FALL 2007

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER BEHAVIORAL HEALTH

ASK THE FIELD

The Dialogue: During the winter months, what are some issues disaster behavioral health responders should be aware of for States that experience severe winter weather?

Rick Calcote: The impact on people who struggle through severe winter weather, which can suddenly cripple infrastructure and threaten survival, is probably the same regardless of where they live. Winter months can drive the heartiest of us indoors. We normally become a bit more isolated. But when ice, snow, and wind bury a town in an unrecognizable landscape and steal the power that lights and heats our homes, isolation takes on a profound new meaning. We feel acutely vulnerable as we realize that many of the expected conveniences of modern life are suddenly inaccessible. It can be unnerving to know that emergency personnel cannot reach you and that you and your family are stranded. Severe winter storms bring with them the specter of cold weather survival. Some people are unprepared and unequipped to respond to unremitting conditions that can threaten health and safety. The work required to simply stay warm and to meet basic needs can be exhausting. When there is no power it can be a frustrating if not desperate task just to feed your family. This is especially true for low-income families or apartment dwellers that rely on restaurants and stores for daily food supplies. It is a disquieting experience to know that you may not be able to protect and feed those you love. The resultant tension and uncertainty can adversely affect family interactions.

Property damage and injury also top the list of problems stemming from severe winter weather. Water pipes can burst flooding kitchens, bathrooms, and basements. Subsequent electrical fires caused by shorted wiring can result once power is restored. Carbon monoxide poisoning as well as fires and explosions are the common results of uninformed attempts to utilize alternative heat sources. These unexpected events bring additional physical, financial, and medical hardships.

continued

A story of surviving winter weather illustrates the power of resilience and community cooperation when coping with disaster. January 9, 2005, the 300 residents of Kaktovik, AK, suffered a blizzard with 75 mph winds that wrapped the little Beaufort Sea community in 20-foot snow drifts, and an ambient temperature of 50 below zero. Though severe winter storms are certainly not uncommon or unexpected along Alaska's northernmost coast, this storm quickly became deadly. Within hours, the town's primary power generator failed. In the midst of already life-threatening conditions, there was suddenly no heat, no light, and no water. More than 150 people sought shelter in a small maintenance building powered by a single backup generator. Though one telephone line miraculously remained open, the fierce weather sealed off the community from the rest of the world for 2 more days.

When Kaktovik's plea for assistance came through from the North Slope Borough offices in Barrow, the Alaska Division of Homeland Security and Emergency Management set in motion what was to become one of the most challenging rescue operations in history. Hundreds of civilian and military personnel staged an airlift operation that spanned the equivalent of a four-State area in the lower 48. But their most determined attempts to mobilize technicians, supplies, and equipment toward the beleaguered community stalled in the face of zero visibility. Responders, already feeling an acute sense of urgency, instituted an amazing plan to reach the community overland.

While this activity built around them, the people of Kaktovik appeared to sit patiently and wait. During a phone conversation from the State Emergency Coordination Center in Anchorage to the little maintenance facility 650 miles away, background laughter was heard over the scratchy static. The people in Anchorage exchanged smiles, and collectively breathed a sigh of relief. Anchorage had just informed them that the last two attempts to reach them had failed. The Kaktovik incident commander eased the tension more when he quipped that they had no other particular place to go and would just sit and wait for company to arrive. Their casual attitude, however, masked that they were all quite busy locating and moving supplies, working overtime to clear paths and roads, and checking on the well-being of family and neighbors.

On the morning of January 11, a lone HH-60 Pavehawk helicopter lifted off from Eielson AFB in Fairbanks, more than 350 miles to the south of Kaktovik. This was the fourth attempt to reach the community. Utilizing an Air Force HC-130 Hercules tanker as a midair gas station, the determined crew started the final leg of their journey through a storm that still raged along the arctic coast. Against all odds, and the advice of the Hercules crew, the Pavehawk helicopter managed to reach Kaktovik where they dropped off emergency generators and two technicians. Shortly after their arrival, partial power was restored. It would take another 2 days before full power flowed again through the entire community.

Severe winter weather, like any natural disaster, challenges our ability to withstand hardship and maintain our strengths. In part, resilience is derived from community. When people expend energy toward care and support of one another they are probably more likely to realistically appraise and accept circumstances. When people band together in common purpose, they are more likely to experience hope and less likely to experience anger and express criticism toward authority for not being able to alter those circumstances. The telephone lifeline in Kaktovik no doubt helped fuel the community's sense of hope. They knew that the outside world was taking steps to rescue them. Information, at the very least, can clearly promote well-being. In times of sudden isolation and disquieting loss of protective comfort, information can help people feel connected and safe.

Rick Calcote, M.S., LMFT, is the Disaster Planning Coordinator in the Division of Behavioral Health for the State of Alaska's Department of Health and Social Services.

SAMHSA CSAT Pilot Project D-ATM To Be Launched

Methadone is used in the treatment of dependence on opioids such as heroin and increasingly, many prescription pain medications. However, it is a heavily regulated medication. The proper dose is critical: too much, and someone can die; not enough, and the person may fail to stay in recovery. Patients must enroll for treatment at a particular opioid treatment program (OTP, or methadone clinic), and many must go to the clinic every day. Methadone is a life-saving medication that is not generally available in pharmacies. So, people in methadone treatment may experience a great deal of distress if they are unable to access their clinics for scheduled doses.

For many methadone patients in the greater New York City area, the memories of September 11, 2001, are especially painful. After the terrorist

attacks of that day, one OTP in the New York area was destroyed, and others were temporarily closed. In the middle of that chaos, with phones and mass transportation not working, and police barricades making some areas unreachable, almost 1,000 methadone patients found themselves displaced and sought treatment where they could find it.

The hosting clinics, often overwhelmed themselves, were faced with an ethical dilemma: whether and how to treat someone who might not even be a patient, but who desperately needs treatment if they are. And what to do, when faced with hundreds of such patients in addition to their normal case load? As much as possible, clinics phoned and faxed patients' clinics repeatedly, but often had to rely on patients' memories. A followup study found that patients' reports were generally accurate. The few who were not, were higher-dose patients who feared they would not be treated at all if they told the truth.

In the weeks that followed, many patients would remember September 11, 2001, as the most stigmatizing day of their lives. But out of the devastation, an idea was born. The American Association for the Treatment of Opioid Dependence (AATOD), Committee of Methadone Program Administrators of New York State (COMPA), National Alliance of Methadone Advocates (NAMA), and other stakeholders in the opioid treatment community, quickly contacted the SAMHSA Center for Substance Abuse Treatment (CSAT) to propose a solution. It would be a centralized, deliberately simple database that would house the minimal information needed to verify that a person was a methadone patient, and if so, provide correct dosing information. Privacy was paramount. The ultimate goal was a system that would allow patients to be treated with dignity and compassion in an emergency.

CSAT sponsored a 1-year planning project working with COMPA, NAMA, and an information technology expert. The resulting report supported the feasibility of the original concept, explored technical solutions, and proposed the use of biometrics to help identify patients for the central system. Focus groups with OTP patients indicated that they were receptive to biometrics, once they understood how they would be used. In fact, biometrics are essential to ensure the integrity of patient data. The system does not need to store patient names or even a graphic image of the finger scan. And importantly,

continued

the system can only be accessed when the patient initiates the process by presenting a finger for scanning. If a scan fails, a PIN is used, constructed in a way that does not require patients to remember a number. As a result, patients will not have to carry or memorize information to be able to access the system.

Following the planning study, CSAT provided additional funding to develop the system and pilot it in real-life OTPs around the country. One major change in strategy was to make the system interoperable with the clinical software many programs already have in place instead of custom-fitting to each individual OTP's system. Three software vendors volunteered to make their systems Digital Access to Medication (D-ATM) pilot-ready. There will also be a version for OTPs that do not have sophisticated systems.

In February 2007, the Lower East Side Clinic (LESC) in New York hosted a prepilot of the system. It was conducted in the middle of a small blizzard. The staff, administrators, and patients were incredibly hospitable. They allowed CSAT to come in and spent time learning about the system. Each and every morning, the same three patients came in to work on the enrollment and scanning process. After the team left, LESC staff members used the system, without incident, for several more weeks. Their suggestions led to significant refinements.

Walter Ginter, vice president of NAMA, who has worked on the project since the beginning, suggested the system's new name: D-ATM; the idea being that patients would be able to access medication in as safe and routine a fashion as they could expect to obtain money from a bank machine. The name reflects an important evolution in thinking about the system. After September 11, 2001, terrorism was discussed, and with Hurricane Katrina, thinking about disaster was expanded. The Steering Committee pointed out that the basic concern is service discontinuity, which in many cases might be due to far more routine causes, like blackouts, water main breaks, or a missed flight, because any of those could be a disaster for the patient.

The new phase kicked off within a week of Hurricane Katrina. SAMHSA provided additional funding so that the pilot program could expand to three or four locations around the country, including California, North Carolina, and Louisiana. At this point, development of the system is almost complete.

Recently, SAMHSA contacted OTPs in the targeted areas about their interest in participating in the pilot. The hope is to launch clusters of D-ATM pilots in three or four areas in the next few months. During that time, OTP staff will be trained, patients will be enrolled, and tests will be run including, potentially, a few real-life tests of D-ATM's usefulness in a water main break.

Ultimately, D-ATM is a program for people who do all they can to stay in recovery, and the OTPs who do all they can to help them. For more information on the D-ATM project, go to http://datm.samhsa.gov. For more information on methadone and medication-assisted treatment, go to http://www.dpt.samhsa.gov.

This article was contributed by Arlene Stanton, Ph.D., NCC social science analyst, SAMHSA CSAT.

Necessary Steps in the Transformation to Trauma-Informed Care

In the early 1990s, public mental health and substance abuse service providers began to recognize the magnitude of the sheer number of people coming in to their programs who had abuse experiences, giving rise to "trauma syndrome." Initially, much attention was focused on the pervasiveness of trauma (prevalence and frequency), the medical and physical health consequences, the precipitous spiritual questioning engendered, and the interrelationship of trauma with commonly labeled psychiatric and substance abuse disorders.

What followed from the recognition of the presence of trauma, however, was a related realization that existing providers lacked the capacity to effectively assist people with histories of abuse and trauma. A number of deeply troubling service delivery failures related to this incapacity to treat trauma within public mental health and substance abuse systems were identified—including widespread lack of screening and assessment for trauma, lack of training in trauma treatment approaches, and misdiagnosis or underdiagnosis of trauma followed by a standard regimen of inappropriately targeted services-as-usual, which often led to the revolving door of treatment and discharge. Even when correctly diagnosed, trauma was typically viewed as a one-shot event in the lives of consumers/survivors, rather than an ongoing series of events woven throughout the life cycle. And even less attention was paid to the intergenerational cycle of trauma that kept recurring in each new generation of children within trauma-impacted families.

These concerns all helped to illustrate that mental health and substance abuse systems of care had long been serving consumers/survivors with little or no awareness of trauma and its impacts. A guiding precept for providers—as well as consumers/survivors—seemed to be, "Don't ask (about trauma), don't tell (about trauma)." What has been learned is that it is necessary to serve trauma survivors in an environment that is immediately and directly supportive, comprehensively integrated, and that strives to be empowering for consumers/survivors. Service systems must be designed, from the first contact, to respond proactively to the special vulnerabilities and triggers of past trauma for consumers/survivors. They must also support an active leadership role for consumers/survivors in developing and implementing their personal goals and life development strategies.

Providers must come to see themselves as supporters of the recovery process rather than controllers of the recovery process. This shift in roles has profound implications for the way business is done under this new treatment paradigm. The goal is trauma-informed care (TIC) which is designed not to treat the symptoms related to traumatic impacts, but to organize and deliver services in a manner that meets the unique trauma-related needs of consumers/survivors. Following are steps that a program, agency, or institution can take to begin the transformation to a trauma-informed environment. These steps may occur in various sequences, but all are critical to the development of TIC.

Facilitate Consumer/Survivor Empowerment

Consumers/survivors must have a leadership role in the development of a recovery plan. They need to be supported in cultivating self-advocacy skills and in developing self-empowerment. Staff needs to be trained to facilitate the recovery process. When we consider that many providers are also trauma survivors, agency planning needs to create separate provisions for staff to address and work through their own trauma experiences in a context outside of the provider-consumer/survivor relationship.

continued

Commit to New TIC Organizational Mission and Dedicated Resources

Build support and buy in from those who control the resources in a given program, hopefully resulting in a new organizational mission statement and related operating procedures that reflect a commitment to develop staff understanding and capacity to respond to and support those they serve.

Conduct Universal Screening for Trauma

Ask each consumer/survivor questions, early in the first contact, to determine whether he or she has experienced violence, abuse, neglect, disaster, terrorism, or war. These questions not only help to obtain the information needed to plan an appropriate safety and recovery plan, but also confirm to consumers/survivors that their trauma histories matter.

Establish Safety for Consumers/Survivors

Measures must be taken, from the time of initial contact, to ensure the physical, psychological, social, and moral safety of consumers/survivors. Safety is defined by each consumer/survivor's personal needs and boundaries. Safety is necessary for recovery to begin and proceed.

Provide Ongoing TIC Staff Training and Education

Provide mandatory TIC training to all agency staff—from custodial workers and receptionists to managerial and treatment personnel—on the nature and impact of trauma, and how to better understand and respond to people with trauma histories. Central to each training session should be the active integration of consumers/survivors.

Improve Staff Hiring Practices

Screen job applicants to assess their trauma-informed values and beliefs and job competencies, with special emphasis on relationship building and de-escalation skills. The screening process should help to foster greater professional and personal self-awareness (including the impact of the applicant's own trauma histories on his or her capacity to provide trauma services).

Update Policies and Procedures

Identify and replace policies and procedures that serve as damaging replications or triggers of consumer/survivor past traumatic experiences, with special attention to replacing highly destructive treatment procedures such as seclusion and restraint with psychiatric advance directives and individually developed crisis stabilization plans.

The challenge of TIC is being welcomed and proactively pursued by many different health and human service organizations and systems, at multiple levels of care, across the Nation. Providers are beginning to see the benefits of TIC—not just for consumers/survivors, but also for the effectiveness of their overall programs and services.

The National Center for Trauma-Informed Care (NCTIC) will continue to help nurture new and developing trauma-informed care programs so that best practices and lessons learned can be identified and shared with others who are making the transformation to TIC. There will be a focus on building relationships with people and organizations from various health and human service areas to distill their wisdom into practical fact sheets and policy guidelines for moving forward with the transformation to TIC. Potential and actual adopters of TIC will be brought together in various types of meetings so that they can share their experiences and concerns. NCTIC welcomes contributions of ideas, comments, case studies, and other information to this learning process.

This article was contributed by Susan Salasin, public health advisor, Prevention and Program Development Branch, SAMHSA Center for Mental Health Services (CMHS).

Minimizing the Ongoing Psychological Impact of Military Deployment

With the large number of military personnel returning from deployments in Iraq and Afghanistan, it is likely that many mental health and medical practitioners will find themselves serving returnees from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Although many of those returning to the United States will successfully pick up their lives in spite of transition challenges, others will continue to struggle with the continuing emotional effects of their deployment experiences, so that healthcare providers must take note when they are serving military personnel or veterans and proactively respond to their needs.

It is now widely appreciated that deployments in the global war on terrorism can take a considerable toll on those deployed as well as on their families. Family separations and exposure to harsh physical conditions are part of the routine experience of those sent overseas. But in addition, stressors encountered in combat include a wide range of potentially traumatic experiences, including coming under fire, being injured/wounded, handling dead bodies, killing enemy combatants, and experiencing the loss of a friend. Such events are part of the common experience of most of those serving in Iraq. Some military personnel will also be exposed to sexual harassment or sexual assault while deployed.

Research to date has suggested that approximately 19 percent of service members deployed to Iraq and 11 percent serving in Afghanistan may experience posttraumatic stress disorder (PTSD) and other mental health problems after their return home. PTSD is a disorder that includes symptoms of re-experiencing, avoidance, and arousal. Trauma survivors commonly continue re-experiencing or reliving their traumas via intrusive thoughts, images, or dreams. Their bodies are on alert and they experience physical hyperarousal. Because re-experiencing the trauma and the feeling of being in constant danger are so upsetting, trauma survivors change their lives to avoid things that remind them of their experiences. Current estimates of PTSD are around 12–13 percent 3–4 months after return, and around 17 percent after 1 year. Depression, generalized anxiety, and alcohol abuse are also significant problems for many returnees, as are difficulties with anger, relationship problems, and sleep problems. Many individuals will experience stress reactions that will not qualify as a mental health disorder because their symptoms are fewer in number or less intense than would be required for a diagnosis. But these reactions may nonetheless cause significant distress, interfere with functioning and quality of life, and require attention from healthcare professionals.

Most mental health care is actually delivered in primary care medical settings. This is, in part, because of the widespread reluctance of many individuals to seek mental health treatment and is common among those returning from Iraq and Afghanistan with PTSD. They report concern about being seen as weak, or being treated differently by others if they go for help. Therefore, individuals with PTSD or other deployment-related problems will seek assistance for a physical health complaint that is related to PTSD. They may describe medically unexplained pain, headaches, difficulty sleeping, stomach problems, or other stress symptoms. Research on OIF returnees has indicated higher rates of sick call visits, missed workdays, and physical health symptoms among those with PTSD.

Given that veterans will be seeking medical care, and sometimes mental health support, there are some key actions that providers can take:

continued

> Know if the patient is an active duty returnee or veteran. Providers should ask patients/clients if they have served in the military and if they have been deployed. Consider including a brief PTSD screen in the written intake information packet. Mental health providers should consider using a validated measure of PTSD to assist in the assessment process.

> Become more familiar with PTSD and other post-deployment problems. The U.S. Department of Veterans Affairs (VA) and the U.S. Department of Defense have collaborated to produce a practice guideline for the management of PTSD, available online at http://www.oqp.med.va.gov/cpg/PTSD/PTSD_Base.htm. Or go to the National Center for PTSD Web site at http://www.ncptsd.va.gov to learn more about the challenges faced by returnees. Of special usefulness is the *Iraq War Clinician Guide* that outlines principles of care.

> Talk to the person. As with disaster survivors, the offer of an understanding ear and education about and "normalization" of reactions can often lead to a productive discussion of problems and the options for addressing them.

> Give written patient education materials. *The Iraq War Clinician Guide* includes handout materials that can be downloaded and shared with clients. Handouts include: *Warzone-Related Stress Reactions: What Veterans Need to Know, Coping with Traumatic Stress Reactions,* and *Warzone-Related Stress Reactions: What Families Need to Know*. A useful self-help book for returnees and their families is: Armstrong, K., Best, S., & Domenici, P. (2006). *Courage after fire: Coping strategies for troops returning from Iraq and Afghanistan and their families*. Berkeley, CA: Ulysses Press.

> Make a referral. If it is determined that an individual may be experiencing PTSD or other reactions requiring assistance, the possibility of referral should be explored. PTSD treatment can be of significant help to these individuals. Research indicates that a number of treatments are effective in reducing trauma-related PTSD and depression symptoms. The VA healthcare system has a range of services available for OIF and OEF veterans. Located across the country, they range from small, local clinics to large hospitals. At these facilities, veterans can receive help for both physical and mental health problems and consult with experts in PTSD and related problems. Vet Centers are another great resource for getting help. Vet Centers are located throughout the country and are primarily focused on helping veterans readjust to life after deployment. They offer readjustment and mental health counseling, and provide veterans with help in facing post-deployment challenges. OIF and OEF

continued

SUICIDE PREVENTION INITIATIVES

Recently, VA implemented two major suicide prevention initiatives. First, it is partnering with the SAMHSA National Suicide Prevention Lifeline (1-800-273-TALK) to link veterans in crisis to a specialized veterans call center, putting them in immediate contact with VA suicide prevention and mental health professionals. Second, VA has hired a Suicide Prevention Coordinator for each of its 153 VA Medical Centers nationwide. Their role is to track and case manage veterans identified as being at high risk for suicide (this includes vets who call the VA suicide prevention hotline and are willing to be contacted); to provide internal and community education to promote awareness of suicide risk factors and crisis management skills; and to conduct outreach to local emergency rooms, police departments, mental health organizations, and veteran service organizations to promote the development of effective veteran suicide prevention programming.

veterans are eligible to receive free healthcare and readjustment services for any conditions related to combat service through VA for 2 years following active duty. Those who served in the National Guard or Reserves and were deployed to a war zone are eligible for the same benefits. To find out more information about veterans' benefits, or to locate the nearest VA clinic or hospital, encourage individuals to call 1-877-VETS or go to http://www.vba.va.gov/EFIF. For Vet Center information, call 1-800-827-1000 or go to http://www.va.gov/rcs.

> Assist partners and families. Significant others are presented with a wide variety of challenges related to their veteran partner's PTSD. The term "caregiver burden" is sometimes used to describe the types of difficulties associated with caring for someone with a chronic illness such as PTSD. Caregiver burden includes the objective difficulties of this work (e.g., financial strain) as well as the subjective problems associated with caregiver demands (e.g., emotional strain). Partners of veterans with PTSD can experience high levels of caregiver burden that include psychological distress, negative mood, and anxiety. In general, the worse the veteran's PTSD symptoms, the more severe the caregiver burden. This means that partners of those who have been deployed may often benefit from getting involved in counseling to receive family education, join a support group that combines both partners and veterans, pursue individual counseling, or participate in couples or family therapy. VA PTSD programs and Vet Centers across the country often offer opportunities for families of veterans to get involved in treatment. The most important messages for partners are that relationship difficulties and social and emotional struggles are common when living with a traumatized veteran. Partners should seek support for themselves as well as their loved ones.

> Stay involved with care. Community providers are part of the treatment team for the returnee and his or her family even if the individual seeks care in the VA system. It is important to continue to support the individual, encourage ongoing treatment participation, and monitor progress. Community mental health providers may provide counseling services (e.g., family counseling) that supplement VA care.

This article was contributed by Josef Ruzek, Ph.D., NCPTSD, Education Division.

USEFUL WEB SITES

VA: VA's Web site provides a wide range of information on veterans' benefits and treatment facilities. http://www.va.gov

Readjustment Counseling Services Vet Centers: Information on the mission, organization, location, and contact information for Readjustment Counseling Service's Vet Centers. http://www.vetcenter.va.gov/Vet_Center_Services.asp

NCPTSD Web Site: NCPTSD is a research and education organization whose mission is to help increase the understanding about trauma and its effects. Their Web site has a wealth of information on trauma and PTSD for all audiences. http://www.ncptsd.va.gov

International Society for Traumatic Stress Studies (ISTSS) Web Site: ISTSS has a membership directory of clinicians by State who are interested or specialize in trauma and traumatic stress studies. http://www.istss.org

National Institute of Mental Health (NIMH) Web Site: NIMH has excellent overviews of a number of disorders related to trauma exposure including anxiety disorders, depressive disorders, and substance use disorders. http://www.nimh.nih.gov/health/index.shtml

Special Feature

FEMA Emergency Management Institute: Independent Study Program

The Summer 2007 issue of *The Dialogue* featured an article on the Independent Study Program offered by the Federal Emergency Management Agency (FEMA). To build on that article, a number of trainings have been selected to be highlighted for disaster behavioral health professionals.

The Independent Study Program is a series of online training courses offered to emergency management staff (Federal, State, local, and tribal) at no cost. These courses can be accessed online through the FEMA Emergency Management Institute (EMI) Web site at http://training.fema.gov. There are 59 courses available on a variety of topics relating to disaster preparedness and response. Following is a selection of courses that may be of particular interest to behavioral health professionals who are active in planning for and responding to disaster events.

IS-197.SP SPECIAL NEEDS PLANNING CONSIDERATIONS FOR SERVICE AND SUPPORT PROVIDERS

COURSE OVERVIEW

All individuals, advocacy groups, organizations, and institutions within the special needs service and support system are encouraged to be proactive and develop emergency plans. The purpose of this course is to provide representatives of the special needs service and support system with the basic information and tools to develop their own emergency plans. This course is designed for people who work with older adults and people with disabilities, and will teach how to partner with local emergency management agencies and better prepare for all phases of an emergency.

http://training.fema.gov/EMIWeb/IS/is197SP.asp

IS-240 LEADERSHIP AND INFLUENCE

COURSE OVERVIEW

Being able to lead others—to motivate them to commit their energies and expertise to achieving the shared mission and goals of the emergency management system—is a necessary and vital part of the job for every emergency manager, planner, and responder. This course is designed to improve leadership and influence skills. It addresses the following topics:

- Leadership from within
- How to facilitate change
- How to build and rebuild trust
- Using personal influence and political savvy
- Fostering an environment for leadership development

http://training.fema.gov/EMIWeb/IS/is240.asp

IS-241 DECISION MAKING AND PROBLEM SOLVING

COURSE OVERVIEW

Being able to make decisions and solve problems effectively is a necessary and vital part of the job for every emergency manager, planner, and responder. This course is designed to improve decisionmaking skills. It addresses the following topics:

- The decisionmaking process
- Decisionmaking styles
- Attributes of an effective decision maker
- Ethical decision making and problem solving

http://training.fema.gov/EMIWeb/IS/is241.asp

continued

IS-242 EFFECTIVE COMMUNICATION

COURSE OVERVIEW

Being able to communicate effectively is a necessary and vital part of the job for every emergency manager, planner, and responder. This course is designed to improve communication skills. It addresses the following topics:

- Basic communication skills
- How to communicate in an emergency
- How to identify community-specific communication issues
- Using technology as a communication tool
- Effective oral communication
- How to prepare an oral presentation

http://training.fema.gov/EMIWeb/IS/is242.asp

IS-547 INTRODUCTION TO CONTINUITY OF OPERATIONS

COURSE OVERVIEW

This course is designed for a broad audience—from senior managers to those directly involved in the continuity of operations (COOP) planning effort. The course provides a working knowledge of the COOP guidance found in Federal Preparedness Circular 65, *Federal Executive Branch Continuity of Operations*. The course provides activities to enhance COOP programs. Topics covered in the course include an overview of what COOP is and is not and the elements of a viable COOP program.

http://training.fema.gov/EMIWeb/IS/is547.asp

IS-700 NATIONAL INCIDENT MANAGEMENT SYSTEM (NIMS), AN INTRODUCTION

COURSE OVERVIEW

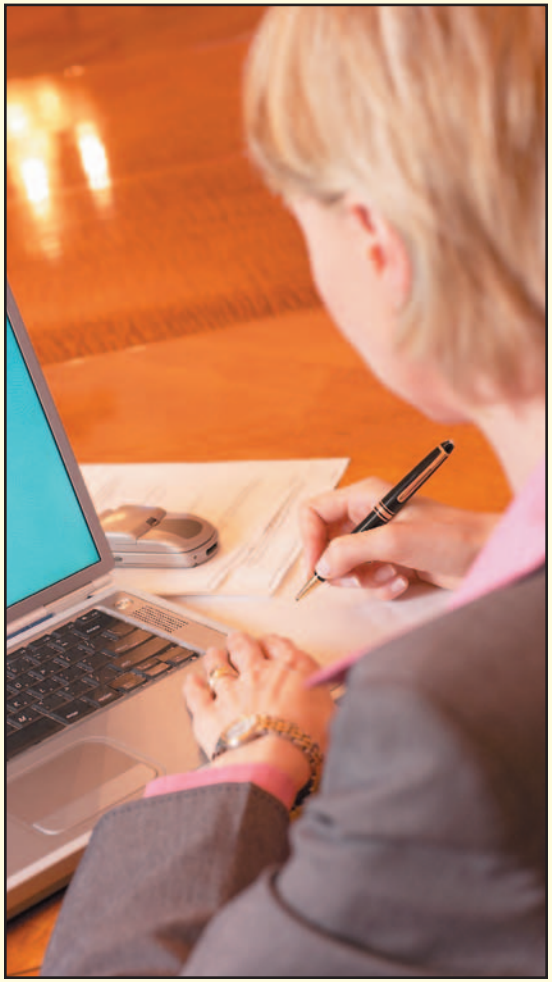
February 28, 2003, President Bush issued Homeland Security Presidential Directive (HSPD)-5. HSPD-5 directed the Secretary of Homeland Security to develop and administer a National Incident Management System (NIMS). NIMS provides a consistent nationwide template to enable all government, private-sector, and nongovernmental organizations to work together during domestic incidents (for more information about NIMS, go to http://www.fema.gov/emergency/nims/index.shtm).

This course introduces NIMS and takes approximately 3 hours to complete. It explains the purpose, principles, key components, and benefits of NIMS. The course also contains planning activity screens that give an opportunity to complete some planning tasks during the course. The planning activity screens are printable so that they can be used after course completion.

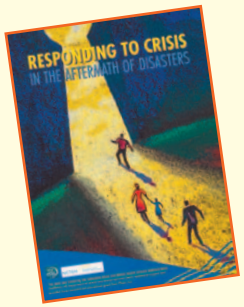
http://training.fema.gov/EMIWeb/IS/is700.asp

INDEPENDENT STUDY PROGRAM COURSE LIST

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



Recommended Reading



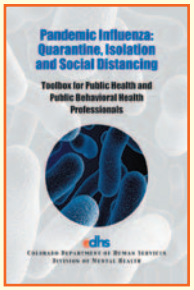
RESPONDING TO CRISIS IN THE AFTERMATH OF DISASTERS

This resource, developed by NCPTSD and the National Child Traumatic Stress Network, is a three-disc DVD series containing 16 educational vignettes that demonstrate intervention strategies for children and adults after a terrorist event or disaster. Each vignette includes background information, key teaching points, subtitles highlighting skills, and closed-captions. The vignettes are consistent with psychological first aid (PFA) and current disaster mental health practices. PFA is designed to reduce initial distress caused by disasters and to foster short- and long-term adaptive functioning and coping. It is a modular approach that includes eight core actions: Contact and Engagement, Safety and Comfort, Stabilization, Information Gathering, Practical Assistance, Connection with Social Supports, Information on Coping, and Linkage with Collaborative Services. The DVD series can be ordered from Nancy Timmons at the National Center for Child Traumatic Stress by calling 310-235-2633, Ext. 229, or by e-mailing her at ntimmons@mednet.ucla.edu

CSAT DISASTER RECOVERY RESOURCES FOR SUBSTANCE ABUSE TREATMENT PROVIDERS CD-ROM—UPDATE

SAMHSA CSAT has updated this resource with new materials, including the following: *Alcohol Screening and Brief Intervention (SBI) for Trauma Patients; Quick Guide for Administrators Based on TIP 45: Detoxification and Substance Abuse Treatment; Quick Guide for Clinicians Based on TIP 45: Detoxification and Substance Abuse Treatment; Digital Access to Medication* presentations; and CSAT Screening, Brief Intervention, Referral, and Treatment initiative information. CD-ROMs are available from SAMHSA by calling 1-800-729-6686 or by visiting http://ncadi.samhsa.gov/. The electronic version is available at http://www.samhsa.gov/csatdisasterrecovery/index.html.

PANDEMIC INFLUENZA: QUARANTINE, ISOLATION, AND SOCIAL DISTANCING TOOLBOX FOR PUBLIC HEALTH AND PUBLIC BEHAVIORAL HEALTH



Written by P. J. Havice-Cover, M.A., LPC, CACIII; and Curt Drennen, Psy.D., RN, Colorado Department of Human Services Division of Mental Health

This resource was designed and created by known experts in the field of disaster behavioral health. It is a field manual that offers planning and response guidance for public and behavioral health workers who may be caring for those infected with a contagious illness, and who may be dealing with the stress of a quarantine and isolation event. Early public health actions are outlined, along with initial-, moderate-, and high-level interventions depending on the level of exposure to disease.

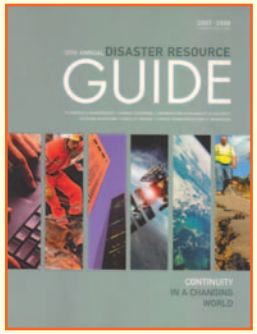
This guide offers insight into public information as it relates to common fear and the tendency for panic and rumors to emerge. The various factors that influence fear are discussed. Fear and misinformation can lead to reactions that may be detrimental to disease containment. Therefore, suggested activities are provided for professionals to help address fear, panic, and anxiety.

Topics in this guide include general disaster preparedness, staff training recommendations, information on personal protective equipment, culture and diversity, and high-risk populations. Economic, social, and compliance issues

continued

are discussed in the context of quarantine and isolation disaster management. This publication also provides the reader with a comprehensive overview of mental health issues including depression, loneliness, grief, stress management strategies, and ways to foster resilience.

12TH ANNUAL DISASTER RESOURCE GUIDE: CONTINUITY IN A CHANGING WORLD



Since 1996, the *Annual Disaster Resource Guide* has brought together the best of the best in one single volume. For those seeking disaster preparation products and materials, this guide focuses on connecting people to preparedness resources in an effort to protect families, businesses, and communities. Magazines, trade shows, associations, nonprofits, and educational institutions were involved in the development of this guide.

Numerous disaster-related articles explore issues in disaster planning and management, social concerns, information availability and security, and crisis communications and response. *Lessons from the Past—Ideas for the Future: A Review of Global Threats and Risks* discusses 23 global threats and efforts to mitigate them. *A Medical Response to Pandemic Flu* reviews health-related planning in the event of an outbreak. *Selecting an Emergency Communications Solution* outlines the need for mass notification tools in the event of disaster, and examines the necessary ingredients of such tools and how they may provide an integral service during initial response efforts.

12th Annual Disaster Resource Guide features a wide range of useful information regarding successful crisis intervention. Successful response and intervention should involve upper-level management and executives, emergency operations centers, and other authorities involved in running businesses or serving citizens. Articles review models for the public and private sectors to unite in their efforts and protect the Nation from the potentially dreadful consequences of catastrophic events.

The publishers have created a miniguide available quarterly, an online e-guide available weekly, and a daily guide, also online. For more information, go to http://www.disaster-resource.com/freeguide.

REVISED CRISIS COUNSELING ASSISTANCE AND TRAINING PROGRAM APPLICATION AND MATERIALS

FEMA, partnering with SAMHSA CMHS, has made a number of revisions to the Crisis Counseling Assistance and Training Program (CCP) application process and materials. All applicants will now be required to use the updated CCP applications.

Revised application documents are available in the CCP Guidance section of the CMHS Web site at http://mentalhealth.samhsa.gov/cmhs/EmergencyServices/progguide.asp.

Conference Highlights

2007 CONTINENTAL DIVIDE DISASTER BEHAVIORAL HEALTH CONFERENCE: SCIENCE TO PRACTICE, PRACTICE TO SCIENCE

This conference, August 6–7, 2007, was established to help bridge the divide between practitioners and scientists in the field of disaster behavioral health, and to increase the effectiveness of care provided to those affected by catastrophic events. The conference was hosted by Curt Drennen, mental health disaster response coordinator for the State of Colorado. Presenters included Steve Crimando, clinician and educator specializing in crisis management, disaster recovery, and traumatic stress; April Naturale, former director of Project Liberty and consultant on disaster response; and Charles Benight, founder and director of the Colorado Springs Trauma, Health, and Hazards Center at the University of Colorado.

"Planning for and Recovering from Pandemic," by Steve Crimando, focused on the production of antiviral medication, nonpharmaceutical remedies such as social distancing, and planning for the increased demand on healthcare systems. "From Research to Practice," by April Naturale, focused on important factors to consider during disaster, the recovery model, and encouraging survivors to tap into their own resilience. "Resilience and Recovery," by Charles Benight, offered insight into resilience, perception of resilience, and how to access people's abilities to take action in crisis.

For complete conference materials, go to http://www.cddbhc.com.

EMI BASIC CRISIS COUNSELING COURSE

This course took place August 13–16, 2007, at the National Emergency Training Center in Emmitsburg, MD. The purpose of this annual course is to prepare State and Territory mental health authorities and federally recognized tribal organizations to successfully complete CCP grant applications to respond quickly and appropriately to disasters. The training curriculum is designed for personnel who are responsible for preparing the CCP grant applications following a Presidential disaster declaration that includes individual assistance.

Up to two individuals per State were invited to participate in the training and to stay on campus. Training topics included the CCP grant application process, grant reporting requirements, disaster mental health concepts, and organizational aspects of disaster response. A fictitious State named Minnark was used for the disaster scenario materials. Participants used Minnark newspaper articles and State demographics to gather enough information to create sample needs assessments, budgets, and staffing plans. Participants were given experience in tailoring their CCP applications to deal with special populations and a late-breaking news report from Minnark revealing serious substance abuse issues.

Representatives from the following States and Territories were present at this year's training: Alaska, Arizona, Arkansas, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Puerto Rico, South Carolina, South Dakota, Tennessee, Vermont, Virginia, Washington, West Virginia, and Wyoming.

For more information on EMI and its trainings, go to http://training.fema.gov/. The Basic Crisis

continued

Counseling Course was cosponsored by FEMA and SAMHSA CMHS.

CALIFORNIA DISASTER MENTAL HEALTH SUMMIT

Cosponsored by the California Department of Mental Health and the California Department of Public Health, this summit was held in Sacramento August 23–24, 2007. It focused on disaster mental health preparedness, response, and recovery for the State of California. County disaster mental health officials from 41 of California's 58 counties attended the summit, as well as disaster mental health experts from academia and the private sector.

Plenary speakers included Harvey Kayman and Bonnie Selzler who addressed the physical, economic, spiritual, and psychological impact of pandemic influenza and the community impact of pandemic influenza, respectively. The summit addressed other topics including risk communications and the development of disaster mental health core competencies for California. In addition, Merritt Schreiber provided participants with an overview of the PsySTART Rapid Mental Health Triage and Incident Management System model. California county disaster mental health officials were actively engaged throughout the summit and worked to assess the challenges to the provision of disaster mental health services and identify priorities for the coming year.

SAMHSA DTAC participated in the summit by presenting an overview of CCP and the behavioral health implications for bioterrorism and pandemic influenza. SAMHSA DTAC also distributed more than 1,500 SAMHSA disaster behavioral health publications to summit participants.

Upcoming Meetings

OFFICE FOR VICTIMS OF CRIME TRAINING AND TECHNICAL ASSISTANCE CENTER WORKSHOP ON COMPASSION FATIGUE AND VICARIOUS TRAUMA

JANUARY 29–30, 2008
ST. LOUIS

This workshop provides an overview of the definitions and symptoms of compassion fatigue, burnout, vicarious trauma, and secondary PTSD, and will include an interactive exploration of self-care techniques, strategies for recognizing symptoms of compassion fatigue, and strategies supervisors can use to ensure balance and self-care for those they supervise. Topics include the following:

- Understanding the prevalence and symptoms of compassion fatigue and vicarious trauma
- The impact of traumatic stress and fear on victim-service professionals
- How to develop healthy coping strategies and build resiliency
- How to develop an agency self-care plan and a personal self-care plan

- Strategies for supervisors to ensure a healthy environment for staff, as well as recognize the signs of compassion fatigue in those they supervise

For more information, go to https://www.ovcttac.gov/.

WORK, STRESS, AND HEALTH 2008: HEALTH AND SAFE WORK THROUGH RESEARCH, PRACTICE, AND PARTNERSHIPS

MARCH 6–8, 2008
WASHINGTON, DC

The American Psychological Association, the National Institute for Occupational Safety and Health, and the Society for Occupational Health Psychology will convene this seventh international conference on occupational stress and health in Washington, DC, March 6–8, 2008, at the Omni Shoreham Hotel. The conference is designed to address the changing nature of work, and the implications of these changes for the health, safety, and well-being of workers. This year, the conference will focus on the translation of research to practice. Numerous topics of interest to industry, employees, and researchers are covered in the series including traumatic stress and resilience for workers in hazardous occupations and disaster relief operations. For more information, go to http://www.apa.org/pi/work/wsh.html.

continued

OFFICE FOR VICTIMS OF CRIME TRAINING AND TECHNICAL ASSISTANCE CENTER WORKSHOP ON THE MENTAL HEALTH RESPONSE TO MASS VIOLENCE AND TERRORISM

MARCH 25–27, 2008
SAVANNAH, GA

This course provides the basics of what mental health providers, crime-assistance professionals, faith-based counselors, chaplains, and others in direct contact with victims need to know to provide appropriate mental health support following incidents involving criminal mass victimization. The training includes the following topics:

- Human responses to mass violence and terrorism
- Mental health intervention
- Organizational response to mass violence and terrorism and the mental health role
- Stress prevention, management, and intervention

For more information, go to https://www.ovcttac.gov/.

18TH WORLD CONFERENCE ON DISASTER MANAGEMENT

JUNE 15–18, 2008
TORONTO, CANADA

The theme for the 2008 conference is Resiliency: Individual, Community, and Business. It will be of interest to people involved in the fields of emergency management, business continuity, emergency response, risk management, information technology disaster recovery, emergency health, and other related disaster management disciplines. Emphasis will be placed on networking and information exchange. For more information, go to http://www.wcdm.org.

CALL FOR INFORMATION

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

Announcing SAMHSA's eNetwork

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

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

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

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