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HOW TO PLAN AND IMPLEMENT A MENTAL HEALTH SERVICE AFTER A DISASTER

This chapter describes a model for the development and implementation of mental health services to help victims suffering from the psychological consequences of a disaster. Mental health administrators facing the chaos of the catastrophe's aftermath and needing knowledge to act as soon as possible frequently find themselves perplexed and unsure as to what actions are necessary. Although responses may differ from disaster to disaster, it is possible to develop a guide for the design and execution of psychological assistance to survivors of calamities. Administrators can use this guide, applied flexibly, as a means to review the necessary activities for promptly and effectively delivering service to those in need.

Through a thorough and clear understanding of the emotional implications of a disaster, mental health leaders must assume the responsibility for making the call to action, mobilizing the required resources, and planning help for victims. They must recognize how people are affected, what elements enter into the design of a plan, what coordination with other services is necessary, and how psychological aid can be effectively delivered to victims. Without this knowledge, administrators may waste valuable time deciding what the task is and how to accomplish it

In order to help mental health managers develop and carry out a program following a disaster, this chapter reviews a model that sets forth elements in the planning and administration of a project. Specifically, this guide considers the requirements for

- Sanction and support;
- Assessment of need;
- Setting the goals of intervention;
- Considering alternatives;
- Designing a program, and
- Implementing and running a project for mental health services.

This chapter also offers case studies that detail step-by-step elements in plan design and program maintenance. By presenting practical illustrations, the authors hope to suggest some helpful hints and recommendations for accomplishing the tasks outlined above.

GUIDE TO PLANNING A MENTAL HEALTH SERVICE

Planning in a postdisaster environment requires knowledge, patience, and flexibility. Accurate data about what has happened and who is suffering are essential, but most often the information available is sorely inadequate or difficult to gather. After a disaster, mental health leaders must work long hours deciding what to do and how to do it. In most cases they will encounter situations that are unique to their community, situations that require flexibility and innovation in their approach toward helping the victims. The following guide has been devised to assist these administrators in their efforts. Although planners may—in fact, must—work on several elements at the same time, the steps in the process are interrelated and may overlap.

Sanction and Support

Before proceeding very far, mental health administrators will need legitimation and sanction for their actions. In some instances these administrators may possess authority by virtue of position or legal status, but in other instances they may have to seek approval actively in order to start a mental health service for disaster victims. At the regional level, the person who usually has the authority to sanction action is the Community Mental Health Center (CMHC) director, or the director of a catchment area. If additional authority is required, administrators may seek the approval and assistance of the director or commissioner of the state's mental health department. Lack of early legitimation creates a situation in which conflict and competition may ensue, thus lowering the chances of success. The following example is illustrative:

> The idea of a mental health intervention project after the earthquake in Managua, Nicaragua, came independently from two professionals, a psychologist and a psychiatrist. Unaware of each other, both called the International Desk of the National Institutes of Mental Health (NIMH) to explore the possibilities of a project and to gain the support of this agency. Agreeing that such a project was interesting and worthwhile, a representative of NIMH traveled to Nicaragua with one of the callers to seek approval and sanction for a joint program to assist the disaster victims. They met with government officials, representatives of the local psychiatric association, and mental health workers to discuss the project. All gave enthusiastic approval. When the U.S. mental health team arrived in April 1973, its members continued the process of solidifying sanction for the project through further discussions with the

groups mentioned above. (In addition, they met with the wife of the country's president and she became the project's sponsor.)

When this team left Managua at the end of April 1973, one of its members spoke to the local Nicaraguan press, saying that the political regime was not only repressive but was also guilty of profiting from the aid sent by other nations to the earthquake refugees. When the team arrived in the United States, these comments were repeated to the *New York Times*. Because of the adverse publicity both in Nicaragua and the United States, official action toward the mental health team was predictable and swift. The project lost formal sanction to continue.

A second U.S. team arrived in May 1973 and had to deal with the loss of formal sanction. Its members considered terminating both the project and any efforts to regain full sanction so as to continue. Obviously the formal sanction was diminished, but could enough informal support be secured to reactivate the project? They were not sure. However, by returning to discuss the matter with mental health professionals (who valued the need for these services), psychiatric leaders, and interested agency officials, their month-long efforts paid off. They got enough informal support to continue the project—even without the formal sanction of the Nicaraguan government.

The second U.S. team left Managua in August 1973 after working with their Nicaraguan counterparts to set up ten community mental health centers for the earthquake's 300,000 refugees. When the project ended six months later, more than 7,000 victims had received some form of psychiatric assistance from these clinics through the efforts of thirty-one Nicaraguan mental health professionals and their North American counterparts.

The mental health leader may take several immediate actions toward securing sanction. First, regional or state mental health officials should be contacted by telephone to communicate an assessment of the disaster's consequences and the need for action. These calls should be followed up with meetings, if possible, to clarify issues of sanction and responsibility. For instance, the lines of authority and the delineation of responsibilities must be clear to all. State and regional officials will often ask for an on-site tour of the disaster area for purposes of surveying what has happened and deciding if a program should be initiated. Finally, approval to act should be put in writing to avoid confusion or conflict later.

Associated with this need for legitimation is the need for formal and informal support at all levels of one's efforts. Mental health activities following a calamity obviously cannot operate in a vacuum but must be interrelated with a variety of relief services. Because mental health service has only recently emerged as a participant in the system of relief, the support of other care-giving groups and organizations is essential. To enter the relief system with mental health services requires the approval and support of authorities—for example, managers of shelters and hotels and Federal Emergency Management Administration officials. Additionally, in an effort to mobilize both manpower and

financial resources, mental health administrators will want to seek the support of health and human services organizations and their community workers. Agreements with agencies and with individual professionals may be formal or informal, but both must serve the purpose of securing cooperation toward aiding disaster victims and organizing the necessary personnel, equipment, and funds for action. These arrangements are usually made by telephone or at informal or formal meetings. They are seldom arranged in writing due to time limitations. An illustration of this follows:

> In February 1978, Massachusetts suffered from a now historic blizzard that produced devastating tidal floods along the state's coastline. Because of the extent of property destruction and the large number of people made homeless by the storm, President Carter declared Massachusetts a disaster area. Various mental health practitioners responded quickly to the emergency in hopes of providing psychological aid to those in need. However, they soon encountered the need to legitimate their role to other disaster workers.
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> One of the mental health professionals who volunteered was a psychiatrist and director of a mental health catchment area which included a community that had sustained serious harm from the disaster. As she entered the principal refugee shelter in this area, she observed representatives from the Red Cross and from various levels of government milling around trying to develop cohesive planning procedures and to clarify their roles. The scene was one of confusion. She invited a small group of these relief workers to gather in an adjoining room and took several minutes to explain who she was and what resources she could bring to the situation. Producing a copy of the federal regulations on disasters which indicate that crisis intervention and counseling are part of the relief effort, she was able to orient other workers to her role and her possible contribution, thus gaining their support and acceptance as a team member.
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> This psychiatrist continued her work at the shelter for several weeks receiving the positive and open collaboration of the other relief workers. Without their legitimation and referral assistance, the psychiatrist would have been an isolated member of the relief team.

One way to maintain support and legitimacy for a mental health project throughout the disaster effort is to establish, as soon as possible, a task force to help plan and operate the project. In organizing such a committee, one should try to recruit individuals from various levels of the mental health services, the human services, and the community at large. A task force may vary from twelve to twenty-five members, with fifteen to eighteen suggested. These individuals should represent four distinct elements of the community:

- Experts — Professionals in mental health and human services who have knowledge of the emotional consequences of disaster and of ways to provide psychological aid,

- Power group: Individuals who, by virtue of their position or social status, have influence in the community and are able to facilitate decisions to grant resources or support (examples include politicians, businessmen, or clergy);
- Sentiment group: Members of the larger community, such as civic and socal groups that do not usually initiate action but have the power to block something with which they disagree. These groups reflect the broad values, norms, and sentiment of the community and include the League of Women Voters, Rotary Club, or local unions;
- Needs group: Individuals who know the problem first hand, i.e., disaster victims (Burke, 1979).

Such a task force can help a proposed mental health project secure legitimation and financial support, interpret need, shape program goals, and publicize its services to the community at large.

Assessment of Need

Any plan to give psychological aid should be responsive to the specific problems of disaster victims. To do this, mental health planners should:

- Understand the community's definition of health and illness;
- Survey existing problems to determine the nature and extent of those problems, as well as the groups affected,
- Ascertain the community resources available to combat the problems; and
- Use these data to help set program goals and strategies.

The way one defines a social problem is important in assessing need Because these definitions often depend upon the interaction of norms and values, and on culture and tradition, different communities delineate problems differently. In the area of mental health, the view of what constitutes health and illness is important. Acceptable behavior in one community may be classified as deviant in another. Therefore mental health planners, especially those from outside the impacted community, must be sensitive to these distinctions when assessing need

Methods to gain information about the problems of victims vary, but they usually combine a study of reactions from other calamities and a sampling of actual problems in one's community. At a very early stage, mental health practitioners should review the literature on disaster behavior to familiarize themselves with the typical symptoms that victims may present. Reports of other mental health projects designed after a catastrophe, detailing the types of reactions experienced by victims,

are also helpful. Usually such reports may be obtained through the disaster unit of NIMH* or directly from the community mental health center in the impacted area.

Mental health professionals will also need to survey in the field the kinds of emotional impairment suffered in the community by victims. Strategies to collect this information can be both formal and informal. By setting up temporary mental health stations in shelters, refugee camps, and affected areas, practitioners can gain in a short time an understanding of victims' problems. They should remember, however, that the nature and degree of these problems change over time. Another useful technique is a careful review of case records at mental health clinics and facilities to discover the types of symptoms expressed by individuals. A more informal approach is to talk with mental health and disaster workers in order to review and analyze their observations of postcatastrophe behavior.

As an example, a rapid, practical approach to the assessment of need was used in the aftermath of the Managuan earthquake. U.S. volunteers and Nicaraguan mental health professionals formed teams that were deployed at key points in the devastated areas, such as refugee camps, hospitals, clinics, and centers operated by volunteers and religious groups. Each team gathered data from the patients seen and sent those statistics to the project headquarters. Here the data were aggregated according to frequency, sex, age, type of problem, and service needed. Within a week, this system of documentation gave ample evidence of the increasing need of Managuans for mental health assistance. It also permitted a crude estimate of the total number of postdisaster emotional casualties.

In assessing need, administrators and planners will have to know some specific facts about victims and their problems. A formal or informal guide constructed to survey need should include the following information, which will become essential in making program decisions later. These data are:

- Background information, i.e., age, marital status, education, number of children, address, etc.;
- Presenting symptoms (classified in broad general categories to avoid psychiatric labeling);
- Degree of loss from calamity, i.e., death of family or friends, destruction of home or property, or loss of income or employment;
- Mental health status prior to disaster, i.e., degree of stress, coping skill, prior mental health treatment; and
- The victim's system of social and psychological supports.

*The full name of the unit is the Disaster Assistance and Emergency Mental Health Section, Division of Special Mental Health Programs, National Institutes of Mental Health, 5600 Fishers Lane, Rockville, Maryland, 20852.

In seeking victims in the field, the practitioner seldom has the time to do a complete history and make a diagnosis. Generally there is only a short time, often minutes, to make a quick assessment and to note some salient facts. The list above may guide the practitioner toward using time efficiently in gaining useful and relevant data.

The major purpose of an assessment of need is to understand the problems of victims so that relevant services can be planned and provided for them. Once the behavioral outcomes of disaster have been identified, planners should try to extrapolate their data to the general population and thus determine the magnitude of problems. This is a difficult task, and many planners who lack sufficient information estimate the affected population by calculating 15 percent of the total, a percentage often cited in the literature on disasters

A second component of the assessment process is a detailed survey of available resources in the community. Mental health planners and practitioners need to know what sources of assistance for disaster victims are available and must be able to mobilize these resources in their treatment efforts. Resources consist of available health and human services, such as local public health clinics, Family Service Associations, and the welfare department. Also included are services to help victims in securing food, shelter, financial assistance, or home repairs. Table 1 is an example of the types of services and agencies that provide help after a disaster.

The Disaster Response and Recovery Division of FEMA coordinates all relief activities after a disaster. The agency has a telephone line that provides information to victims on all available services and also operates one-stop centers that house the varied services (federal, state, and local) available to victims. Some services may also be available in shelters, hotels, trailer camps, or other places where refugees are found

In summary, an inventory of local, state, and federal resources, when compared with existing need, highlights gaps in services. By identifying resources for disaster victims and helping mental health workers understand the system of available disaster resources, these listings are also important for planning and funding new services. Later this knowledge of system resources gains importance when the question of linking services for coordinated efforts is raised

Goals of a Mental Health Service

In setting specific service goals, mental health experts must review and analyze the results of the assessment of need and the inventory of resources in order to complete their identification of problem areas and their listing of service priorities Service goals should be generated from the assessment of problems and should specify priorities and groups targeted for assistance

In most cases, a planning task force or group of mental health ad-

ministrators and practitioners set program goals that emphasize service priorities. They may also consider the project's scope and duration, but these often depend upon other factors, such as funding or personnel.

TABLE 1. Organizational Resources for Services to Disaster Victims

	Services Offered					
Organizational Auspice:	*Food*	*Shelter*	*Income*	*Health*	*Information*	*Other*
Voluntary						
Red Cross	X	X	X	X	X	X
Salvation Army	X	X				X
Catholic Charities	X	X	X			X
Mennonites		X				
Local churches	X	X	X			
Local unions	X		X			X
Civic/social clubs	X		X			X
Local						
Civil defense					X	
Community action	X	X	X		X	
Health department				X		
Local hospital				X		
Mental health				X		
Mayor's office					X	
State						
Health department				X		
Mental health agency				X		
Governor's office					X	
National Guard					X	X
Community development agency		X				
Employment and security agency			X			
Federal						
Health, Education, and Welfare	X		X			
Labor			X			
Agriculture	X					
Housing and Urban Development		X			X	
Small Business Administration			X		X	

Once broad goals have been set, the planner designs specific objectives to meet each goal. By defining these operationally, program monitoring and evaluation become easier.

Alternative Program Approaches

Goals are broad statements of value and priority that may be translated into action through a variety of program strategies. Although most mental health projects will employ a number of approaches, there is usually the choice of one or two methods of intervention over the

others. At this point, planners must determine the best way to achieve their goals, considering the range of options available to them. For example:

> Within a week of the Massachusetts blizzard, mental health leaders had decided to mount a program of psychological assistance, but they were unsure as to how to implement their service. Due to property destruction, refugees were scattered throughout the area. Some went to shelters, others to hotels, and still others to live with relatives. Given their goal to provide mental health services, administrators seriously considered a decentralized approach versus a centralized program. On the one hand, there was a need to identify survivors, define the levels of psychological assistance required, and spell out the alternative procedures to do this. On the other hand, there was the question of cost, time, logistics, and types of personnel needed.
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> Which approach would be best? Each strategy had its advantages and disadvantages. Deciding to meet, the administrators reviewed all the data available, calculated the required resources and cost of each option, and, in the end, decided to decentralize their service component to the affected neighborhoods, while at the same time maintaining a centralized administrative and fiscal component.

Program alternatives can depend upon the preferred methods of treatment or different administrative structures and are chosen for the purpose of achieving the project's goals and objectives. Discussion of alternative ways to carry out the program should lead to early decision and agreement on a specific strategy. For instance, a group may believe that a short-term project, located in refugee camps and emphasizing crisis counseling, is better than a long-range program using a group therapy strategy. Perhaps a new project independent of the existing mental health system may be an alternative considered.

Program Design

Once the program's goals and objectives are clear, the priorities set, and the preference of alternatives known, the mental health administrator or planner is ready to develop the details of the project. In order to design any program, an understanding of the elements in the planning process is necessary. Four key factors—functional, technological, efficiency, and systemic requirements—should be considered (Perrow, 1967). By focusing on these factors and considering the implications of each, the administrator/planner can devise the steps necessary to design a project of psychological aid to disaster victims. In understanding these factors, the following definitions are offered.

Functional requisites consist of the identification and listing of program activities and/or services, including the specific approaches for intervention and providing assistance. Activities such as outreach, prob-

lem identification and diagnosis, and treatment modalities should be detailed.

In carrying out program functions, *technological requirements* reflect the need for financial, material, and personnel resources—for instance, type and number of staff; need for space and facilities; and equipment, materials, and furniture requirements.

A third consideration in program development is the imperative of *efficiency*. This includes formulating a design for the type of administration, accounting, information, and evaluation systems to be employed, as well as a strategy for integrating the units of service and for offering supervision. The following issues must also be decided:

- Program auspices, sponsorship, and administration;
- Centralization vs. decentralization of service;
- Program budget and costs;
- Length of project;
- Forms of accountability; and
- The nature of program supervision.

By tying the proposed effort to existing services in the community through agreements, board representation, and contracts, the mental health planner addresses the last factor in program design, *systemic requisites* The object is to maximize project coordination with other agencies. The main ingredient of these systemic requisites is cooperative arrangements with additional programs and services in order to survive, avoid competition, and offer clients the quality of services they need. In making referral agreements, in educating the public, and in seeking financial, material, and moral support, mental health planners must link the project to existing resources in the community. As an example

> Soon after the storm, the mental health team in Revere, Massachusetts, actively sought affiliations and agreements with other agencies. The first level of agreement was developed at the refugee shelter with the various private and governmental organizations, in order to secure collaborative referral linkages and provide case consultation Later, as the victim population dispersed to temporary housing or the homes of relatives, the team contacted the local interagency relief council and the local mental health clinic. Through a series of personal interviews with these organizations, an agreement was reached that specified procedures for sharing information, making referrals, and exchanging resources and technical assistance

In developing a plan to help disaster victims, it is important to remember that each step in the planning process is interrelated with all other steps. Plan design, as influenced by the assessment of need and by stated project goals and priorities, will influence the implementation stage of the plan. Each step leads to and interacts with the prior and the

next step in the process. Once developed, the plan is usually approved by a committee, task force, or mental health administrator.

IMPLEMENTATION AND ADMINISTRATION OF A PROJECT

During the implementation phase, a number of issues present themselves. These include funding for the project; the selection, orientation, and training of staff, and the design of administrative and information structures. The mental health planner or project director, with the assistance of the task force, deals with each of these issues as the project progresses.

Funding

The cost of a mental health project for disaster victims will reflect the type and size of the program planned, but its financing will depend upon the ability to demonstrate need, the soundness of the proposed project, and the capacity to mobilize community resources. Although monies are available from a variety of sources to finance a mental health project for disaster victims, actual funding is usually less than expected and may be difficult to secure.

There are various funding sources, depending on one's location. In responding quickly to a disaster, there is seldom time to write a grant to secure financial backing. In most cases, the immediate program response is done with volunteers and, in time, aid is requested from the CMHC or other local sources. This aid is usually in the form of borrowed staff, equipment, and space. Later, mental health administrators may petition local or state organizations for financial help. Such sources may include the State Department of Mental Health, Catholic Charities, the Family Service Association, the local Mental Health Association, local foundations, or groups that have raised money for a relief fund.

In the case of a presidentially declared disaster, mental health leaders have another source of funding, the Disaster Assistance and Emergency Mental Health Section of NIMH. Under Section 413 of the Disaster Relief Act of 1974 (Public Law 93-288), monies are available for crisis counseling and aid to victims. Briefly, the law reads as follows

> Sec. 413. The President is authorized (through the National Institute of Mental Health) to provide professional counseling services, including financial assistance to states or local agencies or private mental health organizations to provide such services or training of disaster workers, to victims of major disasters in order to alleviate mental health problems caused or aggravated by major disasters or their aftermath.

Funds for this program actually come from FEMA, but are administered by NIMH's disaster unit. Interested administrators should contact this agency for details on applying for a grant. Current regulations

permit projects for a duration of six months, but in special instances FEMA and NIMH may provide an extension of one to three months. Finally, in applying for a 413 project, a careful needs assessment that documents a need over and above the baseline of average clinic caseloads is required.

Administrative Structures

In most cases, the mental health program plan stipulates the type of administrative structures deemed necessary to deliver services to disaster victims. If this has not been done, it becomes necessary to address the issues of program auspice and sponsorship, of the types and degrees of authority, and whether the program will be centralized or decentralized. Once these decisions are made, project planners must begin to think about recruiting personnel, implementing service delivery, developing an information system, putting in place the budget and accounting procedures, and clarifying the methods of program evaluation and accountability.

Staff Recruitment. A number of personnel are necessary to operate a disaster project, including both professional and nonprofessional workers and clerical assistants. The program plan should detail the number of staff required for the project and should include a description of their assigned duties. It is helpful to have expected activities stated in a job description

In hiring a project director, mental health administrators and/or members of the task force should look for the following characteristics:

- Administrative experience and ability to make decisions, handle budgets, write reports, and analyze data,
- Intimate knowledge of the community and its resources;
- Skill in mobilizing community groups and resources for action;
- Skill in clinical work, with ability to train and supervise staff; and
- Ability to get along and communicate with a variety of people.

This person should be able to instill confidence in others, provide leadership, be well organized, and take the initiative in solving problems.

The individuals who deliver direct service to disaster victims may be professional or nonprofessional, depending on the financial resources and the availability of manpower in the community. In most instances, some trained clinicians skilled in crisis intervention, group treatment modalities, and outreach work should be sought as supervisors, center directors, or trainers. In some instances, nonprofessionals might be recruited to locate victims in need of service and to provide supportive short-term counseling. Administrators should try to recruit people from the affected area and should look for the following in their professional and nonprofessional staffs

- Intimate knowledge of the community and its resources,

- Ability to relate well with others;
- Skill or potential skill in offering counseling assistance to victims; and
- Demonstrated maturity, motivation, and stability.

These potential workers should also reflect the ethnic, racial, class, and religious composition of the community. The process of recruitment may be both formal and informal. Administrators can advertise in local newspapers, send announcements to community agencies and universities, and contact professional societies in their formal recruitment efforts. They may also talk with agency directors, community and civic leaders, and various professionals and nonprofessionals in order to make job possibilities known. Because there is limited time to recruit staff before initiating the project, these steps may be started as funding is sought.

Service Delivery Models: Delivery of assistance to disaster victims requires clarity in organizing help, dividing labor, and delegating authority. Decentralized programs often have centers located in the affected neighborhoods, with a team assigned the responsibility of servicing that area. In these cases, a member serves as administrator and supervisor of team activities and also reports to the project's director. Other projects with a more centralized structure may have only one facility but may assign teams the responsibility of doing outreach work and crisis counseling within a particular geographical area. Both types should address the question of who is to do what and who is responsible to whom. Obviously these choices depend upon the abilities of staff, their interests, and the needs of the program.

In Managua, for example, the disaster team's home and headquarters was one of the few undamaged houses located on the edge of the destroyed area. Each morning all the project workers would meet there to set goals and strategies for the day. After working in the various makeshift clinics, they would return to headquarters at night to share information, evaluate their work, and discuss problems in delivering service These discussions resulted in modifying and reinforcing the organizational structures of the project. In addition, representatives of other agencies often attended the evening meetings This served to orient others to the work of the teams and also produced an opportunity to discuss cooperative arrangements.

Information System. Each program requires a system for keeping records and collecting information. The project director must manage the monies granted to the project by setting up accounting and bookkeeping procedures so as to have accurate records of funds allocated for space, equipment, materials, supplies, and the payment of staff Records

are also required of workers to note the progress of clients; these case forms must be carefully maintained to ensure confidentiality. The forms note the workers' observations, actions, and progress in helping individuals and families and are frequently used in meetings with supervisors. The project must also collect information on its clients and the type of service being provided. This statistical form might include the following information:

- Demographic information in victims, i.e., age, sex, marital status, education, occupation, income, and number of dependents;
- Disaster-related data, such as degree of loss suffered and physical and emotional symptoms;
- Historical information about other problems, prior mental health status, degrees of preexisting stress, and support systems; and
- Treatment data, such as number of visits, type of help, and treatment outcome.

As part of implementing the program, the project director must design the necessary forms for budgeting and accounting, for case management, and for maintaining required statistical information on the project. For instance, the federally funded disaster project in Massachusetts developed an elaborate management information system for the purpose of keeping records, developing trends, and reporting to internal and external sources. Key aspects of the system consisted of strict procedures for the security, confidentiality, and orderly maintenance of files. From records that included a client-case form, a log of staff activities, a team report, and centralized financial and budget forms, the project generated reports to NIMH, the Federal Coordinating Officer (FCO), and the State Coordinating Officer (SCO) of FEMA. In addition, internal reports were prepared for the project's task force and the Commissioner of Mental Health.

Evaluation and Accountability: As the project progresses, there is a need to evaluate individual and collective performances and to report to authorities on program activities. By reviewing statistical forms, authorities will have an understanding of each worker's activities and will have a view of victims and their problems. The data may be used to make reassignments or to alter program strategies. In addition, this information may be aggregated on a regular basis for the purpose of providing the task force, community leaders, and the funding source with a report of project activities. As these reports are frequently required by the funding agency, the statistical data on the project can be used to meet the requirements of accountability.

In review, this chapter presents a model for the planning and administration of a mental health program for disaster victims Description of the planning process includes the steps necessary to obtain

sanction, assess need, survey resources, set goals, consider alternatives, and design a program. The issues of funding, administrative structures, staff recruitment, service delivery strategies, information systems, evaluation, and accountability are also set forth as dimensions applied to the implementation and administration of a project.