with other entities in a coordinated support function. Crisis Response Teams and TIP are not part of the DBHRT and just-in-time training may be developed to ensure an appropriate coordinated response. The Center Director will assume responsibility for coordinating the state of Maine disaster behavioral health assets.

The services that may be provided through the state's behavioral health assets include: Psychological First Aid, Skills for Psychological Recovery, crisis intervention, mediation, education and information, screening and referral, support during site visits, psychological debriefings for first responders and FAC staff members, assistance in completing the Victim Information Profile form, and providing support to the families and survivors during the family victim notifications.

**Additional Duties**

Dignitary Visits – State dignitaries (e.g., governor, elected officials or their representatives, agency heads) often want to visit the Family Reception/ Assistance Center in the aftermath of a disaster to show public support to the families. **The privacy rights of family members will be respected at all times.** Dignitaries will not be accompanied by the press while in the FAC. Family members will be notified in advance of a visit by dignitaries. The FAC Director will determine, in consultation with behavioral health specialists, when dignitary visits can begin – understanding that dignitaries may request visitation almost immediately in the aftermath of the disaster when it may not be emotionally timely for family support.

Among specific issues the Director may address, include the following:

- Determining when visits will take place each day and for how long,
- What size and how many groups will be permitted
- What areas of the Center will be accessible
- Briefing responsibilities prior to visits about the role of the FAC, what can be expected and how best to respond
- Whether additional security might be needed
- Special credentialing and security of dignitaries and their staff
- Briefing for families in advance about the visit(s)

It is recommended that dignitary visits should:

- Schedule in advance
- Be escorted at all times by an assigned PIO designee
- Be limited to an hour or less
- Be confined to public areas of the FAC, allowing for privacy areas where needed
- Coordinate security that may accompany them with the FAC security personnel

**External Media Relations**

There will be intense public and media interest in any mass fatality or potential mass fatality incident. Some members of the Media will attempt to gain access to family members to capture their reactions and to develop human interest stories. The Public Information Officer (PIO) is responsible for all media relations and liaison with the Unified Command. Media briefings may be arranged and families briefed about the presence of media. Every effort should be made to protect the families from media coverage. It should be noted that families sometimes want to speak with the media to tell their story, honor loved ones and/or register reactions to the process. Arrangements should be made to give media an opportunity to view non-confidential areas of the Center and to interview families who desire to speak with them.

In a large scale event, both a Joint Information Center (JIC) and Media Center (MC) will be established to coordinate media relations.

- The JIC is where representatives and public information officers from key local, state and federal agencies assemble to manage the flow of information to the public and press. They coordinate and ensure accurate and timely information is released and that

there is a common message to eliminate confusion and thwart rumors. ESF-8 allows for several individuals to serve in the JIC who regularly confer with responder agencies to ensure accuracy of information.

- The MC serves as the focal point for on-going briefings as well as a work site for visiting journalists. It is usually located near, but not within, the JIC. Homeland Security under ESF-14 (Public Information) provides for establishing and managing the MC, as well as determining scheduling, location and functions within it.

- On the first day the MC is activated, the JIC is responsible for reaching consensus on a protocol that outlines what event(s) will trigger a press conference and who should be present.

- Unless decided otherwise, the primary spokesperson for ESF-8 (Health and Medical Services) is the Commissioner of DHHS (or designee). DHHS staff and representatives from ESF-8 are likely to be invited to attend press conferences. When a media request involves information about the FFRC or the FAC, the spokesperson will be representatives from the Unified Command, and the Chief Medical Examiner's or the NTSB or FBI OVA.

**Public Inquiry & Support Lines**

In general, Maine relies upon 2-1-1 to provide general information to the public about available behavioral health or disaster-related services. It may be decided that 2-1-1 responders will have additional information relating to the event and services that become available in response. In all cases, the PIO will provide approved text to 2-1-1 for their operators to use. Resources may also be available at the DHHS and Ready.gov websites.

Very soon after an event, the SAMHSA Disaster Technical Assistance Center (DTAC) also makes resources available on line at: http://www.samhsa.gov/dtac/resources. In addition, the National Disaster Distress Line becomes available 24/7 and is operated by responders trained to support callers who are impacted by the event and will connect callers to statewide resources through their linkage with 24/7 Crisis Hotlines. The number of the DDL is: 800-985-9550. Callers can also reach the DDL by texting "TalkWithUs" to 66746.

**Accident Scene or Site Visits**

Families of victims and survivors often want to visit the scene as soon as possible. The scope of the site visit will be determined by the circumstances of the mass casualty event and based on the needs and desires of families/survivors. Site visits may be spontaneously set up by the survivors and/or members of the community. In such instances, the FAC can provide consultation and guidance about safety after conferring with Incident Command or Scene Security Officers.

If the incident is a transportation accident and the NTSB has custody of the wreckage, then NTSB investigators and others may be consulted regarding the readiness of the site, the timing of the site visit, and many other considerations. The NTSB does not take responsibility for the transportation of family members to a crash site during a site visit. In Federal disaster assistance programs, the site security would be shared by the transportation carrier and NTSB or FBI OVA. Site visits are highly coordinated events that involve collaboration between the carrier, the investigative agencies, and local and state agencies participating in the incident operation.

Among the many things to be addressed are the following:

- On-scene safety issues
- On-scene security
- Accessible transport/escort to and from the site from a central gathering point
- Media relations and access management
- Identification of natural groupings for site visits (e.g., workers, crew, tourists, perpetrators)
- Symbolic representation of the event (e.g., on-scene debris)
- Communications (e.g., secure channels)
- Medical support (e.g., EMS personnel)
- Privacy needs e.g., tents, privacy screens, cars/buses
- Staffing e.g., behavioral health, medical, law enforcement, guides, greeters
- Temporary memorial location so family members may leave offerings
- On-scene logistical support e.g., water, food, bathrooms, chairs
- Access and functional needs e.g., ADA access
- Bereavement support services
- Joint agency needs and cooperation
- Scheduling considerations with memorial services
- Time allotment for visits
- Weather conditions
- Provisions for children
- Biohazard considerations

The Center Liaison must also work with the Operations Section to determine how to emotionally prepare survivors and families of the victims before a visit. The following guidance may help identify the issues that should be addressed and should be covered in a pre-site visit informational briefing with family members:

- A description of what they are going to see, smell and hear, with a description of what they will experience at the site
- The scope and duration of the event
- Schedule of events
- Guidance on bringing children (e.g., whether parents may visit before deciding to bring children)
- Appropriate clothing and footwear for the scene

- Available support, e.g. before, during and post-visit
- Potential reactions and coping strategies
- Handouts, e.g. reactions and self-care
- Appropriate support for families who do not wish to visit
- Possible exclusions, e.g., medical considerations
- Differing needs of visitors, e.g., families vs. community visitors

**Steps to Set Up a Site Visit**

A Site Visit Coordinator should be selected by the agency responsible for the site memorial activities in coordination with the Center Director to manage and oversee all operations at the site visit location. That individual functions as the 'on scene' coordinator. The site visit coordinator is the liaison with the jurisdictional agency authority to confirm readiness and arrange for a preview visit before arranging family briefings.

Some tasks that the Coordinator will review with partners in preparation for the site visit include:

- Removal of human remains and personal possessions
- Mitigation of safety hazards
- Perimeter security clearly established and patrolled
- Availability of privacy screens or canopy tents
- Security (media not allowed)
- Whether a no-fly zone has been established?
- Availability of support staff?
- Transportation arrangements to and from the site
- Transportation route(s) from FAC to site, e.g. security escorts in place as needed
- Communication frequencies in use, e.g. communication with the site
- Logistical support to be on site

Information about site visits should be provided to families and survivors as far ahead of scheduling as possible – 12 hours is recommended. Based on DBHRT observations, individual team members may be assigned to families to accompany them on the site visit. A time schedule will be included in the briefing following a discussion with site visit partners. Generally, a site visit may require 30 minutes per group, but is negotiable.

## Family Resource Centers

After several days of operations, the Family Centers may identify increasing needs for resources to offer the impacted families. If a separate Family and Friends Resource Center (FFRC) has not

have been established, coordination with other agencies should take place to add a FFRC Resource Section to the FAC. Healthcare organizations have two roles in a FFRC to provide a Social Services Unit Leader and a Family Reunification Leader. Primary among considerations is that those injured or killed by the event have been identified and/or the resource needs of the survivors and families go beyond the initial shock of the event and become varied and significant.

The FFRC is designed to address the needs of survivors and families of deceased in the early post-event period – typically 3-14 days afterward. The goal is to bring together in one location all services that may be needed by those directly impacted. The array of services will be dictated by the nature of the event and will be approved by the Unified Command. Families and survivors may participate in a needs assessment process and be linked directly to appropriate providers. Unified Command representatives in coordination with the FAC Director bear principal responsibility for identifying necessary services, ensuring availability and coordinating delivery processes.

Key tasks associated with providing services are as follows:

- Establish procedures for registering and verifying identity of care recipients
- Conduct needs assessment and assure access to necessary services
- Ensure family reunification processes are in place, especially for vulnerable populations, e.g. young children and frail elderly
- Identify service gaps and track utilization to avoid duplication of efforts and to prevent competition to care between organizations
- Organize, schedule and provide standardized training to family care providers
- Establish a system for referrals and follow-up for professional services
- Integrate services as fully as possible
- Integrate public service information messages with 2-1-1 and other public service entities

The needs of the family members, victims, survivors, etc. will drive what services are required. Examples of services that may be referred through the Family and Friends Resource Center or the Family Assistance Center may include the following:

- Transportation
- Home health care or ongoing healthcare services
- Burial/funeral services
- Translation/interpretation
- Passport assistance, replacement of photo identification, i.e. driver's licenses
- Mental health/substance abuse programs
- Legal advice regarding death certificates, wills, insurance, etc.
- Child welfare and family reunification
- Nutrition
- Housing (temporary or permanent)

**Family Intake/Exit Interview**

Individuals utilizing the FFRC should be asked to register and fill out an intake form to record basic contact information and services requested. Interviews should be conducted upon arrival and after referrals have been made and follow-up completed.

**Logistical Support**

Logistical support for the FFRC will be managed by the Logistics Section. Areas of support may include children services, transportation, lodging information, food services, sanitation, communications, waste removal and other services. Ideally the FFRC is located within reasonable proximity to a hotel which will manage many services independently.

## DEMOBLIZATION of Centers

When the short term needs of family members and survivors have been addressed, the Center Director in collaboration with the Incident Command staff will deactivate the Center operations. On-going identified needs will be addressed by state DHHS resources, American Red Cross, local/community crisis agencies, and long term recovery committees. Refer all family members' questions concerning decedent identification to the State of Maine Medical Examiner's Office.

**Individual Staff Members' Check-Out Procedures**

At the end of the work shift each staff member should address the following:

- Brief replacement on all actions taken during the shift and what the IAP objectives are for the upcoming 12/ 24 and 36-hour periods.
- Document hours worked including mileage driven and any expenses (with receipts)
- Return FAC /FFRC credentials to Security
- Return documentation to appropriate authority for follow-up
- Participate in post deployment debrief with DBH Team Leader/s
- Demobilization with Safety Officer to complete required forms
- Discuss HIPPA, client confidentiality (written, verbal, social media, etc.)
- Return to FAC Staging Area to pick up exit materials and sign-out
- Not remain on scene after check-out.

Typically, a post-deployment check may take about 30 minutes. Facilitators of the process should not have been directly involved in the response effort, and should be familiar with post deployment check list priorities.

*Follow-up post-deployment supports:*

- Additional educational opportunities on trauma-informed practices and models that promotes competence in their own personal coping skills and the ability to find meaning in adversity.
- Emotional support from professionals, and other DBHRT members

- Psycho-social information handouts will be provided immediately after work shifts; and trainings can be scheduled, as needed
- Access and referrals to spiritual and faith-based professionals

## Family and Friends Reception Center, and Family Assistance Center Resources:

- ☐ Psychological First Aid Provider Worksheets: Survivor Current Needs
- ☐ Psychological First Aid Provider Worksheets: Components Provided
- ☐ Psychological First Aid Handouts for Survivors
- ☐ SAMHSA brochures: *Survivors dealing with Grief*
- ☐ Department of Justice, Federal Bureau of Investigations: *We Regret to Inform You…* guide for professionals delivering death notifications with professionalism, dignity and compassion
- ☐ HICS 254- Disaster Victim/Patient Tracking form
- ☐ Disaster Behavioral Health: Critical Response: *Family Reception Center Registration*
- ☐ National Transportation Safety Board: *Transportation Disaster Assistance Point Paper* (April 2016)

## Maine Disaster Behavioral Health Response Team Work Environment

- ☐ Pre-deployment Checklist
- ☐ Self-Care Checklist
- ☐ After-Deployment Checklist

## Maine Disaster Behavioral Health Response Team Pre-Deployment Checklist

This checklist provides a guideline for what to pack for a disaster assignment should you be called outside your local community. You should consider luggage with wheels or a backpack. Bring only what you can carry. Include items that you feel are essential. Some of the items are more critical in longer deployments and may not be necessary for shifts of twelve hours or less.

- ☐ Copy of professional license (if applicable)
- ☐ Copy of driver's license
- ☐ Other professional identification
- ☐ Necessary Forms
- ☐ _____

- ☐ Business cards
- ☐ Steno pad of paper
- ☐ Pens / crayons
- ☐ Envelopes for expense receipts
- ☐ Copies of psycho educational pamphlets

- ☐ Easy-care clothing (enough for 10 days without laundry)
- ☐ Casual slacks (no jeans, as these may not be appropriate for memorial services or funerals)
- ☐ Casual shirts or tops
- ☐ One set of dress clothes
- ☐ Jacket (appropriate to climate/conditions)
- ☐ Sweater
- ☐ Rain gear
- ☐ Comfortable shoes (appropriate to conditions, no open toe shoes)
- ☐ Extra pair of glasses
- ☐ Sunglasses
- ☐ _____

- ☐ Toilet articles, facial tissues
- ☐ Bath towel and washcloth
- ☐ Antibacterial hand wipes
- ☐ Leisure time materials (books, camera, music)
- ☐ Comfort foods and list of special dietary restrictions
- ☐ Water bottle
- ☐ Limited amount of cash
- ☐ Credit card
- ☐ Copy of car insurance policy
- ☐ Photos of family and friends
- ☐ Journal
- ☐ _____

- ☐ Flashlight and batteries
- ☐ Portable radio (battery powered and receives weather/emergency announcements)
- ☐ Extra batteries
- ☐ Sleeping bag/bed roll/blanket and pillow
- ☐ Sewing kit
- ☐ Travel alarm clock
- ☐ _____

- ☐ Contact lens solution
- ☐ Prescriptions/medicines (including a list of all medication names, dosages, prescribing physician, telephone numbers.)
- ☐ Copy of medical insurance card
- ☐ Personal first aid kit
- ☐ Sunscreen
- ☐ Bug spray
- ☐ _____

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# Provider Worksheets

## Survivor Current Needs

Date: _____ Provider: _____

Survivor Name: _____

Location: _____

This session was conducted with (check all that apply):

☐ Child ☐ Adolescent ☐ Adult ☐ Family ☐ Group

Provider: Use this form to document what the survivor needs most at this time. This form can be used to communicate with referral agencies to help promote continuity of care.

**1. Check the boxes corresponding to difficulties the survivor is experiencing.**

| Behavioral | Emotional | Physical | Cognitive |
|---|---|---|---|
| ☐ Extreme disorientation | ☐ Acute stress reactions | ☐ Headaches | ☐ Inability to accept/ cope with death of loved one(s) |
| ☐ Excessive drug, alcohol, or prescription drug use | ☐ Acute grief reactions | ☐ Stomachaches | ☐ Distressing dreams or nightmares |
| ☐ Isolation/ withdrawal | ☐ Sadness, tearfulness | ☐ Sleep difficulties | ☐ Intrusive thoughts or images |
| ☐ High risk behavior | ☐ Irritability, anger | ☐ Difficulty eating | ☐ Difficulty concentrating |
| ☐ Regressive behavior | ☐ Feeling anxious, fearful | ☐ Worsening of health conditions | ☐ Difficulty remembering |
| ☐ Separation anxiety | ☐ Despair, hopelessness | ☐ Fatigue/exhaustion | ☐ Difficulty making decisions |
| ☐ Violent behavior | ☐ Feelings of guilt or shame | ☐ Chronic agitation | ☐ Preoccupation with death/destruction |
| ☐ Maladaptive coping | ☐ Feeling emotionally numb, disconnected | ☐ Other _____ | ☐ Other _____ |
| ☐ Other _____ | ☐ Other _____ | | |

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2. **Check the boxes corresponding to difficulties the survivor is experiencing.**

- ☐ Past or preexisting trauma/psychological problems/substance abuse problems
- ☐ Injured as a result of the disaster
- ☐ At risk of losing life during the disaster
- ☐ Loved one(s) missing or dead
- ☐ Financial concerns
- ☐ Displaced from home
- ☐ Living arrangements
- ☐ Lost job or school
- ☐ Assisted with rescue/recovery
- ☐ Has physical/emotional disability
- ☐ Medication stabilization
- ☐ Concerns about child/adolescent
- ☐ Spiritual concerns
- ☐ Other: _____

3. **Please make note of any other information that might be helpful in making a referral.**

_____

_____

4. **Referral**

- ☐ Within project (specify) _____
- ☐ Other disaster agencies
- ☐ Professional mental health services
- ☐ Medical treatment
- ☐ Substance abuse treatment
- ☐ Other community services
- ☐ Clergy
- ☐ Other: _____

5. **Was the referral accepted by the individual?**

- ☐ Yes
- ☐ No

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# Provider Worksheets

## Psychological First Aid Components Provided

Date: _____ Provider: _____

Location: _____

This session was conducted with (check all that apply):

☐ Child ☐ Adolescent ☐ Adult ☐ Family ☐ Group

Place a checkmark in the box next to each component of Psychological First Aid that you provided in this session.

### Contact and Engagement

- ☐ Initiated contact in an appropriate manner
- ☐ Asked about immediate needs

### Safety and Comfort

- ☐ Took steps to ensure immediate physical safety
- ☐ Attended to physical comfort
- ☐ Attended to a child separated from parents
- ☐ Assisted with concern over missing loved one
- ☐ Assisted with acute grief reactions
- ☐ Attended to spiritual issues regarding death
- ☐ Provided information about funeral issues
- ☐ Helped survivors regarding death notification
- ☐ Gave information about the disaster/risks
- ☐ Encouraged social engagement
- ☐ Protected from additional trauma
- ☐ Assisted after death of loved one
- ☐ Helped with talking to children about death
- ☐ Attended to traumatic grief
- ☐ Helped survivor after body identification
- ☐ Helped with confirmation of death to child

### Stabilization

- ☐ Helped with stabilization
- ☐ Gathered information for medication referral for stabilization
- ☐ Used grounding technique

### Information Gathering

- ☐ Nature and severity of disaster experiences
- ☐ Concerns about ongoing threat
- ☐ Physical/mental illness and medications(s)
- ☐ Extreme guilt or shame
- ☐ Availability of social support
- ☐ History of prior trauma and loss
- ☐ Other _____
- ☐ Death of a family member or friend
- ☐ Concerns about safety of loved one(s)
- ☐ Disaster-related losses
- ☐ Thoughts of harming self or others
- ☐ Prior alcohol or drug use
- ☐ Concerns over developmental impact

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## Practical Assistance

- ☐ Helped to identify most immediate need(s)
- ☐ Helped to clarify need(s)
- ☐ Helped to develop an action plan
- ☐ Helped with action to address the need

## Connection with Social Supports

- ☐ Facilitated access to primary support persons
- ☐ Discussed support seeking and giving
- ☐ Modeled supportive behavior
- ☐ Engaged youth in activities
- ☐ Helped problem-solve obtaining/giving social support

## Information of Coping

- ☐ Gave basic information about stress reactions
- ☐ Gave basic information on coping
- ☐ Taught simple relaxation techniques(s)
- ☐ Helped with family coping issues
- ☐ Assisted with developmental concerns
- ☐ Assisted with anger management
- ☐ Addressed negative emotions (shame/guilt)
- ☐ Helped with sleep problems
- ☐ Addressed substance abuse problems

## Linkage with Collaborative Services

- ☐ Provided link to additional service(s) _____
- ☐ Promoted continuity of care _____
- ☐ Provided handout(s) _____

# Psychological First Aid

**Field Operations Guide**
**2nd Edition**

## Appendix E:

- Handouts for Survivors
  - Connecting with Others: Seeking Social Support (for adults and adolescents)
  - Connecting with Others: Giving Social Support (for adults and adolescents)
  - When Terrible Things Happen (for adults and adolescents)
  - Parent Tips for Helping Infants and Toddlers (for parents/caregivers)
  - Parent Tips for Helping Preschool-Age Children (for parents/caregivers)
  - Parent Tips for Helping School-Age Children (for parents/caregivers)
  - Parent Tips for Helping Adolescents (for parents/caregivers)
  - Tips for Adults (for adult survivors)
  - Basic Relaxation Techniques (for adults, adolescents, and children)
  - Alcohol and Drug Use after Disasters (for adults and adolescents)

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Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

# Tips for Survivors:

## COPING WITH GRIEF AFTER A DISASTER OR TRAUMATIC EVENT

Grief is the normal response of sorrow, heartache, and confusion that comes from losing someone or something important to you. Grief can also be a common human response after a disaster or other traumatic event.

This tip sheet contains information about grief, the grieving process, and what happens when the process is interrupted and complicated or traumatic grief occurs. It also offers tips and resources for coping with both types of grief.

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

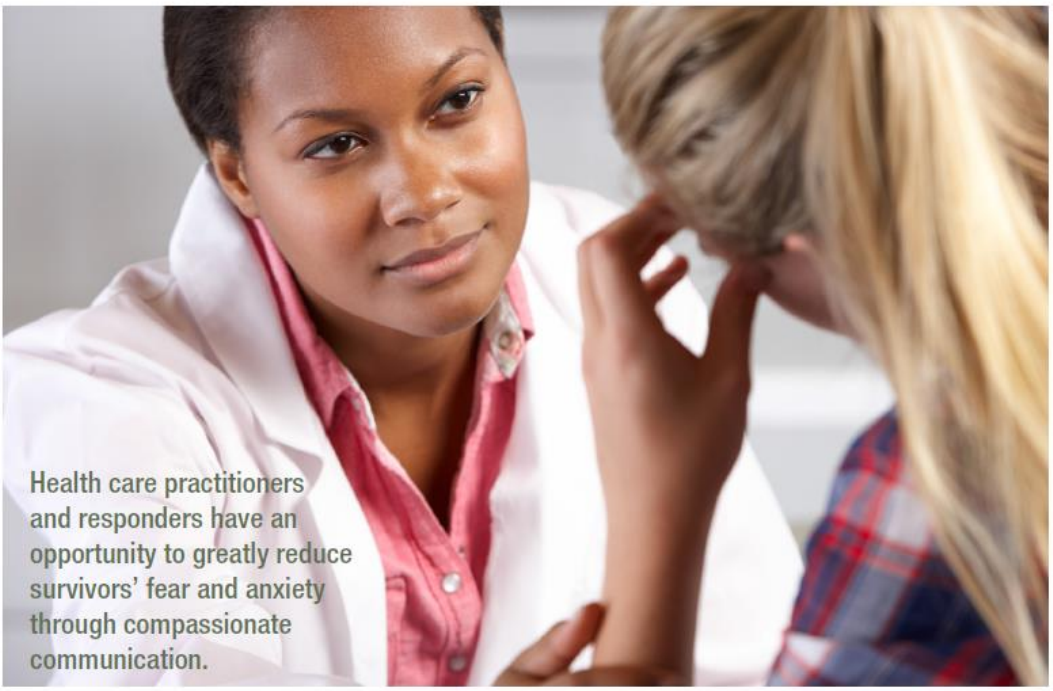
# Tips for Health Care Practitioners and Responders:

## HELPING SURVIVORS COPE WITH GRIEF AFTER A DISASTER OR TRAUMATIC EVENT

### Introduction

Grief is the normal response of sorrow, heartache, and confusion that comes from losing someone or something important. Grief can also be a common human response after a disaster or other traumatic event. As a health care practitioner or responder, you will need to help others cope with and manage their grief after a disaster or other traumatic event—even if you are experiencing grief yourself.

This tip sheet offers health care practitioners and responders guidelines for communicating with survivors experiencing grief. Background information about the grieving process and what happens when the grief process is interrupted and complicated or traumatic grief occurs is included as well as helpful resources for additional assistance.



## Frequently Asked Questions

Commonly asked questions by the NOK during a death notification:

- Who died and how was the decedent identified?
- What happened?
- Where did the death occur?
- When did the death occur?
- Where is my loved one now?
- May I see him/her?
- What is an autopsy and why is it necessary?

Lord, J. & Stewart, A. (2008). *I'll never forget those words. A practical guide to death notification.* Burnsville, NC: Compassion Books, Inc.

## Helpful Delivery Statements

- I am so sorry.
- This is harder than most people think.
- Most people who have gone through this react similarly to you.
- People can experience many different feelings at the same time.
- This is one of the most difficult times in your life.

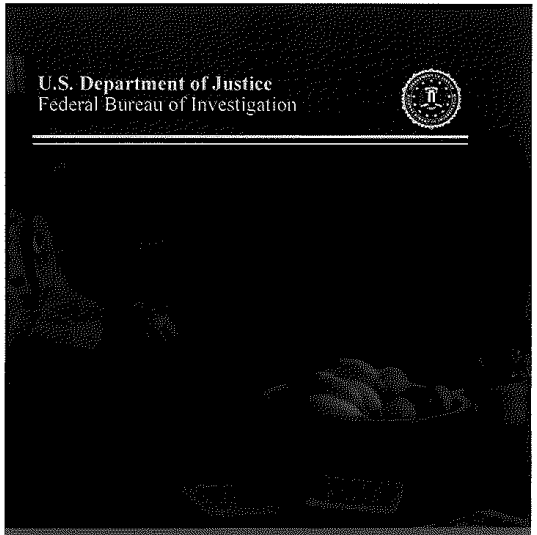
## Statements to Avoid

- I know how you feel. ***(You don't)***
- Time heals all wounds. ***(It doesn't)***
- You need to be strong. ***(They don't)***
- You'll get over this someday. ***(They won't)***
- He was just in the wrong place at the wrong time.
- You must go on with your life.
- You will find closure.
- He didn't know what hit him.
- It's best to remember him the way he was.
- You don't need to know that.
- You don't want to see him/her.
- It must have been his/her time.
- Think of all of your memories.
- Religious phrases

For further information please visit:

**www.deathnotification.psu.edu**

This material has been developed between the Federal Bureau of Investigation and Penn State University through a Cooperative Agreement.



U.S. Department of Justice
Federal Bureau of Investigation

# WE REGRET TO INFORM YOU...

*Guide for professionals delivering death notifications with professionalism, dignity, and compassion.*

## INTRODUCTION

Families want and deserve the truth about their loved one's death. Every death notification has a lasting impact on family members. The manner in which a death notification is provided can positively or negatively affect family members. It can significantly affect the family's cooperation with any investigation. While delivering a death notification can be an extremely stressful experience for all individuals involved, there are methods to ensure the notification is provided to family members with professionalism, dignity, and compassion.

There are four key elements to providing a death notification. They are **planning, preparation, delivery, and follow up**.

## 1 PLANNING

- Identify the deceased. Be prepared to explain the preliminary identification.
- Set up the death notification team.
  - *Who will be in the lead role and who will be in the support role?*
- Identify and verify the legal Next-Of-Kin (NOK) to be notified.
- Know details of when, where, and how the death occurred.
- Be prepared to provide accurate details regarding the death, assuming specific details can be released.
- Ensure that the *Coping with Grief* brochure is available.

## 2 PREPARATION

- Familiarize yourself with the death notification protocols within your jurisdiction.
- Know the process in your jurisdiction for the NOK to view their loved one.
- Check with dispatch for any medical concerns or safety issues at the NOK's location.
  - *If a concern exists, request ambulance support near the residence (not in front of) in the event it is necessary.*
- Prepare for physical and emotional reactions of the NOK.

## 3 DELIVERY

- Confirm the identity of the person with whom you are speaking and their relationship to the decedent.
- Introduce yourself, present credentials, and provide a business card with contact information.
- Ask to come inside and ask/encourage family member(s) to sit down.
- Provide a one-sentence statement to prepare the family for the notification (i.e. "I'm sorry to have to share this information").
- Use decedents name. Do not refer to "your son's body," "your mother's remains," or "the corpse."
- Provide notification immediately following the preparation statement, using clearly understood words such as died, death, or dead. Do not use phrases such as passed on, lost, or expired.
- Provide the NOK with details of when, where, and how the death occurred.
- Provide the NOK with the current location of their loved one and the process to make arrangements to see and/or recover their loved one. This includes the autopsy process.
- Answer all questions honestly. Provide only information you know to be true and that you can release.
- Ask if there are other family members who should receive official notification.
- Do not leave the NOK alone. Ask if you can call anyone for them and wait until the person(s) arrives.
- Ask if you can follow up within 24 hours.
- Provide written material whenever possible, to include the autopsy process, if applicable.

## 4 FOLLOW UP

- Contact the NOK at the agreed-upon time. Ensure you follow through on the promise to contact them.
- Utilize this as an opportunity for the NOK to ask additional questions.
- Be prepared to discuss decedent's personal effects.
- Provide guidance for family members about speaking to the media, if requested.
- Answer questions about the release of their loved one to a funeral home of their choosing.
- Provide additional resources.

## HICS 254 – DISASTER VICTIM / PATIENT TRACKING

| 1. Incident Name | 2. Operational Period (# ) DATE: FROM: _____ TO: _____ TIME: FROM: _____ TO: _____ |
|---|---|

**3. Area** (Triage or Specific Treatment Area)

| FIELD TAG NUMBER | MEDICAL RECORD NUMBER | NAME (LAST NAME, FIRST NAME) | SEX (M/F) | DOB / AGE | TRIAGE CATEGORY IMMEDIATE DELAYED MINOR EXPECTANT EXPIRED | LOCATION / TIME OF PROCEDURES (CT, X-RAY, ETC.) | DISPOSITION / TIME (D) DISCHARGE (A) ADMIT (S) SURGERY (T) TRANSFER (M) MORGUE |
|---|---|---|---|---|---|---|---|
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**4. Prepared by**

PRINT NAME: _____ SIGNATURE: _____

DATE/TIME: _____ FACILITY: _____

HOSPITAL INCIDENT COMMAND SYSTEM

**Purpose:** Records the triage, treatment, and location of victims/patients
**Origination:** Patient Tracking Manager or team
**Copies to:** Situation Unit Leader, Patient Registration Unit Leader, Planning Section Patient Tracking Manager, Medical Care Branch Director, and Documentation Unit Leader

## HICS 254 - DISASTER VICTIM / PATIENT TRACKING

**PURPOSE:** The HICS 254 Disaster Victim / Patient Tracking records the triage, treatment, and disposition of victims/patients of the event seeking medical attention.

**ORIGINATION:** Completed by the Patient Tracking Manager or team members.

**COPIES TO:** Distributed to the Situation Unit Leader, with copies to Patient Registration Unit Leader, Planning Section Patient Tracking Manager, Medical Care Branch Director, and the Documentation Unit Leader.

**NOTES:** The form is completed upon arrival of the first patient and updated periodically. Copies of the form are sent to the Planning Section Patient Tracking Manager each hour and at the end of each operational period until disposition of the last victim(s) are known. If additional pages are needed, use a blank HICS 254 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

| NUMBER | TITLE | INSTRUCTIONS |
|---|---|---|
| 1 | **Incident Name** | Enter the name assigned to the incident. |
| 2 | **Operational Period** | Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies. |
| 3 | **Area** | Enter the triage or specific treatment area (e.g., Triage, Immediate Treatment Area). |
| | **Field Tag Number** | Enter field triage tag number. |
| | **Medical Record Number** | Enter hospital medical record number if available. |
| | **Name** | Enter the full name of victim/patient. |
| | **Sex** | Enter sex: M for male/F for female. |
| | **DOB / Age** | Enter date of birth and age. |
| | **Triage Category** | Enter the triage category assigned to patient. |
| | **Location / Time of Procedures** | Enter location destination and time patient leaves triage or treatment area for a test or procedure. |
| | **Disposition / Time** | Enter the letter of the disposition category and time of disposition. |
| 4 | **Prepared by** | Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility. |

# Family Reception Center Registration Form

## Victim: Name and Address

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

_____

City: _____ State: _____ Zip Code: _____

Home phone: (  ) _____ Work phone: (  ) _____ Mobile phone: (  ) _____

## Next of Kin: Name and Address

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

_____

City: _____ State: _____ Zip Code: _____

Home phone: (  ) _____ Work phone: (  ) _____ Mobile phone: (  ) _____

## Victim Information

Race: _____ Date of Birth: _____ Age: _____

Social Security #: _____ Religion: _____

What did the missing person look like?

Weight: _____ Height: _____ Build: _____

Hair Color: _____ Hair Style: _____ Eye Color: _____

Glasses: ☐ Yes ☐ No Style: _____

Contacts: ☐ Yes ☐ No Color: _____

Blood Type: _____

What was the missing person wearing? (i.e., clothing, shoes, jewelry, etc.)

 

**National Transportation Safety Board**
Transportation Disaster Assistance Division

SPC 04/12
4/2016

# Transportation Disaster Assistance Point Paper

**What is the NTSB?**

The National Transportation Safety Board (NTSB) is an independent federal agency charged with investigating and determining the probable cause of all civil aviation accidents in the United States and selected accidents in rail, highway, marine, and pipeline operations. The NTSB has no authority to regulate the transportation industry, which is the responsibility of the Department of Transportation. Safety recommendations developed from NTSB investigations are aimed at preventing accidents from reoccurring and are issued to public and private organizations in a position to improve transportation safety.

**What is TDA?**

The NTSB's Transportation Disaster Assistance Division (TDA) coordinates the resources of federal, state, and local agencies, transportation operators, and the American Red Cross, in order to meet the needs of family members and survivors. TDA also serves as the primary resource for investigative information for family members and survivors.

**What gives TDA its authority?**

Three federal laws provide the legal mandates under which TDA operates:

- Aviation Disaster Family Assistance Act of 1996 (Public Law 104-264)
- Foreign Air Carrier Family Support Act of 1997 (Public Law 105-148)
- Rail Passenger Disaster Family Assistance Act of 2008 (Public Law 110–432)

These pieces of legislation and the associated Federal Family Assistance Plans for aviation and rail passenger disasters outline the responsibilities of the NTSB, the transportation carrier, the American Red Cross, and supporting federal agencies following an accident where the following criteria apply:

**Legislated Aviation Accidents**

- Accidents in US or territories
- Major domestic and foreign air carriers
- Major loss of life

**Legislated Rail Accidents**

- Accidents in US
- Interstate rail passenger carrier (Amtrak)
- Inter- and intrastate high speed rail passenger carriers
- Major loss of life
- Exceptions: subways and light/commuter, tourist, historic, scenic, or excursion rail carriers

**How are families assisted after an accident?**

Federal, state, and local agencies, transportation operators, and the American Red Cross work together with the guidance of TDA to ensure that the needs of family members and survivors are being addressed. Typical family assistance operations required under these pieces of legislation involve the areas described below.

**Family Assistance Center**
The Family Assistance Center (FAC) is a secure meeting place established by the transportation carrier for family members, survivors, and friends to obtain services and receive information about the investigation. The FAC remains open throughout the on-scene work. Personnel from TDA, the American Red Cross, the transportation carrier, and federal, state, and local agencies staff the FAC.

**Daily Family Briefings**
While on-scene, TDA coordinates briefings for family members at the FAC. These briefings provide information on the progress of the investigation, local agency responsibilities (such as victim identification), and available family assistance services. Following the on-scene phase, TDA maintains contact with families and survivors throughout the NTSB investigative process.

**Personal Effects**
The collection, processing, and return of personal effects are the responsibility of the transportation carrier and the local medical examiner or coroner.

**Emotional Support Services**
The American Red Cross provides crisis and emotional support services for family members, survivors, and friends at the FAC and after their return home.

**Victim Recovery and Identification**
Victim recovery, identification, and death certification are the responsibility of the local medical examiner or coroner. TDA can coordinate technical expertise to assist in this process.

**Assisting Families of Foreign Citizens**
The Department of State secures translation services, provides official notification to foreign governments, assists with visa services, and facilitates consular services.

**National Transportation Safety Board**
**Transportation Disaster Assistance Division**
490 L'Enfant Plaza East, SW
Washington, DC 20594
www.ntsb.gov/tda
202-314-6185
assistance@ntsb.gov

**What are TDA's responsibilities in the legislation?**

- Coordination and oversight of family assistance operations.
- Ensure provision of disaster mental health services in coordination with the American Red Cross.
- Facilitate victim recovery and identification processes (working with local medical examiner or coroner).
- Provision of information to families about NTSB investigations when information is publically released:
  - On-scene factual information
  - Investigative milestones
  - Investigative hearing and Board meeting
- Coordination with federal, state, and local agencies.

Other Legislated Requirements

- No person/state/political subdivision may impede the NTSB or the American Red Cross from providing support to family members, or allowing them to have contact with one another.
- No unsolicited communication to family members by an attorney (or their representatives) or a potential party to litigation for 45 days following the accident.

**What about other transportation accidents?**

Although there is no legal requirement for TDA to respond to accidents not covered under the legislation, TDA can perform, in a limited capacity, similar coordination and information exchange tasks with federal, state, and local agencies and family members. These efforts are conducted only when the NTSB investigates the accident. This work can be done on-scene or via phone and email.

Examples of Non-Legislated Accidents

- Aviation: general aviation, business, emergency medical services, sightseeing
- Selected modal accidents when investigated by the NTSB
  - Highway: motorcoach, school bus, bridge collapse
  - Marine: ferries, fishing vessels, sightseeing vessels
  - Rail: subway, commuter, freight
  - Pipeline and hazardous materials

**Supporting Organizations and Federal Agency Resources**

**Air/Rail Carrier:** Notifies family members of the accident; organizes the family assistance center; arranges for travel, lodging, and other logistics for family members traveling to the accident city; manages the recovery and return of personal effects; and assumes reasonable costs for the recovery, identification, and repatriation of fatalities.

**State, County, and Local Government Agencies:** Conducts life saving, fire/rescue, scene security, and medical examiner/coroner operations. TDA coordinates closely with critical state, county and local authorities to ensure that family assistance needs are being addressed.

**Department of State (DOS):** Secures translation and communication services, provides official notification to foreign governments, assists with visa services, and facilitates consulate and customs services.

**Department of Health and Human Services, Assistant Secretary for Preparedness and Response, Disaster Mortuary Operational Response Team (DMORT):** Assists the local medical examiner or coroner by providing technical assistance and personnel to support the victim recovery and identification process.

**Federal Bureau of Investigation (FBI):** Provides several operational assets to assist both the NTSB investigation and the family assistance responsibilities including the Disaster Squad and Evidence Response Teams.

**Department of Homeland Security, Federal Emergency Management Agency (FEMA):** Assists with emergency management–related issues, facilitates voice and data communication at the accident scene, and assists with public information dissemination.

**Department of Defense (DOD):** Assists the local medical examiner or coroner in the victim identification process with services from the Armed Forces Medical Examiner System and the Armed Forces DNA Identification Laboratory.

**American Red Cross:** Provides family care, crisis intervention, and spiritual care.

**Does TDA offer training?**

With more than 15 years of experience and hundreds of on-scene accident responses, the TDA staff has developed targeted training for the transportation industry and federal, state, and local agencies involved in transportation disaster and family assistance response. Customized training is also available.

**TDA 301: Transportation Disaster Response - Family Assistance**
Designed to provide the key concepts and operational aspects of family assistance in transportation disaster response, this course is instrumental for understanding and implementing an effective family assistance response.
**TDA 403: Mass Fatality Incidents for Medicolegal Professionals**
Designed to address managing the medicolegal response to transportation-related mass fatality incidents, this course discusses strategies and essential concepts for an effective disaster victim recovery and identification operations.
**TDA 406: Transportation Disaster Response – Managing Transportation Mass Fatality Incidents: A Course for Emergency Managers, Law Enforcement, and the Medicolegal Community**
Examines core principles for managing the transition from first response operations into decedent recovery and identification process.

For more information, go to http://www.ntsb.gov/tda/Pages/default.aspx
or view the NTSB Training Center website at http://www.ntsb.gov/Training_Center/Pages/TrainingCenter.aspx

## Secondary Traumatization Signs

Sources: Figley, 1995; Saakvitne et al. 1996; Newell & MacNeil, 2010
the following are some indicators that Disaster Volunteers, First Responders and Family Members may experience through secondary traumatization:

### Psychological Distress

- Distressing emotions, grief, depression, anxiety, dread, fear, rage, shame
- Intrusive imagery of others' traumatic experiences, including nightmares, flashbacks
- Numbing of emotional states; avoidance to working with survivors
- Somatic issues: sleep disturbances, headaches, gastrointestinal distress, heart palpitations, chronic psychological arousal
- Addictive/compulsive behaviors: substance abuse and compulsive eating, working, or spending money
- Impaired functioning: missed or cancelled appointments, lack of self-care, isolation and alienation from supportive relationships

### Cognitive Shifts

- Chronic suspicion about others
- Heightened sense of vulnerability
- Extreme sense of helplessness; or exaggerated sense of control over others or situations
- Loss of personal control or freedom
- Bitterness or cynicism
- Blaming the victim or seeing everyone as a victim

### Relational Disturbances

- Decreased intimacy and trust in personal/professional relationships
- Distancing or detachment from helping disaster survivors, including labeling them, diagnosing them, judging them, cancelling appointments, or avoiding them
- Over-identification with the Survivors or Victims, a sense of being paralyzed in responding

### Frame of Reference

- Disconnection from one's sense of identity
- Dramatic change in fundamental beliefs about the world
- Loss or distortion of values and principles
- Loss of faith in something greater than themselves or disconnect from faith-based practices
- Existential despair and loneliness

## Spirituality and Trauma: Professionals Working Together

**PTSD: National Center for PTSD**

## What is spirituality?

Spirituality is a personal experience with many definitions. Spirituality might be defined as "an inner belief system providing an individual with meaning and purpose in life, a sense of the sacredness of life, and a vision for the betterment of the world". Other definitions emphasize a connection to that which transcends the self. This connection might be "to a God, their Creator, a higher power, a universal energy, the sacred or to nature". Researchers in the field of spirituality have suggested three useful dimensions for thinking about one's spirituality:

- Beliefs
- Spiritual Practices
- Spiritual Experiences

Many individuals describe religion or spirituality as the most important source of strength and direction for their life. Because spirituality plays such a significant and central role in their lives, it is likely to be affected by exposure and reactions to a potentially traumatic event.

## Relationship to trauma to spirituality

Evidence suggests that trauma can produce both positive and negative effects on an individual's spiritual experience and their perception of cause-effect and blame following a traumatic event. Some individuals exposed to traumatic events may experience a renewed appreciation of their life experiences with increased feelings of connectivity to family and friends; some may deepen a stronger devotion to their higher power or their Creator which reaffirms a sense of purpose in their lives and may result in enhanced spiritual well-being. Their spiritual beliefs may increase their level of forgiveness and may lead to more compassionate acts toward themselves and others.

For others, traumatic events may be associated with a decreased trust in their established beliefs that results in diminished participation in religious or spiritual activities, and they may begin to question their previously sustaining beliefs. They may also develop a feeling of being abandoned or punished by their Creator with a diminished sense of meaning and purpose in their lives. Guilt and shame, anger and irritability are possible negative outcomes following a traumatic experience.

Research has been conducted on the pathways by which spirituality might affect the recovery trajectory for survivors of traumatic events. Spirituality may improve post-trauma outcomes through (1) reduction of behavioral risks through healthy religious lifestyles, e.g. less drinking or smoking; (2) expanded social support through involvement in spiritual communities; (3) enhancement of coping skills and helpful ways of understanding trauma that result in meaning-

making; and (4) physiological mechanisms, such as activation of the "relaxation response" through prayer or meditation. Feelings of isolation, loneliness and depression related to grief and loss may be lessened by the social support of a spiritual community who can provide encouragement and emotional support, as well as possible instrumental support, e.g. home and hospital visits, food pantries, or financial assistance programs.

### What issues most often involve spirituality?

*Making meaning of the trauma experience*

Spiritual beliefs will influence a survivor's ability on how to make meaning out of the traumatic experience. Some researchers suggest that traumatic events challenge one's core beliefs about safety, self-worth and shared beliefs. Survivors may question their belief in a loving, all-powerful Creator when innocent people, especially young children, are subjected to traumatic victimization, e.g. school shooting, terrorism. The recovery of meaning in life may be achieved though changing their way of thinking with intensified involvement in meaningful activities, and spiritual practices experienced as part of their involvement in a spiritual community.

*Grief and bereavement*

Grief and loss can be significant issues that survivors must cope with in the aftermath of traumatic events and disasters. Researchers noted that after the 9/11 terrorist attacks, that 90% of respondents reported turning to "prayer, religion or spiritual practices" as a coping mechanism. In general, the positive association between spirituality and grief recovery is that spirituality can provide a frame through which survivors can "make sense" of the loss. Additionally, survivors will benefit from the supportive relationships often provided within their faith communities.

## Post Deployment Checklist

Use the following checklist as a reminder for the activities that you will engage in as you prepare to return home from each assignment.

### Preparing for the Transition Back Home from a Disaster Assignment outside Your Community

- Make travel arrangements.
- Alert people at home once arrangements have been made.
- Return any extra supplies and/or vehicle.
- Settle your financial accounts, including reimbursements.
- Write a narrative about your disaster experience.
- Reflect on your role and responsibilities.
- Identify any challenges you faced in your role.
- Identify any broader systems issues for which you have recommendations or suggestions.
- Reflect on the most rewarding part of your experience.

### Disengaging from "Disaster Mode

- Brief the arriving (or replacement) team.
- Prepare documents the new team may need.
- Help the new team make a smooth transition.
- Say goodbye to everyone with whom you have developed a connection.
- Decide whether or not bringing home gifts is appropriate.

### Returning to Family and Work

- Anticipate that not everyone at home will want to hear your stories or comprehend what you have done.
- Expect sudden changes in emotions (mood shifts).
- Listen to your children and let them share in your experiences, when appropriate.
- Anticipate piles on your desk when returning to work.
- Expect mixed responses from co-workers on your absence and the importance of what you have done.

### Attending to Post-Disaster Self-care

Self-care plans need to include physical self-care; psychological self-care; emotional self-care; and spiritual self-care. A duty to perform as a helper within DBHRT cannot be fulfilled if there is not, at the same time, a duty to self-care. Activities that help DBHRT members to find balance and cope with the stress of working with individuals with trauma-related symptoms include:

- Rest, take breaks, exercise, sleep.
- Give yourself time for your body and mind to reorient.
- Engage in spiritual activities that provide meaning and perspective, i.e. meditation, self-reflection, time in nature, arts and music, and faith-based practices.
- Participate in social activities with family and friends.
- Adjust your pace downward to those around you.
- Assess how much information sharing should take place.
- If distressful symptoms continue after 30 days, seek emotional and psychological help to discuss your feelings and thoughts with a behavioral health and/or spiritual care professional.