



The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER BEHAVIORAL HEALTH

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ASK THE FIELD

The Dialogue: What additional strategies do crisis counselors need to address the unique issues surrounding care for the caregiver? The stresses involved in caring for others are challenging in the best of circumstances, so what effect does a disaster have on this special population and what can crisis counselors do to assist them?

Contributors are listed at the end of this article:

Millions of people in the United States provide unpaid care or assistance to family members, friends, or neighbors who are elderly, or those who have serious and long-term illnesses or disabilities, as well as to those who are recovering from an

injury, accident, or surgery. Although caring for a friend or loved one can be a very rewarding experience, it also presents many challenges and risks for the caregivers. Long hours of physical care, isolation, and emotionally wrenching decisions can take a personal toll on those providing care. Family or friend caregivers are at risk for a wide range of difficulties related to their physical and mental health and financial well-being.

When the trauma and devastation brought about by a disaster in their community is added to the caregiver's experience, the degree of risk may increase dramatically. The person receiving care is already in a vulnerable situation, suffering from an

illness or disabling condition. And some conditions, such as Alzheimer's disease, make communication during and after a disaster very difficult.

From a long-term perspective, people needing care are more frequent consumers of health care and social services in the community. When a disaster strikes, some of these facilities may be damaged, destroyed, or relocated. Even if they are not damaged, these organizations are likely to be overwhelmed with providing care to people with injuries or property loss so that the usual availability to caregivers and care receivers can be delayed or hampered.

When attempting to cope with a disaster, one must also consider the notion that many long-term caregivers have developed a rather sophisticated set of coping and problem-solving skills during the course of their caregiving careers. For some caregivers, these skills may better equip them to cope with trauma brought about by a disaster than their non-caregiving peers. Crisis counselors offering assistance to unpaid caregivers should keep this factor in mind so that they may focus on potential strengths of the caregivers as well as their needs.

The first task of crisis counselors in assisting unpaid caregivers is to locate and identify them through proactive and aggressive outreach. This outreach is often complicated by the fact that many unpaid caregivers are reluctant to identify themselves as caregivers, and they may be reluctant to seek or accept assistance, even in the wake of extremely difficult circumstances. When providing crisis



counseling and outreach services, crisis counselors should not just rely on use of the term “caregiver,” but they should define what they mean by giving examples of the types of activities a family member may be performing to assist a loved one or friend (household chores, transportation, shopping, running errands, giving medication, bathing, dressing, feeding, financial management, and offering emotional support).

When engaging in outreach, crisis counselors should think about places that family caregivers may frequent including waiting rooms of doctors’ offices, hospitals, and nursing homes; grocery stores and pharmacies; and congregations and other faith-based organizations. Many caregivers tend to feel confined to their homes, so making information available by telephone or through Web sites, as well as printed material that can be read at home, is a useful strategy.

The second task of crisis counselors in assisting unpaid caregivers is listening to the caregiver’s concerns and views. Most caregivers are focused on providing the best possible care for their loved ones, often to the point of neglecting their own care. Offering tangible methods of assisting the person they are caring for may facilitate a caregiver’s acceptance of help in tending to their own care.

Unfortunately, unpaid or family caregivers are often invisible to others in the community and their value is not always recognized by professional healthcare providers. Family caregivers bring a

wealth of experience and indepth knowledge about the specific person for whom they are providing care. Many have also become very knowledgeable about community resources and policies affecting care. Counselors should consider unpaid caregivers to be equal partners in providing care and assistance to people with illnesses or disabilities. And, they should show them respect for their knowledge and work with them in a way that encourages cooperation and mutual support.

The next step is to encourage family caregivers to take the following actions in recovering from a disaster in their community:

- > Plan to take some extra time with the person for whom they are caring, attending to any additional concerns or needs they have because of the disaster
- > Return to daily caregiving routines as soon as possible
- > Reconnect with the healthcare and social services system, noting any changes that occurred as a result of the disaster
- > Find someone with whom they can talk comfortably, and who will listen
- > Allow themselves to be nurtured by family members, friends, and other important people in their lives

- > Lower expectations of themselves as compared with their usual caregiving accomplishments and realize the limitations brought about by the disaster
- > Increase the time they spend in stress reduction activities, such as exercise, relaxation breathing, and resting
- > Nurture and express faith and spirituality—their own and that of the person for whom they are caring
- > Be alert for signs of more serious emotional difficulties, such as burnout or depression, in both the person they are caring for and for himself or herself
- > Return to relationships and activities outside their caregiving roles (e.g., hobbies, membership in organizations, and recreation) as soon as possible after disruptive circumstances brought about by the disaster have stabilized
- > If the situation allows it, take time to help and support other caregivers in the community

The last step in providing crisis counseling to unpaid or family caregivers is referrals. While some caregivers may have become very knowledgeable about resources available to them in the community, many others will need assistance in locating resources to assist them and the person for whom they are providing care. Make sure to keep the needs of both the care receiver and caregiver in mind as you explore community resources. Encourage them to take advantage of the disaster behavioral health and stress management resources available through the Crisis Counseling Assistance and Training Program (CCP). Following are a few of the national organizations that provide support and assistance to family caregivers:

- > Family Caregiver Alliance (<http://www.caregiver.org>)
- > National Alliance for Caregiving (<http://www.caregiving.org>)
- > National Family Caregiver Association (<http://www.nfcacares.org>)

- > Rosalynn Carter Institute for Caregiving (<http://www.RosalynnCarter.org>)

Finally, the crisis counselor must remain diligent in reaching out to all caregivers. The needs of this special population are great, yet they are usually the last to accept help. It will take a great deal of creativity and determination to engage caregivers, but the payoff is a strengthened infrastructure of care throughout the community.

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Managing Communications and Media Relations During a Disaster



Photo courtesy of FEMA Photo Library

Would you know how to handle communications and engage the media during a disaster in which scores of individuals, including children and families, are affected? There are many tactics that organizations can implement to best engage the media, and through them, the public at large.

Disasters typically strike unannounced, catching most people off guard. Even for occurrences that can be forecasted, the severity of such incidents can never be predicted with total accuracy. Natural disasters are naturally occurring events that can directly or indirectly cause severe threats to public health and well-being, while human-caused disasters are either intentional or accidental incidents that also pose serious risks to public health. Both natural and human-caused disasters can be effectively dealt with through proper planning, preparedness, and effective response.

The most effective way for organizations to deal with disasters is to have a disaster plan in place ahead of time—one that includes a crisis and disaster communications component. In the event of a disaster, effective communication and public education are key, as misinformation, fear, and ignorance can fuel public panic. So, it is essential that accurate information be released promptly

to the public in the immediate crisis area and surrounding areas through established traditional media including radio, television, and newspapers, and also through newer forms of media, including the Internet and text messaging.

Some steps that organizations can take to manage pre- and post-disaster communications and media engagement cover acute or immediate response, as well as long-term tactics. Some examples include the following.

Pre-Disaster Communications Planning:

- > Identify and Prepare Staff Spokespeople:
 - » Identify individuals in the organization who can serve as spokespeople. These individuals may be experts across a variety of disciplines
 - » Provide organization spokespeople with professional media training
 - » Prepare spokespeople with key messages, facts, answers to relevant questions, and the mission of the organization* (See sample messaging below)
 - » Ensure that spokespeople represent the organization professionally, including proper grooming and attire

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- > Identify Target Media Outlets and Specific Journalists:
 - » Mainstream, traditional media, such as television, radio, and local newspapers, are the most efficient means of communicating with large, general populations
 - » Get to know the media outlets in the organization's locale by reading, viewing, and listening to various media outlets on a regular basis
 - » Develop a specific list of local journalists to contact in the event of a disaster to share with them information that would be of importance and value to the public. Targeted journalists include those who cover disasters, emergencies, schools, health, and government
 - » Send the targeted media list background information on your organization, so that these journalists can become familiar with your organization and will recognize it more readily when disaster strikes

Immediate Response in the Aftermath of a Disaster:

- > Identify Tools for Proactive Outreach to the Media:
 - » Expert advisories—This specific resource provides the media with briefs on

spokespeople in the organization, sharing their specific expertise and contact information, including mobile phone numbers. Advisories can be distributed by e-mail or by newswire services

- » E-mail—A short e-mail offering your organization and its experts as credible sources of information for a particular disaster are a welcome communiqué for journalists, who are typically on deadline when writing about a disaster
- » Phone call—A brief phone call (and brief message if the journalist is not available) is also a welcome communication strategy
- » Special feature box on homepage of organization Web site—This resource can identify the expertise the organization has to share regarding a particular disaster

> Respond to Inquiries from the Media:

- » If your organization is successful in proactively connecting with a journalist or if a journalist contacts your organization for an interview regarding a disaster, be prepared to respond quickly. As reporters have hard deadlines, they typically need quick responses to requests for interviews
- » If you are not prepared to participate in the interview due to a lack of time or other work commitments, let the journalist

know immediately, but try to offer another spokesperson within the organization as a contact

- » If you agree to do an interview, make sure you are prepared. Never “wing it.” You should always view an interview as an opportunity to communicate what you want to say. Before you begin, decide what two or three key points you want to get across and have both data and human examples ready to highlight each one. Be sure to make these points during the interview, even if the journalist does not ask about them
- » Anticipate difficult questions and prepare responses to them. Never say, “No comment.” Instead, explain why you can not or will not answer the question. If you do not know the answer to a question, simply say, “I don’t know, but I’ll try to find out for you.” Then follow up
- » Give simple, direct answers and be brief. Journalists will likely use short quotes, clips, or sound bites. Avoid jargon and explain the topic as simply as possible. It is best to avoid flippant or joking comments that sound acceptable in conversation but might be taken out of context
- » Use anecdotes. Nothing reinforces credibility and believability as much as stories about real people

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- » Always remember that nothing is “off the record.” Do not say anything you do not want to read in the newspaper or see on the evening news. Be especially mindful of conversations during introductions—before the formal interview begins—and small talk once the interview concludes

Long-Term Communications Strategy:

> Maintain Ongoing Dialogue and Good Relations with the Media:

- » Once the immediate aftermath of disaster passes, an organization will still want to maintain solid relations with the media to continue to build awareness of the

organization and position it as a valuable resource to the community

- » After having established itself as an expert during a disaster, an organization will want to continue to educate the public about issues or causes the organization supports or advocates
- » Organizations may wish to continue to share with journalists any followup stories that may be related to the recent disaster. Perhaps the organization has developed some new resources or processes as a result of the disaster
- » Differentiate your organization from others who do similar work and stress your organization’s strengths to the media
- » Offer expertise to the media by responding to a news story that relates to your organization’s mission or cause. Send an e-mail or letter to the editor responding to the issue or story and cite your organization’s relevance to it
- » Make use of editorial boards, in which you craft organizational messages and make appointments to share them before editors at newspapers, news directors, community relations directors, and general managers at television and radio stations. Conduct this activity at least every other year

> Develop an Op-Ed Program:

- » One of the best ways to gain credible visibility for your organization is to have key experts submit an opinion piece to the local newspaper. The process, while not necessarily difficult, does require an investment of time to understand the type of “hot button” issues the paper typically covers and to craft an effective and persuasive article
- » An op-ed is an opinion piece on a given topic of importance to constituents in your community. An op-ed, which ranges in length from 500 to 750 words, is not an essay, which starts with a thought that builds to a conclusion. It is just the opposite. In an op-ed, it starts with the strongest point—essentially the conclusion—then the rest of the article makes the case by providing key facts, anecdotes (as appropriate) and statistics, if any
- » In writing the op-ed, following are some key points to remember:
 - Focus on one issue or idea. Be brief
 - Have a clear editorial viewpoint—come down on one side of the issue. Do not equivocate
 - Be timely and controversial, but not outrageous. Be the voice of reason

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- Provide insight and understanding. Educate the reader without being preachy
 - Use clear, powerful, and direct language
 - Appeal to the average reader. Clarity is paramount
 - Be personal and conversational
- > First Anniversary of the Disaster:
- » In the weeks before the first anniversary of the disaster, develop a small media plan to contact target journalists and share your organization's thoughts regarding the first anniversary of the disaster
 - » Offer your organization's experts as spokespeople to comment on the outcomes of the disaster including progress, successes, challenges, and failures
 - » Share your organization's expertise about how recovery efforts have taken shape during the last year and how the organization may have contributed to these efforts
 - » Remind journalists that whenever individuals experience a disaster, the anniversary of the occurrence typically serves as a strong reminder and often triggers earlier reactions and feelings about the event

- » An op-ed discussing some critical point or concern related to the disaster could be a good way to engage a local newspaper
- » Depending on the magnitude of the disaster, it may make sense to revisit issues year after year

***SAMPLE MESSAGING ON NATURAL AND HUMAN-CAUSED DISASTERS**

The following core messages were developed by the Terrorism and Disaster Program at the National Center for Child Traumatic Stress (NCCTS) for use by its staff and by members of the National Child Traumatic Stress Network (NCTSN). These messages are meant to support and guide NCCTS and NCTSN expert response to the media.

Natural and Human-Caused Disasters:

- > Terrorism and disasters can lead to personal injury, loss of loved ones, destruction of homes, schools, workplaces, and other trauma
- > Terrorism and disasters are traumatic events
- > Traumatic events are difficult for adults, and can be more difficult for children. A child exposed to a traumatic event is at risk of developing traumatic stress

- > Children are more vulnerable to trauma because of their size, age, and dependence. Prior trauma, past mental health problems, or a familial history of such problems may increase a child's risk
- > Even children without direct exposure to a traumatic event or loss can experience fears and uncertainty about risks and dangers
- > Different types of terrorism and disasters may present their own psychological issues and concerns
- > Human-caused disasters can be more stressful than natural disasters

This article was contributed by the NCCTS, which is the coordinating center of the NCTSN. The NCTSN is a unique Congressional initiative that seeks to improve the quality, effectiveness, and availability of care and services for children and families who are exposed to a wide range of traumatic experiences including physical and sexual abuse; domestic, school, and community violence; natural disasters and terrorism; and life-threatening injury and illness. The NCCTS and NCTSN are funded through SAMHSA CMHS.

TOPOFF 4 Exercise: The Oregon Venue



The importance of behavioral health and the needs of vulnerable populations are finding their way to the forefront of national disaster preparedness concerns. The U.S. Department of Homeland Security (DHS) identified behavioral health response and meeting the needs of vulnerable populations as two of the primary goals for TOPOFF 4 (T4), the fourth installment of the congressionally mandated top officials' mass casualty disaster exercises. The behavioral health planners of the Portland, OR, venue of T4, elected to engage in a full-scale emergency response exercise.

THE SCENARIO

The scenario planned for the Oregon venue featured a radiological dispersal device (RDD) or

“dirty bomb” exploding at the east end of a bridge in downtown Portland. Such an occurrence would result in substantial damage, and hundreds of citizens would be expected to be injured and/or deceased. A cloud of radioactive dust could be expected to settle over hundreds of miles to the east of the explosion. The impact would likely result in numerous deaths and injuries; large-scale evacuations, contamination, and health screenings and decontamination procedures; large numbers of concerned citizens who would be seeking missing loved ones; and other expected behavioral health fallout relating to terrorist and radiological incidents.

THE CHALLENGES

The Oregon behavioral health planning team faced numerous challenges including the following:

- > The Addictions and Mental Health (AMH) division of Oregon's Department of Human Services (HHS) had only recently established a State plan and guidance materials for behavioral health emergency response, and local implementation was still uneven.

- > Oregon has experienced very few disasters, thus many relevant local stakeholders were inexperienced with disaster response and unfamiliar with the role played by behavioral health emergency response.
- > There was a limited number of HHS behavioral health staff who could be released from their duties and attend.

THE T4 BEHAVIORAL HEALTH PLANNING STRATEGY

During the previous year, four relevant area programs had engaged behavioral health planners: AMH, Health Resource Service Area (HRSA) Region 1, Multnomah County HHS, and the Portland-area Cities Readiness Initiative (CRI). The consensus of this team of planners was that an exercise design reflecting their true state of preparedness and ability to respond would be more useful to Oregon than attempting to mimic implementation of a statewide volunteer registry.

Behavioral health planners and other stakeholders had been meeting for several years as the AMH All-Hazards Workgroup, exploring best practices and providing direction for developing Oregon's

behavioral health emergency response plan. They were therefore already familiar with a number of agencies and organizations that maintained or had access to crisis response human resources that might be applied during a disaster. The planning strategy they selected was to identify the sites to be included in the overall exercise that appeared appropriate for behavioral health staff and identify human resources available to apply.

AGENCY ORGANIZATION AND PARTICIPATION

More than 5,000 individuals participated in the October 15–19 Oregon venue T4 exercise. Specifically within *Emergency Support Function 8—Health and Medical* response, more than 30 government agencies, individual HHS programs, and private organizations became involved.

Settings identified for T4 behavioral health participation included operations at the site of the explosion, evacuation shelters, medical care point, rapid screening center, participating hospitals, and the administrative headquarters/emergency operation centers. Depth of participation by local agencies and organizations in providing behavioral health services varied from notional to administrative to full-scale deployment and response.

Oregon Addictions and Mental Health. AMH provided trainings for both county and State

leadership of behavioral health response that was consistent with the new State plan. During the exercise, AMH positioned a behavioral health representative at the State HHS operations center in the form of a behavioral health branch director. Technical guidance and support was provided to counties and communications took place with other State-level behavioral health agencies and organization leadership, as well as interviews with the media regarding behavioral health topics. In addition, both virtual and real-world, stress-related services were provided for operations center staff.

Multnomah County. Multnomah County set up its response format as multidisciplinary HHS teams staffed with a lead, behavioral health services, services to seniors, services for those with developmental disabilities, security, and staff support services. For the purpose of the exercise, Multnomah County was able to release two such teams for play during the exercise, with the exception of security positions played notionally.

The rapid triage center was implemented by means of the point of dispensing (POD) plan developed by the CRI, which included a just-in-time training for behavioral health response. Planners arranged to recruit behavioral health students from the schools of professional psychology at Pacific University and George Fox University to play the role of the “spontaneous” professional volunteers, who in fact would be

appropriate for psychological first aid training and deployment during an actual disaster. They received the POD training and were assigned to service delivery sites, supervised by the Multnomah County staff. Support by the Oregon Disaster Medical Assistance Teams (ODMAT) was also successfully requested, and recruited and deployed by Multnomah County operations.

American Red Cross. The Oregon Trail and Southwest Washington Chapters of the American Red Cross were responsible for shelter operations, which included involvement of Red Cross Disaster Mental Health (DMH) staff. There were 34 DMH staff from these chapters and a few others in Oregon participated in the exercise. In addition to the shelter operation, sites receiving DMH services included the medical care point, the incident site respite/feeding/medical centers for responders, and the Red Cross headquarters. DMH interventions were provided both as an exercise with “clients” and for real-world circumstances impacting those who participated as responders.

Trauma Intervention Program. The local Trauma Intervention Program (TIP) trains volunteers to provide emotional first aid services at the request of incident first responders. Given their well-established relationship with the local fire departments, TIP was an ideal candidate for providing services at the site of the incident.

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Victims' Assistance Agencies. Representatives of the Victim Assistance Program (VAP) of the Federal Bureau of Investigation (FBI) worked out of the Joint Operation Center, receiving guidance from the Terrorism Victim Assistance Coordinator. Activities focused on preparing to identify victims, providing immediate services, and meeting short- and long-term needs of those impacted. The VAP secured a staging area for victim assistance providers, established a victim tracking system, notionally established a toll-free phone number, established an agreement with the Red Cross to share victim information, developed a press release for the U.S. Attorney's Office describing services available, and began developing a plan for notification. Setting up a Family Assistance Center for facilitating service delivery and deployment of the Victim Assistance Rapid Deployment Team were practiced notionally. The VAP coordinated with the Oregon Department of Justice Crime Victims' Assistance Section, establishing strike teams that would be able to assist law enforcement with crisis intervention and death notifications for victims. At the Joint Field Office the VAP worked with the Federal Emergency Management Agency (FEMA), American Red Cross, behavioral health operations, and others to plan for long-term support for victims.

EXERCISE OUTCOME

The Oregon venue of T4 successfully activated, deployed, and provided behavioral health response for multiple sites by means of coordination and collaboration among numerous agencies and organizations capable of providing immediate behavioral health emergency care. While this outcome demonstrated successful ability to respond using a team approach rather than relying upon a State volunteer registry, progression beyond initial deployment of responders would not have been as likely to be successful.

Difficulties encountered surrounded the HHS operations centers and some absence of Incident Command understanding regarding the role of behavioral health response, its proactive nature, and its need to be fully integrated into the incident command information loop to be able to predict need and respond effectively. Those representing behavioral health were typically not approached for consultation.

CONCLUSION

Oregon continues to move forward in its behavioral health preparedness efforts. Collaboration during the exercise strengthened relations among the multiple local behavioral health response agencies and organizations, who now meet regularly as a Mass Casualty Victims

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of Crime workgroup hosted by the victims' assistance agencies. The AMH All-Hazards Workgroup, to be facilitated by a new permanent behavioral health coordinator position, also continues to meet and collaborate. Regional planners continue to support local preparedness efforts in whatever manner funds allow.

However, Oregon and other States experiencing infrequent disasters would benefit from stronger support both for exercise and preparedness purposes. National-level collaboration among relevant behavioral health entities could result in more successful support and funding for local behavioral health emergency response training, participation in drills and exercises, and general preparedness. This is critical for preparedness in States that do not commonly apply for funds through the CCP. As has been so frequently demonstrated in recent years, disasters can happen virtually anywhere and everyone needs to be prepared.

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Building Resilience Among First Responders in Child Protective Services

As outlined by the Homeland Security Presidential Directive, first responders are “those persons who, in the early stages of an incident, are responsible for the protection and preservation of life, property, evidence, and the environment.” In its most conservative interpretation, first responders are the first trained individuals to arrive at the site of an emergency, accident, natural disaster, or terrorist attack. First responders include members of emergency communications centers (ECCs); emergency medical services (EMS), fire, and rescue services; hazardous material (HAZMAT) teams; law enforcement agencies; bomb squads; SWAT; security; emergency and disaster management; transportation and public works; gas, water, and electric companies; and the American Red Cross.

First responders are widely recognized as having extremely dangerous and stressful occupations. They often encounter direct danger in situations that are unsafe, violent, and tragic. Many times, they are expected to manage the injuries of others while under the threat of injury themselves. First responders endure high exposure to traumatic events, stressful work demands, and sometimes extended separation from home and loved ones. As a result of exposure to stressful

situations, many first responders develop a host of physical health problems such as heart disease, hypertension, back and knee injuries, hearing loss, and other impairments resulting in total or partial disability. Because of their exposure to catastrophic events, first responders are also at risk for developing secondary traumatic stress (STS). STS results from protecting and caring for those who have been exposed to a traumatic event. STS is an occupational risk that has been well documented in various groups of first responders including firefighters, police, medical personnel, and body handlers. The long-term repercussions of secondary traumatic stress include anger, sleeplessness, hyper-arousal, poor concentration, depression, abuse of drugs or alcohol, and a loss of interest in relationships with family and friends.

By the very nature of their work, child protective service (CPS) workers are de-facto first responders. CPS workers are the front-line professionals charged with protecting the health and well-being of children. They assume responsibility for the protection and preservation of a child’s life in the face of abuse or neglect. Like first responders, CPS workers are prepared for emergencies, and are able to synthesize information and organize resources quickly and

effectively. They are required to make sensitive decisions and solve a variety of interpersonal problems to protect the welfare and security of a child.

Child welfare work can be extremely dangerous and stressful. CPS employees often work in very poor and unsafe communities that are plagued by drug use and violence. The management teams under which they work can be hierarchical, and therefore can come across as rigid and unsupportive. CPS workers are expected to carry heavy case loads and complete significant paperwork demands often on very short deadlines. They are required to keep up to date on policies and regulations that can change frequently and without much notice. Additionally, they are expected to find safety and protection for children in a system that often does not have enough resources or foster homes.

Studies concerning secondary exposure to traumatic material have focused primarily on the traumatization of crisis workers (e.g., paramedics, firefighters, emergency medical technicians, police officers). However, CPS workers are just as likely as crisis workers to be directly exposed to a number of traumas throughout their careers.

While interviewing child abuse victims or reading case files, CPS workers learn graphic details of violent crimes and are put into positions where they must acknowledge the presence of cruelty to children in society. CPS workers, like traditional first responders, are therefore vulnerable to the effects of STS.

CPS work is associated with various health and job-related consequences including psychological distress, job dissatisfaction, and increased job turnover. On the individual level, CPS work results in high levels of psychological distress in general and traumatic stress in particular. CPS work-related stress not only affects the individual, but also has a direct impact on the agency for which the individual works. On an agency level, work-related stress often results in problems with staff satisfaction and retention. Low rates of staff retention affect child welfare agencies across the Nation. Not only does turnover decrease agency efficiency and morale, it also negatively affects the continuity of relationships between clients and the agency. Miscommunication and mistakes can occur when a child's case is transferred to a new caseworker. Also, when caseworkers resign from their positions, the caseloads and stress levels increase for those workers who stay behind. Many child welfare professionals believe that these turnover-related effects delay permanence for children, and lower the quality of services children receive while they are in foster care. On top of

these negative consequences, turnover is also an expensive economic loss to the agency, given the costs associated with training.

Given the deleterious consequences of secondary traumatic stress on CPS workers, the Mount Sinai School of Medicine (MSSM) has formed a partnership with New York City's Administration for Children's Services (ACS) in designing a trauma-informed intervention intended to promote work-related resilience among ACS caseworkers. The conceptual framework for the resilience intervention joins the principles of positive psychology and trauma prevention. Borrowing from positive psychology, the intervention is structured around cultivating well-being and building on people's pre-existing strengths. Drawing on the principles of trauma prevention, the intervention is focused on providing psycho-education around normal responses to trauma and helping people to regulate their emotions and not engage in avoidance behaviors in response to traumatic stressors.

The intervention incorporates two major components: cognitive restructuring and skills training. Together, these components are designed to promote mastery, optimism, and collaboration. The cognitive restructuring component teaches a variety of techniques to counter pessimism and promote more accurate and optimistic thinking styles. CPS workers are taught how to view work-related problems as temporary setbacks and to

recognize the skills they possess for managing these challenges. Cognitive-behavioral techniques are used to help workers manage work-related stress. Psycho-education is used to illustrate that isolating behaviors are a consequence of excessive work-related stress. Workers are then taught the importance of staying connected with each other and their management teams.

The 6-month resilience intervention was composed of weekly sessions for the first 3 months and then biweekly sessions for the next 3 months. Biweekly supervisor and manager sessions were conducted in tandem to develop a supervisory culture supportive of staff resilience. The intervention was structured around the three prisms of Mastery, Optimism, and Collaboration. Below is a description of each of these prisms.

MASTERY

Promotion of mastery increases people's beliefs about their capabilities to manage work-related stress, principally through self-regulation of thought, emotions, and behavior. In an effort to increase mastery, the resilience intervention reminds individuals of their efficacy and value to the mission of child welfare, encourages adaptive coping around how to manage conflict and stress, enhances sense of control over work-related stressors, and regulates professional expectations and goals. Throughout the intervention,

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individuals are taught to problem solve and set achievable goals to buffer themselves from feeling overwhelmed and burned out. Participants are encouraged to focus on their experiences of work-related success, which in turn help to establish a sense of environmental mastery and control.

OPTIMISM

The resilience intervention's promotion of optimism is based on research indicating that individuals who retain hopefulness for the future and positive expectancy are likely to have more favorable outcomes after exposure to traumatic



stressors. The resilience intervention includes cognitive behavioral approaches that help workers identify and amplify already exhibited strengths, reframe situations to appraise them more positively, normalize responses, manage avoidance behavior, control self-defeating self statements, and encourage adaptive coping behaviors.

COLLABORATION

The resilience intervention's promotion of collaboration is based on research indicating that social support is related to better emotional well-being and recovery following exposure to a traumatic event. Collaboration with coworkers and supervisors not only increases opportunities for knowledge about how to respond to work-related stress, but also provides opportunities for a wide range of social support activities, including practical problem solving, emotional understanding and acceptance, sharing of traumatic experiences, normalization of reactions and experiences, and mutual instruction about coping. The resilience intervention is designed to keep individuals connected, train workers how to access support, and provide training units with formalized support. The intervention is specifically designed to bridge the gap between workers and management, and to establish a workplace atmosphere of positivity and support.

EVALUATION OF THE RESILIENCE INTERVENTION

To evaluate the effectiveness of the resilience intervention, ACS workers who participated in the intervention were compared to a control group who received a 2-hour secondary trauma training workshop. Assessments were completed at pre-treatment, after the initial 3-months (3-month), at the completion of the intervention (post-treatment), and 3 months later (followup). At each assessment point, job satisfaction, burnout, optimism, resilience, reactivity to stressful work events, staff-to-staff support, and supervisor-to-staff support were measured.

At the final followup, the intervention group reported statistically significant increases in job satisfaction, optimism, and resilience compared to the control group. They also had significantly lower reactivity to stressful events, lower levels of job burnout, and fewer total case assignments. There were no changes in staff-to-staff support or supervisor-to-staff support.

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Special Feature

Responding to School Violence



U.S. DEPARTMENT OF JUSTICE OFFICE FOR VICTIMS OF CRIME OCTOBER 23–24, 2007, RALEIGH, NC

After numerous violent school-related events in recent years, such as the shootings at Virginia Tech and Northern Illinois University, school districts and universities across the Nation are now responsible for developing comprehensive crisis response plans. The U.S. Department of Justice Office for Victims of Crime (OVC) hosted this conference in Raleigh, NC, October 23–24, 2007, to help schools in their planning and

preparedness efforts. Some mitigation measures discussed at the conference are described below.

CREATING A CULTURE OF NONVIOLENCE

The task of creating a nonviolent culture in schools falls on school districts, administrators, teachers, and all responsible adults. Respect must exist between students, as well as between students and staff. If respect is ingrained, connections are more likely to exist between students and at least one adult in school. Problem-solving and conflict-resolution skills must be taught and reinforced early on, so that students learn alternatives to violence when they feel angry or frustrated. Faculty should teach social skills and demonstrate appropriate ways to interact through modeling. If children and teens are expected to socialize with respect and understanding toward one another, adults must be conscious of their own responsibilities in this regard.

USING A THREAT ASSESSMENT MODEL

A threat assessment model can be used to collect information that may indicate a student's risk for violent behavior. It can identify students

who might be on the path toward violence, how soon this violence might occur, and strategies for preventing it. Following are the six principles of a threat assessment model:

- > A violent attack is most often the end result of thinking, planning, and behaving
- > A violent attack results from interaction among person, situation, setting, and target. School officials should do the following:
 - » Focus on gathering information on students who have shown signs of hopelessness and desperation, or who have expressed violent thoughts
 - » Look for situational stress, such as bullying, loss of significant relationships, or perceived failures
 - » Note whether the setting is one that is intolerant of violence as a solution, or one in which violence can easily occur
 - » Consider whether the student has a specific target, such as another student or teacher, or a more general target, such as “jocks” or “the football team”
- > Common sense is critical to successful threat assessment. School officials should be

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thoughtful, verify facts, and pay attention to behaviors

- > Effective threat assessment is based on facts. School officials should avoid blanket generalizations or profiles when assessing for potential threats
- > Threat assessment should be guided by a systematic approach. School officials should consider whether separate “small indicators” add up to a potential threat and establish agency relationships with law enforcement, social services, and mental health services
- > A threat assessment should be based on whether a student poses a threat. Less than 20 percent of attackers make a threat. School officials should notice both behavior and communication. There is a difference between making a threat and posing a threat. Every threat should receive immediate attention

IDENTIFYING STUDENTS AT RISK: EARLY WARNING SIGNS

The following early warning signs might assist in identifying students in need of intervention. The more indicators that are noted, the more potential for acting-out behavior. Early warning signs include the following:

- > Expressions of feelings of hopelessness, depression, or withdrawal
- > Expressions of self-destructive behavior, or having a history of such behavior
- > Changes in mood or low tolerance of frustration
- > Bullying behavior, or target of bullies; victim of teasing, fighting
- > Sleeping and eating disturbances
- > Prior traumatic experiences and/or abuse
- > Gang involvement
- > Poor academic performance, truancy
- > Substance abuse
- > Preoccupation with television, movies, or games, often with violent themes
- > Blaming others for one’s own difficulties
- > Preoccupation with, or access to, guns or other weapons
- > Harming small animals
- > Engaging in fire setting

For more information about conferences provided by the OVC, as well as related resources, go to <http://www.ojp.usdoj.gov/ovc>.

As a further resource, the U.S. Department of Education has developed a useful resource titled *Early Warning, Timely Response: A Guide to Safe Schools*, which offers research-based practices designed to assist school communities identify these warning signs early and develop prevention, intervention, and crisis response plans. The guide includes sections on the following:

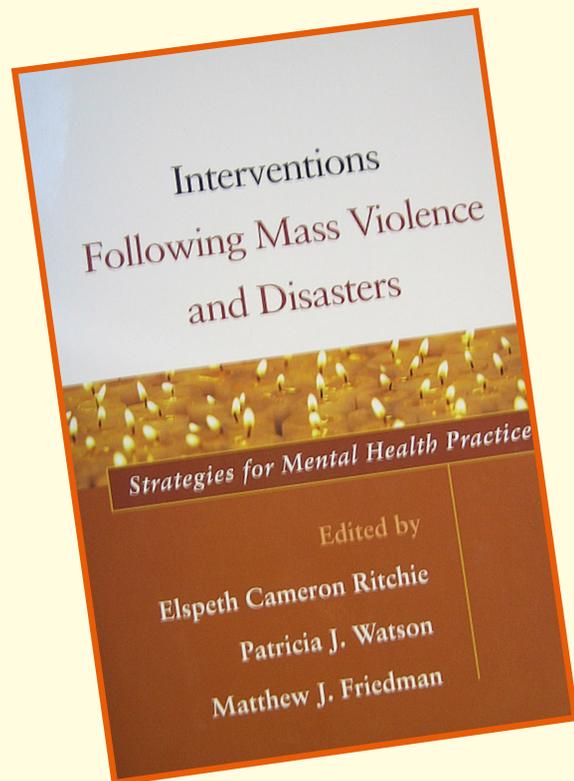
- > Characteristics of a School that is Safe and Responsive to All Children
- > Early Warning Signs
- > Getting Help for Troubled Children
- > Developing a Prevention and Response Plan
- > Responding to Crisis

To access this guide, go to <http://www.ed.gov/about/offices/list/osep/osep/gtss.html>.

Another valuable resource is the National Threat Assessment Center and the article, *Evaluating Risk for Targeted Violence in Schools: Comparing Risk Assessment, Threat Assessment, and Other Approaches*. To access this article go to http://www.treasury.gov/usss/ntac/ntac_threat_postpress.pdf.

For more information on the National Threat Assessment Center go to <http://www.ustreas.gov/usss/ntac.shtml>.

Recommended Reading



INTERVENTIONS FOLLOWING MASS VIOLENCE AND DISASTERS

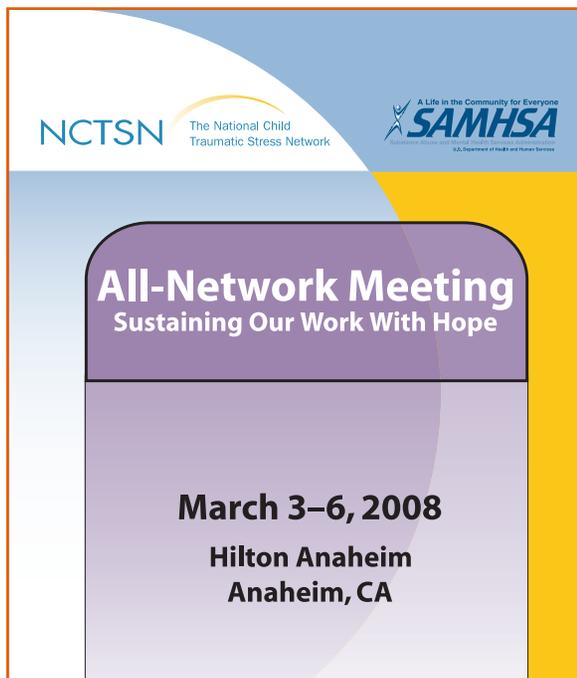
An excellent resource for practicing psychotherapists, psychologists, psychiatrists, counselors, nurses, and first responders, *Interventions Following Mass Violence and Disasters*, brings together more than 40 leading experts in disaster mental health. The focus is on what first responders, clinicians, and

policymakers need to know about effective intervention in the immediate, intermediate, and long-term aftermath of large-scale traumatic events. Lessons learned from a variety of mass traumas and natural disasters are incorporated into the book's review of strategies for helping specific victim and survivor populations. The authors clearly summarize each intervention and provide other guidance based on experience and consensus recommendations.

The following key components of early intervention are recommended to promote individual and community-wide recovery following a disaster or episode of mass violence:

- > **Provision for Basic Needs**—Intervention and counseling can only take place once the survivor's basic needs are met. Basic needs include safety; security; food and shelter; and communication with family, friends, and community
- > **Psychological First Aid**—Basic strategies to reduce psychological distress
- > **Needs Assessment**—A systematic assessment of the current status of individuals, groups, and the overall affected community is important
- > **Technical Assistance, Consultation, and Training**—Assistance available to counselors, organizations, and caregivers to improve their outreach efforts within the community affected by the disaster or violent episode, as well as services provided in the many environments where survivors can be found
- > **Fostering Resilience/Recovery**—Resources provided to improve social interactions, coping skills, risk assessment and self-assessment, and referral
- > **Treatment**—Methods to help survivors recover their emotional stability and well-being

Conference Highlights



NATIONAL CHILD TRAUMATIC STRESS NETWORK ALL-NETWORK MEETING

MARCH 3-6, 2008, ANAHEIM, CA

This year's National Child Traumatic Stress Network (NCTSN) All-Network Meeting was titled *Sustaining Our Work With Hope*. The meeting provided participants an opportunity to network, collaborate, learn, and share knowledge about issues relating to children and families exposed to traumatic events. More than 250 participants were in attendance and had access to a wide variety of plenary sessions, interactive workshops, training opportunities, mini sessions, and collaborative group meetings. A highlight of the meeting was the networking fair, during which NCTSN sites from across the country exhibited their resources, products, and research findings. Each site brought a treat or giveaway item representative of their organization or home State. This gave the event a relaxed feel and participants had fun going from table to table speaking with representatives about their center and its activities. Below are brief descriptions of some sessions that have applications in disaster behavioral response and associated programs.

The Effective Engagement Strategies with Schools, Local Communities, Parents, and

Students Workshop was presented by a panel that included Ruth Campbell, LCSW; Heidi Ellis, Ph.D.; Erum Nadeem, Ph.D.; and Darrell Stolle, Ed.D. They presented effective, culturally competent engagement strategies with schools, local communities, and parents. There was a focus on the needs of immigrant, refugee, and Native American populations. The engagement strategies presented at the workshop could also be utilized by disaster behavioral health and CCPs to provide culturally competent services to communities affected by disaster.

One mini session, *Sustaining Our Work Via the Internet: Online Trauma Education and Training*, presented by Ayme Turnbull, North Shore University Hospital, Adolescent Trauma Treatment Development Center, discussed a variety of ways the Internet can be used to facilitate training in the areas of trauma-specific assessment tools and interventions. Dr. Turnbull and her colleagues plan to adapt the training to allow players to practice administering psychological first aid to participants acting as disaster survivors.

Upcoming Meetings

2009 INTERNATIONAL DISASTER MANAGEMENT CONFERENCE

FEBRUARY 19–22, 2009
ORLANDO, FL

This conference has been designed to meet the educational needs of all people and agencies involved with emergency preparedness, response, and disaster recovery. For more information, go to <http://www.emlrc.org/disaster2009.htm>.

2009 NATIONAL HURRICANE CONFERENCE

APRIL 6–10, 2009
AUSTIN, TX

This conference serves as a national forum for Federal, State, and local officials to exchange ideas and recommend new policies to improve emergency management. For more information, go to <http://www.hurricanemeeting.com> or send an e-mail to mail@hurricanemeeting.com.

EFFECTIVE MENTAL HEALTH INTERVENTIONS IN THE IMMEDIATE AFTERMATH

APRIL 17, 2009
NEW PALTZ, NY

This conference will present the latest evidence-based research about effective mental health interventions in response to disasters. Topics will also include ways of developing effective interagency coordination for maximizing community response to mental health needs following these events.

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.

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>.

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