



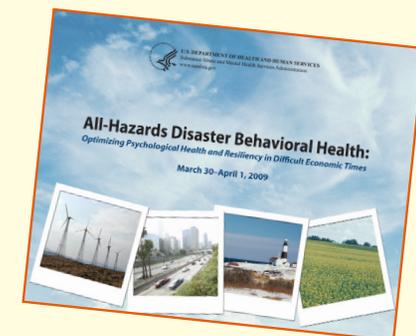
The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER BEHAVIORAL HEALTH

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All-Hazards Disaster Behavioral Health: Optimizing Psychological Health and Resiliency in Difficult Economic Times Conference

This issue of *The Dialogue* summarizes the information presented and discussed at the All-Hazards Disaster Behavioral Health: Optimizing Psychological Health and Resiliency in Difficult Economic Times Conference. This three-day conference (March 30 to April 1, 2009) brought together disaster mental health coordinators, scholars, and other professionals from across the country to discuss how to maximize resources and build resilience in difficult economic times. The conference succeeded in providing a collaborative environment in which participants, facilitators, and speakers gained valuable information to inform further thinking, discussion, and application when they return to their organizations.



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DAY ONE

RADM Eric Broderick, Acting Administrator for SAMHSA, welcomed the participants on day one. Dr. Kermit Crawford, Director of the Center for Multicultural Mental Health at Boston University School of Medicine and Boston Medical Center, gave an overview of the entire conference and acted as the Master of Ceremonies.

Video Montage: *The Economic Crisis: An All-Hazards Event* & Keynote Address: *The Economic Crisis and Disaster Behavioral Health*

The conference officially kicked off with the video, *The Economic Crisis: An All-Hazards Event*. The video, which depicted Americans dealing with unemployment and home foreclosure, painted a picture of the parallels between loss and grief felt in an economic crisis and loss and grief felt as a result of more “typical” disasters. In summary, the message was that either type of situation carries an impact that can result in high levels of stress, depression, feelings of helplessness, and suicidal ideation.

The video showcased two interviews: The first with A. Kathryn Power, Director, Center for Mental Health Services (CMHS), SAMHSA, and the second with Steven Crimando of Steven Crimando and Associates. Ms. Power emphasized that SAMHSA has a responsibility to address the behavioral outcomes of the crisis. She

stressed that although the economic crisis is an unusual definition of an “all-hazards disaster,” it is a situation that States are and should be prepared to address by using the strategies and skills honed from meeting behavioral health needs that occur after more typical incidents. Mr. Crimando supported this concept in his interview, encouraging State government officials and representatives to tap into knowledge gained over the years in preparing for and responding to natural and human-caused disasters.

Ms. Power followed the video with her keynote address, tying the economic crisis to the need to foster resilience across the Nation—not only as a coping mechanism but also as a preventative measure. She charged the group with building



upon the work that President Obama has been doing to address the economic crisis, mobilizing existing resources in order to maximize effect. Ms. Power underscored this point by repeating her belief that through previous and present work on addressing disaster behavioral health for other types of incidents, State disaster behavioral health stakeholders are well positioned to help individuals and communities become resilient. She pointed out that the longer-term benefit of fostering resilience is that resilience can be used extensively outside the context of disaster and could be of practical use to society as a whole.

Ms. Power expressed that the Nation appears to have reached the tipping point where it knows and understands that there is no health without mental health. To support this statement, and to underscore the importance of establishing mental health and resilience, particularly in youth, Ms. Power discussed the recently released National Research Council and Institute of Medicine report, *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities*. The report reaffirms the importance of treating and preventing mental health disorders, as well as the crucial need for mental health promotion. “We have to consider the development of emotional and social competence as a piece of mental health policy. In addition to reading, writing, and arithmetic, we need to add resilience,” Ms. Power said. She went

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on to emphasize the importance of both ethically and financially fostering resilience as a foundation of health for our community and country, stating, “It is not how we stand, but the direction in which we are moving, which includes health promotion and illness prevention, resilience, and the creation of psychological health. We need to help people discover in themselves what they need to survive and prevail in the wake of calamity.”

Reflections of Resilience During Stressful Economic Times

During this panel, individuals directly affected by the economic crisis shared their stories with participants. Four people, each experiencing the crisis differently, spoke about how the economic crisis has affected them, what resilience means

to each of them, and how they have tapped into formal and informal supports in order to endure psychological strains and stress. Joshalyn and Robert, a couple with children, became homeless after Robert lost his job. Frank, laid off after 17 years at the same company, faces a struggle to find employment at this stage of his life and feels additionally strained as his retirement plans are jeopardized. Abigail, a recent college graduate, is dealing with mounting educational loans and fewer job prospects; she is living with her parents while she seeks employment. Throughout these stories—becoming newly homeless, seeking employment as a senior citizen, and attempting to enter a tenuous workforce as a recent college graduate—one message rang loud: Resilience, at any level, is something that can be nurtured and

built. Panelists noted that those facing challenges due to the economic crisis should try to remain optimistic, rely on family and friends for support, and realign goals and work with what they have. Additionally, spirituality and social supports and networks are critical to maintaining hope and taking care of oneself.

Understanding and Facilitating Resilience

During this plenary, Dr. Fran Norris, Director of the National Center for Disaster Mental Health Research; Dr. Gilbert Reyes, Associate Dean for Program Development at Fielding Graduate University in Santa Barbara; and Bonnie Benard, Senior Program Associate for WestEd, discussed what it means to understand and facilitate resilience in individuals and families, communities, and organizations. CAPT Dana Taylor, Chief of SAMHSA’s Emergency Mental Health and Traumatic Stress Services Branch (EMHTSSB), introduced the panel and explained that people in this country are altering ideas, resources, and services to meet needs during this difficult economic time. He expressed the tremendous opportunity mental health professionals have to use the synergy of the all-hazards conference to continue thinking differently about how we respond and prepare to meet the needs of communities during disasters.



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Dr. Norris asked participants to think of resilience as a process, a set of adaptive capacities, and a strategy for disaster readiness. The concept of resilience is found in many different arenas, but all have the same underlying framework: the ability to bounce back. Resilience is a process, not a trait, and understanding this concept is important when deciding how to build and foster resilience. People know that resources are critical to developing resilience; the real challenge is for individuals to identify and foster the adaptive capacities they can use in challenging times.

Dr. Reyes also examined resilience, taking the individual and family into consideration. He noted that resilience is a psychological construct. To know their resilience level, people must be exposed to something that forces them to acknowledge risk to their optimal functioning and development. Dr. Reyes discussed a list of personal attributes of resilient individuals. He also discussed threats to resilience, including



deprivation of psychological, biological, and social resources and exposure to potential harmful events. He believes that, as a society, we need to look at resilience from a developmental perspective; we need to understand both the varying developmental stages of resilience and how we can improve resilience promotion to facilitate resilience in individuals and families. Finally, we must pay attention to cultural variability if we are going to cultivate resilience in this country.

Building on Dr. Reyes' comments, Dr. Norris discussed community resilience and how to facilitate it. She described resilience to disaster, terrorism, and other crises as resting not only on traditional preparedness activities but also on efforts to build resilient communities. Communities have to plan for the unexpected. When disasters occur, the ability to bounce back will be more enduring than traditional preparedness activities. For communities to facilitate resilience, disaster planning needs to include four key adaptive capacities: Economic development, social capital, community competence, and information and communications. If communities incorporate these adaptive capacities, their ability to foster resilience will continue to increase.

Bonnie Benard spoke about fostering resilience in individuals, families, and communities. She reinforced the idea that resilience is the human

capacity to transform and change. Through fostering and promoting caring relationships, meaningful participation, and high expectations, institutions have the opportunity to enable service providers to empower people and promote positive development. When organizations are proactive in the support of and belief in resilience, it leads to positive prevention and successful life outcomes.

CAPT Taylor concluded this plenary by noting that change is inevitable. The human capacity to adapt to change exists, and mental health professionals need to cultivate it so individuals, families, communities, and organizations will be capable of handling adversity.

Case Study on Community Resilience During Stressful Economic Times

This plenary session featured Tracy Soska, Assistant Professor, Continuing Education Director, and Community Organization and Social Administration Chair in the School of Social Work at the University of Pittsburgh. Mr. Soska gave an overview of the River Communities Study that included information on social work and community response in the wake of crisis. The study looked at the impact of economic crisis on households, women, the elderly, fathers, youth, and African-Americans. The community impact included everything from an increase in crime and drug use to changes in the social fabric.

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The community experienced family instability, stress, and poor health. Mr. Soska expressed the importance of remembering that people in crisis are vulnerable; service providers need to build partnerships with communities, educational institutions, and other organizations to foster social connection, support, and resilience.

Based on lessons learned from the River Communities Study, Mr. Soska presented recommendations for responding to the current economic crisis and other crises. He reported that a community's first need after crisis is rebuilding of the social fabric. This rebuilding is done through working with the community and tapping into the assets and abilities of individuals and institutions. Communities also need opportunities to develop social capital—opportunities that include fostering networks and exchanges between people and organizations. In many ways, crisis can bring out the best in people. If people have community and institutional support that responds to needs and respects the informal ties of communities, they can recover from adversity. Mr. Soska stressed that institutions need to work collaboratively, especially in crisis, and remember the long-term poor and marginalized people in the population. Finally, communities, organizations, and institutions must be “in it for the long haul.” There is no quick fix in the recovery process, but with continued cooperation and support, we can foster resilient communities.

Concurrent Small Group Discussions: Stress Inoculation Through Building Resilience

> Individual and Family

This small group discussion focused on how individuals and families can build resilience. The group was asked, “What are the key challenges promoting individual and family resilience through your communities?” As service providers and mental health planners, most participants reported that what has been difficult in fostering resilience, aside from access to people, is cultural norms. Participants reported that fostering resilience in different cultures can be challenging because recognizing what being dependent or interdependent looks like in each culture can be difficult. The group agreed on the importance of building resilience in a culturally competent manner.

> Community

This small group discussion focused on the challenges of and solutions to promoting community resilience and tailoring programs to meet the needs of the community. The biggest challenge among States and Territories is the lack of funding and support from other agencies to promote mental health programs. This situation is due largely to the fact that other agencies are unsure of the behavioral health implications in community planning.

For example, a challenge unique to rural areas is the geographical obstacle of promoting community resilience in areas where residents are spread out. States and Territories have learned that the best way to address the challenges they face in promoting community resilience is to build relationships with non-mental health agencies during times of non-disaster so that relationships are already in place when a disaster strikes. Another solution is to have a presence during community planning meetings to stress the importance of addressing mental health issues that arise in times of disaster.

The States and Territories agreed that one of the best ways to tailor a program to address community resilience is to integrate individuals from a community in the healing process of affected areas. This can be accomplished by hiring from within that community for Crisis Counseling Assistance and Training Programs (CCPs) and working with faith-based organizations that are trusted within that community. Participants stressed the importance of remembering that every community has its own way of doing things, so enlisting community members will help bridge gaps in understanding a community's culture.

> Organizational

The group was asked, “Has your State or Territory played an active role in promoting

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organizational resilience?” Participants discussed how organizational resilience needs to start in the State and Territory organizations that they represent. Once these organizations have promoted resilience, service providers can help them foster resilience. Participants expressed the importance of being realistic in planning organizational resilience and the challenge with the bureaucracy of State government. The groups expressed it as a step-by-step process and one that has to be examined and strategically reviewed continuously. Only then will organizations truly be able to build their resilience.

DAY TWO

Participants were welcomed on day two with opening remarks from CAPT Carol Coley, Senior Program Management Advisor, Division of State and Community Assistance of SAMHSA’s Center for Substance Abuse Treatment (CSAT).

Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities—Report Findings

Dr. Linda Randolph, President and Chief Executive Officer of the Developing Families Center, reviewed the findings from the report *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and*

Possibilities. The report was released in February 2009 by the National Research Council and Institute of Medicine. Dr. Randolph highlighted the need for a paradigm shift in prevention efforts, specifically looking at interventions occurring before the age of fifteen. She also emphasized the role of community-level systems in supporting young people and said this support must incorporate a developmental perspective. Another needed shift in the prevention paradigm is to view the mental health spectrum more broadly—rather than focusing on diagnoses alone. Dr. Randolph concluded by advocating multiple approaches at multiple levels.

Mary Ellen O’Connell, Senior Program Officer in the Division of Behavioral and Social Sciences and Education at the National Research Council, presented the report’s recommendations, emphasizing the overarching theme of putting knowledge into practice. The report advocated the idea of the Federal government making the healthy mental, emotional, and behavioral



development of young people a national priority. Toward that end, the report recommended that the Federal government establish public goals and provide needed research and service resources. The report also called for the White House to create an ongoing mechanism to develop and implement a strategic approach for the promotion of mental health and behavioral health. Ms. O’Connell stressed the need for effort at the State and community level as well, specifically highlighting the need for States and communities to apply their resources toward promoting mental health and preventing mental disorders. Ms. O’Connell underscored the need for community investment in this process.

You can read this report at http://www.nap.edu/catalog.php?record_id=12480 or http://www.bocyf.org/prevention_of_mental_health_disorders.html.

Disaster- and Crisis-Related Suicide Prevention and Intervention: Impact of Current Economic Crisis

During this plenary, Dr. Jerry Reed, Director of the Suicide Prevention Resource Center (SPRC), and Dr. John Draper, Director of the National Suicide Prevention Lifeline (Lifeline), discussed suicide prevention and intervention in disaster- or crisis-related situations. Dr. Richard McKeon, Team Leader for the Suicide Prevention Branch of SAMHSA’s Division of Prevention, Traumatic

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Stress, and Special Populations (DPTSSP), introduced the panel by describing the SPRC and Lifeline. Dr. McKeon stated that the country faces a dilemma with this economic crisis and its correlation to suicides. Mental health professionals do not want to be alarmists, but they can't simply hope for the best. It is essential for professionals to take prudent measures to deal with what they see as a foreseeable risk. This means knowing the signs and risk factors and how this current economic crisis and other disasters relate to suicidal ideation, completion, intervention, and prevention.

Dr. Reed discussed the SPRC and the services and resources available. He gave general statistics about suicide, including the fact that most suicides in this country are committed by men. He discussed the similarities and differences between the impact of a natural disaster and that of the economic crisis. From a suicide prevention perspective, the two are very similar. In light of these similarities, Dr. Reed asked participants to remember the importance of prevention when working with individuals who could be experiencing suicidal ideation. He explained that the current economic situation is not causing suicides; however, challenging financial times or unemployment can contribute to suicidal ideation. Therefore, it is important during this time to know the warning signs of suicidal ideation, to work with the media in order to portray suicide in the

correct fashion without causing panic, and to emphasize the importance of seeking assistance.

Many people are seeking assistance via Lifeline, a free hotline. Dr. Draper explained how Lifeline presently functions and how it was used in past disasters, such as 9/11. He explained that the mission of Lifeline is to reach and serve all American residents who are dealing with suicide in some capacity. He focused his discussion on how a hotline is beneficial during a disaster or crisis and reported four important functions a hotline serves during a crisis:

1. A hotline is immediate—it helps to mobilize outreach services and other resources quickly.
2. A hotline can be a point of entry—it can connect people with new disaster treatment and support services.
3. A hotline can track levels of anxiety throughout the community—it is able to provide mental health professionals with information about the level of distress in communities.
4. A hotline can coordinate trainings—it can facilitate linking providers with crisis support and mental health training.

The panel stressed the importance of keeping suicide prevention and intervention in mind when preparing and responding to a disaster or crisis.

Both the SPRC and Lifeline are valuable resources. You can get more information at <http://www.sprc.org/> and <http://www.suicidepreventionlifeline.org/>.

Psychological First Aid (PFA): Models, Applications, and Training

This session reviewed the development of PFA and some of its applications. Linda Ligenza, Project Officer for SAMHSA's EMHTSSB, opened the session by reviewing the basic tenets of PFA. Ms. Ligenza explained that PFA is an approach that provides skill building and coping strategies to people experiencing distress. She also reviewed the timeline of response following a disaster and the use of PFA in the immediate post-disaster phase. A goal of PFA is to fill the gap between when a disaster strikes and when a CCP can be implemented. Should the need rise to a higher level and the State choose to take the option, a Federal Emergency Management Agency (FEMA)-funded CCP may be implemented after 14 days.

Dr. Melissa Brymer, Director of Terrorism and Disaster Programs for the UCLA/Duke University National Center for Child Traumatic Stress, provided an overview of the National Child Traumatic Stress Network. Dr. Brymer provided further clarification about PFA. PFA is a modular approach to assist children, adults, and families in the immediate aftermath of disasters and

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terrorism and is only one piece of efforts that facilitate disaster recovery.

Dr. Laurel Hughes, primary author of *Coping with Deployments: PFA for Military Families*, discussed the American Red Cross (Red Cross) adaptations of PFA. Dr. Hughes reviewed the factors that led to the development of Red Cross PFA and explained that there was a need for techniques that non-mental health professionals could use. Dr. Hughes also reported that the Red Cross is adapting PFA into two new models: One for military families and one for communities, called Neighbor-to-Neighbor PFA.

After the PFA plenary session, participants broke out into small groups by region (Northeast, South, Midwest, and West) to discuss the ways PFA is utilized in their States or regions. Regions expressed varying levels of knowledge and skill regarding PFA. While some States are utilizing PFA, others have never been trained or are not



implementing it at this time. Most of the States who have not had PFA training voiced an interest and wanted to know how to acquire training. Participants across all groups agreed that State-to-State learning and knowledge exchange is extremely important in this area.

Concurrent Breakout Sessions

> Navigating Fiscally Strained Systems

Dr. Nikki Bellamy, Public Health Advisor, EMHTSSB, facilitated this breakout session, which allowed seasoned disaster mental health and substance abuse coordinators to interact with coordinators who have had less experience with CCPs. Fiscal management of a CCP has always been an important task. Although experience is beneficial, fiscally managing a grant is a big responsibility. With the current economic crisis, navigating fiscally strained systems is on everyone's mind. Chance Freeman, Texas Disaster Substance Abuse Coordinator, and Acquanetta Knight, Alabama Disaster Mental Health Coordinator, led discussions about this issue, which were particularly beneficial around the subject of collaboration. Most States are financially strained, and facilitating collaborations throughout State infrastructure has proven to be valuable for disaster behavioral health coordinators. Participants stressed the importance of

working with others and being supportive of different departments before a disaster occurs. Forming relationships beforehand lays the foundation for collaboration during crises and is much more effective than attempting to make connections during hectic times. This collaboration makes working with public health, contract management, accounting, and other departments flow smoothly when a crisis occurs.

> Building Nontraditional Partnerships and Collaborations in Challenging Economic Times

CAPT John Tuskan, Jr., Senior Program Management Officer for the Refugee Mental Health Program, DPTSSP, facilitated this breakout session. Jane Bishop, Disaster Mental Health Coordinator for Pennsylvania, and Dr. Curt Drennen, Colorado Disaster Mental Health Coordinator, presented this topic. Ms. Bishop discussed the nontraditional partnerships on a micro level. She explained that nontraditional partners are groups not typically involved in disaster preparedness and response. These groups include faith-based organizations, consumers of mental health services, family advocacy organizations, State hospitals, non-English speaking communities, and drug and alcohol agencies.

Dr. Drennen discussed the development of nontraditional partnerships on the macro level.

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He discussed the development of the Colorado Crisis Education and Response Network (CoCERN). CoCERN is an umbrella structure for a wide array of community behavioral health organizations to work together in times of crisis and community disaster. It is a partnership between groups and organizations that aim to address the immediate behavioral health needs of communities affected by an all-hazards incident. Included in this partnership are community mental health and substance abuse organizations, emergency management agencies, employee assistance programs, public health entities, Red Cross, and the Salvation Army. Together, these organizations have developed trainings, a team structure, a team mission, and various guidelines regarding resource utilization. Dr. Drennen explained that the formation of this structure could provide a template to use at community, regional, and State levels. CoCERN also helps to decrease any one agency's responsibility for disaster response resources and helps to build better local partnerships.

> **Getting Substance Abuse Providers Ready to Respond . . . Are We There?**

CAPT Carol Coley, Senior Program Management Advisor for CSAT, moderated this session. Dee Owens, Director of the Alcohol/Drug Information Center at Indiana University, opened the session with

a historical perspective on substance abuse response, providing a review of the response to the Oklahoma City bombing. Ms. Owens specifically highlighted the lack of planning and integration of substance abuse issues and providers in the response to the bombing and explained that the field had to develop almost overnight. The growth of the field is demonstrated by its inclusion in conferences such as this, as well as the funding and support available for substance abuse response after 9/11 and Hurricanes Katrina, Rita, and Wilma. Ms. Owens emphasized that the two most critical pieces to effective substance abuse disaster response are relationship building and planning; both are possible in spite of the economic state. Ms. Owens also stressed the need to institutionalize knowledge so that these relationships are not dependent upon one personality being in a leadership role.

Katie Wells, Colorado Disaster Substance Abuse Coordinator, provided a specific case study of work done in Colorado. Ms. Wells noted that not a single request for substance abuse providers followed the school shooting in Columbine. However, drunk driving rates in that county increased in the following months and years. Ms. Wells emphasized that effective planning and service provision requires knowing the population you will be serving. Toward this end, Colorado has prepared by

identifying a local disaster coordinator and a substance abuse disaster coordinator at every mental health center.

Colorado's planning efforts were put to the test following Hurricane Katrina as evacuees were flown to the State. The State experienced challenges when the Red Cross would not allow Narcotics Anonymous or Alcoholics Anonymous onsite in shelters. Colorado is still actively seeking to overcome this challenge by working to get credentialed staff into all Red Cross shelters. A large part of overcoming this challenge is continued relationship building. Colorado has also established a credentialing plan with two levels of responders. Disaster behavioral health responders will eventually have badges and vests, which will facilitate access into Red Cross shelters.

> **Credentialing Crisis Counselors**

LCDR Jamie Seligman, Public Health Analyst, EMHTSSB, facilitated this breakout session, which examined the history, purpose, timeline, and phases of credentialing crisis counselors. It focused on the benefits of having registered and credentialed crisis counselors, the levels of credentialing, and a basic overview of the curriculum required for certification. Robert Snarr, Utah Disaster Behavioral Health Coordinator, and Gladys Padro, New Jersey Disaster Mental Health Coordinator, presented on the crisis counseling credentialing

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programs currently operating in their respective States.

Mr. Snarr discussed Utah's program. Program developers worked closely with Georgia, FEMA, and SAMHSA, when creating Utah's program in preparation for the 2002 Winter Olympics. Currently, the program works with approximately 50 agencies ranging from faith-based organizations to the Medical Reserve Corps. The Utah model is unique in that participating agencies reimburse crisis counselors and provide liability insurance while services are being rendered. The funding for this model was developed through grants from the U.S. Department of Health and Human Services (HHS), the HHS Assistant Secretary for Preparedness and Response, and the Department of Homeland Security.

The standardized crisis counseling training includes basic emergency management skills and examples and exercises from previous disasters, such as Hurricane Katrina and the Charlie Square shootings. On the first day of training, participants learn about PFA, cultural competence, burnout, resilience, and recovery. On day two, participants learn how to respond to the media, foster teamwork, and test their new skills in a mock disaster scenario.

Ms. Padro explained the crisis counseling credentialing program in use in New Jersey.



Originally started as a pilot program in 2004, the program is now in all 21 counties in New Jersey and has produced approximately 800 credentialed crisis counselors. The State uses a level system to separate credentialed crisis counselors by ability and mandates that a crisis counselor achieve 12 hours of training every two years in order to stay credentialed. The curriculum used for basic training includes an introduction to disaster behavioral health, the National Incident Management System and Incident Command System training offered by FEMA, PFA, ethics, and cultural competence. For advanced participants, or those seeking to maintain their credentials, New Jersey offers recertification topics that include managing the consequences of chemical, biological, radiological, and nuclear emergencies and substance abuse issues in disaster and trauma recovery. Ms. Padro went on to stress the importance of a certification process and a

few benefits from such a process, including the standardization of training, support and development of the workforce, and the integration and enhancement of disaster and crisis response.

> **Pandemic Influenza: Preparing for the Psychosocial Impact**

Terri Spear, Emergency Coordinator for SAMHSA, facilitated this session. Steven Crimando, of Steven Crimando and Associates, and Brian McKernan, Technical Assistance Manager for the SAMHSA Disaster Technical Assistance Center—presented the session. During the session, the presenters touched on a variety of issues related to pandemic influenza:

- » How planning for pandemic influenza differs from other emergency planning
- » Similarities between the economic downturn and a pandemic influenza outbreak
- » Current efforts for increasing attention to behavioral health interventions as a means to increase individual and community resilience and reinforce non-pharmaceutical interventions
- » Strategies that jurisdictions have found helpful in overcoming obstacles in planning
- » Resources available to assist efforts

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The discussion also centered around the challenges for substance abuse treatment, especially the impact of social isolation on support groups. For example, what groups would look like if social isolation and quarantines were imposed. Presenters also discussed the potential increase in substance use and abuse. When comparing a pandemic influenza outbreak to the financial crisis, Mr. Crimando used the “Dread Formula” from Amanda Ripley’s book, *Unthinkable*. The formula includes the following concepts: uncontrollability, unfamiliarity, unimaginability, suffering, scale of loss, and unfairness.

The panel stressed that when thinking about behavioral countermeasures, States have to be way out in front of the curve. Countermeasures require looking at existing models and adapting to future needs and anticipated needs. Steps that States can take include talking to planning partners, promoting self-efficacy, thinking about the State’s role reinforcing countermeasures for behavioral health responses, becoming familiar with resources, and looking at the State’s pandemic influenza plan and forging ahead.

This conference occurred prior to the recent H1N1 outbreak, but that event underscores the relevance of planning for the behavioral health needs of pandemic influenza.

> **Approaches for Basic Disaster Behavioral Health Training**

CDR Maryann Robinson, Project Officer, EMHTSSB, facilitated this breakout session, which featured David Benelli, Team Leader for the First Responder Law Enforcement Team for Louisiana Spirit, and Ashley Pearson, Massachusetts Disaster Mental Health Coordinator. Mr. Benelli talked about his experience with a special crisis counseling team in Louisiana. This team, made up of first responders, was developed to provide crisis counseling to fellow first responders. The need for this special team was apparent. First responders typically feel that seeking mental health assistance is a sign of weakness, and they often fear departmental ramifications. However, they are more willing to talk to another first responder because they trust a peer not to breach confidentiality.

Ms. Pearson discussed Massachusetts’ crisis counseling training courses and PFA 202. Massachusetts has developed a crisis counseling curriculum including Web casts. The State also has a refresher course every three years and developed PFA 202. This course offers a more hands-on approach to PFA. Crisis counselors who would like more training can participate in this course.

> **Opioid Treatment Continuity of Care During the Disaster Response**

Dr. Arlene Stanton, Social Science Analyst for the Division of Pharmacologic Therapies, CSAT, reviewed lessons learned from past disasters and current practice in the continuity of care provided by opioid treatment programs. Nicholas Reuter, Senior Public Health Advisor for CSAT, outlined many of the barriers to providing continued opioid treatment under various circumstances. Mr. Reuter highlighted the need for specialized solutions to these barriers, given their variance. He provided the example of Alaska, where the cold has been so severe that people were unable to start their cars to get to treatment.

Currently, 1,200 licensed treatment programs exist in the United States, although North Dakota, South Dakota, Montana, and Wyoming have none. Mr. Reuter reviewed the different ways in which the economic situation has affected treatment provision: Some States have reported no effect on treatment. Other States, often where there are more private providers, have observed an increase in involuntary detoxification as individuals have become unable to pay for their treatment. Mr. Reuter emphasized that treatment providers need to work with individuals to create a step down plan for those no longer able to afford their treatment.

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Mr. Reuter specifically examined the interruption of services caused by natural disasters. He explained that CSAT policy requires each potential new methadone provider to go through an accreditation review by professional staff, and this policy is not suspended during disasters, as society is not ready to accept the unregulated methadone treatments that would result from suspending the policy. During Hurricane Katrina, methadone treatment patients were given a week's supply in preparation for the storm. However, given the extensive devastation of the hurricane, a week's supply was insufficient to carry people through the time it took to reestablish treatment centers. This situation was complicated by the number of patients displaced and looking for treatment in new States. CSAT provided the following guidance to the field: States were provided contact information for new providers, States were advised to admit all patients, and States were advised to be cautious with the distribution of medication. Following the hurricane, many were surprised by the number of opioid-dependent individuals not previously in treatment who began requesting treatment. Providers were also surprised to see that the old and new patients did not mix well.

While many lessons have been learned from Hurricane Katrina, planning for opioid

treatment during a possible pandemic requires a different strategy. Planners need to allow for the possibility that the pandemic will be highly contagious and have a high fatality rate. Given the need for social distancing for extended periods, opioid treatment providers will have to reexamine the current practice of daily distribution at a treatment center. Mr. Reuter concluded that providers will need to make emergency exceptions on a case-by-case basis. He also noted that the need to dispense large doses at once as an emergency precaution could strain the supply of available methadone. Both concerns are policy issues that States and providers should be considering.

Michelle McDaniel, Emergency Manager for the Preparedness Section of Public Health, Seattle and King County, WA, reviewed the steps that King County is currently taking toward improving continuity of operations planning for their opioid treatment programs. King County has developed a healthcare coalition, consisting of healthcare organizations as well as healthcare providers who are committed to coordinating their emergency preparedness and response activities. One of the goals of

the coalition is to avoid surges on hospitals should a disaster happen.

One of the most critical steps in their planning process was to hold a summit including all five opioid treatment programs located in the county. One outcome of the summit was clarity about roles among county, State, and Federal partners. Planners also established that opioid treatment programs are not responsible for treating new patients or those who were previously un-enrolled. Additionally, the summit clarified the treatment rules and regulations and how they would change in a disaster situation, and attendees left with an increased understanding of available resources.

An additional outcome of the summit was the development of specific action steps. Participants developed a phone tree encompassing all opioid treatment programs



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and public health responders. King County opted to use WATrac (available at <http://www.watrac.org>), an incident management software that can send alerts to providers. Participants also discussed and planned training on when and how to request medical and non-medical resource assistance from the local government. Opioid treatment programs wrote and signed mutual aid agreements. And finally, all attendees participated in a tabletop exercise, the results of which are currently being processed in an after-action report.

You can find more information about the King County project at <http://www.kingcounty.gov/health>.

DAY THREE

Participants were welcomed on day three with opening remarks from Frances Harding, Director of the Center for Substance Abuse Prevention, SAMHSA.

Promoting Psychological Resilience in Stressful Times: Getting the Word Out

The foundation of this session was a synthesis of the information presented on Day One and topics discussed between participants on Day Two of the conference. Carmie McCook, President of Carmie McCook and Associates, and Steven Crimando, of Steven Crimando and Associates, presented information about effective communication styles. The objective was for participants to use effective communication techniques when applying the

knowledge gained from the conference to move forward with building resilience in communities across the country. Ms. McCook and Mr. Crimando guided participants through knowing their audience, body language and its importance, and managing question and answer sessions. Participants were divided into regional groups and encouraged to practice requesting funds or promoting resilience to vital stakeholders using the communication techniques presented. A representative from each group presented their information to the larger group so they could practice addressing a wide audience. Attendees enjoyed the collaboration and appreciated information on how to effectively present information to stakeholders.



Upcoming Meetings

2009 NATIONAL COMMUNITY PREPAREDNESS CONFERENCE

AUGUST 9–12, 2009
ARLINGTON, VA

This conference is open to all who are interested in making their communities safer, stronger, and better prepared for all types of hazards. It will bring together approximately 600 State and local elected officials, emergency management services, fire and police services, public health and emergency medical services, private business and industry, advocacy groups, and members of the public. For more information, go to <http://www.iaem.com/NCCP2009.htm>.

DISASTER MANAGEMENT 2009—FIRST INTERNATIONAL CONFERENCE ON DISASTER MANAGEMENT AND HUMAN HEALTH: REDUCING RISK, IMPROVING OUTCOMES

SEPTEMBER 23–25, 2009
NEW FOREST, UNITED KINGDOM

This conference focuses on current global health risks and how best to prepare for, respond to, and recover from disasters to reduce the impact on human health. Topics will help participants understand the nature of global risks, learn risk management strategies to prepare for disruptive events, and identify the best prevention methods in disaster management and public health. For more information, go to <http://www.wessex.ac.uk/conferences/2009/disman09/index.html>.

DISASTER MANAGEMENT, RESPONSE & RECOVERY 2009: BUILDING RESILIENCE AT EVERY LEVEL

OCTOBER 27–29, 2009
SINGAPORE

This conference is open to all who are interested in exchanging best practices in disaster management. Discussions will involve responses to natural and human-caused disasters, as well as how to build better capacity for disaster management and response. For more information, go to http://www.asiansecurity.org/media/events/pdf/DMRR09_brochure.pdf.

INTERNATIONAL ASSOCIATION OF EMERGENCY MANAGERS (IAEM) ANNUAL CONFERENCE

OCTOBER 31–NOVEMBER 5, 2009
ORLANDO, FL

This conference will provide a forum for current trends and topics, information about the latest tools and technology in emergency management and homeland security, and advances of IAEM committee work. For more information, go to <http://www.iaem.com/events/annual/intro.htm>.

DISASTER MENTAL HEALTH CONFERENCE: ROCKY MOUNTAIN REGION

NOVEMBER 5–7, 2009
CHEYENNE, WY

This conference is intended for disaster mental health professionals and health and mental health professionals in the Rocky Mountain region. The objective is for the participants to learn more about how to serve the people in this region and discuss disasters and response relevant to the area. For more information, go to <http://www.rmrinstitute.org/cys.html>.

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 SAMHSA DTAC at dtac@samhsa.hhs.gov.