



The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER BEHAVIORAL HEALTH

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ASK THE FIELD

The Dialogue: What are some of the responsibilities of a disaster substance abuse coordinator?

Rodrigo Monterrey: In Massachusetts, the Bureau of Substance Abuse Services sits within the Department of Public Health, which is different from most other States, where substance abuse services are part of the Department of Mental Health (DMH). Some of the disaster substance abuse coordinator's responsibilities include the following:

- > Acting as the point person for developing emergency preparedness capabilities among substance abuse providers

- > Coordinating the provision of substance abuse prevention, treatment, and recovery support services in disasters through community providers
- > Collaborating with DMH to coordinate Behavioral Health Disaster Response training and recruitment initiatives
- > Developing tools and resources for coping with disasters, such as the Disaster Behavioral Health Statewide Plan and the All-Hazards Planning Guide
- > Overseeing the MassSupport helpline and Web site contract and providing ongoing

training and technical assistance regarding disaster behavioral health interventions

- > Cochairing the Disaster Behavioral Health Committee with the DMH Emergency Management Director
- > Facilitating Introduction to Disaster Behavioral Health and Psychological First Aid workshops for local emergency planners, responders, substance abuse service providers, and volunteers

The Dialogue: What are some ways that substance abuse professionals or paraprofessionals respond to disasters, including

providing or offering useful substance abuse interventions?

Rodrigo Monterrey: Substance abuse professionals play an important role as care providers to the residents of their communities. They inform local, municipal, and even State planners about programs, needs, and capabilities, which are determined by the clients they serve, their staff, and their facilities. In Massachusetts, the disaster substance abuse coordinator provides ongoing training and technical assistance to substance abuse providers around all-hazards planning and disaster behavioral health interventions, such as psychological first aid.

Some important points to consider include the following:

- > It is critical for substance abuse programs to have an all-hazards plan and a defined role in the local emergency plan. During an emergency, program staff, equipment, and shelter may be required to care for others.
- > People in substance abuse recovery or with substance abuse issues are at particular risk for harm, so there is a need for cross-training about disaster preparedness and response among substance abuse workers.
- > Although about one-third of the population consider themselves “abstainers,” the majority

of people are either moderate substance users, abusers, or in recovery. Since everyone exposed to a disaster is in some way affected by it, even emergency response personnel will need prevention, education, and support services to avoid or manage problems.

- > The use of alcohol and drugs, and the abuse of prescribed medication can interfere with a person’s ability to think clearly, which is a critical asset in any emergency. Therefore, prevention and education programs are important components of community-wide disaster preparedness.

- > Substance abuse prevention is an often overlooked way of building resilience, not only for individuals but also for communities. It serves to establish and restore support systems that benefit everyone affected by a disaster. It educates people about coping strategies that are constant and healthy and helps individuals avoid the onset of posttraumatic stress disorder and addictions.

Rodrigo Monterrey is all-hazards coordinator for the Massachusetts Department of Public Health, Bureau of Substance Abuse Services.



Tourists, Terrorism, and Disasters

A WAKE-UP CALL

I was in bed a little before 7 a.m. on Sunday, September 25, 1999, when I received the news that the wreckage of Big Island Air flight 58 had been found in Hawaii Volcanoes National Park. All 10 people on board died when the plane crashed onto the slopes of Mauna Loa, the world's largest active volcano. Eight of the ten were not from Hawaii. Two came from New England, three from California, two from Australia, and one from Germany. Most of them had been traveling with loved ones who were not on the sightseeing tour flight and were waiting alone in their hotel rooms for news. I shortly discovered there was no plan in place for helping families of the deceased. While larger airlines were required to have plans in place under the Aviation Disaster Family Assistance Act of 1996, smaller operators like Big Island Air were



not. It had no plan and neither, it turned out, did anyone else.

Individuals from the Hawaii Chapter of the American Red Cross and Hawaii County Civil Defense responded to the demands of the situation and saw to the needs of surviving family members. Good people did what good people do in times of disaster. They figured out a way to offer the compassionate service that the situation demanded. However, it was clear to me from the first moment that things could have gone much more smoothly if we had had a plan to guide us rather than making it up as we went along.

The Big Island of Hawaii is the most disaster-prone county in the United States. It has the world's largest active volcano, earthquakes, tsunamis, hurricanes, and even blizzards in its mountains—you name it, we probably are threatened by it. It is also an island whose primary industry is tourism. While the county is as prepared as any place for disasters, the events of that Sunday morning demonstrated we had big holes in our plans when it came to meeting the needs of the island's visitors when disasters strike.

Most jurisdictions in the United States have significantly improved readiness since September

11, 2001. Funding and public awareness increased in the wake of the terrorist attacks and high-profile disaster response events like Hurricane Katrina. Discussions with disaster managers indicate that tourists are an important population that is often overlooked in disaster planning. While many communities have important tourism industries, often there is a lack of in-depth planning for how tourists are to be assisted before, during, and after a disaster. Tourists have needs that differ from the resident population and are a difficult variable to account for in disaster planning. The purposes of this article are to describe some of the dynamics presented by tourist populations in a major disaster and to propose that disaster planners instigate efforts to work with government and industry stakeholders to prepare for those eventualities.

ASKING TOUGH QUESTIONS

Shortly after moving to Hawaii, I talked with one of the State's disaster managers about how authorities would assist the 187,000 tourists who are in the islands on an average day. I was specifically concerned about the 60,000 visitors who are in Honolulu on any given day, mostly in

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the tiny area of the island called Waikiki. If there was a large earthquake, tsunami, or hurricane, what would they do? He talked about concepts of vertical evacuation (moving people to upper floors of a hotel during a storm surge) and evacuation in place, but it was soon apparent that given all of the dynamics involved, none of his ideas would be satisfactory. When I pushed him a little harder, he said in frustration, “Well, I guess we could call the Navy and ask them to send in some aircraft carriers.”

After that conversation many years ago, I felt bad. I know how difficult it is to plan for relatively static populations. The variables involved with planning for significant transient populations compound the difficulty. Most planners will propose that the best way to assist tourists is to get them out of town before a disaster strikes. That is a tough assignment even when there is advance warning of an impending catastrophe, as in the case of a hurricane. It is even more difficult when an area is caught by an earthquake or unexpected storm.

Just convincing visitors of potential danger can be a challenge. Vacations tend to breed denial. There is often reluctance on the part of normally rational people to give up on a long-awaited trip just because a storm “might” come ashore near where they are staying. That denial can lead to badly-jammed roadways as tourists, along with residents, try to escape at the last minute. The

crush at airport terminals can be overwhelming as desperate individuals bargain for overbooked seats. Such 11th-hour evacuation may not even be an option on an island.

The point of this article is not to provide specific answers to questions regarding how to deal with tourists following a disaster or terrorist attack. The variables are too complex to provide anything more than a general schema of the various aspects of tourism-related disaster planning. The point of this article is to impress upon disaster managers, planners, and responders, as well as the government and private sectors, the importance of getting serious about asking the questions. A lack of sufficient preparation and followthrough could cripple important tourism industries for a long time.

TOURISM ISSUES TO ADDRESS

Every disaster plan should provide guidance regarding the number and locations of tourists.

It should also contain an assessment of which disasters are most likely to impact tourists and address a number of additional factors. Among the issues that should be addressed are how to warn tourists about an impending disaster, how to evacuate them, how to communicate with them and their families back home, how to ensure their safety, how to provide transportation home, how to attend to their mental health needs, how to retain local staff to assist them, and how to protect tourists from acts of terrorism. Key concepts regarding these issues appear below.

- > **Warning Tourists.** Warning citizens of an impending disaster is a primary concern in most communities. Various governmental and nongovernmental agencies make a considerable effort to educate residents regarding disaster warning procedures through a range of media so citizens will know how they can expect warnings and where they

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can turn for direction. Tourists do not have the advantage of this educational process and may be unfamiliar with potential disasters in an area they are visiting or how they will be warned if danger approaches.

Attention should be given to providing necessary information to travelers as they arrive at airports, bus or train depots, ports, or by highway. Hotels and other lodging establishments should be included in disaster planning efforts and encouraged to provide their guests with information regarding



potential dangers and how warnings will be delivered.

- > **Evacuating Tourists.** Disaster warning requirements are compounded when a potential disaster (or damage from an unexpected disaster that has already occurred) requires evacuation. It is important that every property have an evacuation plan for their guests. The traditional map of fire escapes found universally in hotel rooms is insufficient. Visitors deserve easily accessible information regarding potential disasters and what management has planned so that they will be safe.

It is also imperative that local authorities, property owners, and relief organizations, such as the American Red Cross, work together to determine when, where, and how guests are to be evacuated. Efforts should be made in advance to inform visitors how they will be notified of potential disasters, where they are likely to be moved, and what they should bring with them. Such foreknowledge will increase the chances of an orderly and complete evacuation while reducing the risk of panic.

- > **Keeping Communication Lines Open.** People impacted by a disaster need to know what has happened and what is being done to respond. They need assurance that loved ones are okay and that they can call for help if it is

needed. People outside of the impacted area need to check on the status of those they care about. These needs are magnified for people who are just passing through a disaster zone. It is important for planners to recognize that tourists may find talking to loved ones as important as food or dry clothes. If an evacuation is necessary, plans should be made so that tourists will be able to at least get messages out regarding their condition as soon as possible. That means that properties should plan in advance to set up phone banks for evacuees or arrange for ham operators to be present to relay messages.

In 1994, I was visiting Disneyland in Anaheim, CA, with my 8-year-old son when the Northridge earthquake struck. We were staying upstairs in a two-story wooden motel across the street from the park. We were literally bounced out of our beds that morning. As soon as the shaking stopped and I confirmed that the building was safe, I picked up the hotel phone to call my wife in Utah. I told her there had been a big earthquake, we were safe, and we would come home when we could. I also told her that it was likely the phone circuits would go down in a few minutes and that it might be quite a while before I would be able to talk to her again. Within a few minutes phone lines ceased working. The volume of calls by residents

trying to let others know what had happened and outsiders trying to check on the well-being of friends and family overwhelmed the phone system's capabilities, and telecommunication became problematic for some time.

Many people count on cellular phones for communication. We found out after our recent Hawaii earthquakes that when the electricity goes off, cell phone transmitters do, too. When people on the outside are unable to reach their loved ones at their hotels or on their cell phones, panic may set in. Incoming calls to local authorities may tie up all of an agency's lines and personnel once the phones are working. It is important that advance plans are made to set up a communication system at a location outside the disaster zone to handle the distribution of information including press inquiries and requests for information from the general public.

Language is also an important consideration. Some tourist spots attract large numbers of visitors who do not speak English. It is important that disaster plans include translators. Many larger hotels will have staff members who are fluent in the most common languages. Many destinations receive foreign visitors in waves, with various countries of origin predominant during different months.

> **Ensuring Safety and Security.** It is important that guests are assured that both they and their possessions are going to be safe. Whether guests are evacuated to a safe place in a hotel or to an off-property shelter, they need to be confident that they, and the valuables they have left in their rooms, are going to be protected. Unfortunately, there are those who will take advantage of disasters and loot, rob, or molest. Hotels have the responsibility to see that their guests are not victimized. It is important that hotels ensure that security staff is present at both evacuation sites and throughout the guest floors.

> **Providing Transportation Home.** Once an immediate disaster has passed, the first thought for most tourists will be about getting home. Depending on the extent of the devastation, many people may want to terminate their trip and return home immediately. It is always a good thing to reduce the population in an area impacted by disaster. However, transportation away from a disaster area may be difficult to provide. This is particularly true in island tourist destinations and is compounded if airports and harbors have been damaged. Tourism facilities, airlines, and civil authorities need to be prepared to deal with the stresses people experience when they are not able to leave a disaster location.

> **Offering Disaster Mental Health Services.** Plans should be made to assist with the emotional and psychological reactions that both employees and guests will experience before, during, and after a disaster. Fear, exhaustion, adrenalin, and uncertainty can play havoc on the well-being of both groups. A frightened, stressed-out staff will not earn the confidence of guests. An overwhelmed guest can increase the emotional burden of staff and other customers. During the past decade or so, thousands of mental health professionals around the country have been trained to help people cope with these stressors. Their services may help calm the staff and guests as well as decrease the liabilities a property might face following a disaster.

It is important that properties identify and retain disaster mental health professionals who will actually be available to serve their employees and guests during a disaster. Many disaster mental health professionals are committed to work for the American Red Cross, Federal Emergency Management Agency (FEMA), or other disaster response agencies. As with busses, it does not do any good to count on mental health resources that others are also counting on. When a disaster occurs, mental health professionals can only be in one place at a time.

> **Retaining Staff.** The greatest plans will not be helpful if there is no one around to follow them. When a disaster strikes, it is natural for hotel staff to be more concerned about the safety of their own families and property than about hotel guests. If hotel staff desert during the run-up to a disaster or in the aftermath of an unexpected event like an earthquake, there will be nobody left to look after the guests and ensure their safety.

One solution is to include staff and their families in disaster response planning. Letting staff know that their families will be able to shelter at the hotel with the guests or in whatever alternative evacuation location is used may go a long way in preventing staff loss. Plans can be made to allow staff members time to retrieve family members and bring them to the hotel prior to an event. The plan may even include using hotel vans to pick up employees' families so that the staff can remain on duty to take care of guests. If employees believe that their families are of equal or even greater importance to their employer, it may engender the loyalty that will be required to see a hotel through a disaster.

> **Protecting Tourists from Acts of Terrorism.** Terrorists have concluded that hotels and resorts are soft targets of high public relations value. Hotels, especially those with American brand names, have been attacked by suicide

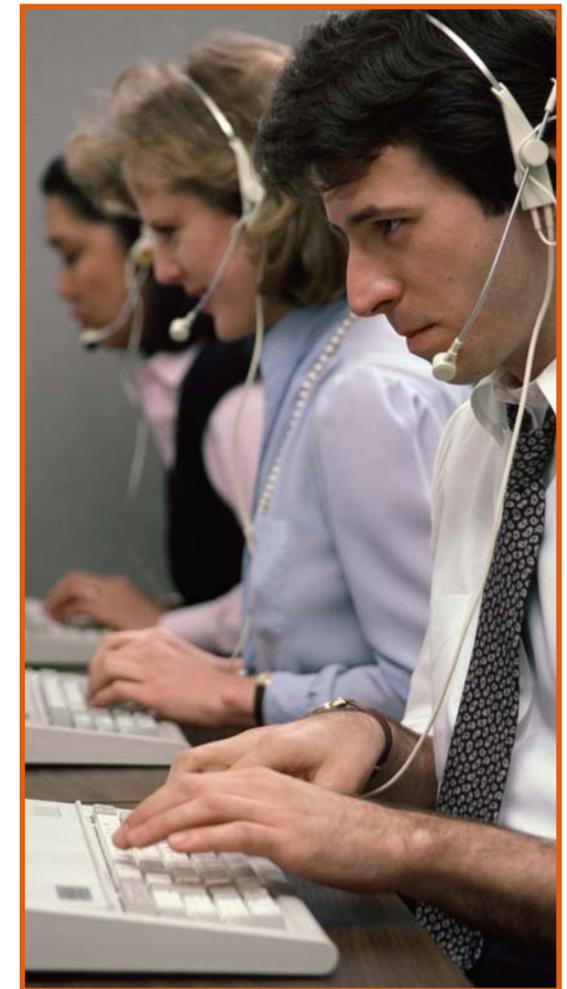
bombers with frightening frequency. Terrorism experts fear that terrorists may bring this practice to the United States where hotels and associated business such as restaurants and entertainment venues are still very unprotected compared to those elsewhere in the world. The protection of tourist destinations is beyond the scope of this article, but it is a serious topic that emergency managers and property owners must confront. It is especially important to have competent mental health specialists available to assist guests and staff with terrorist events, even in properties that are not directly attacked.

CONCLUSION

When a disaster strikes, every locality will face different challenges in assisting tourists. Many of these challenges are predictable and can be addressed with proper planning. It is important to remember that disaster plans are of little value if they are not up to date or if their assumptions are unrealistic. Community-wide planning involving hotels, motels, bed and breakfasts, hostels, and campgrounds should be instituted everywhere. The process should include all emergency service and disaster response agencies as well as airlines, airports, cruise lines, ports, bus and train depots, and telecommunication companies. Failure to invest the required time and energy to develop, drill, and revise disaster plans is almost a

guarantee that unnecessary suffering and expense will result when a disaster strikes.

This article was contributed by Thom Curtis, Ph.D., associate professor of sociology, Division of Social Sciences, University of Hawaii at Hilo.



Silent Survivors of Disasters: Older Adults



At the site of any disaster, there are a multitude of survivors, the challenges of caring for them, and, frequently, not enough caretakers to meet their needs. One group that is often not planned for and whose needs are generally not well understood is the older population, particularly those in long-term living facilities. The purpose of this article is to look at this special-needs population and review some aspects of planning and response that will facilitate their proper care and treatment during and after disaster.

On any given day, there are approximately 1.6 million people residing in 17,000 nursing homes and another 900,000 to 1 million who are living in 45,000 long-term care facilities. By the year 2025, there will be more than 4 million people in nursing homes. The fastest growing population in America is the age 85 and older group. Older adults already may be suffering from preexisting trauma related to changes in living situations, chronic health problems, and reduced personal freedom. When yet another traumatic event occurs, such as a hurricane, tornado, flood, heat wave, or devastating cold spell, their trauma is compounded.

Given this already complex psychological picture, several things are important to consider. First, older people in nursing homes often struggle with change, particularly sudden change. Therefore, the rapid changes that occur in time of disaster are even more traumatic. Demands to move quickly, change locations, and leave treasured things behind are made, and often older people lack a clear understanding of what is transpiring. In light of this, every effort should be made to reassure older adults, explain why changes are necessary, tell them where they are going, and most importantly, reassure them that they will be safe and cared for. Older people's need for reassurance cannot be underestimated. This population has grown used to rigid routines with regard to virtually every phase their lives: when to eat, when to bathe, when they get their medications, and who will care for them. When these routines are disrupted, their anxiety increases greatly. Any semblance of routine and structure that nursing home residents can realize is invaluable in minimizing the shock of sudden upheaval.

The individual needs of residents, such as medications, oxygen, and wheelchairs must be carefully considered. Most Americans now die of chronic illnesses rather than acute illnesses.

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Nursing home residents typically have 2–3 serious chronic illnesses, and some have 10–12 chronic conditions. Therefore, it is imperative that serious consideration and plans for the appropriate continuation of medical care be incorporated into disaster planning. The provision and availability of medications alone poses a serious, often critical problem in a catastrophic situation. Access to medical records is also critical. Arrangements for alternate placement, medical assistance, and mental health assistance should all be in place. The more comprehensive a disaster plan is for this population, the smoother the appropriate response will be. This is a very vulnerable population, and often a silent one. Their care and well-being is a tremendous challenge, especially during a disaster when there are so many other pressing demands and emergencies at hand. The time to plan for the proper provision of services is prior to an emergency. This planning can only be done if there is a comprehensive knowledge of this special population and the unique challenges they present.

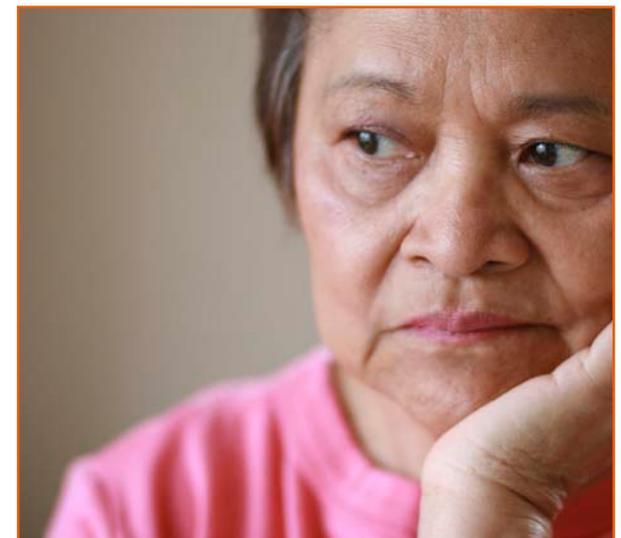
Another complicating factor facing disaster relief workers and planners is the mental health status of this population. Various studies estimate that 51 to 94 percent of this group exhibits psychiatric symptoms. The most common maladies encountered are depression, delirium, dementia, and anxiety. Very probably, the residents who will have the hardest time with the sudden

upheaval and rapidly changing situations that occur in times of disaster will be those with some degree of dementia. Dementia is one of the most devastating and dreaded psychiatric diseases. Taking a quick glimpse into the future of just one of these dementias, Alzheimer's disease, is quite sobering and, once again, emphasizes the need for special planning for this population. At current prevalence rates, approximately one-half of the population older than 85 years of age will have Alzheimer's disease. By 2050, we will have 19 million people older than 85. This translates to approximately 9.5 million people who will have this condition.

Another mental health and social issue that is often overlooked, and one in which this population differs from other victims of disasters, is that the vast majority of older adults who are in nursing facilities will remain there for the rest of their lives. They will not get to go home, to rebuild, or to start over. Their "going home" will likely be to another long-term care facility. This is a challenge for mental health professionals because this is quite different from helping those survivors who will get to start life anew. In addition, many nursing home residents suffer from varying degrees of anxiety and depression. Residents who have dementia will likely be the most afflicted during a disaster. As long as they possess cognitive abilities, they are aware of their gradual decline and are devastated by the process.

During a disaster, the negative impact on this population is significant. The demands, confusion, sudden changes, and vast unknowns, coupled with the inability to accurately and rapidly process all of this imposed chaos is simply overwhelming, resulting in an exacerbation of their emotional instability.

In addition, professionals trained in geriatric medicine and geriatric psychiatry are increasingly scarce. The latest numbers available indicate that approximately 330 physicians completed geriatric medicine residencies and 86 psychiatrists completed geriatric residencies in psychiatry last year. This indicates at least two critical issues for future planning. First, there may not be professionals who are trained in geriatrics available to provide guidance and care. Second,



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the burden falls on the first responder to become more proficient in and cognizant of the special needs of this population, both for service provision purposes and formulating comprehensive disaster plans.

One final issue bears serious consideration. This population, like other trauma victims, will be in a state of shock for days, weeks, or even months after a disaster. First responders are generally most helpful with initial triage, placement, and identifying special needs. However, most of them go home shortly after the major issues surrounding the disaster have been handled. The mental health issues will be just beginning and the posttraumatic stress will last for many months, if not longer. Further problems will arise if there is a severe shortage of trained professionals to provide the appropriate long-term care after the first responders are gone. The end result is that many survivors may get no care. This is especially true for those people who are dependent on others for their care. A critical aspect of disaster planning and intervention has to be to ensure that long-term mental health help is available for all the survivors who are in need of such care.

In summary, there is a very large and rapidly growing older population in this Nation. The first Baby Boomers turned 62 in January 2008, and this group will stretch the capacity of all types of healthcare systems in the next 10–20 years. The average life expectancy is increasing at a steady

pace. It is obvious that any future disaster plans must factor in the aging population. This means that there must be a clear understanding of the special needs and challenges posed by this group. Given the medical, psychiatric, and social issues of this growing population, there is an urgent need for serious, comprehensive disaster plans that take into account the vast array of special needs of this group. It is important that planning and

preparedness measures be put in place quickly. The challenges are great and complicated, but so are the ingenuity and resourcefulness of those who work in this difficult field. These challenges too will be met, and the care and safety of the silent older population will be assured.

This article was contributed by John G. Jones, Ph.D.



Survivor-to-Survivor Storytelling and Trauma Recovery

The primary goal of the Surviving Katrina and Rita in Houston (SKRH) project is to voice, as intimately as possible, the descriptions and reflections of people displaced to Houston, TX, by the gulf coast hurricanes of 2005. SKRH is the first large-scale project in which survivors have taken the lead in documenting their own experience of disaster. The interviews, now numbering more than 400, not only illuminate individual survivor's lives and concerns, but, collectively, may guide more effective assistance for people faced with catastrophe, loss, and sudden relocation in the future.

Drawing upon their professional experience as folklorists, project directors Carl Lindahl and Pat Jasper recognized early on that survivors would need to tell their stories, and not necessarily to mental health professionals. For example, the most powerful accounts in the September 11, 2001, collection housed in the Library of Congress were recorded by friends, family members, and fellow workers of the narrators.

Hurricane survivors recruited as interviewers first participated in a week-long field school developed in conjunction with the American Folklife Center at the Library of Congress. Then they were paid

to record and process nondirected interviews of fellow survivors. The ideal was to create a “kitchen table” conversation in which the interviewer establishes a comfortable, neighborly atmosphere before posing a set of basic scenario questions: “Describe your life in the neighborhood where you lived before the storm,” “Describe what happened to you during the storm,” and, “Describe your life in the Houston area since the storm,” followed by, “Please share anything else you wish to say about the storm and its effects.” By the end of the training period, each participant had served as both interviewer and interviewee and gained proficiency with the recording equipment and necessary documentation.

As survivors assembled for the first training sessions, they began to establish connections that, in many cases, have become lasting friendships. Reunions and other social events enable participants from different training sessions to solidify existing bonds while creating new ones. SKRH succeeds largely on the power of the relationships forged among interviewers, narrators, and an extended network including all members of the project staff and the mental/behavioral health advisors. The work of the project has been shaped by the following precepts:

- > **Survivor stories are best told in a “deframed” situation to counteract the distorting frames the media and others have often forced upon evacuees.** Stories are sought only from



those who *want* to tell them. Survivors are asked for *accounts*; the interviewers are directed not to elicit emotions and interpretations.

Interviewees often are fully aware of the emotional weight of their stories, but remain eager, even driven, to tell them. One narrator told his interviewer, “I’m going to cry all the way through this, but don’t turn off that machine.” Others wander unaware into emotional depths. One interviewer summed up such moments with these words, “I was never surprised that they cried, but I was often surprised that *they* were surprised when they cried.” Narrators are often overcome with surges of emotion surrounding seemingly small details, for example, in speaking about the people they had seen daily in the course of walking to work—people whose last names they had never known, people whose whereabouts and status are unknown to

them now. Many narrators who had steeled themselves to tell about their “big troubles” were unprepared to speak of the enormous effects of losing the everyday comforts of their former lives.

- > **Narration of stories on the survivors’ terms benefits the speakers through “going on the record.”** Participants are buoyed by the prospect that their stories are, in some ways, official records of what happened, and that their voices will be preserved in the Library of Congress. For these survivors, the interviews seem to exert a positive, healing effect similar to that documented by psychologists Elizabeth Lira and Eugenia Weinstein (writing as Cienfuegos and Monelli), in their work with Chilean survivors of the Pinochet regime. More recently, the role of narrative has been explored among refugees from the Balkan genocide, whose testimony—and its healing power—were studied by psychiatrist Stevan Weine and his colleagues.
- > **Interviewees derive a sense of security and intimacy through speaking to someone with whom their stressful history is shared.** When trainees were asked, “Why are you here?” the most frequent response goes along these lines: “We want people to know who we are. So many have been so generous, but even the most generous often do not have a clue about what we’ve been going through....

We don’t want people to scorn or pity us. We want them to see us.” These interviewers bring to the project a personal commitment to compassionate listening that elicits remarkable and little-heard narratives. For those who distrust official service structures and organizations, the survivor-to-survivor interview often constitutes the first welcome response or intervention. More than 2 years after the hurricanes, interviewers still bring back reports of narrators sharing words such as, “This is the first time I’ve felt listened to,” and, “I was so tired of *not* telling my story and I’m glad to finally get the chance.” Many narrators thank their interviewers profusely for the opportunity to share their experiences.

- > **The interviewers avoid compounding their own trauma by processing the interviews.** They derive a sense of purpose through their logs by representing their fellow survivors. Although there were stories about “vicarious” traumatization, those who respond most healthfully in interview situations are those who process the interviews—especially those who view their processing work as helping others. On the basis of experience with survivors, it is believed that they are working from the position of “compassionate witnessing” described by Harvard psychologist Kaethe Weingarten. As fellow survivors, they clearly have awareness of the impact of the

event, and as representatives of SKRH, they have the capacity for effective action through preserving the tellers’ stories and connecting them with needed resources.

- > **The products of the interviews are shaped largely by the survivors themselves to create public statements with immediate social impact.** These products include educational programming, live storytelling, radio programs (both live and prerecorded), and installations featuring the photographs and recorded words of survivors. Most of the public events have involved a mix of survivors and long-time Houstonians; both groups report overwhelmingly positive responses to these events, and many survivors specifically mention their healing effects.
- > **The products of the interviews are put to immediate use to help effect a positive, reciprocal climate of respect between Houstonians and their new neighbors.** The need for social healing was evident in the immediate aftermath of the hurricanes, but perhaps is even greater today. By late 2007, the phrase, “Katrina’s not over,” had become a kind of proverb among narrators, and many who quoted it referred repeatedly to negative news reports and stereotypes projected by the media, including highly publicized conflicts between Houston and New Orleans children in local schools, claims of evacuees abusing

FEMA funds, and alarming crime statistics. Some narrators also spoke about unpleasant personal experiences in which they or their children had been stigmatized. SKRH directly counters media stereotypes by setting up situations in which survivors and their Houston hosts can meet and speak face to face.

RESEARCH IMPLICATIONS

Because the interviews are close to the ideal of natural narrative, they reveal the emotional consequences of the disaster as understood and



articulated by the survivors. For example, the disturbing experiences recounted by children and adults have been examined in the following two timeframes: children's accounts of their experiences during and after the storm, and adults' accounts of their storm and post-storm experiences. For adults in both timeframes, as well as for children's storm accounts, the most pervasive negative experience was separation from family and loved ones in the chaos of the storm or during the subsequent evacuation. However, for children in the post-storm period, the most frequently reported negative experiences revolve around problems in their Houston schools: fights, stigmatization, unsympathetic teachers and administrators, and other distressing issues. At the same time, parents' evaluations of Houston schools were overwhelmingly positive, and many contemplated staying in Houston because they believed the schools provided good opportunities for their children. Elsewhere in the interviews, there is little evidence of a generation gap, but the school issue is an explosive one that threatens to divide otherwise close families. Because intrafamily support has been such a strong protective factor in the lives of most survivors, a rift of this nature is cause for concern.

CONCLUSION

Survivors continue to say that "Katrina's not over." Indeed, it seems the need for the project is as great

today as in the fall of 2005. As lessons are learned from survivor interviewers and interviewees, it is evident that the primary interviewing experience is valuable to social science research because it is not perceived by survivors as a social science project, and it is valuable to behavioral and mental health initiatives because it is not perceived as a mental health project. This body of trauma-rife narratives collected in "natural" contexts offers enormous potential for assessing the psychological impact of storytelling in vivo, beyond the clinical frame. Because the great majority of survivor stories are told outside clinical settings, insights derived from analysis of this interview data could contribute to development of more effective narrative healing strategies. As this model is maintained, collaborators are attracted from multiple disciplines, and innovative ways to assess and enhance outcomes are explored, the project's contribution to the understanding of trauma recovery will expand. For more on SKRH, visit www.KatrinaAndRita.org or write hurricaneshtown@aol.com.

This article was contributed by Carl Lindahl, Ph.D., Martha Gano Houston Research Professor of English, University of Houston; and Sue Nash, Ph.D., research fellow in primary care, Department of Family and Community Medicine, Baylor College of Medicine.

A New Model for a Statewide Disaster Behavioral Health Response Plan

Often, disaster behavioral health has not been prioritized in emergency preparedness efforts. That is because the overwhelming evidence of significant to severe psychological consequences of disaster has not received the same level of attention compared to the more widely televised dramatic physical trauma. However, the aftermath of the September 11, 2001, terrorist attacks, the 2004 Florida hurricanes, and the 2005 gulf coast hurricanes reminded the country that the psychological footprint of disaster is as important as the physical footprint. Disaster behavioral health now has become a major public health concern and a national issue that deserves a logical, systematic, proactive approach within the structure of the National Incident Management System (NIMS) and Incident Command System (ICS). One thing is sure: There will be another disaster. Together, this issue can be addressed with collaboration, organization, and better utilization of qualified yet limited behavioral health resources. The predictable needs of future disasters' victims, communities, and responders can be met.



FLORIDA'S EXPERIENCE

The State of Florida, with its history of numerous natural disasters, inevitably bestows more exposure to disaster situations and a keen set of first-hand experiences involving disaster management challenges and successes. In 2004, Florida experienced four major hurricanes in a 50-day period. The rain, wind, and threats of storm surge found residents caught between removing the shutters from their windows after one storm and reinstalling them within days for the next storm looming off Florida coastlines. Exhaustion, frustration, and anger impeded survivors' abilities to respond to the repeated challenges.

In addition, disaster relief workers were stymied, moving in to assist but then having to evacuate to safer ground in response to the threat of the next encroaching storm. Responders, who included emergency first responders, repair personnel, volunteers, and survivors' families and friends, became secondary disaster victims themselves. Tempers flared, anger ensued, and many relationships faced new tests.

THE CONSORTIUM

The Florida Crisis Consortium (FCC) was formed in the aftermath of these hurricanes. Composed of representatives from the State of Florida's Department of Health, Department of Children and Families, and Department of Education; several universities; faith-based organizations; the American Red Cross; the Florida Crisis Response Team; the Green Cross; Critical Incident Stress Management of Florida; community-based mental health agencies; private industry; and other interested stakeholders, this group is all-inclusive and has held an open-invitation policy since its inception.

The goals of FCC were to collectively construct a disaster behavioral health plan that would eventually become part of the State's Comprehensive Emergency Management Plan. The plan needed to be consistent with NIMS and the National Response Plan, and work within the framework of ICS. Asset-typing of teams, credentialing standards, and protocols were developed to support the structural processes. The plan needed to be constructed with collaboration and input from all stakeholders. Accountability, a backfill plan, clear operational protocols, and

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defined lines of authority needed to be established. Funding was another consideration for sustainability. It took roughly 2 years to complete the first approved plan for statewide applications. Like any plan, the need to refine and adjust is anticipated with utilization and review provisions.

THE FLORIDA DISASTER BEHAVIORAL HEALTH RESPONSE PLAN

The intent of Florida's disaster behavioral health response plan is to mitigate the adverse effects of disaster-related trauma by promoting and restoring psychological well-being and daily life functioning to affected individuals and communities. Like other preventive mental health interventions, it is aimed at providing supportive human contact as close to the time of impact as possible. The plan encompasses the psychological, social, behavioral, and educational-related supports required to facilitate recovery. It provides a framework for the following activities:

- > All hazards planning for disaster events
- > Responding to the immediate impact of a disaster event
- > Assisting Florida's residents and visitors in recovering from the impact of a disaster

Research suggests that, following a disaster, most people are resilient and will return to pre-event psychological functioning within a relatively short time. Outreach, early psychological first aid, and referrals can assist disaster survivors to meet new challenges, and offer support in their recovery process to return them to pre-disaster performance and functioning levels. The public will require information on how to recognize and cope with the short- and long-term risks of sustained stress caused by a disaster or arising from its effects. An informed public will be better able to respond and cope with the stresses associated with a disaster.

Individuals with special needs, especially those with preexisting mental illnesses and substance abuse disorders, older individuals, children and adolescents, or people with disabilities, may be more prone to experience severe stress reactions and adverse outcomes. The plan creates regional behavioral health consultants to work with communities to develop local capacity and creates regional disaster behavioral health teams to respond, at the request of local jurisdictions, by assessing behavioral health needs resulting from an incident and managing the behavioral health response.

At the heart of the plan are the disaster behavioral health teams, one located in each of seven regions throughout the State, overseen and coordinated by

an operations director and clinical director who function out of the State Emergency Operations Center (EOC). These teams provide a multitiered response, as they consist of personnel with escalating levels of experience and training. Each team has three advanced or specialty responders and two licensed mental health professionals, a primary and backup team leader. Team composition was determined after comprehensive literature review, communication with other governmental entities and nongovernmental organizations, and much discussion about what personnel, in terms of skills, experience, and knowledge, were required to get the job done. Another addition to the traditional mental health response model is the adoption of a triage matrix for assessment, much like the system that has been used in prehospital care by emergency medical services for decades.

Through a process of preincident education and coordination with the local EOC and other emergency services providers; careful selection, training, and preparation of personnel with the right skills, knowledge, and experience; accurate assessment and triage; and provision of effective post-incident support and psychological first aid, referral options, and followup, Florida's statewide disaster behavioral health plan is now in place.

COORDINATING THE PLAN

Requesting an assessment team begins at the local level. When a disaster occurs and local mental health resources are exhausted, the incident commander can request additional assistance through Emergency Support Function (ESF) 8, Health and Medical at the local EOC. The local ESF 8 representative then makes a request to the State EOC through their ESF 8 desk. At that point, a Regional Disaster Behavioral Health Assessment Team (RDBHAT) is mobilized by the operations director in consultation with the clinical director to respond to the staging area within 24 hours of the request. With the support of the State EOC, supplies and other necessities are quickly assembled so that the team can become operational as soon as possible. Within the first full day of being onsite, the RDBHAT will conduct an assessment of the targeted population; conduct an assessment of the current state of local, indigenous mental health facilities and other service providers; brief local authorities; and make recommendations to the local ESF 8 representatives. An Incident Action Plan (IAP) will be submitted to the operations chief. The IAP will outline the recommendations for behavioral health services with measurable objectives and request Disaster Behavioral Health Teams as needed to provide the services.

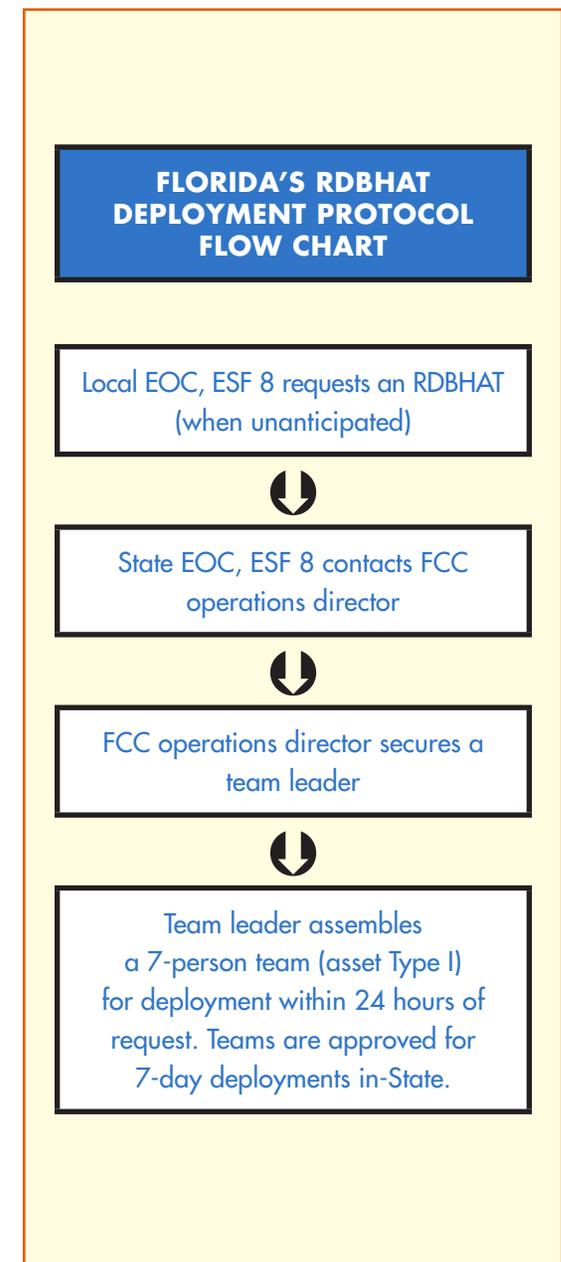
Once the teams are on the ground, the RDBHAT switches roles and becomes an oversight and

management team. The RDBHAT is responsible for briefing all incoming teams, providing assignments consistent with the assessments conducted, assisting in the coordination and management of logistics, conducting end-of-day briefings, and monitoring team members for exposure and compassion fatigue. Prior to demobilization, the RDBHAT may recommend or conduct assessments and interventions aimed at the health and wellness of all deployed team members. The intention is to monitor and ensure the safety of all those who come to help.

Post-incident, the RDBHAT collects all the data from the responding teams and compiles it into a report to the State on the number of victims, number of victims assisted, hours worked, costs, and other pertinent information that may be useful in the after-action phase. The FCC reviews the report to revise the plan based on lessons learned. A Post Action Staff Support (PASS) meeting also is scheduled for all team members participating in the deployment.

The funding source for planning and training is the Federal Assistant Secretary for Preparedness and Response funds. There has been only a small amount of money devoted to this. The plan relies on volunteer activity through the FCC. Deployment costs are covered through ESF 8, and then the State seeks reimbursement through FEMA.

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SMALL-SCALE INITIAL TEST

The first opportunity to deploy a plan-coordinated disaster behavioral health assessment team was February 2, 2007, when three tornadoes struck central Florida claiming 21 lives and causing \$10 million in property damage. The tornadoes took many people by surprise, striking in the early morning hours. One tornado reached level EF-3, with winds between 160–165 miles per hour.

One community, made up of approximately 65,000 residents, suffered extensive damage. The local fire department made a request through the local ESF 8 representative for a team to respond. In less than 24 hours, a RDBHAT team of three was on the ground conducting an initial assessment. By the next morning it was decided that the RDBHAT team could provide the needed services and that they did not need to request any other disaster behavioral teams. The team worked 12–14 hours a day conducting one-on-ones, holding crisis management briefings, and distributing information on stress management following disasters. The team stayed in constant contact with the local ESF 8 representatives and their RDBHAT operations director. This ensured maximum utilization of resources and continuous communication between the field and the EOC. The deployed team completed operations at the end of the fourth day.

The PASS meeting was held 3 weeks later. The deployed team and the operations director

attended the PASS meeting. One of the State's clinical directors conducted the meeting. This same group contributed to the after-action report.

OBSERVATIONS AND FINDINGS

The after-action report revealed several important findings, including the following:

1. The time to establish relationships with other agencies involved in community mental health is before disasters occur.
2. Mental health professionals need to have a good working knowledge of the ICS and take the FEMA IS 100, IS 200, IS 700, and IS 800 courses prior to deployment.
3. Documentation and incident action plans are mission critical.
4. The need for equipment such as computers, satellite phones, wireless Internet connections, and preprinted materials should be given equal importance regardless of the perceived scope of the event. Although the equipment had been procured in advance, because of the small size of this event, not all support services were activated and the items were not delivered to the team that needed them. In preparation for a hurricane, for example, delivery to the staging area should occur in advance.

5. No matter how big or small an event, the RDBHAT needs to attend a PASS meeting after deployment.
6. Overall, the plan worked!

CONCLUSION

To be prepared for the next disaster is a challenging assignment. It requires a meeting of the minds to plan strategies that will work to preserve the health and well-being of citizens and responders. For multiple partners to develop a plan that will provide the greatest good to those impacted by disaster requires a broad understanding of emergency management systems and an overarching need to blend expertise in two entirely different fields, emergency management and behavioral health. Psychological and emotional after-effects of disasters can leave a footprint larger than the one left by the physical consequences, and the time to address these disaster behavioral health concerns is now. To obtain more information, contact: dfojt@corporatecrisis.net.

This article was contributed by Diane Fojt, M.Sc., REMT-P, CFT, operations director, FCC, and CEO, Corporate Crisis Management; Martin Cohen, Ph.D., licensed psychologist clinical director, FCC; and Janet Wagner, CMA.

Special Feature

The Americans with Disabilities Act and Disaster Response

One of the most important roles of local government is to protect its citizenry from harm, including helping people prepare for and respond to emergencies. Making local government emergency preparedness and response programs accessible to people with disabilities is critical and required by the Americans with Disabilities Act (ADA). In planning for emergency services, the needs of people who use wheelchairs, scooters, walkers, canes, or other assistive devices must be considered. Plans should include those who use oxygen respirators, are blind or have low vision, are deaf or hard of hearing, or have cognitive and other disabilities, including mental illness.

Interest in emergency evacuation planning has increased dramatically since the September 11, 2001, terrorist attacks. Employers have requested more information about their legal obligation to develop emergency evacuation plans, and how to include employees with disabilities in those plans. The ADA, the Rehabilitation Act of 1973, and the Occupational Safety and Health Act all require accessible emergency planning. In fact, some State and local governments have additional stipulations. The person responsible for a community's emergency planning or response activities should involve people with disabilities as leaders in identifying needs and evaluating effective emergency management practices.

Issues that have the greatest impact on people with disabilities include the following:

- > Notification
- > Evacuation
- > Emergency transportation
- > Sheltering
- > Access to medications, refrigeration, and backup power
- > Access to mobility devices or service animals while in transit to and at shelters
- > Equal access to information

Since all disasters are local, there is a need to define which special populations exist in the local community and then determine what to do to meet their needs. One size does not fit all. People with special needs include the following groups:

- > **Children** in childcare facilities, K–12 schools, residential treatment centers, or youth correctional centers
- > **Adults** in supervised congregate care facilities, group homes, their own homes with physical challenges, and medically fragile adults and older adults

- > **Unique populations** in correctional or detention facilities, hospitals or other treatment facilities, and summer camps or recreational programs

All facilities should be registered with the local emergency management organization. That means developing a database that lists each facility by name, address, and phone number, and includes schedules, points of contact, census data, and number of staff. Of course, planning for hospital emergencies must focus on bed capacity and include hospital authorities' protocols for moving critical-care patients. Transportation capability using wheelchair-accessible vehicles must be considered. It is important to determine how many of the onsite population can be moved at one time by existing facility resources, and to allow for the

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facilitation of additional transportation options through other community resources.

Some adults who are usually self-sufficient may need additional assistance during an emergency. This includes older people, people who are blind and deaf, people with mobility limitations, and others with special circumstances. Individuals who are medically fragile may require electrically-powered medical support devices, such as oxygen respirators. Arrangements must be made in advance so that all are aware of the necessary steps toward safety in the event of disaster.

In State prisons or penitentiaries, the government has a duty to ensure that each inmate's health and safety is provided for, and standard emergency plans may require some accommodation. Inmates are considered a special needs population due to their inability to be released on their own recognizance. Some inmates may require physical restraints under armed guard; the U.S. Marshal Service might need to be included in specific planning. Shelters may need to allocate separate space for this population. Emergency management can be a valued partner in planning and securing additional resources. Many local emergency management offices keep lists of people who need extra assistance so that they can be located quickly in an emergency. People with disabilities or medical concerns should be encouraged to wear medical alert tags or bracelets to help others identify their special needs.

Educate these individuals about the location and availability of alternative facilities.

Many traditional emergency notification methods are not accessible to or usable by people with disabilities. People who are deaf or hard of hearing cannot hear radio, television, sirens, or other audible alerts. Those who are blind or have low vision may not be aware of visual cues, such as flashing lights. Combining visual and audible alerts will reach a greater audience than either method used alone. Warning methods should be developed to ensure that all citizens have the information necessary to make sensible decisions and take appropriate, responsible action. For all Americans, able-bodied and not, preparedness is essential. Local governments, agencies, and administrations must be educated about emergency preparedness and disaster response for all citizens, and be leaders in planning. For more information on people with disabilities, disability laws, reasonable accommodations, and related disaster information, go to the following Web sites:

http://add-em-conf.com/confdocs/special_people_special_care.pdf

<http://www.disabilitypreparedness.gov>

<http://www.dotcr.ost.dot.gov/asp/emergencyprep.asp>

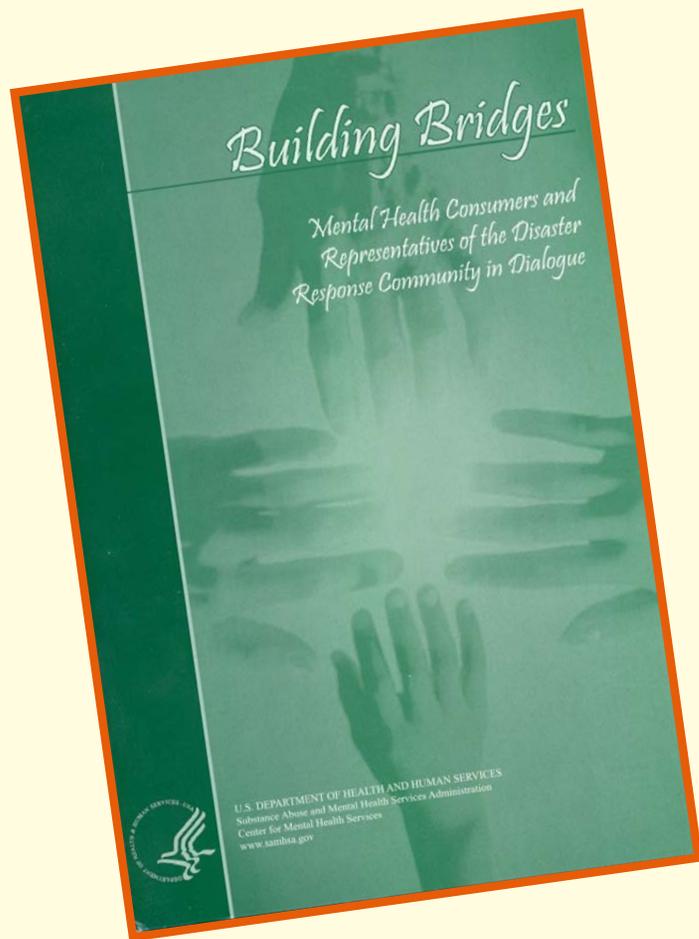
<http://projectaction.easterseals.com/site/DocServer?docID=7624>

<http://www.ready.gov/america/getakit/disabled.html>

<http://www.usdoj.gov/crt/ada/emergencyprep.htm>



Recommended Reading



BUILDING BRIDGES: MENTAL HEALTH CONSUMERS AND REPRESENTATIVES OF THE DISASTER RESPONSE COMMUNITY IN DIALOGUE

This new publication from the SAMHSA Center for Mental Health Services (CMHS) highlights the important relationship between mental health consumers and disaster responders. In the introduction to this pamphlet, the contributors explain that “In recent years, self-help and peer support, through Federal and State government funding, have become part of the array of services in response to disasters. Such services may include outreach, individual and family crisis counseling, group counseling, public education, community support groups, referral, home visits, transportation services, and warmlines. In concert with the growing self-help and mutual aid models nationally within the arena of mental health services, mental health consumers have initiated peer support services in response to the Northridge earthquake, the Oklahoma City bombing, the 9/11 tragedy, and recent hurricane disasters.”

In an effort to foster recovery by establishing productive communication and building effective relationships, CMHS hosted a facilitated roundtable meeting to bring together mental health consumers, policymakers, providers, and others involved in the disaster response community.

The meeting was held August 9–10, 2006, in Washington, DC. Twenty invited participants shared their experiences, perspectives, and insights with one another and with representatives of CMHS. On the basis of these discussions, participants developed recommendations and identified opportunities for improved disaster responses to people with mental illnesses. This publication reports on the results of this work.

The booklet is HHS Publication No. SMA 07-4250 and can be ordered from the SAMHSA National Mental Health Information Center at 800-789-2647. It can also be accessed electronically at:

<http://download.ncadi.samhsa.gov/ken/pdf/SMA07-4250/SMA07-4250.pdf>

Conference Highlights

ROCKY MOUNTAIN REGION DISASTER MENTAL HEALTH INSTITUTE

NOVEMBER 8–10, 2007, CHEYENNE, WY

The purpose of the Rocky Mountain Region Disaster Mental Health Institute was to provide a forum for the presentation, discussion, and sharing of ideas regarding research results, advances, education, training, and consultation in the disaster mental health field.

Institute presentation topics included how to develop a statewide disaster behavioral health response plan, reunion and reintegration for military personnel following deployments, ethics and disaster mental health, and how to optimize personal wellness when working in high-stress occupations. A number of tabletop discussions also were held on a variety of topics, including dealing with and planning for critical incidents in the workplace, cultural competence, school violence, children and traumatic events, suicide prevention, posttraumatic stress disorder, and rural disaster mental health.

Attendees hailed from a broad range of fields, including emergency medical services and trauma

units, crisis intervention, mental health, law enforcement, traumatic stress, emergency services, and disaster mental health. Firefighters, chaplains, military, National Guard and Reserve personnel, school staff, and other first responders were also present. For more information, go to <http://www.rmrinstitute.org/>.

NORTHEAST REGIONAL DISASTER BEHAVIORAL HEALTH PLANNING WORKSHOP

NEW YORK STATE OFFICES OF MENTAL
HEALTH, HEALTH, AND EMERGENCY
MANAGEMENT

NOVEMBER 13–14, 2007, ALBANY, NY

The New York State Offices of Mental Health, Health, and Emergency Management hosted the second in a series of regional disaster behavioral health planning workshops for northeastern States. Attendees included representatives from State mental health, substance abuse services, public health, and emergency management agencies as well as representatives from Federal agencies such as SAMHSA CMHS.

The first workshop in this series was hosted by Pennsylvania in April 2007 and focused on multi-State pandemic disaster planning. These successful gatherings are due to the commitment of the northeastern States to develop forums to continue to meet, collaborate, and plan. These workshops serve as followup to earlier regional and national meetings such as the SAMHSA-sponsored Delivering Behavioral Health Care in Emergencies regional meeting held in Boston, and the Spirit of Recovery Summit held in New Orleans, in May 2006.

The workshop consisted of breakout sessions to explore the horizontal and vertical relationships that exist in both planning and response for public health and human services in time of disaster. Sessions explored the established organizational relationships between Federal, State, and local government agencies (i.e., the vertical axis), as well as the relationships between the State and local health, mental health, and emergency management agencies (i.e., the horizontal axis). The sessions focused on identifying both challenges and practical solutions to effectively translate planning into execution and operations by these government partners. Issues such as barriers to collaboration and integration

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of response services with the FEMA Crisis Counseling Assistance and Training Program also were addressed.

The workshop was well attended, engendering a dynamic discussion of issues and promoting State-to-State collaboration and problem solving. The resulting deliverable from the workshop was a set of strategies and tasks to create a roadmap for States to successfully develop locally focused efforts that respond with maximum effectiveness.



THE 23RD ANNUAL MEETING OF THE INTERNATIONAL SOCIETY FOR TRAUMATIC STRESS STUDIES

NOVEMBER 15–17, 2007, BALTIMORE, MARYLAND

The theme of the 23rd annual meeting of the International Society for Traumatic Stress Studies (ISTSS) was Preventing Trauma and Its Effects: A Collaborative Agenda for Scientists, Practitioners, Advocates, and Policy Makers. The goal of the conference was to foster communication about three major topics: (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, posttraumatic stress disorder, and other trauma-related sequelae.

The conference provided multidisciplinary information on both research and clinically oriented topics. Tracks focused on subjects related to assessment, clinical practice, children and adolescents, community programs, culture, disaster, international issues, media and education, and prevention. The featured presentation for the disaster track was The Aftermath of Virginia Tech: School Violence, a Social and Public Health Concern. A panel of experts discussed the mental health response that took place at Virginia Tech after the shooting and how schools can respond effectively to similar

crisis situations. A review of the 1999 Columbine High School shooting was included in this presentation, as well as a discussion of identifying and treating potentially dangerous individuals. Other disaster-related presentations included: Narrating Collective Trauma: The Case of Hurricane Katrina, The Long-Term Psychological Effects of November 1999 Earthquakes in Turkey, Promoting Wellness and Resilience Among Firefighters and Other First Responders, Differences in PTSD Prevalence and Risk Factors among World Trade Center Disaster Rescue and Response Workers, and The Immediate Aftermath: Stress, Coping, and Distress in Hurricane Katrina's Evacuees.

Many National Child Traumatic Stress Initiative (NCTSI) grantees are leaders in the field of trauma, and many are very active in ISTSS. NCTSI grantees were presenters in more than 20 workshops at the 2007 ISTSS meeting. Workshops relevant to disaster mental health in which NCTSI grantees were involved, in addition to those listed above, included: Theoretical and Practical Issues in Early Intervention, Psychological First Aid and Skills for Psychological Recovery, Hurricane Katrina: Successes and Challenges in Child Treatment Studies, Secondary Prevention Following Trauma, and Washington Perspectives: Federal Initiatives for Trauma Prevention and Early Intervention.

Upcoming Meetings

CONTINENTAL DIVIDE DISASTER BEHAVIORAL HEALTH CONFERENCE

JULY 8–10, 2008
COLORADO SPRINGS, CO

This year's Continental Divide Disaster Behavioral Health Conference will focus on preparing for pandemic influenza. The conference is designed to promote partnerships and improve interventions following a disaster, terrorist event, or pandemic outbreak. Scientists and practitioners will come together to share their work, ideas, and best practices. For more information, go to <http://www.cddbhc.com/default.asp>.

116TH ANNUAL AMERICAN PSYCHOLOGICAL ASSOCIATION CONVENTION

AUGUST 14–17, 2008
BOSTON

The American Psychological Association (APA) will hold its 116th Annual Convention, August 14–17, 2008, in Boston. The Boston Convention & Exhibition Center will be the site of most of the divisional and APA convention activities. For more information, go to <http://www.apa.org/convention08/>.

THE U.S. DEPARTMENT OF JUSTICE OFFICE FOR VICTIMS OF CRIME TRAININGS

COMPASSION FATIGUE—AUGUST 19–20, 2008
SPOKANE, WA

This training will help participants recognize compassion fatigue and build resilience.

**PROVIDING CULTURALLY COMPETENT SERVICES
TO VICTIMS OF CRIME—SEPTEMBER 16–18, 2008**
LINCOLN, NE

This training will focus on what an agency needs to know to provide culturally appropriate services.

**SUPPORTING CHILDREN LIVING WITH GRIEF AND
TRAUMA: A MULTIDISCIPLINARY APPROACH—
OCTOBER 8–9, 2008**
RENO, NV

This training will assist victim service providers and others to best serve children suffering from grief.

For more information, go to <http://www.ojp.usdoj.gov/ovc/assist/welcome.html>.

INNOVATIONS IN DISASTER PSYCHOLOGY 2008

SEPTEMBER 4–6, 2008
VERMILLION, SD

This conference is intended for disaster mental health professionals, as well as health and mental health professionals nationally and internationally. The overall objective is for participants to learn more about how to apply the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings, not only internationally, but also within the United States. The conference will be held in the Allen H. Neuharth Media Center on the campus of the University of South Dakota in Vermillion, SD. For more information, go to <http://www.usd.edu/dmhi/conference.cfm>.

AMERICAN PUBLIC HEALTH ASSOCIATION 136TH ANNUAL MEETING AND EXPOSITION

OCTOBER 25–29, 2008
SAN DIEGO, CA

The theme of the American Public Health Association Annual Meeting and Exposition is Public Health without Borders. Participants will hear from experts in the field and learn about

the latest research and best practices. For more information, go to <http://www.apha.org/meetings/>.

INTERNATIONAL SOCIETY FOR TRAUMATIC STRESS STUDIES 24TH ANNUAL MEETING

NOVEMBER 13–15, 2008
CHICAGO, ILLINOIS

The theme of this meeting will be Terror and Its Aftermath. For details and registration 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.

Announcing SAMHSA's eNetwork

SAMHSA's eNetwork is a link to SAMHSA for the latest news about grants, publications, campaigns, programs, and statistics and data reports. The eNetwork is for anyone who wants to receive information about SAMHSA's work in the substance abuse and mental health fields.

Once you join the eNetwork and indicate your areas of interest, you will receive up-to-the-minute information that is important to you. You also can unsubscribe at any time to instantly stop receiving information from SAMHSA. What you receive depends on what information you want. For example, you can receive the following:

- > New grant announcements
- > New National Survey on Drug Use and Health data findings
- > SAMHSA news releases
- > Information about SAMHSA campaigns and initiatives, such as underage drinking prevention, suicide prevention, and recovery month
- > Newly published substance abuse treatment publications, such as *Treatment Improvement Protocols (TIPs)* or *Substance Abuse Treatment Advisories*

To join SAMHSA's eNetwork, register at <http://www.samhsa.gov/enetwork>.