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The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER BEHAVIORAL HEALTH

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ASK THE FIELD

The Dialogue: How can disaster behavioral health responders at the State and local levels use the techniques and tools of the Incident Command System (ICS) to target their response to and preparedness for disaster to work within the overall disaster response structure?

Denise Bulling: Disaster behavioral health is more than a set of clinical interventions or the delivery of psychological first aid. The behavioral health response has to be organized and deployed in a way that fits with the greater response to disaster or our ability to reach those who could benefit from education or

intervention will be limited. ICS principles provide a common base from which to begin a conversation about organizing a comprehensive behavioral health response to disaster that fits within an overall response structure. ICS is a standard, on-scene, all-hazards incident management system that is already in use by firefighters, hazardous materials teams, rescuers, and emergency medical teams.

One simple way for disaster behavioral health responders to be seen as viable response and recovery partners is to incorporate ICS terminology into our State and local plans. For example, ICS provides an organizational schema with standard titles that provide a framework

for organizing a workforce. Using these titles (e.g., Leader, Supervisor, and Director) helps traditional disaster response groups see that behavioral health professionals respect and use a clear chain of command that is recognizable to everyone in the response. We can avoid confusion by applying these titles consistently to job descriptions for behavioral health volunteers, forms of identification (e.g., vests for fieldwork), and planning documents. Using standard titles and clear command lines also help disaster behavioral health workers understand their role and objectives in the field. Standard titles can assist planners in identifying competencies for each position and subsequently targeting training opportunities to enhance the workforce.

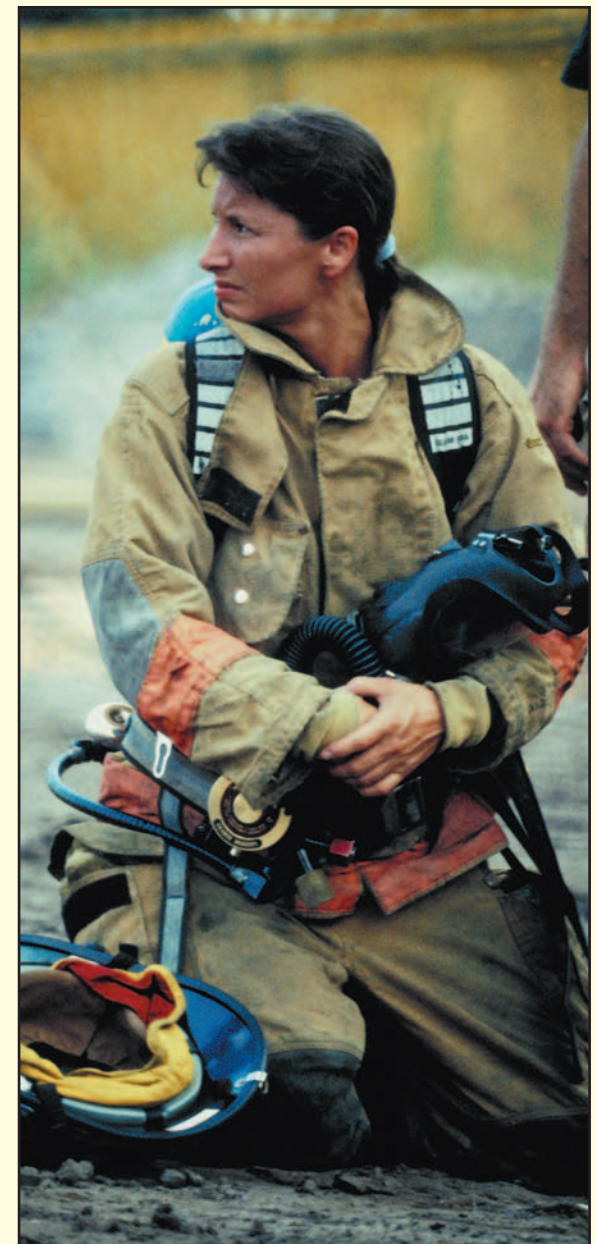
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Disaster behavioral health supervisors can more effectively direct response activities and meet incident objectives if the roles and boundaries of workers are predetermined and clearly understood. ICS structures do not limit the flexibility of service delivery, but rather make it easier to maintain accountability and coordination during the chaos that is the hallmark of disaster.

ICS principles also include the idea that although most disasters occur locally, responders should be prepared to work across functions and jurisdictions. State and local disaster behavioral health planners are often faced with planning and response issues requiring coordination across jurisdictions, disciplines, or organizations. For example, behavioral health responders could broadly include American Red Cross clinicians, Critical Incident Stress Management teams, disaster chaplains, Medical Reserve Corps volunteers, and a growing number of other State and local behavioral health volunteers. Coordinating with these entities is not always easy when things are calm and is even more challenging after a disaster. Nobody wants to needlessly duplicate efforts in a response or deal with turf issues on the fly. Unified command is an ICS concept that provides guidelines to help leaders coordinate with each other before and during a response. Unified command

allows for the development of a single set of objectives for the delivery of behavioral health services during the entire incident. Although we, as behavioral health professionals, are never really in command of an incident, we do face coordination issues within our own response function. Practicing with specialized behavioral health tabletop exercises helps all of us learn together so we can respond together. Exercising the concept of unified command within our own functional area during calm planning periods has the additional benefit of creating valuable relationships and generating expectations that disaster behavioral health efforts will be well coordinated.

Denise Bulling, Ph.D., University of Nebraska Public Policy Center, is a licensed professional counselor and has more than 20 years of experience as a behavioral health clinician, manager, and planner. She is a member of the Association of Threat Assessment Professionals and the American Evaluation Association, and is an active mental health volunteer with the American Red Cross.



A Profile of the Center for Disaster and Extreme Event Preparedness

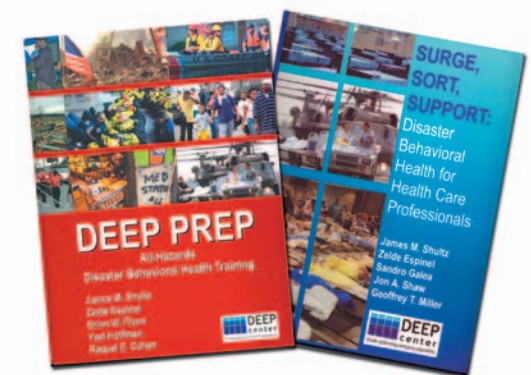
The Center for Disaster and Extreme Event Preparedness (DEEP Center), a program of the Miller School of Medicine at the University of Miami, conducts trainings, research, and service in the areas of disaster behavioral health, special populations, and disaster epidemiology. DEEP Center programs are primarily designed for public health, health care, first responder, and behavioral health professionals. According to the Center's director, Dr. James Shultz, the Center is based on an expertise model utilizing national disaster behavioral health experts for both curriculum development and the provision of training. The DEEP Center is funded through grants and contracts, with much of the behavioral health training support coming from the Florida Department of Health through their cooperative agreements with the Centers for Disease Control and Prevention and the Office of the Assistant Secretary for Preparedness and Response. Several of the DEEP Center's training programs are described below.

DEEP PREP: All-Hazards Behavioral Health Training—The DEEP PREP: All-Hazards Behavioral Health Training is a 1-day, interactive program that focuses on optimal function for disaster and emergency workers responding

to extreme events. It incorporates generalist skills that can be integrated into the role of all response professionals. The training covers basic disaster behavioral health principles such as issues for special populations, providing support for disaster survivors, and resilience and optimal performance in disaster response. The interactive training exercises prompt participants to apply disaster behavioral health principles to hurricane, pandemic influenza, or terrorism scenarios. For example, the training's pandemic influenza scenario addresses many psychosocial and planning concerns such as risk characteristics related to psychosocial impacts, unique disaster stressors specific to each phase of the pandemic, implications for intervention, and support for responders.

SAFETY, FUNCTION, ACTION: Psychological First Aid Training—The SAFETY, FUNCTION, ACTION training is offered in conjunction with materials and trainers from the SAMHSA-funded National Center for Child Traumatic Stress and the National Center for Posttraumatic Stress Disorder. Dr. Shultz reports that 551 public health professionals in Florida participated in this training during 10 sessions earlier this year. The manual for this training has the following three sections:

- > **Disaster Behavioral Health: An Ecological Perspective.** This section presents an overview of disaster behavioral health and discusses the psychosocial consequences of disasters.
- > **SAFETY, FUNCTION, ACTION: Psychosocial Support and Intervention for Disaster Survivors.** The Safety, Function, Action paradigm presented in this section helps participants identify the elements of disaster response that provide psychological support and enhance resilience for disaster survivors.
- > **Psychological First Aid: Field Operations Guide, Second Edition.** This section presents the SAMHSA-funded *Psychological First Aid Field Operations Guide*. Skill-building exercises are used to teach the eight core actions.



continued

SURGE, SORT, SUPPORT: Disaster Behavioral Health for Health Care Professionals Training—

The SURGE, SORT, SUPPORT training was developed to enhance the ability of healthcare and hospital personnel to function optimally in the face of disasters, acts of terrorism, and mass casualty incidents (MCIs). A major theme of this training is achieving resilience in the face of adversity. It focuses on the ability to meet the medical and psychosocial needs of disaster survivors who arrive at hospitals with a combination of injury and illness, fear, and distress. It also emphasizes that the psychological footprint of disasters is larger than the physical footprint. The training is composed of several modules including the following:

> **SURGE: Behavioral Realities of Hospital Surge.**

The magnitude of hospital surge is greater in both number and complexity than what is portrayed in most hospital exercise scenarios. This module asks course participants to think about how people actually behave during MCIs and to prepare for the influx of medical and psychological casualties, citizens searching for missing loved ones, and widespread distress among inpatients currently under care.

> **SORT: Triage and Distribution of Casualties.**

This module examines approaches to medical and behavioral triage during an MCI and presents guidance for activating a support center for psychological casualties and a family center for citizens searching for missing loved ones.

> **SUPPORT: Psychosocial Support for Disaster Survivors.**

A wide range of hospital personnel are able to provide practical help and support to disaster survivors in a manner that will diminish fear and distress. Hospital-based applications of psychological first aid and supportive communication are described as elements of early intervention for disaster survivors.

> **Special Situations: Behavioral Perspectives.**

Behavioral issues are presented for special contingencies: patients potentially exposed to harmful agents, patients requiring decontamination, and patients admitted to isolation. The dynamics of mass panic are presented.

> **RESTORE: Resilience Tools for Responders.**

This module systematically presents a toolkit of resilience strategies at the individual and institutional levels, organized by disaster phase (pre-event, disaster event, and post-event).

Dr. Shultz reports that an increasing number of Florida hospitals are recognizing that the behavioral health surge of concerned community members converging on a hospital after a disaster or MCI is greater than the medical surge. Many of these hospitals are now using support centers as part of their emergency protocols. Hospital support centers can provide calm settings for those who are overwhelmed and they can assist with further behavioral health triage. Most people

at hospital support centers or family centers would benefit from supportive interventions such as psychological first aid. Family centers can offer assistance to citizens looking to reconnect with missing loved ones. Such strategies allow hospitals to greatly increase their surge capacity during a disaster or MCI.

Hispanic Disaster Preparedness Training—

The Hispanic Disaster Preparedness Training, “¿Cuando el desastre llega, estas preparado?” or “When the disaster comes are you prepared?” is presented by disaster preparedness experts who are also native Spanish speakers. The 1- to 2½-hour program is available throughout the year and is at peak demand at the beginning of hurricane season. The training has four components: plan, prepare, practice, and protect. According to Dr. Shultz, part of the success of the Hispanic Disaster Preparedness Training is due to outreach efforts to community-based organizations, churches and other faith-based groups, migrant worker organizations, and consulates.

For more information on the DEEP Center, contact Dr. James Shultz at (305) 219-9011, <http://www.umdeepcenter.org>.

This article is based on an interview that was conducted by SAMHSA DTAC staff with Dr. James Shultz on July 26, 2007.

Program Design Elements of Successful Crisis Counseling and Outreach Programs Following a Disaster

Options for Independence (Options) is a nonprofit social service agency that serves seven parishes (counties) in southeastern Louisiana. During the past 15 years, Options has pursued its mission of assisting people to live and work in the community of their choice. This mission led Options to accept a request from the Louisiana Office of Mental Health in 2002 to provide crisis counseling and outreach to survivors of Hurricanes Lili and Isidore. Again, in 2005, the agency was asked to meet the needs of survivors of Hurricanes Katrina and Rita. The challenges of quickly building a large workforce and effectively deploying crisis counselors and outreach workers in the field led to many lessons learned. The lessons learned have evolved into nine design elements that are useful in planning and delivering a successful crisis counseling and outreach program. These elements revolve around the following items:

- > Planning and designing crisis counseling and outreach services
- > Delivering the correct type and amount of services at the correct times and places and to the desired populations
- > Measuring the quantity, type, and, most importantly, the quality of services delivered

and using information in a meaningful way to improve performance

Options' nine program design elements are described below.

Element One

Leadership or Organizational Structure

This element creates the overall leadership guide and sets up the chain of command and clear communication channels for all participants. The leadership structure is characterized by low team leader-to-project-supervisor ratios and provides a framework for the clear role identification that is vital in coordinating recovery worker activities.

Element Two

Training and Technical Assistance

This element contains the training and technical assistance needed to support crisis counselors and outreach workers in the field, as well as the ongoing planning processes needed to achieve success.

Element Three

Supplies and Equipment

This element details the supplies and equipment items needed to support crisis counseling and outreach teams in the field. They range from simple items such as sunscreen and bug repellent

to more complex items such as high-speed copiers to produce large volumes of printed materials to be distributed in the field.

Element Four

Bases of Operation

This element provides a base or multiple bases of operations for the teams in the field. These bases are used for staff training, planning, and daily team briefings. Community organizations are eager to partner with recovery operations by donating space and providing other supports for such bases.

Element Five

Coordinated Communication System

This element incorporates the use of the Internet and cellular and radio communications and sets the frequency and type of communication to be used between the teams and team leadership.

Element Six

Coordinated Meeting System

This element outlines the number, type, and contents of meetings between participants. The coordination of meetings and their contents is useful in communication, training, team stress management, data reporting, and continuous quality improvement.

continued

Element Seven

Integrated Calendar System

This element details the use of a Web-based integrated calendar system to provide the framework for coordination, planning, delivery, and evaluation of crisis counseling and outreach services provided in the field. It is an open system allowing team members to view all team calendars to enhance communication and coordination activities. It is used by project leadership to determine the appropriate amount and type of service delivery “sampling” needed for quality assurance.

Element Eight

Data Management

This element concerns the collection, analysis, and reporting of data to enhance the delivery of recovery services. Data elements include numbers of individual and group encounters and amount of printed materials distributed, as well as information on activities producing the best results and reaching the highest numbers of survivors. Well-designed data management processes will provide useful information on tracking targeted populations and service delivery in targeted disaster areas. Reporting of data to teams utilizing coordinated meeting and communication systems provides valuable information that can be used to adjust team activities and increase impact on community recovery.

Element Nine

Quality Assurance

This element describes the functions of the quality assurance system and how it is integrated into the overall recovery operation. A key ingredient is the “sampling” or observing of services delivered in the field and how the results of the sampling are shared with staff. The goal is to build a workforce to deliver quality services and collect useful information to improve performance. The sampling technique also provides a useful way to cross-train team members and improve the consistency of service delivery between teams.

Crisis counseling and outreach programs following hurricanes present many challenges due to the need to quickly hire, train, and deploy a large workforce over a large area in a short amount of time. These challenges revolve around communication between the leadership of the organization and the teams out in the community. Sometimes in the rush to hire a workforce and deliver services as quickly as possible it is easy to lose track of the “who, what, when, where, how, and why” of effective community outreach. These design elements assist recovery teams in answering the following critical questions:

- > Who are we serving?
- > What services are we supposed to be delivering?

- > When is the most effective time to deliver the services?
- > Where should we be delivering the services?
- > How should we deliver the services?
- > Why is this service needed at this time?

This article was contributed by Barry Chauvin, M.Ed., executive director of Options for Independence, a nonprofit social service agency that serves seven parishes in southeastern Louisiana.



A Model for Entry into Schools: A Practice Module Which Demonstrated Success

The children and adolescent teams of Louisiana Spirit-Harmony Family Support and Outreach Services (HFSOS) provide crisis counseling services to children and youth impacted by the devastation of Hurricane Katrina. The goal of the organization is to assist in the healing process and encourage survivors to recognize and apply their own resilience to their recovery. It has developed specialized services for children and adolescents, as well as support and educational services for teachers and school personnel. What follows is a brief look into the organization's strategies for outreach to schools.

BEST PRACTICES FOR SCHOOL ENTRY

HFSOS chose two counselors with expertise in working with children and youth as well as with school personnel to present information on the services of the Crisis Counseling Assistance and Training Program (CCP). These counselors, known within the agency as "trailblazers," were able to access the schools through outreach to school board superintendents and other school district representatives. They approached school officials with professionalism and a business-like sense of purpose. As a result of their compassion,

skills, and abilities, they were able to assist traumatized schoolchildren and their families in their recovery from trauma and crisis. The complementary relationship between crisis counselors and school personnel was apparent and beneficial.

The crisis counselors emphasized partnering and collaboration; however, they also clearly explained their roles. They informed students, teachers, and parents that their services could be utilized only within the framework and boundaries of the CCP mission and purpose. The counselors were not there to make changes or take charge; they were available to provide support to all those affected by disaster. They emphasized partnering and collaboration regarding crisis counseling, resource information, and referrals.

PLAN OF ACTION

The organization used the following plan of action:

- > HFSOS identified school board superintendents from each of the targeted parishes within the Federal Emergency Management Agency (FEMA) Service Area IV. The affected parishes in this service area are East Baton Rouge, West Baton Rouge,

Iberville, East Feliciana, West Feliciana, Pointe Coupee, and Ascension.

- > HFSOS set up meetings with school officials, including superintendents, principals, social workers and guidance counselors responsible for reviewing and authorizing program coordination. If a call was not returned, outreach workers contacted school board officials at board meetings. They visited each parish and each school board office. Once they were able to present the mission of the CCP Regular Services Program and provide crisis counseling, the doors to the schools were opened.
- > HFSOS acquired Memoranda of Understanding (MOUs) from each school district. The MOUs outlined clearly defined roles for HFSOS and each school board. The MOUs gave clearance to contact school principals, guidance counselors, and social workers. As a result of these relationships, school staff became crisis counseling advocates. HFSOS contacted them to collaborate in the schools and provide individual and group counseling. The word began to spread to other schools.

- > HFSOS reached out to school-based health clinics. They met with the clinical teams to present the program's services. As a result of these efforts, the program was able to begin crisis counseling in nine health clinics in East Baton Rouge. Good working relationships were fostered all around.
- > HFSOS met with the local director of Head Start. Head Start invited crisis counselors into high school centers where they were able to educate students and staff about behavior issues, positive interventions, and coping strategies, and to provide general disaster-related information. Head Start has 15 centers in East Baton Rouge; at this time, CCP services are offered in nine. These centers have enrolled large numbers of survivor children.
- > HFSOS met with the Big Buddy Program, a community organization that oversees 15 afterschool programs in the Baton

Rouge area. Its services for at-risk youth include tutoring, behavioral support, crisis intervention, and information on summer camps. Six Big Buddy Program sites have coordinated afterschool crisis counseling services for children impacted by the storm.

ACCOMPLISHMENTS

The organization's accomplishments include the following:

- > HFSOS' children and adolescent teams prepared a PowerPoint presentation and distributed HFSOS brochures to school administrators and parents.
- > HFSOS informed school personnel about the psycho-educational services available to school communities. Staff members were educated about sensitively handling the needs of traumatized children.

- > HFSOS notified school personnel about CCP services for parents and families. They continue to work closely with parents and teachers.
- > HFSOS advised schools about resource and referral services; these services linked children and families with outside clinics and agencies.

SUCCESSES AND TESTIMONIES

Currently, Louisiana Spirit-HFSOS programs are established in 40 local schools. Letters of appreciation and support have been received from many of them. One school board gave the organization a commendation in recognition of the services provided to children and adolescents in their parish. A middle school teacher requested that a local newspaper write an article about services provided at their parish's schools. Additionally, school principals and teachers have reported improved behavior, fewer visits to the principal's office, and fewer suspensions and expulsions since the initiation of crisis counseling with students. The program continues to serve about 5,000 children each week.

This article was contributed by Cheryl Spooner, trailblazer and specialty counselor for children and adolescent teams, Louisiana Spirit.



Remote Management of Crisis Counseling Program Teams in Colorado

In the weeks and months following Hurricane Katrina, the State of Colorado had approximately 14,000 Hurricane Katrina evacuees arrive by plane, bus, car, and even bicycle. At one point, there were evacuees living in each of the 64 counties in Colorado. To help understand why remote program management was essential, it is important to know some interesting facts about Colorado. It is the eighth largest State with more than 104,000 square miles. To illustrate this, Colorado is larger than Pennsylvania, Maryland, and Virginia combined. Colorado's population is 4.3 million, with more than 2 million within the Denver metropolitan area. As a result, most of Colorado is rural and many counties are designated as "frontier" which means there are less than 15 people per square mile.

The Colorado Hurricane Evacuee Support and Recovery Project had four Crisis Counseling Assistance and Training Program (CCP) teams covering approximately 40 counties. The teams were based in Denver/Aurora, Colorado Springs, Pueblo, and a fourth team, known as the Western Slope Team, had two bases of operation: one in Grand Junction and the other in Durango. The Program Manager had a 4-hour drive through the Rocky Mountains to reach the Western Slope

Team. The Western Slope Team Leader had a 4-hour drive between Grand Junction and Durango through high mountain passes that became treacherous and frequently impassable during winter. Travel times for the Program Manager to the other two teams were 2 and 2½ hours.

As many are already aware, CCP was challenged in many ways in response to the aftermath of Hurricanes Katrina, Rita, and Wilma. For example, a mainstay of CCP is providing outreach to survivors. If the disaster, response, and recovery all occur in the same general location, then outreach is a natural and straightforward endeavor. With survivors evacuated to several different States and with many of them in constant motion for several months, outreach took on new dimensions and levels of complexity. In Colorado, this led to more reliance on technology as a way to manage and foster communication and collaboration among the CCP teams.

Between face-to-face site visits and trainings, the management of three of the teams took on characteristics most frequently associated with the management of virtual teams. Much of the work was done through conference calls, e-mails, and telephone calls between the Program Manager and

individual team leaders as well as crisis counselors and outreach workers. The following are some points for consideration when managing teams under these kinds of geographical, cultural, and technological conditions:

- > **Work with the teams to develop a shared vision, mission, and goals for the project that are consistent with a CCP.** This can enhance buy in and help keep everyone, if not exactly on the same page, at least reading the same chapter.
- > **Build trust from the beginning through transparent communications and responsible actions.** The Program Manager must model these behaviors. Be deliberate about setting up relationship-building activities within teams and between teams as part of the trainings. Help set clear expectations, and establish a routine of regular and frequent contact between teams. Face-to-face interactions and time spent together facilitate familiarity and develop a "benefit of the doubt" mentality, both of which are essential for the success of a CCP.
- > **Be explicit at the outset concerning when, and under what circumstances, the Program Manager must be informed and involved in**

team activities. It needs to be clear to all of the team members that the Program Manager is accountable for all team projects related to the grant.

- > [Have an open and frank discussion at the outset with all team members about how to integrate work methods, organizational cultures and structures, and technologies.](#) Identify potential issues, both positive and negative, and establish ways to address them. This will save time and good will.

For example, there were four different organizations sponsoring each of the teams. Each of these organizations had their own policies, procedures, and hierarchical reporting requirements. In hindsight, there should have been deliberate conversations in the beginning about how the management hierarchy of the project would mesh with those of the sponsoring organizations.

- > [Develop a clear understanding between the organizations and teams regarding what communication technologies will be utilized, and demonstrate their use by providing hands-on training to the team members.](#) In addition to e-mail and conference calls, social media technologies (wikis, blogs, podcasts) may increase the effective management of remote teams. The following is a description of these technologies and how they can be used:

- » A wiki provides an Internet-based workspace where multiple people can log on to work on common documents, make suggestions for procedures, and define processes. A well-known example is Wikipedia, at www.wikipedia.com. A wiki enables shared knowledge, peer communication, formulation, and continual editing, as well as a way to store documents and track revisions. The benefit of a wiki over e-mail is that the process is housed in one location as opposed to streaming e-mails that can be lost or hard to track. A wiki can be set up to facilitate teams sharing information, handouts, and educational materials to be included in report updates and final reports. One person typically is the “gardener” of the workspace, ensuring the site remains uncluttered and simple to navigate. All information remains on the site; it simply gets posted where it makes the most sense and archived when no longer of immediate use. This CCP has implemented three wikis: one for conference planning, one for statewide mental health disaster response planning, and one for an exploration of collaboration between Colorado Department Communication Directors and Governor Ritter’s office.
- » A blog is essentially an ongoing, open conversation that occurs online. It can

be password protected (as can wikis and podcasts), enabling certain communities of users to discuss various issues under specific headings. Like wikis, one person typically monitors the conversation to ensure that there is forward progress as well as mutual respect on the site. A blog can be utilized for ongoing conversations among teams to facilitate a more open and timely exchange of ideas. Blogs are currently being used widely in schools for student collaboration and participation in projects, and for public organization, discussion, and group training. Passively, they are useful tools for observing public opinion and gathering information on specific topics. This CCP has not yet implemented blogging, but in at least one incidence the Colorado State Patrol used a passive observation of a news blogspot to gather public opinion information following a high-speed pursuit resulting in the death of a bystander.

- » Podcasts are excellent tools for online trainings called Webinars (Web + seminars). Podcasts can also be downloaded and used in classroom settings. They are simple to create with low-cost equipment and next-to-no-cost delivery to as many online participants as needed. A podcast can be used to give directions, provide trainings, and reach survivors. This CCP has not

yet implemented this technology, but staff are preparing to use this for many of the trainings created and disseminated each year, especially CCP trainings.

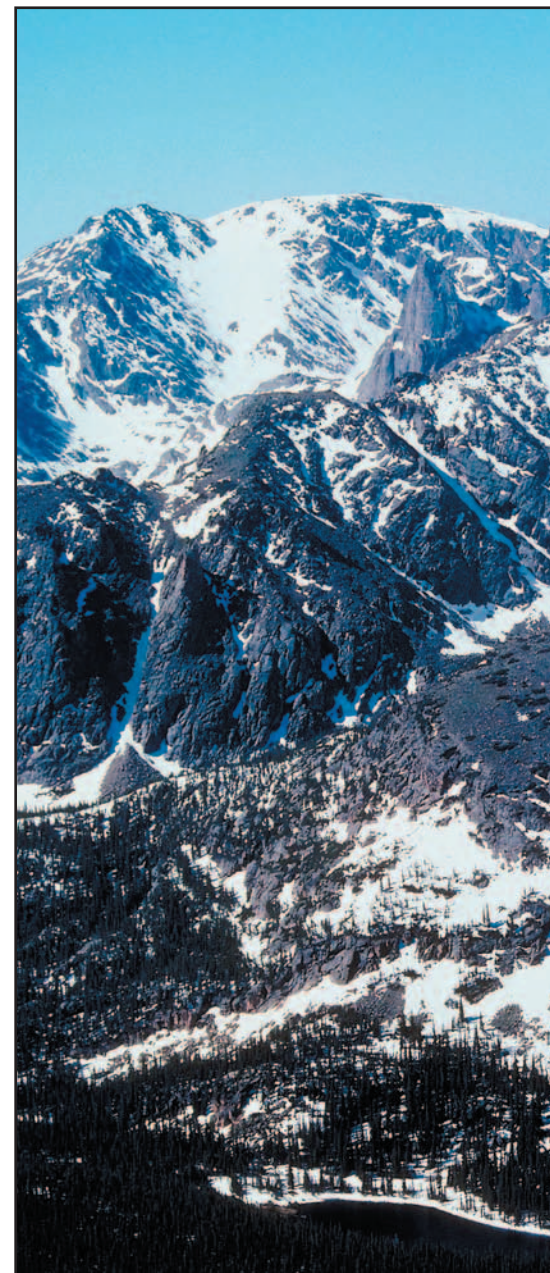
These new technologies help in the management of remote teams by allowing crisis counselors to feel more connected to each other and to CCP leadership. It also helps supervisors keep in touch with the members of their teams. In addition, these technologies help leave a legacy of services and strategies for future disaster behavioral health needs.

- > **From the outset, establish an ongoing conversation about the opportunities and vulnerabilities of the technological media being used.** Acknowledge up front how easy it is to have miscommunication and misunderstandings creep into electronically based communications. Humans rely on vocal intonation, facial expressions, and body language to understand the “true” meaning of a message. In the absence of this kind of information, fears or insecurities can readily be projected onto the message and messenger. This is where “benefit of the doubt” is essential.
- > **Recognize that members of remote teams can easily feel their contributions and accomplishments are not seen and therefore not valued.** It is imperative that the Program Manager find ways to tangibly acknowledge

the teams’ successes and sacrifices. This can be done by taking some time during conference calls to deliberately detail the week’s accomplishments for each team. The Program Manager can keep the teams informed of opportunities he or she has had to tell upper management and grant managers of the teams’ successes. Talking openly with team members about how to leverage their accomplishments into job or educational advancement opportunities is another way the Program Manager can communicate collective and individual accomplishments. This also acknowledges that there is life after a CCP.

Author’s note: There were so many things I learned during this project. One of the best was how fortunate I was to work with such a dedicated and creative group of professionals. Each and every day they brought such compassion and heart to their work with evacuees and their families. From all of the team members, along with other community volunteers and the evacuees, I gained a renewed sense of how kind, generous, and gracious people can be in the face of loss and adversity. I sincerely thank them for teaching me.

This article was contributed by Laura Williams, M.A., LPC, Colorado Department of Human Services, Division of Mental Health, Disaster Behavioral Health Team.



Special Feature

Learning from the Past: Historical Disasters—Perspectives for the Field

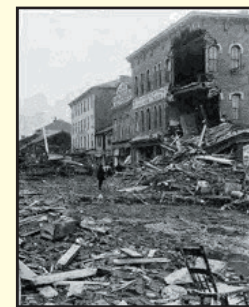
Disasters have always been part of the human experience. In 1930, the Federal approach to problem-solving became popular. At that time, the Reconstruction Finance Corporation was given authority to provide disaster loans for repair and reconstruction of public facilities following an earthquake or other disaster. In 1934, the Bureau of Public Roads was asked to provide funding for highways and bridges damaged by natural disasters. The Flood Control Act, which gave the U.S. Army Corps of Engineers greater authority to implement flood control projects, was also passed. This piecemeal approach to disaster assistance prompted legislation that required greater cooperation among Federal agencies, and authorized the President to coordinate these activities. However, it was not until 1979 that President Carter's executive order merged many of the separate disaster-related responsibilities into a new Federal Emergency Management Agency (FEMA). The historical disasters described below took place during the days before the existence of a national infrastructure on disaster and disaster behavioral health that are currently part of the mission of SAMHSA and FEMA. In this context, they offer a clearer perspective on current disasters and the history of disaster response.

JOHNSTOWN FLOOD JOHNSTOWN, PA MAY 31, 1889

On the chilly, wet afternoon of May 31, 1889, residents heard a low rumble that grew to a “roar like thunder.” Some knew immediately what had happened as floods were a regular fact of life to the citizens of this town built between two rivers. After a night of heavy rains, the South Fork Dam had finally broken. This dam had been neglected and had collapsed due to a treacherous storm. Twenty million tons of water crashed into the narrow valley.

Most saw no sign of danger until the 36-foot wall of water, already choked with huge chunks of debris, rolled over them at 40 miles per hour, consuming everything in its path.

Those who did see it said it “snapped off trees like pipe stems,” and “crushed houses like eggshells.” A violent wind preceded it, blowing down small buildings. The blanket of black smoke and steam that covered the area was remembered by survivors as the “death mist.”



Thousands of people desperately tried to escape the wave, but they were slowed by the 2 to 7 feet of water already covering parts of town. One observer said the streets “grew black with people running for their lives.” Some remembered reaching the hills and pulling themselves out of the flood path seconds before it overtook them.

Those caught by the wave found themselves swept up in a torrent of oily, yellow-brown water; they were surrounded by tons of debris which crushed some people and provided rafts for others. Many became helplessly entangled in miles of barbed wire from a destroyed factory. People indoors

raced upstairs seconds ahead of the rising water, which reached the third story in many buildings. Some never had a chance, as homes were immediately crushed or ripped from foundations and added to the churning rubble, ending up hundreds of yards away.

Everywhere, people were hanging from rafters or clinging to rooftops or railcars being swept downstream, frantically trying to keep their balance as their rafts pitched in the flood.

The day after, committees met at a local schoolhouse and set up a distribution of supplies,

continued

messengers, information, and transportation. Citizens were asked to report on those who survived and those who were lost. Residents volunteered to assist with removal of debris and dangerous buildings, and committees were established to handle issues related to sanitation and employment.

A clearinghouse was set up to assist those seeking loved ones, and patients were treated in a temporary hospital. Within 2 days, 2,209 bodies were buried, including 99 entire families and 396 children. More than 750 victims were never identified.

Less than 2 weeks later, the town was divided into districts, each with its own engineer and contractor. This event marked a new chapter in hazard mitigation, the process for States and communities to identify policies, activities, and tools to act in response to disaster. Response activities that followed this disaster helped reduce or eliminate long-term risk to life and property. After the flood, people came together to organize resources, assess risks, and develop a mitigation plan, and then implement and monitor the plan. By October 12, the State Board of Health determined that Johnstown was no longer a threat to the public health.

After this disastrous event, increased recognition was paid to river ecosystems, and increased focus and resources were paid to important ecologic functions. Restoration goals began to include the

development of sustainable management plans that minimize flood hazards while improving and maintaining the ecologic values of rivers and other bodies of water. The Johnstown Flood helped establish the recognition of rivers as evolving systems that respond to major human interventions which alter landscapes. Soon after, management plans evolved which included the integration of maintenance plans into any structural modifications. Eventually, this led to an effort, consistent with those identified by resource and regulatory agencies, of developing alternative approaches to restoring and managing river corridors while reducing flood hazards.

THE FIRE AT THE TRIANGLE SHIRTWAIST COMPANY NEW YORK CITY MARCH 25, 1911

The date was March 25, 1911, and the bell signaled the end of the workday. Many women worked for Isaac Harris and Max Blanck at the Triangle Shirtwaist Company. Clothiers on lower floors had closed shop at noon this Saturday, but the girls on the 8th, 9th, and 10th floors stayed late to earn some extra money. As they prepared to leave, someone yelled, “Fire!”

The Triangle Shirtwaist Company kept its doors locked to ensure that the young immigrant women did not steal. When the fire broke on the eighth floor of the New York City factory, the locks



sealed the workers’ fate. Witnesses first thought the owners were tossing their best fabric out the windows to save it, then realized workers were jumping. In just 30 minutes, 146 people were killed.

When the fire broke out, it spread through the fabric piled up in the factory. The single fire escape soon collapsed under the weight of people trying to get out of the building, and many of those left inside were forced to jump from the upper floors. No one survived the fall.

Those killed were mostly young women from the Lower East Side. The owners of the building escaped criminal charges for the deaths, but had to pay civil penalties. The American Labor Movement was already in full swing by 1911, but it gained support in the aftermath of the fire. This led to the development of many of the labor protections we currently enjoy in the United States. In fact, this was the first time that a trade union in the United States collected money, organized its own relief work, and directly administered the funds collected. In addition, the New York legislature created a commission to investigate work conditions in the city’s sweatshops.

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The Triangle disaster spurred a national crusade for workplace safety. Laws were established to protect factory workers, including those related to disability insurance and fire prevention. The Division of Fire Prevention was created as part of the fire department to rid factories of fire hazards. As a result of the disaster, all doors must now open outward, and none are to be locked during work hours. Sprinkler systems must be installed for companies employing more than 25 people, and fire drills are mandatory for buildings that lack them.

THE BOSTON MOLASSES DISASTER BOSTON'S NORTH END JANUARY 15, 1919

On January 15, 1919, people in Boston's North End were distressed by a loud rumble on Commercial Street. There stood a giant storage tank, built 4 years earlier by the Purity Distilling Company. It was massively constructed, with great curved steel sides and strong bottom plates set into a concrete base, pinned together with rivets. Boston's Purity tank could hold about 2½ million gallons of molasses.

The big Boston tank was just about full. It contained up to about 2.3 million gallons a few days earlier. At noon on this day, work around the molasses tank routinely slowed as laborers took time out for lunch. At approximately 12:30 p.m., the giant molasses tank came apart. It seemed to

rise and then split, the rivets shooting off in a way that reminded many ex-soldiers of gunfire. And then downtown Boston began to flood.

Citizens watched in shock as a five-story tank caved in, releasing a wave 15 feet high and 160 feet wide. Two million gallons of molasses exploded onto the streets of Boston. Steel was propelled in all directions, buildings were destroyed, and an elevated train was lifted off its rails. Enormous structures were buried under the flow of thick molasses. There was chaos and terror, survivors to be rescued, and anguished families rushing to find relatives. It was a horrible scene.

Fourteen thousand tons of the thick, sticky fluid had ruptured from the tank in a choking brown wave, wiping out everything that stood in its way. One steel section was hurled across Commercial Street, nearly collapsing one of the uprights supporting the elevated train tracks. An approaching train screeched to a stop just as the track ahead sagged into the surge of molasses below.



When the wave hit, homes collapsed and people were killed instantly. Pieces of the tank hit structures and had the effect of shellfire. Most nearby laborers were killed, and the fireboat company quarters were splintered. A truck was blasted right through a wooden fence and the driver, found later, was frozen in time like a figure in the ashes of Pompeii.

The wave moved at around 35 miles per hour. One child, walking with his sisters, was lifted and carried, tumbling on its crest as though he were surfing. The molasses rolled him like a pebble as the wave diminished. He passed out, and later opened his eyes to find three of his four sisters staring at him. One of his sisters was killed. The girls had found their brother stretched under a sheet on a body-littered floor. Molasses had traveled over 2 blocks, damaging everything in its path. Twenty one people died and 150 were injured.

In Boston during that time, you could not have given the product away. The gluey chaos caused by the flood was hosed down with salt water from fireboats and then the streets were covered with sand. All the rescue workers, cleanup crews, and sightseers squelching through molasses managed to spread it all over the city. Boots and clothing carried it to the suburbs. Molasses coated streetcar seats and public telephones. Everything Bostonians touched was sticky. The inner harbor was brown as hoses washed the gunk into the bay.

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Most of the facts about the Great Molasses Disaster emerged in the lawsuits that swamped Boston after the event. The litigation took 6 years and involved some 3,000 witnesses and numerous lawyers. Eventually, the court found that the rupture resulted from faulty inspections, and the company was held to blame for the horror. Settlements of more than 100 claims were made. Industrial Alcohol paid off between \$500,000 and \$1 million. Survivors of those lost reportedly received about \$7,000 per victim.

The Great Molasses Disaster helped inspire court decisions that increased involvement of local officials in financial liability for certain disaster consequences when the community was not prepared or did not respond properly. The “Act of God” defense for disaster losses is less frequently accepted by the courts. As a result, the ability of governments to claim immunity has been substantially reduced. And the duty of governments to develop disaster countermeasures is becoming more frequently stipulated in legislation. The litigation following the Great Molasses Disaster helped initiate a trend toward countering apathy about real disasters and the people who suffer as a result of them.

THE GREAT TRI-STATE TORNADO ILLINOIS, INDIANA, AND MISSOURI MARCH 18, 1925

On March 18, 1925, the Great Tri-State Tornado

developed during an afternoon thunderstorm near Ellington in southeast Missouri and crossed the Mississippi River about 75 miles southeast of St. Louis. It soon followed a northeast course as it plowed through southern Illinois and southwestern Indiana. The fast-moving tornado, described by witnesses as “an amorphous rolling fog” or “boiling clouds on the ground,” fooled normally weather-wise farm owners (and people in general) who did not sense the danger until the storm was upon them. People described seeing homes lifted up and then exploding like bombs. Witnesses recalled seeing fires from as far as 60 miles away.

As the greatest and most devastating tornado in American history, it ripped through Missouri, Illinois, and Indiana. In its 219-mile-long wake, it left four completely destroyed towns, six severely damaged ones, 15,000 destroyed homes, and 2,000 injured. Most significantly, 695 people were killed, a record for a single tornado. This tornado left a legacy evidenced by ghost towns, lost ancestors, and stories passed from generation to generation.

It took the greatest toll on southern Illinois. Although the tornado crossed predominantly rural land, its path followed a string of railroads. The destruction was historic, and thousands were left without food or housing. Fire further damaged homes and property, and it was reported that desperate victims looted property belonging to the dead.



Radio and telephone communications technology flourished during this decade, providing rapid dissemination of warnings based on ongoing tornado events. It is likely that the deadly Tri-State Tornado made it clear to the Nation that publicizing alerts could positively impact people in a storm’s path. This disaster seems to have initiated a trend toward public awareness with new communications technology, and encouraged preparation for potentially disastrous tornadoes that continues to this day.

FOR FURTHER READING

http://gothamist.com/2006/03/24/a_terrible_day.php

http://www.cimms.ou.edu/~doswell/spotter_history/spotter_history.html

<http://www.cr.nps.gov/nr/twhp/wwwlps/lessons/5johnstown/5facts1.htm>

<http://www.geocities.com/Hearthland/7847/tornado2.htm>

<http://www.jaha.org/FloodMuseum/oklahoma.html>

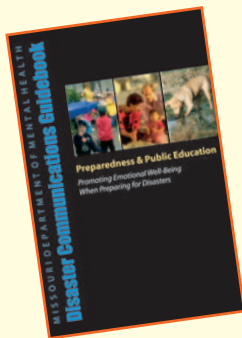
<http://www.crh.noaa.gov/pah/1925/>

<http://www.historybuff.com/library/refshirtwaist.html>

<http://www.massmoments.org/moment.cfm?mid=19>

<http://www.annenberg.northwestern.edu/pubs/disas/disas32.htm>

Recommended Reading



DISASTER COMMUNICATIONS GUIDEBOOK: PREPAREDNESS AND PUBLIC EDUCATION

Developed by the Missouri Department of Mental Health, this guidebook focuses on blending mental health-oriented messages into public communication as part of State and local response and recovery efforts. The goals of these messages are to encourage adaptive and cooperative behavior, provide realistic reassurance, promote self-care strategies, and increase emotional resilience. Primary audiences for this publication include State and local public health, public mental health, and emergency management officials.

During the last few decades, interest in the effects of public health messaging on the community in times of crisis has increased. The manner in which public health officials, spokespeople, and elected leaders convey messages regarding safety and health issues can have a great influence on the public's emotional well-being. Through the integration of disaster psychology and risk communication, public representatives have the ability to promote healthy outcomes, public cooperation, and adaptive responses.

The first section of this guidebook provides core mental health talking points that can be adapted to most incidents and is geared toward a general audience.

The second section of the guidebook contains event-specific messages that include agroterrorism, bioevents, chemical events, incendiary incidents, natural disasters, radiological events, and terrorism.

The third section of this guidebook pertains to audience-specific talking points that allow the user to more effectively address the unique circumstances of different populations such as culturally diverse groups, emergency responders, healthcare workers, parents, people with disabilities, older adults, and survivors who may have additional emotional risks due to their role in the response efforts, their history of trauma, or the nature of the disaster.

The last section, called Spokesperson Preparedness Resources, provides tools that are useful when preparing to serve as a spokesperson during a crisis. These quick reference tools include the World Health Organization's Media Communication Guidance, questions to ask reporters prior to an interview, questions commonly asked by journalists during a crisis, and a glossary of disaster mental health terms.

This guidebook is available online at: <http://www.dmh.missouri.gov/diroffice/disaster/disaster.htm>.

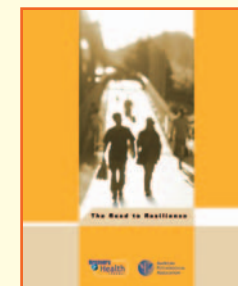
THE ROAD TO RESILIENCE

Provided by Project Pennsylvania Responds
(Project Katrina and Project Thrive)

The Road to Resilience is a brochure developed in a joint effort between Discovery Health and the American Psychological Association. It is designed to help people build their own resilience to adapt and emotionally heal following a difficult or traumatic event. The brochure stresses that resilience is something that is present in everyone and that can be improved and strengthened.

A helpful portion of this publication is 10 Ways to Build Resilience. This part of the brochure presents 10 strategies that have been successful in helping people to build resilience. The strategies are universal and practical. Additionally, suggestions and resources are included for people to consult when they need assistance building resilience. A key point in *The Road to Resilience* is that increasing your resilience is an ongoing process that requires time and effort. This brochure is an excellent resource for people who have encountered a hardship and would like to increase their personal strengths to cope with and grow from their difficult experience.

To obtain copies of *The Road to Resilience* go to <http://www.apahelpcenter.org/featuredtopics/feature.php?id=6>.



FEMA EMERGENCY MANAGEMENT INSTITUTE INDEPENDENT STUDY PROGRAM

The Federal Emergency Management Agency (FEMA) offers training to public emergency response personnel through the Emergency Management Institute (EMI) online courses. This training is offered at no cost to those who are qualified to enroll.



The primary audience for EMI's Independent Study Program (ISP) is United States emergency and recovery responders, including FEMA emergency management personnel, and U.S. residents. One must provide a U.S. address to receive printed materials, take final exams, and receive certificates of completion. The National Preparedness Goal identifies nine "mission areas" that include incident management, operational planning, disaster logistics, emergency communications, service to disaster victims, continuity programs, public disaster communications, integrated preparedness, and hazard mitigation.

Fifty-nine independent study courses are available through ISP, including Introduction to Hazardous Materials, Animals in Disaster, Developing and Managing Volunteers, and Anticipating Hazardous Weather and Community Risk. These online classes provide an opportunity to improve public awareness and promote national disaster preparedness. More than 3 million individual course completion certificates are distributed each year. Continuing education credits are available through the International Association of Continuing Education and Training.

For a complete list of available courses, or to download the brochure, go to <http://training.fema.gov/IS/>.

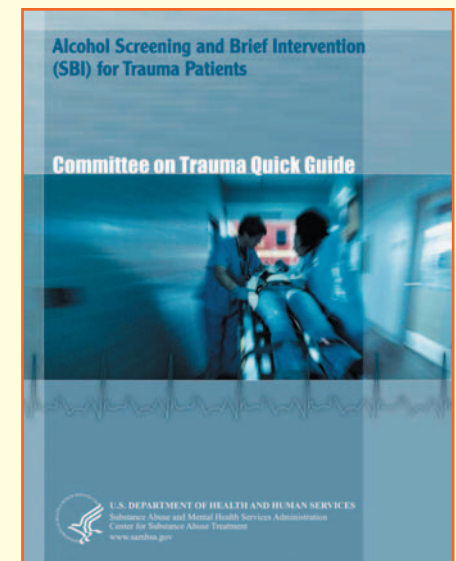
ALCOHOL SCREENING AND BRIEF INTERVENTION (SBI) FOR TRAUMA PATIENTS GUIDE

Disaster-related substance abuse screening efforts may benefit from a new publication that was developed by SAMHSA's Center for Substance Abuse Treatment. *The Alcohol Screening and Brief Intervention (SBI) for Trauma Patients Guide* was developed to help Level I and Level II hospital trauma centers implement an alcohol screening

and brief intervention program. According to the guide, 22.7 percent of the U.S. population does not meet the criteria for alcohol dependence but does engage in at-risk drinking. Using the principle of the "teachable moment," SBI maximizes motivation to decrease at-risk or problem drinking among this group. The goal of SBI is to help patients lower their risk for alcohol-related problems. SBI uses nonjudgmental language to focus on at-risk or problem drinking.

SBI utilizes a simple, three-step process: screen patients, conduct brief intervention, and refer as needed. Screening serves the dual function of identifying those who could benefit from SBI and gathering the information needed to provide an appropriate brief intervention. Brief interventions fall into one of three components. First, specific information or feedback about the patient's situation can be given to the patient. This can include basic alcohol-related education. Second, engaging patients in a non-confrontational conversation can help clarify the patient's views of drinking and enhance the patient's motivation to decrease at-risk drinking. Finally, the intervention can include giving respectful advice or negotiating goal setting.

The guide presents considerations on implementing the program such as defining the target population, developing a screening protocol, and establishing mechanisms to ensure patient confidentiality. It ends with a sample brief intervention and several recommended SBI screening instruments. These include the Alcohol Use Disorders Identification Test (AUDIT) self-report version, the Consumption + CAGE questionnaire (for adults), the CRAFFT instrument (for adolescents), and the binge drinking question. Additional resources are given, such as the link to SAMHSA's Screening, Brief Intervention, Referral, and Treatment Web Site at <http://sbirt.samhsa.gov>.



Conference Highlights

PUBLIC HEALTH PREPAREDNESS SUMMIT

The National Association of City and County Health Officials' annual Public Health Preparedness Summit was held in Washington, DC, February 19–23, 2007. Attended by more than 2,000 health professionals, the goal of the summit was to improve the ability of participants to plan, prepare, respond to, and recover from public health emergencies. Behavioral health professionals were in attendance and many sessions focused on pandemic influenza preparedness strategies.

Staff members of SAMHSA's Disaster Technical Assistance Center (DTAC) attended the meeting and presented on disaster behavioral health issues relevant to public health workers. Due to the rising risks of human-caused and natural disasters, public health workers are increasingly being called on to serve affected populations in

crisis situations. Public health workers responding to disasters are often positioned to respond to a variety of psychosocial concerns and traditional health issues. An understanding of disaster psychology and effective disaster behavioral health approaches can complement the work of public health workers and benefit disaster survivors. The presentation addressed key disaster behavioral health concepts including individual and community reactions to disasters, resilience, and differences between traditional behavioral health and disaster behavioral health approaches. Typical psychological reactions were compared with pathological reactions. Populations at risk for increased mental health or substance abuse problems were identified. The population exposure model was used to explain the impact of disasters on individuals and communities as well as the behavioral health outreach-oriented intervention strategies employed after disasters.



NATIONAL EMERGENCY MANAGEMENT SUMMIT: THE LEADING FORUM ON MEDICAL PREPARATION AND RESPONSE TO DISASTERS, EPIDEMICS, AND TERRORISM

The National Emergency Management Summit: The Leading Forum on Medical Preparation and Response to Disasters, Epidemics, and Terrorism, was held March 4–6, 2007, in New Orleans. Focusing on public health issues, the Summit aimed to assess risks and articulate practical emergency management approaches to address the heightened risk of natural disasters, epidemics, and terrorism in the United States. It drew hundreds of emergency management stakeholders from diverse fields including health, behavioral health, emergency management, public safety, business, and academia. The following conference objectives were of particular interest to disaster behavioral health planners and responders:

- > Describing the lessons learned for emergency managers after the September 11, 2001, terrorist attacks, Hurricane Katrina, the Oklahoma City bombing, the Northridge earthquake, and the anthrax letters scare

continued

- > Identifying best practices in medical planning and response to disasters, epidemics, and terrorism for hospitals, physician organizations and health plans
- > Analyzing mental health issues raised by disasters and responsive strategies
- > Recognizing the special problems raised by implementing emergency preparedness plans for racially and ethnically diverse communities
- > Establishing alternatives for mechanisms of disaster triage from planning to implementation and analysis
- > Outlining performance metrics in healthcare emergency preparedness
- > Presenting ways of using health plan data as part of the arsenal against bioterrorism and epidemics



SAMHSA DTAC staff presented a session titled, State of the States, Lessons Learned, and Future Directions in Disaster Behavioral Health. This presentation reviewed the current status of disaster behavioral health preparedness in the Nation and included promising practices that had been identified by States related to both continuity of operations and response issues. Topics included using evidence-informed interventions, establishing critical partnerships, preparing for surge capacity within State systems, and incorporating accepted emergency management practices such as the Incident Command System.

AMERICAN COUNSELING ASSOCIATION 2007 ANNUAL CONFERENCE AND EXHIBITION

The American Counseling Association (ACA) 2007 Annual Conference and Exhibition was held March 23–25, 2007, in Detroit. The conference presentations covered a wide range of topics relating to the profession of counseling. There were more than 400 educational sessions with speakers who conveyed firsthand knowledge of strategies and intervention techniques. Speakers also discussed practical information for counselors and identified significant trends in the counseling profession. Exhibitors were onsite to introduce attendees to the latest counseling resources and tools. Additionally, there were research poster sessions where graduate students were able to present and discuss their research.

A number of the educational sessions related directly to the field of disaster behavioral health, including: Counselors without Borders: Effective Counseling with Hurricane Katrina and Disaster Survivors, Effectiveness of Logotherapy Counseling in Reduction of Anxiety and Depression Among Victims of Natural Disasters, Creative Uses of Technology in Counseling, Enhancing Resiliency and Coping Skills in Displaced Youth and Their Families, Project Relief: Counselors Assisting Children and Their Families after Hurricane Katrina, Responding to Pandemic Flu: What Counselors Need to Know, and Cultural-Centered Disaster Response in a Global Context.

Next year's ACA Annual Conference and Exposition will be held in Honolulu, March 26–30, 2008. Registration for the 2008 conference is open and available at <http://www.counseling.org/Convention/Registration.aspx>.

MULTI-STATE PANDEMIC DISASTER PLANNING FORUM

The Multi-State Pandemic Disaster Planning Forum took place April 5, 2007, in Harrisburg, PA. The purpose of the Forum was to bring together northeastern States to review their behavioral health plans' readiness to deal with pandemics and other public health emergencies; to share resources and planning activities, developing common strategies where possible;

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and to discuss crisis counseling programming as it relates to pandemic influenza.

Highlights included a keynote address from Charles Curie, CEO of The Curie Group and former SAMHSA Administrator, a lecture from Dr. Bonnie Selzler on pandemic plans and behavioral health's role, and a presentation from Brian McKernan, SAMHSA DTAC, regarding State and local behavioral health planning strategies for pandemic influenza. A tabletop exercise, executed by Erik Wittmann, consultant to Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS), and Steven Crimando, consultant to New Jersey's Division of Mental Health Services, also helped participants learn how certain populations would be impacted by the pandemic and how to intervene appropriately. The day concluded with reports from attending States regarding the status of their pandemic planning, training, overall preparedness, and next steps.

Representatives were present from Pennsylvania, New York, New Jersey, Virginia, West Virginia, the District of Columbia, Maryland, Delaware, and Massachusetts, along with representatives from the American Red Cross, SAMHSA, SAMHSA DTAC, Voluntary Organizations Active in Disaster, and others active in emergency management, health, special needs, and response entities. The forum was sponsored by the Department of Public Welfare and OMHSAS in

collaboration with the Pennsylvania Department of Health and the Pennsylvania Emergency Management Agency.

2005 HURRICANES: BEHAVIORAL HEALTH LESSONS LEARNED MEETING

SAMHSA coordinated and sponsored the 2-day 2005 Hurricanes: Behavioral Health Lessons Learned Meeting May 15–16, 2007, in New Orleans. The purpose of this meeting was to encourage State Mental Health Coordinators to interact in a peer-to-peer environment to review lessons learned from the Crisis Counseling Assistance and Training Program (CCP), examine and share experiences with the overall disaster behavioral health response to the 2005 hurricanes, and identify opportunities for improving all-hazards preparedness and crisis counseling efforts for future disasters.

Dr. Paul Brounstein, chief of the Emergency Mental Health and Traumatic Stress Services Branch, for SAMHSA's Center for Mental Health Services, welcomed disaster behavioral health professionals from the Federal, State, and local levels. Dr. Nikki Bellamy, project officer, led the plenary session and introduced participants to SAMHSA DTAC staff who helped coordinate and facilitate the conference.

SAMHSA DTAC staff explained the process for multiple Strengths, Weaknesses, Opportunities

and Threats (SWOT) sessions. This type of analysis was originated at the Stanford Research Institute, and has been utilized for strategic planning in numerous businesses and agencies, including SAMHSA's suicide prevention programs. Its purpose is to identify successes, challenges, and avenues for change to enhance CCP implementation and service provision for future disasters. The session was facilitated by Christina Mosser, acting project director; Darrin Donato, technical assistance manager; and Brian McKernan, disaster behavioral health specialist.

Participants actively engaged in the SWOT process. Topics of analysis included service provision, fiscal and budgeting issues, management, and continuity of operations. Various behavioral health issues were discussed in the context of CCP from the time of its initial stages and implementation until phasedown. Opportunities were provided for all to share experiences and expertise, concerns, and feedback, as well as ideas for change. Although group consensus was not the goal, State participants reported on what were common obstacles and challenges. Positive aspects of the CCP, as well as ways to modify the process moving forward, were discussed.

Participants noted that partnering with other State agencies was invaluable to the outreach process during times of crisis. Hiring knowledgeable and effective staff, and obtaining reputable local

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contractors to help provide needed services all proved to be great assets. Budgetary requirements and application time constraints were common frustrations, requiring that painstaking attention be paid to prioritizing needs. Multiple, co-occurring events such as Hurricanes Katrina and Rita create enormous hardships; allocating staff appropriately seemed nearly impossible. However, participants also noted that opportunities exist to increase trauma education and overcome hurdles created by limited resources, stigma, and other outside forces. Participants discussed moving forward, focusing on numerous topics including further developing resources, centralizing services with the assistance of technology, and improving partnerships with other agencies.

When Hurricane Katrina transformed the gulf coast, SAMHSA directed its resources toward recovery. Through CCPs and this meeting, SAMHSA's work ensures that residents and evacuees of areas affected by Katrina and Rita continue to receive necessary services. Using the SWOT process, participants returned to their States and continued to analyze the effects of the hurricanes on behavioral health systems in their communities. This 2-day meeting was reported to be beneficial to all participating Federal, State, and local disaster behavioral health professionals.



Upcoming Meetings

OFFICE FOR VICTIMS OF CRIME RESPONDING TO SCHOOL VIOLENCE

OCTOBER 23–24, 2007
RALEIGH, NC

This interactive training will cover the following topics: past school shootings and current statistics on school-based violence; prevention, intervention, and response strategies; student, parent, and faculty reactions and interventions; how to develop mental health crisis response plans for school settings; and emergency management systems. For more information, go to <http://www.sei2003.com/ovcttac/school.htm> or call 1-866-682-8822.

THE AMERICAN PUBLIC HEALTH ASSOCIATION 135TH ANNUAL MEETING

NOVEMBER 3–7, 2007
WASHINGTON, DC

The American Public Health Association (APHA) Annual Meeting is usually attended by approximately 13,000 public health professionals, including mental health and substance abuse professionals. Many sessions focus on disasters

and disaster behavioral health. SAMHSA DTAC staff participated in last year's APHA meeting and gave both a mental health and a substance abuse presentation on lessons learned from the 2005 hurricanes. For more information, go to <http://www.apha.org/meetings/highlights>.

SIXTH ROCKY MOUNTAIN REGION DISASTER MENTAL HEALTH CONFERENCE

NOVEMBER 8–10, 2007
CHEYENNE, WY

The theme of the conference is From Crisis to Recovery: Resilience and Strategic Planning for the Future. The conference is designed for people working in the fields of: emergency medical services and trauma units, crisis intervention, mental health, traumatic stress, emergency services, and disaster mental health, as well as those in the military, National Guard and Reserve personnel, law enforcement officials, firefighters, chaplains, and other first responders. For more information, go to <http://www.rmrinstitute.org>.

INTERNATIONAL ASSOCIATION OF EMERGENCY MANAGERS 55TH ANNUAL CONFERENCE

NOVEMBER 11–14, 2007
RENO, NV

This conference provides a forum for current trends and topics, and information about the latest tools and technology in emergency management and homeland security. Sessions encourage stakeholders at all levels of government, the private sector, public health, and related professions to exchange ideas on collaborating to protect lives and property from disaster. For more information, go to <http://www.iaem.com/events/Annual/intro.htm#about>.

CONFERENCE ON INNOVATIONS IN TRAUMA RESEARCH METHODS

NOVEMBER 13–14, 2007
BALTIMORE

The goal of this conference is to promote methodological advances in the study of stress, trauma, and PTSD. The theme of this year's conference is Research Methods for Studying Violence and Trauma in Children, Intimate



Partners, and Families. The conference welcomes submissions for oral presentations and posters by conference attendees. Submissions should emphasize research methods, not content. Presentations and posters can address issues related to research design, sampling and recruitment, measurement and assessment, data analysis, or a key theoretical issue in trauma research methods. Submissions related to ethical issues in trauma research are also welcome. For more information, go to <http://www.citrm.org>.

INTERNATIONAL SOCIETY FOR TRAUMATIC STRESS STUDIES 23RD ANNUAL MEETING

**NOVEMBER 15–17, 2007
BALTIMORE**

The theme of the meeting is Preventing Trauma and its Effects: A Collaborative Agenda for Scientists, Practitioners, Advocates and Policy Makers. The meeting will highlight the advancement and exchange of knowledge about the prevention of traumatic events and maladaptive trauma-related reactions. The goal of the meeting is to foster communication between presenters and participants about science, practice, policy and advocacy as it relates to: (1) preventing trauma exposure itself; (2) preventing trauma-related adverse mental health outcomes once exposed to severe stress; and (3) preventing the recurrence of trauma exposure, PTSD,

and other trauma-related sequelae. By sharing multidisciplinary knowledge about prevention from multiple perspectives, cultures, countries, and stakeholders, information that can foster effective prevention programs will be enhanced. As always, science and practice related to tertiary prevention (clinical treatment to reduce impairment) will be considered. For more information, go to <http://www.istss.org/meetings/index.cfm>.

CALL FOR INFORMATION

The Dialogue is an arena for professionals in the disaster behavioral health field to share information, resources, trends, solutions to problems, and accomplishments. Readers are invited to contribute profiles of successful programs, book reviews, highlights of State and regional trainings, and other news items. If you are interested in submitting information, please contact Kathleen Wood at kathleenw@esi-dc.com.