



The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER BEHAVIORAL HEALTH

The Dialogue is not responsible for the information provided by any Web pages, materials, or organizations referenced in this publication. Although *The Dialogue* includes valuable articles and collections of information, SAMHSA does not necessarily endorse any specific products or services provided by public or private organizations unless expressly stated. In addition, SAMHSA does not necessarily endorse the views expressed by such sites or organizations, nor does SAMHSA warrant the validity of any information or its fitness for any particular purpose.

SAMHSA DTAC Director's Corner

It is with much enthusiasm that we premier the first edition of *The Dialogue* in this new contract period for the Substance Abuse and Mental Health Services Administration's Disaster Technical Assistance Center (SAMHSA DTAC). Since stepping into the seat as the new SAMHSA DTAC Project Director in September 2009, I have seen our team provide technical assistance to American Samoa to address its post-tsunami

disaster behavioral health needs; gather and disseminate materials for disaster behavioral health professionals responding to the earthquake in Haiti; and provide—on a daily basis—technical assistance to those who seek our services. Needless to say, it has been a busy few months. This edition of *The Dialogue* features a variety of articles ranging from the challenges of disaster preparedness and the homeless community to an update about how

Louisiana is fairing as it wraps up its services. It is my hope that you find all of the articles informative and inspiring. Please feel free to e-mail me at AMack@icfi.com with your feedback and suggestions for future articles.

Warmest Regards,

Amy R. Mack, Psy.D.
SAMHSA DTAC Project Director

Haiti Response Information

Contributed by SAMHSA DTAC staff

The U.S. Department of Health and Human Services (HHS) and SAMHSA continue to support the Federal Government's response to the earthquake that struck Haiti on January 12, 2010. The U.S. Agency for International Development is asking that all those offering assistance other than monetary donations (volunteers, goods, services) submit their offers to the Center for International Disaster Information at <http://dex.cidi.org/>. Updates to HHS's relief and support activities, including guidance for responders, can be found at <http://www.hhs.gov/haiti/>.

The impact of the earthquake in Haiti has also been felt in communities across the U.S. Many States with large Haitian populations have sought to deliver culturally appropriate mental health services for this population. Florida, for example, has received over 19,440 survivors, including refugees and American citizens repatriating from Haiti. In addition to essential services, the Florida Department of Children and Families (DCF) has provided mental health services and around-the-clock operations across southern Florida. Updates on DCF's Haiti disaster response efforts can be found at <http://www.dcf.state.fl.us/initiatives/haiti/>.

SAMHSA DTAC will continue to support SAMHSA, States, and local communities by gathering and disseminating disaster behavioral

health response materials that have been translated into Haitian Creole and French, self care resources for disaster relief workers, and other materials appropriate for use with U.S.-based Haitian communities. Please visit the DTAC Discussion Board at <http://dtac-discussion.samhsa.gov> and sign up if you'd like to access resources related to the Haiti earthquake response, post additional resources, or exchange information with peers.

Multi-State Disaster Behavioral Health Consortium's Response to the Earthquake in Haiti

Contributed by Gladys Padro, M.S.W, LSW¹

The Multi-State Disaster Behavioral Health Consortium ensures that State mental health authorities are represented in disaster and emergency response planning and preparedness activities at the national level as key partners in all Federal public health and medical preparedness and response activities. The Consortium also provides States with a forum for a collective and unified voice in national decisionmaking toward the continual shaping of the nation's emergency behavioral health preparedness and response system. In an effort to obtain a broader perspective on the response to the earthquake in Haiti, the Consortium recently

asked its members to complete a brief survey with the following items:

1. Briefly describe what you are doing in response to the Haiti disaster. If there is no response, please indicate that as well.
2. What behavioral health resources do you need to support the response in your State or Territory?
3. What gaps in services are you experiencing?
4. Do you want to participate in a multi-State call we plan to hold?
5. Would you like us to invite representatives from SAMHSA and the Office of the Assistant Secretary for Preparedness and Response's Office for At-Risk Individuals, Behavioral Health, and Human Services Coordination (ASPR ABC) to be on either this call or a future call?

The Consortium received responses from 16 States. States reported planning and preparedness activities, including meeting with their respective response partners in anticipation of needing to provide services. Some States reported a range of direct responses, while others reported no response to date but were willing to respond in the future, if needed. Response activities included meeting repatriated citizens arriving from Haiti at various airports; conducting outreach to community and faith-based organizations;

¹ Co-Chair, Multi-State Disaster Behavioral Health Consortium

and developing, translating, and disseminating materials including information to help educate responders about the Haitian culture. At the onset of the disaster, the Consortium immediately began sharing information and resource materials. In order to ease access to this content, the Consortium has added to its Web site a tab specifically focused on the Haitian disaster: <http://statedisasterbehavioralhealthconsortium.web.officelive.com/HaitiDisaster.aspx>.

The Consortium arranged a conference call to facilitate a discussion with both State and Federal partners on the issues related to the Haiti disaster response. Members of the Consortium invited all States and Territories to be on the call to share information and ask questions. A total of 28 invitees participated in the call, held January 27, 2010. Representatives from SAMHSA, ASPR ABC, and the National Association of State Mental Health Program Directors also participated. States shared their response and preparedness efforts

to date, as well as concerns regarding both the immediate and long-term ramifications of this disaster. Federal participants provided information about resources available to support States, including funding and informational materials. A discussion of target populations included persons repatriated to the United States, persons living in the United States who have ties to Haiti, and returning first responders. Feedback regarding the usefulness of the call was extremely positive.

Call participants also identified issues of concern raised by service providers as they interact with those who have been affected. Impacted individuals have reported feelings of helplessness due to the inability to help loved ones in Haiti and concern regarding lack of information about family members. Many have been grieving over the loss of loved ones, including children who have experienced the death of young family members. Others have expressed financial and immigration concerns and a great desire to facilitate bringing family members from Haiti to the United States. Lastly, States expressed concerns regarding resources to provide the following:

- > Long-term services
- > Services by people who are bilingual and bicultural
- > Case management services
- > Training focused on cultural sensitivity



Following his speech in the White House Rose Garden on March 10, 2010, President Barack Obama thanks rescue and aid workers who helped in Haiti after the earthquake. President Obama is shaking hands with Darryl Madden of FEMA External Affairs (Official White House Photo by Chuck Kennedy).

Special Feature

Louisiana Spirit Hurricane Recovery Program: Bringing Back the Spirit of Louisiana

Contributed by Louisiana Spirit Staff from the Department of Health and Hospitals, Office of Mental Health: Danita LeBlanc, M.S.W., LCSW; Pierre Washington; and Jody Bennett

The Louisiana Spirit Hurricane Recovery Crisis Counseling Assistance and Training Program (Louisiana Spirit CCP) began in October 2005, in the aftermath of hurricanes Katrina and Rita. The State of Louisiana sustained damage that no other natural catastrophe in history had created in this State. Louisiana Spirit incorporated three basic principles: engagement, empowerment, and recovery—engage citizens in their own recovery process, empower them through the services offered, and assist them with their own recovery. We discuss how the Louisiana Spirit CCP applied these principles in the sections that follow.

Engagement

The Louisiana Spirit CCP overcame cultural and situational barriers to engaging citizens in their own recovery process. The program had to consider cultural changes and had to address the fact that many first responders were themselves

survivors—and thus needed to be included in the recovery efforts with which they were helping:

The Cultural Element. Known as a “sportsman’s paradise” because of its fertile hunting and fishing areas, about 70 percent of Louisiana is rural. Hurricanes Katrina and Rita, however, affected city populations, displacing them to these rural areas. Therefore, many survivors who were familiar with the conveniences of public transportation, stores, shopping centers, and restaurants within one mile of their homes, had to adjust to vastly different surroundings. Outside their transitional living sites, their nearest neighbors could often be several miles away—and the nearest store even farther. Louisiana Spirit CCP counselors found many survivors who were experiencing signs of culture shock; they were upset, homesick, and feeling like they were in the middle of nowhere with little or no chance of ever returning home. As many homogenous communities quickly diversified with little preparation, many survivors only felt comfortable with speaking to and living amongst those who shared their race and nationality—and in some cases only those

native to a particular area or region of the State. Some survivors quickly learned that they were not welcome or safe and that it would be in their best interest to search for somewhere else to settle until completing their recovery.

A Louisiana Spirit Counselor’s Account

I met a young woman who immediately shouted out ‘I don’t want any! Whatever you are selling or giving away I don’t want any!’ I replied by saying, ‘All I have is hope,’ and I began to walk away. She asked what I meant. I then explained to her that I was with Louisiana Spirit Hurricane Recovery and we had a free crisis counseling program. I told her we could assist with referrals, so we just had hope for people who thought that things were hopeless, and for some people who just needed somebody to talk to. After talking to the survivor, hearing her story, and being able to get important resources that helped her, she said, ‘GOD bless you and the things you are doing. I will tell my neighbors about you guys!’

continued



Houses in the Jackson Barracks community of the 9th Ward, reflect the pace of recovery—one house at a time (Photo by Barry Bahler/FEMA).

Core service providers were encouraged to hire staff that matched the demographics of their local populations and to hire workers who could help broker Louisiana Spirit services into the cultures with which they were familiar. Thus, every effort was made to hire local residents and re-located survivors in order to establish rapport with and between the transplanted survivors and the local citizens.

As Hurricane Katrina approached New Orleans, many residents in the area felt that Katrina would be “just another hurricane” and thought they would be displaced for only 2–3 days. Following hurricanes Katrina and Rita, however, the scope of the damage began to sink in. Many people realized it would be weeks—if not months or

even years—before they could return home. Some began to understand that their houses were gone forever and that they would need to find a new city to call home. New Orleans would never be the same. Crisis counselors repeatedly heard the same words:

“I want to go home.”

“I miss my home.”

“Will we ever get to go home?”

“I’m so frustrated.”

“I want to give up.”

“My soul has been taken away.”

“My home is gone.”

Responding to First Responders. First responders were an essential and unique part of the hurricane recovery process. Firefighters, police officers, emergency medical personnel, and military personnel were in many cases the first to respond to the material damage and security breakdown experienced in the immediate aftermath of the devastating storms. Many of the first responders were themselves hurricane survivors who directly assisted the larger communities in the immediate aftermath of the hurricanes, often sacrificing their own personal needs and recovery issues. They were separated from or lost their families, friends, homes and property while they responded to and assisted the greater community.

For these reasons, the Louisiana Spirit CCP made first responders a priority target group of the program. Louisiana Spirit staff actively sought first responders to offer an outlet for managing the stress and grief they experienced. In addition, the program hired former and retired first responders to engage, empower, and help their peers who lost everything while supporting the larger public need. The program even created Brother’s Keeper, a DVD for first responders that addressed the impact their work had on their personal and professional lives. It was followed by a Brother’s Keeper DVD for families of first responders, which included a discussion guide.

Empowerment

Empowering survivors had everything to do with “helping survivors help themselves,” a phrase that became the cornerstone of the program and distinguished program services from clinical interventions. Louisiana Spirit focused on helping survivors find their own voice in their recovery process. Providing survivors with access to resources and information that would assist with their physical and emotional recovery and helping them learn techniques to manage their stress and the stress of their loved ones was an ongoing process involving stress management and specialized services:

Stress Management. Louisiana Spirit placed a great emphasis on stress management and self-care for both program staff and survivors. Louisiana Spirit employees were encouraged to both monitor their own stress and be attentive to the stress levels of their coworkers. This was often as simple as reminding coworkers and survivors to take a deep breath. Provider- and State-level teams included individuals designated as stress managers. Team leaders and program managers were encouraged to vary the intensity of work activities and utilize flexible scheduling to provide workers with time off for rest and recuperation. A variety of presentations and activities related to managing stress were developed and utilized with

different groups. Following presentations, many individuals approached presenters requesting more information, additional services, or both. In some workplaces, where staff regularly experienced intense interactions with survivors, stress managers conducted regular walk-arounds to touch base with employees regarding their stress management, provide opportunities to learn new skills, or offer referral to additional sources of assistance. Presentations about managing stress in the general community were also offered and created nonstigmatizing spaces for larger discussions about individual and community recovery. Louisiana Spirit employees



Louisiana Spirit worker, Michelle Young, is providing door-to-door outreach (Photo by Louisiana Spirit staff).

credit the attention paid to managing stress with being a factor that allowed them to remain positive and passionate about the work they did, and they identify stress management as a factor in their own personal recovery.

Specialized Crisis Counseling Services. The Specialized Crisis Counseling Services (SCCS) program was implemented in early 2007 as an extension of the Louisiana Spirit CCP and was based on lessons learned from programs instituted after other disasters (e.g., 9/11). SCCS goals were to (1) help individuals most affected by hurricanes Katrina and Rita return, as much as possible, to pre-disaster levels of functioning, (2) enhance resilience among those most vulnerable, and (3) prevent the development of long-term mental health problems.

The SCCS model was structured but remained flexible in order to provide assistance that met the wide range of emotional, social, and practical needs of a widely diverse population in a variety of settings. Services were supported by expert consultation and ongoing assessment by the Louisiana Spirit Compliance and Practice Directorate—a collaboration between Louisiana Spirit staff, the Department of Psychiatry at Louisiana State University–Health Science Center, the National Child Traumatic Stress Network (NCTSN), and the National Center for Posttraumatic Stress Disorders (NCPTSD).

Training, supervision, and consultation played an integral role in the SCCS program. Members of NCPTSD and NCTSN provided intensive training in brief cognitive and behavioral interventions through biweekly training and consultation sessions via videoconference. The training, entitled Skills for Psychological Recovery (SPR), includes strategies to manage stress reactions following disaster and strategies to enhance coping skills. Participants took part in a consultation session following the introduction of each new skill, and local consultants continued to provide training and supervision to develop competence and confidence in applying skills-based strategies.

SCCS interventions, in comparison to traditional crisis counseling, provided more individualized and intensive support to address the self-identified needs and priorities of survivors.

SCCS staff worked in dyads, each consisting of a Specialized Crisis Counselor (SCC) and a Resource Linkage Coordinator (RLC). SCCs provided psychological/emotional support, education, and coping skills, and RLCs provided information and assistance in accessing local resources for tangible needs and for traditional mental health and substance abuse treatment.

Following referral for SCCS, 3,009 adult and child survivors were provided a total of 10,897 SCCS contact visits. Evaluation of outcomes

revealed a significant decrease in the number and/or severity of reactions following SCCS intervention in both adults and children. Counselors reported that the interventions offered through SCCS were appropriate and beneficial for working with survivors who experienced prolonged and more intense reactions, many of whom had not responded to traditional crisis counseling. Providers favorably rated the SCCS program and reported that the documentation and paperwork involved in SCCS legitimized clinical observations and identified survivors and problems that normally would have been undetected. Providers also

highly rated the training and ongoing support for enhancing professional skills and providing feedback/advice for difficult cases. However, providers commented that training and the overall SCCS program should have started earlier in the recovery program.

Recovery

As people began returning to their homes, rebuilding their lives, and moving forward, a new dynamic took form. Staff began to see neighbors helping other neighbors recover. Counselors began to see neighborhoods coming together again, which illustrated the heart and



spirit of Louisiana—Louisiana citizens are resilient and love Louisiana. At the same time, Louisiana Spirit made an effort to hire survivors to provide services in their old neighborhoods and nearby communities. The reasoning was that community members know their community best and are thus best equipped to communicate with and obtain resources for returning residents. This eased efforts to provide services, especially in New Orleans, where there are many small, unique communities.

Recovery is never a static event like crossing a finish line; it's an ongoing process that each individual navigates in his or her own way. Survivors are on the road to recovery when they are able to establish or re-establish a support network, manage their own stress effectively, apply their lessons learned, and use new coping skills during future life-altering events. Louisiana citizens who lived through this time will always divide their life into before Katrina and after Katrina, but while some individuals are broken by adversity, many in Louisiana report that this experience made them stronger.

Life after the 2005 hurricanes in Louisiana has included both the worst and the best times of the State's residents. The catastrophe devastated many areas of the State and continues to have an impact on many parts of their lives, but the same catastrophe brought out the best in people who discovered strengths they never knew they had

and who functioned as unsung heroes in their communities. Louisiana Spirit is one pillar of the bridge that helped Louisiana citizens move from despair and destruction to the resilient recovery of their future.

Three Lessons Learned

Don't underestimate the impact of a disaster on your staff.

Many workers in a catastrophe are likely to be survivors and/or responders who have both personal and professional stressors to manage. Accept the fact that the disaster WILL have an impact on staff, and act accordingly. Monitor stress levels and the emotional intensity of the work, and facilitate a culture of self-care among staff at all levels. Developing a climate that emphasizes self-care as necessary to the effectiveness of disaster workers is crucial. Being stressed is not a determinant of fitness for duty nor a sign of mental illness, it is how effectively one manages that stress that has an impact on work and life functioning.

Social networks are crucial.

They help to keep some sense of normalcy. During the mass exodus from the coast, residents were dispersed throughout the country; there was no time to consider maintaining social networks in the evacuation process. Social networks had a huge impact on survivors' recovery processes; those individuals who re-established their social networks or created them in their new homes fared better than those who did not.

Hope is the enemy of despair.

Resilience of survivors comes from within; program staff are only catalysts in the process. It is important that CCP workers present a strong, hopeful, and resilient demeanor to survivors and community partners. Hope truly is the enemy of despair, and offering it to those who feel hopeless is one of the CCP's greatest gifts.

Emergency Preparedness, Homelessness, and Mental Health: Caring for Challenged Populations During a Disaster

Contributed by Michael Williams, M.D.¹

The basic tenets of emergency preparedness and response involve establishing such principles as clear lines of communication, a clear chain of command, and span of control. These principles are difficult enough to implement with a stable population, residing in clearly defined geographic environments with stable support systems already in place. Any of us who have provided care for people with mental health problems or people who are homeless knows that the phrase “clearly defined” does not readily lend itself to these populations.

Careful collaboration and planning between existing mental health, emergency, and community service providers is essential to ensuring that those who live on the margins of society are not subjected to disproportionate risk during emergency situations such as natural disasters, pandemic outbreaks, and human-caused circumstances like terrorist attacks. Identifying the unique hazards faced by both people with mental health problems and people who are homeless, in advance of the

need to respond, represents the crucial first step in disaster preparedness for this population. Who are the people under your care? What environmental/geographic risks are they exposed to under everyday circumstances? What particular incidents (natural or human-caused) put them at extraordinary risk? These questions are properly asked and answered by conducting thorough and frequent Hazard Vulnerability Analyses.

Given that various systems of health care, homeless services, and emergency preparedness traditionally have limited interaction under normal circumstances, I will reference the Incident Command System (ICS), rather than these other systems, to help frame the subsequent conversation. ICS and the National Incident Management System (NIMS) became the common language and framework for U.S. emergency responders in the wake of 9/11. ICS is structured to allow emergency responders to handle essentially any circumstance that might arise. In order for NIMS to be beneficial for health care and homeless services, it is important for service providers to understand the language that is typically used to manage an emergency and communicate with all involved parties. The challenge remains for the mental health and homeless services communities to not only understand the language but also be active participants in conversations.



The campus of FEMA's National Emergency Training Center, located in Emmitsburg, MD, offers a beautiful environment for first responders, emergency managers, and educators to learn state-of-the-art disaster management and response (FEMA News Photo by Jocelyn Augustino).

¹ Dr. Williams is a general surgeon who has practiced trauma surgery in Washington, DC, for the last 10 years. He most recently served as Chief Medical Officer and Assistant Fire Chief for the DC Fire and EMS Department. He is also the founder and CEO of Healthworks, LLC.

In addition to emergency response training for homeless services and mental health providers, the following suggestions could benefit any agency or care network that may need to provide health care and other services to homeless populations under emergency or disaster circumstances. Most of the systems that will be mobilized during a disaster are well versed in the language of Incident Command. What may be lacking is an understanding of the unique needs of people who are homeless or who have mental health problems. Our role as service providers is to bridge that gap. To that end, I offer the following:

Get Help! Agencies and entities that provide services to homeless populations under normal circumstances infrequently have a wealth of experience in emergency response. Gaining that experience is impractical at best, but a variety of services are available to provide training to individuals or to an entire enterprise. Free online modules are available from the Federal Emergency Management Agency (FEMA) and other U.S. Department of Homeland Security entities at <http://training.fema.gov>. Larger providers should strongly consider having as part of their staff at least one individual with practical experience in NIMS/ICS.

Know That You're Not Alone.

Emergency Medical Services (EMS) are widely available throughout the United States, frequently provided as a public service of the

local municipality. They are commonly the most frequent interface between homeless populations and other public services, and local EMS workers are often familiar with the homeless population in their service area. Local paramedics, emergency medical technicians, and homeless outreach teams will know where they live, down to the street corner or alleyway, and what other needs they might have. Establish structured, face-to-face relationships with personnel in your local EMS department; local police, fire and emergency management personnel; and homeless drop-in centers and shelters. Service providers can collaborate with these groups in training exercises, and these groups can help inform providers' disaster response plans. Any agency supporting people who are homeless or who experience mental health problems should be a partner and ally in disaster preparedness planning and training exercises. Reach out to them.

Know Which Cards You're Already Holding.

Identify internal resources well in advance of the need for them. Who will activate your internal response plan? Who will develop it for that matter? Who will serve as your incident commander, and who will interface with the rest of the incident command team? These and several other questions must be answered long before any incident arises. How do you communicate internally and will that resource work if there is a widespread power outage? This is but one

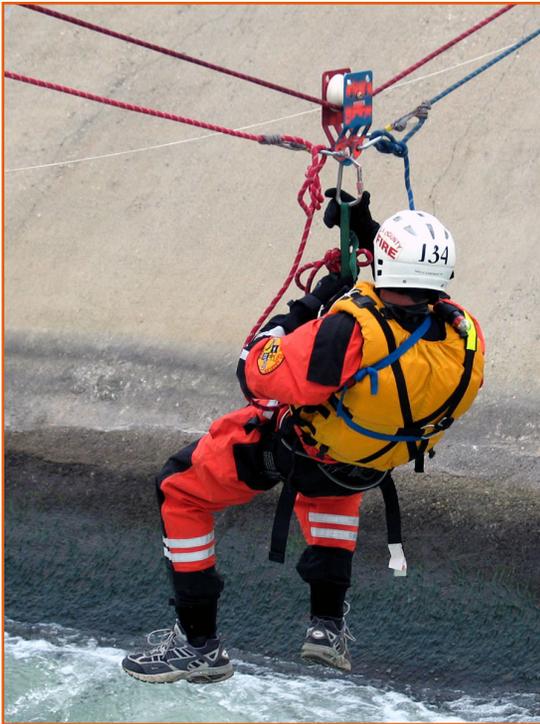
example in a long list of questions that must be answered. Again, I strongly recommend that your agency identify an outside resource or recruit new personnel to provide guidance, instruction, and training. These personnel can also serve in leadership roles during a disaster, if necessary.

Practice, Practice, Practice . . .

Develop an Emergency Response Plan. The recognized phases of Emergency Response include Mitigation, Preparedness, Response, and Recovery. Mitigation refers to the reduction of risk prior to an event occurring. This will be particularly challenging when dealing with homeless populations and people who have mental health problems, as they face immediate risks to life and health under the best of circumstances. These risks are only accentuated during disasters. How do we effectively tell an individual experiencing psychosis to seek higher ground to escape rising flood waters? How do we convince a person diagnosed with paranoid schizophrenia that the H1N1 vaccine is only going to help, not hurt him or her?

Clearly, mitigation will be among the most difficult phases of Emergency Response for this population. Having as much knowledge as possible about homeless populations under your care will likely be your best mitigation strategy. Having established routine systems of care that reduce the risk of harm to the vulnerable populations under your care will provide the best opportunity to prevent harm to

continued



Preparedness involves routine training and practice. As pictured, firefighters with L.A. County's water rescue team practice their skills during company drills (FEMA News Photo by Jason Pack).

them during a disaster. Response and Recovery are fairly self-explanatory, but I would like to expand on the challenges that the recovery phase will present. The system reads like a storybook. There is a beginning, middle, and end to each incident: fires are put out; hurricanes pass through; earthquakes end. The problem is that people who are homeless remain homeless after the event “ends”—only now the tunnel that someone used to sleep in at night may be flooded. In other words, the normal coping

mechanisms that vulnerable populations use to survive under normal circumstances are either severely compromised or entirely absent after a disaster. The mental and emotional distress that accompanies any major emergency or disaster will almost certainly affect people with existing mental health problems more severely than others. Perhaps the most difficult aspect of Recovery for vulnerable populations is that chronically stable mental states can be durably or even permanently altered.

Once you develop a plan, you and your staff must practice. Conduct drills; invite other agencies to participate in your drills; take part in theirs. Work with any and all partners you can to use those exercises to identify the unique gaps in services that vulnerable populations will face in the wake of a disaster. Alter your plan to address them. Identify additional resources that you might need to meet those needs.

Think Outside Every Box.

The day that you need to make all of this work will be incredibly challenging. Things that seemed well thought out the day prior will be derailed in the first half hour of the event. Do not worry, but be ready for it. Assume that your plans will not work completely as intended, and have “Plan B” ready to go. One of the realities of the response to Katrina was that Federal, State, and local disaster preparedness and response systems failed. That thinking lasted too long and people who should not have suffered ended up suffering. Assume

that a situation will arise that overwhelms all the tremendous plans you make in preparation. Good planning includes pre-identifying resources outside of your usual geographic location, be it your city, county, or State. Develop a regional plan that includes the means to (1) transport those who are your responsibility out of your locale and (2) receive others from neighboring jurisdictions. Partner with your counterparts in neighboring cities, counties, and States in advance so that those in your care have a place to land should circumstances require them to relocate entirely, as was the case with hurricane Katrina in New Orleans and Ike in Galveston.

In summary, preparing for a disaster that will affect people who are homeless or who experience mental health problems involves having good systems in place to meet the complex needs of the population on a daily basis, gaining a working understanding of NIMS and ICS, developing solid response plans, conducting trainings, and developing a vast network of partnerships that can help you respond to any circumstances that may arise. Considering the unique environmental challenges that homelessness poses and developing effective mitigation strategies before you need them is essential. Establishing strong, adaptable pre-disaster partnerships with other agencies that work with vulnerable populations will greatly enhance the chances that a coordinated disaster response will save lives and ease suffering during an emergency.

SAMHSA Launches the Crisis Counseling Assistance and Training Program (CCP) Online Data Collection and Evaluation System

Contributed by SAMHSA DTAC staff

SAMHSA launched the CCP Online Data Collection and Evaluation System in November 2009, representing a significant advance in disaster behavioral health data collection and evaluation. FEMA funded and SAMHSA administered CCP efforts to provide ongoing assessment and reengineering to improve the efficiency of its data collection and evaluation activities. New CCP grantees, funded as of November 2009, will use this system, rather than the Microsoft Access database in use for the last four years. The American Samoa CCP is the first to be trained on and to use the new system. The new system is more user friendly than the previous one and allows access to real-time data analysis and reporting, thus enabling the CCP to implement quick changes to program intervention strategies when necessary.

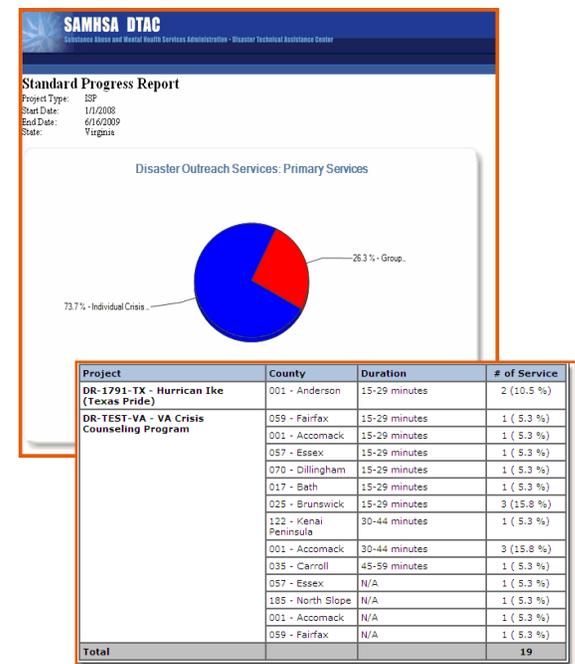
This Web-based system, in which CCP data are entered and maintained, provides for multiple levels of user access at the Federal, State, and provider levels—again in real time. Users can now generate and view program service data in a variety of report formats, allowing users to

easily insert service data reports into required quarterly and final CCP grant reports. Program personnel can also select a variety of variables to generate their own ad hoc reports. Users are better able to analyze, track, and report on various activities occurring in a CCP. The new system is designed and engineered from the ground up. It simultaneously addresses the needs of CCP local service providers, States and Territories, and the Federal partners, FEMA and SAMHSA. The Web-based format allows for data roll-up capabilities, data-archiving capabilities, and the opportunity to create charts and graphs with “the click of a button” to provide data analysis and results in various formats.

The new CCP Online Data Collection and Evaluation System also incorporates the revised CCP standard data collection forms, with an approved Office of Management and Budget (OMB No. 0930-0270) expiration date of January 2012. The CCP data forms enable CCPs to collect accurate information about service provision and service recipients, which is essential for monitoring and evaluating programs. In the past, States and Territories developed their own procedures and forms. This process was time-consuming, often missed important questions, and did not allow for cross or aggregate program reporting. SAMHSA Center for Mental Health Services (CMHS) recognized that standard reporting methods need to be implemented in

order to make the data meaningful and more accurate across disasters and across States and Territories. Thus, SAMHSA CMHS created these data collection forms to address the different components of the CCP.

The revised CCP standard data collection forms include the six previous forms (Individual Encounter Log, Group Encounter Log, Weekly Tally Sheet, Adult Assessment and Referral Tool, Participant Feedback Survey, and Service Provider Feedback Survey), as well as one new form (Child/Youth Assessment and Referral Tool). As part of the revision to the Individual Encounter Log Form, an event reactions section was added.



continued

Events include the behavioral, emotional, physical, and cognitive reactions to disaster. Responses to the event reactions section will allow CCPs to determine whether an individual needs additional or more-intensive service so that program staff can appropriately refer him or her.

As new CCPs are awarded and implemented, SAMHSA DTAC will provide training on how to use the system and the data collection forms. SAMHSA DTAC will also be available to provide ongoing technical assistance on how to use the system. The continuing acceptance and support of the CCP depends, at least in part, on its ability to show sponsors and other stakeholders that it delivers the services it intends to deliver and that disaster survivors benefit from the services provided. Therefore, SAMHSA is excited to have a new system in place to ensure the accuracy of data collection mechanisms and the soundness of evaluation findings—achievements that will prove critical to the ongoing success of CCPs on the national, State/Territory, and local levels.

If you have any questions regarding the CCP data collection forms, please contact Dr. Nikki Bellamy with SAMHSA CMHS at 240-276-2418 or nikki.bellamy@samhsa.hhs.gov.

For questions regarding the new CCP Online Data Collection and Evaluation System, please contact Brian McKernan with SAMHSA DTAC at 800-308-3515 or dtac@samhsa.hhs.gov.

Recommended Reading

Practice Guidelines: Core Elements in Responding to Mental Health Crises

People with mental health problems are vulnerable to repeated clinical and life crises that can have profound effects on the individual, as well as families and communities involved. A new resource from SAMHSA, Practice Guidelines: Core Elements in Responding to Mental Health Crises, defines appropriate responses to mental health crises. Developed by a diverse expert panel that includes individuals with and without serious mental health problems, these crisis guidelines promote two essential goals:

1. Ensure that standards consistent with recovery and resilience guide mental health crisis interventions.
2. Replace today's largely reactive and cyclical approach to mental health crises with one that works toward reducing the likelihood of future emergencies and that produces better outcomes.

Several principles are key to ensuring that crisis intervention practices are enacted appropriately. These include the following:

- > Access to supports and services is timely, allowing for 24/7 availability and a capacity for outreach when an individual cannot come to a traditional service site.
- > Peer support is available, affording opportunities for contact with others whose personal experiences with mental health crises allow them to convey a sense of hopefulness.
- > Plans are strengths-based, which helps to affirm the individual's role as an active partner in the resolution of the crisis by marshalling his or her capabilities.
- > Emergency interventions consider the context of the individual's overall plan of services.
- > Services are congruent with the culture, gender, race, age, sexual orientation, health literacy, and communication needs of the individual being served.

For a more extensive list of response principles, please read the full report. *Practice Guidelines: Core Elements in Responding to Mental Health Crises* is available in PDF format at <http://download.ncadi.samhsa.gov/ken/pdf/SMA09-4427.pdf>.

Conference Highlights

SAMHSA Task Force Presents at the International Society for Traumatic Stress Studies Annual Meeting (November 2009)

The number of large-scale disasters and mass-violence incidents in the last decade has contributed significantly to both our understanding of and the literature on behavioral health response to these events. FEMA's CCP is an integral part of the nation's disaster behavioral health response. In an attempt to improve the CCP and incorporate interventions identified by the empirical literature as most effective for ameliorating behavioral health reactions, SAMHSA commissioned a task force to analyze the CCP model and make recommendations for improving disaster behavioral health intervention. The task force recently presented its work at the International Society for Traumatic Stress Studies (ISTSS) 25th Annual Meeting, held in November 2009.

The theme of the ISTSS Annual Meeting was Traumatic Stress Disorders: Toward DSM-V and ICD-11. Many of the presentations focused on the process of revising the DSM and ICD, as well as specific issues being revised. Additional topics included innovations in evidence-based

interventions, diversity, posttraumatic stress disorder, and assessment.

Led by Linda Ligenza, ACSW, of SAMHSA CMHS, presenters on the CCP model analysis also included Patricia Watson, Ph.D., from NCPTSD; Patcho Santiago, M.D., from the Uniformed Services University of Health Sciences; and Kristine Thimm, M.A., from SAMHSA DTAC. Titled "Making Disaster and Mass Trauma Behavioral Health Services More Evidence-Informed," the presenters reviewed the process of analyzing the CCP and outlined next steps.

The CCP model analysis itself consisted of three different efforts. To begin with, the task force reviewed stakeholder feedback on the CCP and its interventions. This included a review of reports from or about the CCP, including the 2005 hurricanes Katrina, Rita, and Wilma meeting report; the Office of the Inspector General Assessment; the U.S. Government Accountability Office Review; and a sampling of CCP final reports. This effort also included feedback from the evaluation of SCCS as implemented in Mississippi, Louisiana, and New York following hurricanes Katrina, Rita, and Wilma and 9/11. Data from participant and provider feedback collected from 22 CCPs were also integrated.



The second effort of the analysis was to review recent empirical literature regarding risk and resilience factors, as well as post-disaster individual- and community-level behavioral health interventions. The task force searched the NCPTSD database, resulting in 40 published empirical studies from the last 6 years and 60 published studies discussing traumatic stress and grief interventions applied in non-disaster settings. Interventions reviewed include psychological debriefing, cognitive behavioral therapy, eye movement desensitization and reprocessing, school-based interventions, family-support interventions, and community-level interventions, as well as medical and complementary interventions.

continued

Finally, a panel of disaster behavioral health experts in both research and practice reviewed findings from the literature review and stakeholder feedback. Panelists included representatives from FEMA, NCTSN, NCPTSD, and the U.S. Public Health Service; academic researchers; State disaster behavioral health coordinators; and behavioral health providers with experience in implementing CCPs. The panel received a written summary of the report and participated in a teleconference, both of which reviewed the findings of the task force. Panel members provided feedback through two rounds of questionnaires that gathered information about programs and services, individual and community interventions, staffing and program issues, and policy recommendations.

The findings and recommendations of this process have been analyzed and compiled in a white paper currently under review by SAMHSA and FEMA. This analysis is one component of the ongoing process to ensure that the CCP provides the most current, evidence-based interventions, as well as the most efficient strategies, for reaching large populations.

Upcoming Meetings

INFORMATION SYSTEMS FOR CRISIS RESPONSE AND MANAGEMENT (ISCRAM) 2010: DEFINING CRISIS MANAGEMENT 3.0

MAY 2–5, 2010; SEATTLE, WA

The purpose of the ISCRAM 2010 conference is to define Crisis Management 3.0 and bring together perspectives from the socio-technology and human behavior domains of crisis response and management. <http://www.iscram.org/iscram2010>

DISASTER FORUM 2010

MAY 10–13, 2010; ALBERTA, CANADA

The forum will discuss emergency management, psychological response, legislative issues, and aspects of emergency preparedness and training. <http://www.environmental-expert.com/resultteachevent.aspx?cid=21654&codi=3826>

NATIONAL VOAD 18TH ANNUAL CONFERENCE

MAY 11–13, 2010; ORLANDO, FL

Sessions include collaborative planning, disaster case management, pastoral care, and community resilience. The conference will be attended by Federal representatives and hundreds of national, State, and local VOAD representatives. <http://www.nvoad.org/Conference/2010/tabid/99/Default.aspx>

2010 DISASTER RESPONSE AND RECOVERY EXPO

MAY 11–13, 2010; NASHVILLE, TN

The purpose of the Expo is to provide an opportunity for local, State, and Federal public health and emergency preparedness practitioners and policy makers to discover the latest equipment, technologies, and services available in a disaster preparedness, response, and recovery situation. <http://events.jspargo.com/drre10/public/enter.aspx>

INTEGRATED MEDICAL, PUBLIC HEALTH, PREPAREDNESS AND RESPONSE TRAINING SUMMIT

MAY 12–16, 2010; NASHVILLE, TN

The training summit, sponsored by the U.S. Department of Health and Human Services, will focus on integrating the knowledge, skills, and abilities of the participants to improve their capability to deliver public health and medical services during disasters of any origin. <http://www.integratedtrainingsummit.org/>

NATIONAL DISASTER PREPAREDNESS SUMMIT

MAY 13, 2010; MIAMI, FL

Presentations will cover pandemic, avian influenza; risk analysis and impact of potential disasters; county fire department planning; Federal, State, and local government disaster planning preparation; and many other topics. Resources are from the Department of Homeland Security, Centers for Disease Control and Prevention, and the American Red Cross. <http://www.nationaldisastersummit.org/>

continued

Upcoming Meetings

INTERNATIONAL CRITICAL INCIDENT STRESS FOUNDATION (ICISF) CONFERENCE

MAY 13–16, 2010; GRAND RAPIDS, MI

This ICISF conference will focus on emergency services and crisis response. <http://www.icisf.org/Training/calendarofcon.cfm>

DISASTER MANAGEMENT AND CRISIS RESPONSE 2010

MAY 23–26, 2010; ABU DHABI, UNITED ARAB EMIRATES

Presentations will address emergency and disaster management issues from the perspectives of military and government officials, as well as medical representatives. <http://www.disasterandcrisisresponseme.com/Event.aspx?id=262892>

2010 COMMUNITY WELLNESS CONFERENCE

MAY 26–27, 2010; BILOXI, MS

Conference topics include mental and primary health, faith-based programs, and disaster preparedness and response. <http://www.msidf.org/2010cwchome.html>

DAVOS 2010: INTERNATIONAL DISASTER AND RISK CONFERENCE (IDRC)

MAY 30–JUNE 3, 2010; DAVOS, SWITZERLAND

IDRC Davos 2010 will focus on the risks society is facing today, as well as integrated strategies to manage and reduce these risks and disasters. Topics include urban risks, critical infrastructures, pandemics, and climate change adaptation. <http://www.idrc.info/>

WORLD CONFERENCE ON DISASTER MANAGEMENT (WCDM)

JUNE 6–9, 2010; TORONTO, CANADA

The WCDM brings together practitioners, certifying bodies, and service and product suppliers for emergency management, as well as business continuity and other disaster management disciplines. <http://www.wcdm.org/>

INTERNATIONAL CONFERENCE ON DISASTER PSYCHOLOGY

JUNE 7–8, 2010; BERGEN, NORWAY

This conference will address the psychological aspects of disasters. http://krisepsyk.no/Engelsk/English_presentation.htm

INTERNATIONAL CRITICAL INCIDENT STRESS FOUNDATION (ICISF) CONFERENCE

JUNE 9–13, 2010; SAN FRANCISCO, CA

This ICISF conference will focus on emergency services and crisis response. <http://www.icisf.org/Training/calendarofcon.cfm>

NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS ANNUAL CONFERENCE 2010

JULY 14–16, 2010; MEMPHIS, TN

Speakers will discuss evidence-based practices, programs, policies, and systems that advance both the physical and mental health of individuals and the wellness of communities. <http://www.naccho.org/events/nacchoannual2010/>

NATIONAL DISASTER PREPAREDNESS SUMMIT

JULY 22, 2010; HOUSTON, TX

This conference will include presentations about pandemic, avian influenza; risk analysis and impact of potential disasters; county fire department planning; Federal, State, and local government disaster planning preparation; and many other topics. Resources are from the Department of Homeland Security, Centers for Disease Control and Prevention, and the American Red Cross. http://www.nationaldisastersummit.org/index.php?option=com_events&task=view_detail&agid=19&year=2009&month=7&day=16&Itemid=1&catid=13

AMERICAN PSYCHOLOGICAL ASSOCIATION (APA) ANNUAL CONFERENCE

AUGUST 12–15, 2010; SAN DIEGO, CA

This conference will offer the latest information on current topics in education, public interest, behavioral health, practice, and science, as well as provide a selection of workshops, sessions, and exhibits on behavioral health. Psychological products, publishers, and testing materials will also be on exhibition. <http://www.apa.org/convention/index.aspx>

continued

Upcoming Meetings

15TH INTERNATIONAL CONFERENCE ON VIOLENCE, ABUSE, AND TRAUMA

SEPTEMBER 12–15, 2010; SAN DIEGO, CA

This conference will focus on adult survivors, at-risk youth, child maltreatment, children exposed to violence, intimate partner violence, victims and offenders, sexual assault victims and offenders, human trafficking, trauma in the military and military families, and other special trauma topics. <http://www.ivatcenters.org/>

AMERICAN ASSOCIATION FOR THE TREATMENT OF OPIOID DEPENDENCE CONFERENCE 2010

OCTOBER 23–27, 2010; CHICAGO, IL

The conference theme, “Building Partnerships: Advancing Treatment and Recovery,” focuses on the opportunities afforded by partnering with other entities to advance treatment and recovery. <http://www.aatod.org/2010chicago.html>

ABOUT SAMHSA DTAC

Established by SAMHSA, DTAC supports SAMHSA's efforts to prepare States, Territories, and local communities to deliver an effective mental health and substance abuse (behavioral health) response to disaster. SAMHSA DTAC provides disaster behavioral health preparedness and response consultation; develops resource collections addressing disaster behavioral health planning, special populations, and emergent topics; and supports collaborations between Federal entities, States, local communities, and nongovernmental organizations. To learn more about SAMHSA DTAC, please call 1-800-308-3515, e-mail dtac@samhsa.hhs.gov, or visit <http://mentalhealth.samhsa.gov/dtac/>.



Louisiana Spirit workers from Northern Louisiana pose at the end of their Federal site visit presentation (Photo by Louisiana Spirit staff).

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. *The DTAC Bulletin* is a monthly e-communication's vehicle intended to serve as a supplement to *The Dialogue*. Through *The DTAC Bulletin*, SAMHSA DTAC announces updates of interest to the disaster behavioral health field, posts upcoming activities, and highlights new resources.

If you would like to receive *The Dialogue* or *The DTAC Bulletin* or have information or resources you would like to share with your colleagues, please contact SAMHSA DTAC at 1-800-308-3515 or e-mail dtac@samhsa.hhs.gov.