



# The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER MENTAL HEALTH AND SUBSTANCE ABUSE

## 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 Kerry Crawford at [dtac@esi-dc.com](mailto:dtac@esi-dc.com).

## JOIN THE DIALOGUE DISCUSSION BOARD

Do you have a question you would like to share with fellow disaster behavioral health

coordinators? Are you frustrated with thwarted efforts of collaboration with other agencies or organizations? Have you found a resource you think others might find useful in planning?

Send your questions and responses to *The Dialogue* Discussion Board, and we will include your comments and queries in the next issue (Summer 2005).

**Our first discussion topic was:** How could your department benefit from a disaster behavioral health online training? What topic do you think is of the highest priority and the greatest use to your State/Territory?

## RESPONSE:

“The topic I currently would most like to see is information on behavioral health issues and response associated with quarantine and isolation circumstances. I’m also interested in any information on behavioral health support in a Federal model (probably NTSB) Family Assistance Center-Virginia wants to establish FACs in the aftermath of a major event.”  
*Bill Armistead, Virginia Disaster Mental Health Coordinator*

**Our next discussion topic question is: Does behavioral health participate in your State’s Homeland Security exercises and simulations?**

# *A Strategic Approach to Integrated Disaster Mental Health and Substance Abuse All-Hazards Planning and Response*

Upon receipt of the State Capacity Expansion (SCE) Grant from SAMHSA, the Maryland Mental Hygiene Administration (MHA) and the Maryland Alcohol and Drug Abuse Administration (ADAA) created the position of Coordinator of Disaster & Emergency Services. This position was to work with MHA's Director of Trauma and Disaster Mental Health Services, who had been solely managing disaster-related projects in addition to numerous other trauma treatment programs and activities.

Among the duties assigned to the Coordinator was facilitation of integrated and collaborative all-hazards planning for the two separate administrations, both of which are part of the Maryland Department of Health and Mental Hygiene (DHMH). Each administration functions independently having its own mission and activities. This created a significant challenge when efforts to accomplish integrated planning were initiated. The needs and mandates of each administration were such that activities directed at enhancing the emergency response abilities of both were undertaken, separately at first. Concurrently, however, opportunities for overlap and collaboration between mental health and substance abuse services, as they relate to

emergency planning and response, were pursued and today remain a focus. The Coordinator, along with the MHA Director of Trauma and Disaster Mental Health, developed a strategy to maximize integrated planning by focusing on educating MHA and ADAA leadership and staff, and on fostering the creation of cooperative prevention and response methods and protocols in both administrations.

## **CREATING “BUY-IN”**

Prior to the creation of a useful all-hazards plan, buy-in from every level of each administration and among local service agencies was essential. The Coordinator, to this end, established regular meetings with MHA and ADAA managers and staff to provide information and education about the role mental health and addictions providers and each administration could play prior to, during, and after an emergency event. Senior managers were encouraged to consider the daily operational duties of their areas in the context of a disaster and to speculate on how tasks and functions may temporarily be disrupted or altered to meet emergent needs of local providers and community members. During this process, it became

clear that personnel at the MHA were able to conceptualize the role mental health community providers would play during and after a disaster or emergency event, although the role of administration personnel was less clear. The ADAA, as more of an oversight agency, seemed to find the articulation of an expanded role in relation to emergency planning and preparedness more of a shift in their priorities and operational expectations than MHA, as did many of their local agencies and providers. Largely, this was due to the perception of the limited role addiction services have played in all-hazards event response and recovery.

To address these issues, the Coordinator attended staff meetings and also spoke with key staff members one-on-one to familiarize them with the concepts of disaster, all-hazards planning, the Incident Command System, and disaster mental health. Increasing the awareness of the broad range of behavioral health implications that most emergency events include was of primary concern. Scenarios that necessitated thinking beyond normal daily business practice and that highlighted needs precipitated by natural and manmade emergency events helped both MHA and ADAA staff better understand

*continued*

the importance of planning ahead and establishing realistic emergency protocols and procedures.

The Coordinator also established and chaired an All-Hazards Behavioral Health Planning Advisory Committee, made up of representatives from State and local government, providers, and advocacy groups in both the mental health and substance abuse communities. The Advisory Committee determined that each administration should have its own all-hazards plan, but that each plan should complement and overlap with the other to as large a degree as possible. Gaps in the State's ability to mitigate the distress and behavioral health implications that typically follow a disaster were identified and ideas were generated to address them. Each administration was asked to assign staff to write the first draft of their All-Hazards Plan, with the technical support and guidance of the Coordinator. By the end of the first year of the SCE Grant period, the first draft of both ADAA's and MHA's all-hazards plans had been submitted to the All-Hazards Behavioral Health Planning Advisory Committee for review and feedback.

## TRAINING AND EDUCATION

A critical aspect of the overall planning strategy was to develop and deliver disaster-related

training to State and local public health, mental health, and substance abuse agencies as well as to agency and individual providers in both fields. New training programs, designed by the Coordinator and contracted consultants, emphasized skills necessary to manage the behavioral health aspects of emergency events. The training sessions were funded through Health Resources and Services Administration (HRSA) and Centers for Disease Control and Prevention (CDC) grant funds, as well as through the DHMH's general training funds. The topics developed included: All-Hazards Planning and Emergency Response, Crisis Communication During Disaster, Stress and Self-Care During Emergency Response, Psychological Reactions to Disaster and Terrorism, and Incident Command. These training sessions were made available free of charge to anyone interested and were marketed specifically to State and local public health department personnel as well as to crisis hotline staff, volunteers, and service providers.

## VOLUNTEER CORPS

A useful vehicle to encourage collaboration and participation of professionals from both the mental health and addictions fields was the Maryland Mental Health Volunteer Corps. Established by DHMH as part of its overall health and medical services volunteer program,

the Volunteer Corps recruited State-licensed behavioral health professionals to be trained to provide disaster mental health services in response to any emergency event that exceeded a local jurisdiction's resources. Volunteers were trained to understand State emergency and disaster response systems and protocols and were taught psychological first aid interventions that could assist community members and responders in the acute phase of emergency response.

Due to the limited nature of disaster mental health training and experience among most of the State's substance abuse providers, the Coordinator modified the Volunteer Corps curriculum to better engage addictions prevention and treatment professionals. A 4-day training on disaster mental health for substance abuse providers, as well as for ADAA leadership and staff, was delivered at the ADAA's annual training retreat. The workshop provided an overview of all-hazards planning and response. It allowed providers to practice crisis intervention skills for both individuals and groups affected by disaster. The training also addressed the relationship between substance use and abuse and the psychological impact of disasters.

Participants were asked to determine their potential role and the role of their agencies during each phase of emergency response: preparedness, mitigation, response and

*continued*

recovery. They were asked to determine specific things they could do now to be better prepared to provide disaster-related service both to their own consumers, as well as to the population at large. Finally, the workshop addressed self-care during disasters and participants created a self-care plan to allow them to manage the unique stress often experienced by behavioral health responders during an emergency event. The course was well-received and ADAA training staff decided to offer it on an annual basis during the summer educational retreat. In addition, sections of the course will be delivered throughout the year through ADAA's Training Division by instructors trained by the Coordinator to ensure the administration's long-term ability to provide this curriculum.

## PARTICIPATION IN DRILLS AND SIMULATIONS

Prior to the SCE Grant award, MHA and ADAA typically had little input or participation in State and local drills and simulations, even those sponsored by DHMH. The Coordinator was able to advocate for inclusion of behavioral health staff in the planning of emergency exercises and for local behavioral health providers to be participants in the resulting drills and simulations. As the awareness of the need to monitor behavioral health concerns in addition to physical health and safety concerns

grew, the role of staff involved in disaster planning at MHA and ADAA expanded to include exercise evaluation. The Coordinator was eventually able to ensure that injects specifically related to behavioral health were included during exercises so that public health and emergency management staff could better understand that mental health and substance abuse providers are a significant resource. Incorporating Medication Assisted Treatment (MAT) program closures or the arrival of individuals with mobility, language, or cognitive issues at mass inoculation sites and shelters, challenged drill planners to reach out to behavioral health professionals and volunteers and to welcome their presence and participation in these exercises.

## MEDICATION ASSISTED TREATMENT

A particular challenge was the need for improved all-hazards planning for MAT providers, particularly those dispensing methadone. Although all such programs are required to have an emergency plan, most of these were basic and primarily outlined procedures to be utilized during weather-related emergencies. The concept of all-hazards planning had not been considered overall and many plans were not adequate when looked at in relation to complex and potentially traumatic

events. The Coordinator worked with the Maryland Methadone Authority (MMA) to address this by convening meetings designed to assist the MAT providers to create an all-hazards plan for each of their programs. In the first meeting, the concept of all-hazards planning was introduced and the ways in which this planning approach differs from emergency planning that has traditionally been done by MAT programs were highlighted. A template and a checklist of essential components to an all-hazards plan were provided and MAT program representatives were asked to review current emergency plans in comparison and then to complete the checklist.

During the second meeting, program representatives brought back their checklists and discussed the specific actions they would take to revise and update their plans. A model health clinic plan was obtained from SAMHSA which was given to each program to use as a template. Programs were then asked to complete a draft all-hazards plan and send it to the Coordinator and the MMA for feedback and assistance. In the third meeting, a local MAT program's plan, based on the model and modified to better reflect the needs of MAT programs and clients, was provided electronically to all programs. They were encouraged to use this plan and alter it to reflect their specific pro-

*continued*

gram needs. Final drafts of all-hazards plans have been and continue to be forthcoming from MAT programs across the State. A multi-staff review process of the plans has been established to include ADAA compliance personnel in addition to the MMA and disaster planning staff.

## HOTLINE ONLINE TRACKING SYSTEM

Prior to receiving the SCE Grant, MHA and ADAA had commenced work on some collaborative projects related to emergency response. The Hotline Online Tracking System (HOTS) is a real time reporting and surveillance system, developed for the Maryland Crisis Hotline Network. It allows calltakers at the hotlines to record relevant demographic and assessment information during a call. Information collected during the call, which includes behavioral health data, can be pulled from the system to assist public health personnel monitor needs and concerns, mobilize resources, and implement interventions efficiently.

HOTS has an instant messaging capability that allows designated individuals to broadcast information to every user on the system. Emergency procedures, shelter locations, alternate MAT program sites, and public health advice can be disseminated quickly and

uniformly across the State to all participating crisis hotlines. Most importantly, HOTS is part of the hotlines' everyday business practice as they utilize it to record and report data for MHA and ADAA about behavioral health issues during periods of non-emergency. The HOTS program was utilized by DHMH when the influenza vaccine shortage was announced. The hotlines were provided with scripts and information that was disseminated to callers. Additionally, the hotlines were asked to track whether or not there was an increase in calls related to the vaccine shortage. Because HOTS is utilized every day, mental health and substance abuse issues are, therefore, considered by both administrations even prior to an all-hazards event, making integrated efforts to meet these needs during emergency events that much more seamless and likely to be successful.

## ALTERNATE SITE

The MHA and the ADAA are located in separate buildings which contributes to the difficulty of collaborative programming efforts. To foster the likelihood of successful and integrated emergency response, the disaster planning staff elected to identify one site for both administrations to utilize or to share in the event of a disaster that rendered their primary sites unavailable. Command and essential staff for MHA and ADAA will be able to work side-by-

side while assessing behavioral health issues and concerns and mobilizing resources. Duplication of effort or conflicts in strategy will be minimized and the entire behavioral health response will be more comprehensive with both administrations' leadership and incident command staff at the same location.

## MODIFICATION OF REGULATIONS

Along with efforts to improve the knowledge and abilities of those providing and monitoring behavioral health services in the State, it was decided by both MHA and ADAA that modifications to the regulations and guidelines for their providers were needed. Both administrations recognized that, at a time when personnel and financial resources are limited, many providers and programs are struggling to prioritize efforts to meet the complex and numerous needs of the populations they serve. To encourage State-funded agencies and programs to include all-hazards planning and response in their focus, both ADAA and MHA drafted and included language into their regulations that specifically requires an all-hazards plan that meets guidelines developed by each administration. These guidelines have been developed into a checklist that has been provided to all funded agencies, programs, and facilities. Procedures have been established by

*continued*

both administrations for a committee review of the all-hazards plans and all programs have been offered or given technical assistance to meet this regulatory stipulation. A template developed by a contractual consultant was given to each mental health authority and, as previously discussed, the MAT programs received a template to refer to as well. Not every mental health and substance abuse program has submitted an all-hazards plan to date. However, the majority of them have and the new ADAA and MHA regulations will require those programs with plans outstanding to complete a draft for submission and review in order to remain in compliance with funding criteria.

## CONCLUSION

Effective all-hazards planning can best be done through efforts aimed at every level. Policy, administration and service provision personnel must recognize the need for participation in and a focus on disaster and emergency response. They must also realize that effective response requires their involvement at the planning and preparedness stages. Collaboration and cooperation are best achieved through pre-established relationships and clear expectations of roles and duties. Planning, like emergency plans, is a process that requires a strategic approach with short and long-range goals. One way to make advancements in the considerable challenge of

integrating and elevating substance abuse and mental health services in relation to emergency events, is to utilize education, drills, cooperative projects, and policy to achieve the buy-in and prioritization necessary to effect real change. Finally, it is advisable to identify personnel or establish a position whose primary role is to advocate for and enhance the role of behavioral health in State and local emergency planning and response efforts.

*This article was contributed by Rachel E. Kaul, L.C.S.W., C.T.S., coordinator of disaster & emergency services for the Maryland Mental Hygiene Administration and the Maryland Alcohol and Drug Abuse Administration.*

## *Reflections from the Project Director: Wildfire Recovery Project, FEMA 1498 DR-CA*

Beginning October 21, 2003, a series of 13 wildfires burned throughout a five-county area of southern California including San Bernardino, San Diego, Los Angeles, Riverside, and Ventura Counties.

Fueled by years of drought, forests of dead trees and erratic shifts of seasonal Santa Ana winds, the firestorm's path left many communities with little time to evacuate. Some people had no warning how close and fast the fires were burning until flames were shooting through residential backyards in suburban areas rarely in danger of wildfires. More than 300,000 people were evacuated to shelters across the region. Business as usual stopped in the wake of the fires in some counties. City and county offices, private businesses, and schools were temporarily closed; two international airports had to discontinue flights due to visibility problems; and major arterial freeways and public roads were impassable for several days.

The fire conditions presented unprecedented challenges to firefighting experts. At the peak of the fires, approximately 13,200 first-response personnel were dedicated from throughout

California and other states. In total, 23 people were killed, approximately 600 injured, and more than 3,500 homes were destroyed or severely damaged. Classified as one of the worst, and at that time, the most expensive disaster in California history, some of the fires were not fully extinguished until December 16, 2003.

California received a Presidential Disaster Declaration for the five-county region on October 27, 2003, and the FEMA Crisis Counseling Program (CCP) Immediate Services Program (ISP) and Regular Services Program (RSP) grants were implemented in three of the most severely affected counties. Ending December 22, 2004, the ISP and RSP combined to provide up to 14 months of services for fire survivors in San Bernardino, San Diego, and Los Angeles Counties. The California Department of Mental Health (DMH) was the administering state department. In my role as the department's Disaster Assistance Coordinator, I was the Project Director for the FEMA 1498 Wildfire Recovery Project.

The ISP and RSP were very successful in serving fire survivors through outreach and brief

counseling services, support groups, public education and speaking, facilitating community capacity building and promoting resiliency, thereby empowering people and communities to heal from the trauma of the fires.

Many lessons were learned from the Wildfire Recovery Project. A brief summary of some of the key lessons follows:

**>> Give careful consideration to funding a sufficient level of State staff to administer the FEMA CCP ISP/RSP**

Heading into the FEMA CCP funding cycle, it is difficult to gauge how many State administrative staff will be needed to administer the ISP/RSP. Key administrative responsibilities remain constant regardless of the funding level of the grants: overseeing daily project operations; data collection; ensuring sufficient orientation and training for all levels of project personnel; organizing training events; developing and injecting “just in time” training as needed; and conducting site visits and providing technical assistance as well as fiscal oversight of grants.

DMH contributed my participation as the Project Director in-kind to the FEMA CCP

grants. This caused a reduction of attention to other crucial work activities, such as statewide planning/preparedness, participation with bioterrorism and capacity-building grant duties and other responsibilities conducted in non-disaster times. Multitasking is an art, but it took on new forms during 2004.

In the future, DMH will request funding for additional State-level personnel to assist with implementation of the FEMA CCP or to backfill for other disaster-related duties.

>> **Increase service levels as soon as the need for increases are identified**

ISP outreach efforts identified the need to expand services to new communities.

Accordingly, increased staffing was included in the RSP grant application. Delays in receiving the RSP grant, coupled with the hiring process time for new outreach workers, caused a lag in services to some communities by nearly 6 months. Upon entering the communities so long after the actual fires, community members were skeptical of the services after such a long delay. Eventually, outreach workers made strides in the new communities. In the future, as soon as need is identified, the State will request additional funding under the ISP to increase the number of outreach workers to expand services rather than wait for the RSP to begin.

>> **Challenges in reaching target populations**

Many target populations were identified for

outreach services. However, the most well-intended plans met challenges in delivering services to:

• **First-response personnel**

Based on the disaster mental health needs assessment following the fires, the State and county perspective was that first-response personnel, especially firefighters, could benefit from stress management services after witnessing unusually high numbers of home and personal property losses.

The advent of organized and provider-specific Employee Assistance Programs (EAP) resulted in fire and law enforcement departments declining services from the Wildfire Recovery Project. Any and all stress management services must be provided by a contract EAP provider. Of continuing concern for many months, reports indicated that EAP services might never have been arranged for a majority of responding departments.

Some progress was made in providing services to ancillary personnel, such as 911 operators, dispatch personnel and other public works employees, but fire and police never participated in the services offered.

• **Native Americans**

Several Native American reservations experienced wide-scale loss from the fires. While services were eventually accepted, it took many months of continued efforts by

indigenous outreach staff to enlist Native American participation in services. It was a valuable lesson that culturally-appropriate persistence pays off, but must conform to the timeline and interest of those who take part in services.

• **Children**

Another lesson in persistence and patience was based on engaging children and their families through affiliation with schools. Enlisting the participation of schools was challenging and took an extensive period of time. Then, once inroads were made, summer vacation disrupted the rhythm of established services. Services had to be promoted and reestablished at the beginning of the new school year. Even though there are inherent challenges, providing services through the school network is one of the best ways to serve children and families.

After a disaster, there is a flurry of concern over reaching numerous priority target populations based on assessed and perceived needs. While fervent planning and outreach efforts are necessary, it is important to recognize that the timeframe and methods for engaging each target population will be unique. People participate in services when they are ready. A proof of success is in the quality of the efforts made to reach specific target populations, not just the number of people served.

*continued*

>> **Naming and describing FEMA CCP services**

By hearing the name FEMA Crisis Counseling Program, some people presumed that counseling services, such as the type offered through EAP, insurance or private pay would be provided: private, 50-minute sessions in an office location over a period of weeks or months as needed. For best results, promoting the FEMA CCP as an outreach and community support program can reduce misconceptions about “counseling” services. Also, avoiding a project name that has the word “counseling” in it will help. Over time, all outreach teams referred to the project as the Wildfire Recovery Project and avoided using the term Crisis Counseling Program.

The three county-based Wildfire Recovery Projects were quite successful and rewarding to administer. While they were ongoing, I often looked forward to returning my attention to duties temporarily set aside. In retrospect, I miss the projects and look forward to helping Californians if a future disaster impacts the State.

*This article was contributed by Kathy Clark, project director of the Wildfire Recovery Project and disaster assistance coordinator, California Department of Mental Health.*

## *Disaster Mental Health Institute: 10 Years and Counting at The University of South Dakota*

Disasters come in countless varieties and levels of intensity. They strike suddenly and unexpectedly, as exemplified by the tsunami of December 26, 2004. The most apparent effects are physical, particularly that which can be counted in terms of lives lost, property destroyed, and economic costs in dollar amounts. The emotional suffering and psychological impact are also palpable, and can be felt by those who arrive to help the often stunned and overwhelmed survivors. Grief and loss are often profoundly present, but so are relief and a sense of hope for recovery as neighbors and strangers come from far and wide to lend their skills, energies, and resources to those less fortunate. A majority of the affected population are likely to recover with few apparent signs of lasting harm. Life will return to “normal,” though normality will have been redefined. The disaster and its consequences will be woven into personal and collective histories. Some survivors, however, will bear a more lasting emotional and psychological toll and may benefit from mental health psychological support to ease their pain and support effective coping.

Several key events have informed the mental health community regarding common psychological responses to disasters and which approaches to intervention might prove most effective. A very brief list includes Hurricane Andrew (1992), the Oklahoma City Bombing (1995), and September 11, 2001. Each of these disasters led to major disaster mental health operations and all were studied by researchers who confirmed that grievous psychological harm was inflicted by these devastating events. Several airplane crashes, including United 232 in Sioux City, IA (1989), ValuJet 592 in the Florida Everglades (1996), and TWA 800 off Long Island, NY (1996) also contributed to the creation and development of a specialized response model for assisting survivors and family members. The lessons learned across these events included some assurance that an emergency mental health component of the response model is welcomed and may provide psychological benefits both to survivors and to first responders exposed in the course of professional activities.

*continued*

## MISSION OF THE DISASTER MENTAL HEALTH INSTITUTE

The Disaster Mental Health Institute (DMHI) was founded within the department of psychology at The University of South Dakota (USD) in 1993 with the mission of promoting, developing, and applying disaster mental health research and practice. The director of the DMHI, Gerard A. Jacobs, founded the institute in response to the growing awareness among mental health practitioners and relief organizations of the need for research and training of disaster mental health personnel. Dr. Jacobs' pioneering work with the American Red Cross (ARC) and the American Psychological Association (APA) throughout the 1990s helped to lay the foundation of disaster psychology as an area of clinical expertise rooted in community psychology and traumatology.

## UNDERGRADUATE AND GRADUATE EDUCATION

As part of a department of psychology, the design of DMHI includes both graduate and undergraduate educational components, which make it truly unique as a multifaceted educational and training resource. Undergraduates are offered a variety of courses in the DMHI

curriculum in which they learn about how disasters affect people and their communities and what is done to help those in need of assistance. Students majoring in psychology can choose a Specialization in Disaster Response, while those majoring in other fields can complete a Minor in Disaster Response.

DMHI also offers a doctoral level Specialty Track in Clinical/Disaster Psychology as part of the APA-accredited Clinical Training Program at USD. Graduate courses in the DMHI curriculum provide a strong foundation in preparing psychology trainees for careers that may include working with survivors of disasters and other traumatic events. Two students from each entering class of the Clinical Training Program are awarded fellowships in DMHI and provided with substantial mentoring as they develop their careers. These are typically students with a keen interest in pursuing careers that will involve special expertise in trauma and disaster psychology. Other students in the Clinical Training Program, however, are equally welcome to take advantage of the DMHI Specialty Track, or individual courses and faculty projects without the extensive commitment required of the DMHI Fellows.

People from outside the USD campus frequently express an interest in completing

DMHI courses via distance learning technologies or other means that do not require residency in South Dakota. In response to this need, DMHI faculty have begun exploring a variety of options and recently initiated an annual Summer Intensive Program (SIP) in Disaster Mental Health as an intermediate option. College graduates from anywhere in the world may now enroll in the SIP as a Special Student with Post-Graduate Status and receive all but 3 weeks of the coursework by distance education. This compromise was achieved by separating the courses into self-study and face-to-face components, which reduces the required time in-residence to the minimum necessary to assure adequate learning. A Graduate Certificate in Disaster Mental Health can be earned upon successful completion of three required courses, one elective course, and a capstone exercise judged by a faculty committee.

## ANNUAL CONFERENCE ON INNOVATIONS IN DISASTER PSYCHOLOGY

Each year DMHI convenes a conference on Innovations in Disaster Psychology. Topics are chosen that reflect timely issues for development of this rapidly evolving field and major figures are invited to both inform those in attendance and initiate constructive debate. Past

*continued*

topics have included: Weapons of Mass Destruction, Refugee Mental Health, International Collaboration, Terrorism, and Public Health Models of Intervention. For 2005, the topic will be Research Strategies and Methodology, and the roster of speakers will consist of researchers who practice and promote innovative approaches. The conference will be held in Rapid City, SD, September 22-24, 2005.

## CONTINUING EDUCATION

DMHI is approved by APA to provide continuing professional education to psychologists. DMHI maintains responsibility for the program. The annual conference described above is the major continuing education offering, but other programs are also offered. For instance, the Summer Intensive Program has recently been approved to be offered on a continuing education (CE) basis, as an alternative to the previously described graduate education option. Members of the DMHI faculty are also beginning to offer workshops and other training opportunities that can qualify for CE credit and are examining proposals for cosponsored training events.

## DISASTER AND TRAUMA RESEARCH

As part of an academic institution, the work of DMHI includes supervision of thesis and dissertation research, as well as publication of scholarly products. Accordingly, the faculty and graduate students at DMHI are all actively involved in research and scholarship related to disasters and trauma. Some studies focus on the relationships among traumatic event exposure, trauma-related symptomatology, personality functioning, and posttraumatic stress disorder while others examine barriers to care and strategies for improving health services for trauma survivors. DMHI is also conducting a large ongoing study of psychological adjustment among ARC relief workers who responded to the terrorist attacks of September 11, 2001. The recent scholarly output of DMHI faculty has included several articles in peer-reviewed journals, several book chapters, and an edited book on international disaster psychology to be published later this year. DMHI faculty members have also been involved in authoring and reviewing training materials produced by ARC and the International Federation of Red Cross and Red Crescent Societies.

## SERVICE TO DISASTER-AFFECTED COMMUNITIES

Every faculty member and several graduate students at DMHI are members of ARC Disaster Services Human Resources and regularly respond to local and national disasters by providing direct service to the affected communities. These have included several major aviation incidents, as well as numerous hurricanes, tornadoes, floods, fires, and earthquakes. Four DMHI faculty and several students also responded to the September 11, 2001 terrorist attack that destroyed the World Trade Center. In cooperation with APA's Disaster Response Network, DMHI faculty have served as statewide network coordinators and advised the network at the national level. Most recently, Dr. Jacobs was chosen to serve as APA's consultant for the Asian tsunami.

## CONCLUSION

Now in its 12<sup>th</sup> year, DMHI has developed into a multidimensional resource for training, education, research, and operational services in the field of disaster psychology. As this rapidly emerging and evolving field has changed, so has DMHI responded accordingly with expansion of its offerings and options to serve growing and diversifying educational needs. The

*continued*

institute remains unique in its ability to offer a doctoral Specialty Track in Clinical/Disaster Psychology and undergraduate courses to prepare the next generation of disaster psychologists. In an era of limited resources, DMHI is committed to fulfilling its multifaceted mission in the face of unforeseen challenges while maintaining optimal attention to training and supervision, operational integrity, and rigorous scholarship.

**For more information about the Disaster Mental Health Institute and its programs, please contact:**

Disaster Mental Health Institute  
The University of South Dakota - SDU 114  
414 East Clark Street  
Vermillion, SD 57069-2390  
Phone: (605) 677-6575  
Toll-Free: 800-522-9684  
Fax: (605) 677-6604  
E-Mail: [dmhi@usd.edu](mailto:dmhi@usd.edu)  
<http://www.usd.edu/dmhi>

## Resource Center: Refugee/Recent Immigrants

According to the United Nations High Commissioner for Refugees (UNHCR), the global population of refugees was 9.7 million at the end of 2003, with the greatest number of refugees originating from Afghanistan, Sudan, Burundi, and the Democratic Republic of Congo. The countries that host the most

refugees are Pakistan, Iran, Germany, and Tanzania; and the main countries of resettlement for refugees are the United States, Australia, Canada, and Norway.

In 2004, the United States admitted 52,868 refugees into the United States. Refugees have been resettled in every State and one Territory of the United States.

### SPECIAL CONSIDERATIONS WHEN WORKING WITH REFUGEES

It is important to include refugees and recent immigrants in your disaster response planning efforts. Some special considerations when working with refugees include:

- >> **Language:** Refugees frequently do not speak English well, and this may present communication challenges throughout all phases of a disaster.
- >> **Economic marginalization and differences:** Many refugees can barely manage economically, and many are supporting relatives at home. However, some refugees, especially those with education and highly sought skills, find well-paying jobs quickly.

The U.S. Immigration and Nationality Act defines refugees as: “any person who is outside any country of such person’s nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.”

*continued*

>> **Fractured social relations:** The communities of origin of many refugees have failed to provide needed security, and some have experienced personal attacks by representatives of their community or the larger society. Some refugees are so traumatized by this experience that they are reluctant to form new community bonds. Some refugees respond by only forming relationships with small groups who have emigrated from the same geographic area. When a disaster forces relocation, this can break up the small community and make recovery more problematic. Refugees may also be distrustful of the government, and refugees who have achieved legal status may fear that accepting assistance following a disaster will put them at risk for deportation.

>> **Experience of traumatic stressors and loss:** Refugees have often experienced horrific events that cause symptoms of post-traumatic stress disorder. A disaster can exacerbate the symptoms and lead to an emotional re-experiencing of these events. However, some refugees may have gained strength and resilience from their previous experiences and bring that strength to the new disaster.

>> **Family dynamics and role changes:** Refugee children may have seen their parents fearful, helpless, and stressed during the flight, and anxious, powerless, and exhausted upon resettlement. Children may come to believe that adults are not to be trusted. Intergenerational conflict resulting from differing rates of acculturation presents additional family problems.

*This article was taken from Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations (DHHS Pub. No. SMA 3828). To obtain a copy, contact the National Mental Health Information Center at 1-800-789-2647.*

## *National Child Traumatic Stress Network Helps Refugees and “Children of War”*

In 2001, in recognition of the national impact of traumatic events on the nation's children and youth, the U.S. Congress passed the Donald J. Cohen National Child Traumatic Stress Initiative establishing the National Child Traumatic Stress Network (NCTSN). Under the auspices of the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), the NCTSN now encompasses 54 centers around the United States, overseen by the National Center for Child Traumatic Stress (NCCTS) at UCLA and Duke University. The NCTSN mission is to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States.

Refugee trauma is addressed by a number of members of the NCTSN. A collaborative work group composed of representatives of more than 10 organizations serving

*continued*

refugee/immigrant children developed *Children of War: A Video for Educators*. This video was created to inform school personnel—teachers, administrators, social workers, and guidance counselors—about the often unrecognized lives of many youth in their schools. The purpose of the video is to define the importance of exposure to war and displacement and to describe the effects of this trauma exposure on school behavior, academic performance, and school violence. This video may also be educational for those who set up emergency management systems in States and local communities as well as those who provide mental health services in a variety of settings.

## WHY IS IT IMPORTANT TO KNOW ABOUT REFUGEE TRAUMA?

Families and children who have experienced sudden changes in their lives and exposure to life-threatening events may find painful and frightening memories triggered by a natural disaster, terrorist event or other emergency in their community. Sirens and other emergency notification systems may cause strong reactions in children and adults who have already experienced traumatic experiences in their lives

Relocation to an emergency shelter as part of a community emergency plan may generate

strong reactions from families who have been dislocated in the past. These traumatic reminders may occur, even if the actual circumstances and danger are not the same as the earlier events.

Some ways that emergency response teams can use knowledge of refugee trauma in their planning are to:

- >> Identify refugee populations who may have been placed by refugee resettlement organizations in your community. Sometimes small groups may be located in rural communities not used to refugees and immigrant populations
- >> Educate school emergency planners, especially those who may be managing family reunification plans. Children may have strong reactions to being separated from their families, echoing the chaos of their flight from their homelands
- >> Identify, in advance, mental health providers or other community members who may be familiar with the specific refugee groups. Individuals who have been in this country long enough to better understand the culture may be able to help explain the process of emergency preparedness, shelters, etc. These individuals may also be able to help translate, easing the experience of both the families entering emergency shelters and the staff responsible for managing the shelters.

## WHAT IS REFUGEE TRAUMA?

Refugees are specifically distinguished from economic migrants, who may leave a country voluntarily to seek a better life. Such immigrants would continue to receive the protection of their government if they were to return home. However refugees flee because of the threat of persecution and cannot return safely to their homes. Many children in our schools have experienced war-related trauma or political violence in their homelands. Coming to the United States has presented them with additional challenges as they adjust to language and cultural differences, economic difficulties, and educational demands.

The number of refugees being resettled in urban and rural communities grows every day. Many of these children and their families are dealing with language barriers, cultural expectations for parenting, school participation, and day-to-day survival issues.

Children and adolescents who have faced the violent conditions of war or civil unrest often suffer from traumatic stress reactions that may endure for months or years after the danger has passed. Children can heal from these experiences with the support of caring adults, the security of a safe environment, and access to

*continued*

appropriate care. Educators can help refugee children develop hope for the future and the skills to meet their goals.

## CHARACTERISTICS OF REFUGEE TRAUMA

- >> **Re-experiencing:** Dwelling on or having to ward off unbidden thoughts, memories, sights, sounds, and other sensory impressions of past traumatic experiences. Everyday school and classroom events can serve as traumatic reminders to a vulnerable child. A buzzer sounding, fire alarm ringing, or even a locker door slamming can reimmerge a child in the experience of trauma. A child or adolescent reacting to a traumatic reminder might dive under a desk, freeze, start to shake, or withdraw from classroom activity.
- >> **Avoidance:** Avoiding talking or thinking about anything associated with the past trauma. This avoidance may cause a child to seem rigid or emotionally withdrawn. To avoid strong feelings, a child may become cut off or detached from other people or be unable to form healthy relationships with peers. In the classroom, a child may seem disinterested in schoolwork or unwilling to make commitments.

- >> **Hyperarousal:** In the wake of traumatic events, a child may suffer from nervousness or hypervigilance—a state of being on the alert for danger and of interpreting mundane events as dangerous. A traumatized child may startle easily or be quick to interpret neutral events as potentially dangerous or negative.
- >> **Sleep Disturbances:** Refugees of war and unrest may suffer from insomnia or from frequent nighttime awakenings, night terrors, or nightmares. They may appear tired or listless during the day because they are not getting enough sleep at night.
- >> **Traumatic Bereavement:** Many refugee children have lost parents, siblings, other family members and peers, often in violent acts committed before their eyes. Traumatic bereavement occurs when a child or adolescent becomes so preoccupied with memories, images, and thoughts about the circumstances under which the person died that he or she cannot go through a normal grieving process. It is not unusual for a refugee child or adolescent to dwell on and reexperience these traumatic events or to fantasize about reversal, revenge, or returning to bring to justice those responsible. Some children may need to work with a therapist who specializes in grief or trauma issues.

### WHAT IS *CHILDREN OF WAR: A VIDEO FOR EDUCATORS*?

*Children of War: A Video for Educators* is a moving, 30-minute program depicting the experiences of refugee children in America. It opens with highlights from the play *Children of War*, in which a group of refugee youth from around the world present their stories in their own words. The program goes on to document the consequences of refugee trauma and focuses on ways that these traumatic experiences affect children in American schools. This video may also help educate those in communities who plan for emergency situations.

An accompanying resource guide contains discussion questions, suggests ways that teachers and administrators can help refugee/immigrant children in their schools, and provides avenues to additional resource materials.

Contact Judy Holland, National Center for Child Traumatic Stress, [judy.holland@duke.edu](mailto:judy.holland@duke.edu) to obtain a copy of the video. The *Children of War* Resource Guide may be downloaded from [www.NCTSNet.org/refugees](http://www.NCTSNet.org/refugees).

## REFUGEES/RECENT IMMIGRANTS: SOURCES OF ASSISTANCE AND INFORMATION

### FEDERAL GOVERNMENT ORGANIZATIONS AND RESOURCES

- >> **Office for Refugee Resettlement, Administration of Children and Families, U.S. Department of Health and Human Services**  
<http://www.acf.hhs.gov/programs/orr/geninfo/index.htm>
- >> **Bureau of Population, Refugees, and Migration, U.S. Department of State**  
<http://www.state.gov/g/prm>
- >> **U.S. Citizenship and Immigration Services, U.S. Department of Homeland Security**  
<http://uscis.gov/graphics/index.htm>
- >> **Executive Office for Immigration Review, U.S. Department of Justice**  
<http://www.usdoj.gov/eoir>

### INTERNATIONAL ORGANIZATIONS

- >> **United Nations High Commissioner for Refugees**  
<http://www.unhcr.ch/cgi-bin/txis/vtx/home>
- >> **The International Organization for Migration**  
<http://www.iom.int>

### NATIONAL ORGANIZATIONS

- >> **National Child Traumatic Stress Network** provides information on aspects of child trauma, such as refugee trauma, maltreatment, exposure to domestic violence, disasters, and terrorism. For specific information about refugees, including information on *Children of War*, go to [www.nctsn.org/refugees](http://www.nctsn.org/refugees).
- >> **Bridging Refugee Youth and Children's Services** is a national technical assistance project working to broaden the scope of information and collaboration among service providers in order to strengthen services to refugee youth, children, and their families. For more information go to [www.brycs.org](http://www.brycs.org).
- >> **The USA for UNHCR** builds support in the United States for the humanitarian work of United Nations High Commissioner for Refugees and its partners. Its mission is to raise the consciousness of Americans about the work and accomplishments of the UNHCR through education and advocacy. For more information go to [www.usaforunhcr.org](http://www.usaforunhcr.org).
- >> **U.S. Committee for Refugees** provides information about U.S. Government policy as it pertains to refugees. For more information go to [www.refugees.org](http://www.refugees.org).

### DID YOU KNOW?

Every State has a Refugee Coordinator. To find your local contact, go to <http://www.acf.hhs.gov/programs/orr/partners/coordina.htm>.

## Suggested Reading List

Have you discovered a useful planning document or resource? Or, have you read an interesting book, column, or journal article that you would like to share? Following are three recent suggestions:

- >> **New York Academy of Medicine (2005).** *Redefining Readiness: Terrorism Planning Through the Eyes of the Public.*  
Funded by the W. K. Kellogg Foundation, this year-long study involved indepth conversations with government and private-sector planners, 14 group discussions with diverse community residents around the country, and a telephone survey of 2,545 randomly selected adults in the continental United States. To view the report online, go to <http://www.cacsh.org/eptpp.html>.
- >> **McDuff, J. & Ford, W.E. (2005).** *A Report on the Post-September 11 State Disaster Relief Grant Program of SAMHSA's Center for Substance Abuse Treatment.*  
DHHS Pub. No. SMA 3993. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

- >> **National Child Traumatic Stress Network, Refugee Trauma Task Force (2005).** *Mental Health Interventions for Refugee Children in Resettlement: White Paper II.*

To view the white paper online, go to [http://www.nctsn.org/nctsn\\_assets/pdfs/materials\\_for\\_applicants/MH\\_Interventions\\_for\\_Refugee\\_Children.pdf](http://www.nctsn.org/nctsn_assets/pdfs/materials_for_applicants/MH_Interventions_for_Refugee_Children.pdf).

## Upcoming Meetings

### JOINING FORCES: PREPARING COMMUNITIES FOR THE BEHAVIORAL HEALTH IMPACT OF TERRORISM OR DISASTER

**APRIL 14-15, 2005  
COLUMBUS, OH**

The Ohio Departments of Mental Health and Alcohol and Drug Addiction Services are hosting a conference to cross-train behavioral health providers and first responders on the psychosocial effects of terrorism and disaster. The conference will educate first responders, disaster recovery workers, and local government officials on the behavioral health effects of terrorism or disaster on individuals and the community. Simultaneously, the conference will aim to educate behavioral health providers on

the roles of first responders and recovery workers.

The National Association of State Mental Health Program Directors has estimated the expected ratio of behavioral to physical casualties after a terrorist attack is four to one. The Joining Forces conference will encourage increased integration of behavioral health services to victims, families, the elderly, children and first responders in the existing response system during the weeks, months, and years, if necessary, following a terrorism or disaster event.

The opening session will include remarks from State officials including Ohio Department of Public Safety Director Kenneth Morckel. Former Oklahoma City Assistant Chief of Police Lawrence Johnson and Dr. Kermit Crawford of the Boston College of Medicine will deliver the keynote addresses.

Thirty-six workshops will cover all aspects of behavioral health, and disaster response. Some workshops include:

- >> **Disasters, Trauma, Behavioral Health, and Substance Abuse**
- >> **Post-Deployment Behavioral Health Issues Among Reserve Component Military**

*continued*

- Personnel Returning from Iraq and Afghanistan: A Community Response
- >> The Role of Hospital-Based Behavioral Health Units in Disaster Preparedness
- >> Special Considerations for Older Adults in Emergency Preparedness and Response
- >> Lives in the Balance: Stress and Mental Health in Crisis Response and Recovery

## PUBLIC SAFETY WORKERS GRANTEE MEETING: PRESERVING THE LEGACY

APRIL 14–15, 2005  
ROCKVILLE, MD

SAMHSA's Emergency Mental Health and Traumatic Stress Services Branch will hold the third annual meeting of the Public Safety Workers (PSW) Grant Program April 14–15, 2005, at the Doubletree Hotel in Rockville, MD. The meeting is titled Preserving the Legacy, and the agenda will focus on providing guidance in the phasedown and transition of the grants, sharing project accomplishments and lessons learned among grantees, and developing a plan to preserve the legacy and contributions of the grantees to the disaster behavioral health field. The meeting will bring together the following programs:

- >> Safe Horizon, New York
- >> Mental Health Association of Westchester County, New York

- >> Arlington County Community Services Board, Virginia
- >> Fire Department of the City of New York, New York
- >> St. Vincent's Catholic Medical Center, New York
- >> South Nassau Communities Hospital, New York
- >> Mt. Sinai School of Medicine, New York

## 2005 NATIONAL DISASTER MEDICAL SYSTEM (NDMS) CONFERENCE: CATASTROPHIC CARE FOR THE NATION

APRIL 30–MAY 4, 2005  
ORLANDO, FL

The purpose of the 2005 National Disaster Medical System (NDMS) Conference is to promote interaction between local, State and Federal public health practitioners and policy makers. Expert faculty from a variety of local, State, and Federal agencies as well as from academic entities will present on key topics such as clinical medicine, mental and public health, and disaster response.

Networking with these expert faculty members as well as many of the Nation's leaders in the field of emergency management will give participants access to the latest in emergency response and coordination capabilities.

The conference is designed for physicians, nurses, social workers, psychologists, pharmacists, infectious disease specialists/epidemiologists, veterinarians, emergency medical services personnel, morticians, environmental health specialists, dentists, health care administrators, State and local public health officials, emergency managers, emergency planners, industrial hygienists, safety officers, laboratorians, members of law enforcement, public health workers, and response team personnel.

The conference is structured in a manner in which participants will be able to interact with faculty. Courses will include a brief question and answer period at the conclusion of each session. The sessions have been designed in tracks emphasizing different perspectives in emergency management. The following are the tracks that will be included in the 2005 conference program: Clinical Care, Disaster Research, Health Systems Management and Coordination, Mass Fatality Response, Mental Health, NDMS Training, NDMS Work Groups, Patient Movement and FCCs, Public Health, Response Teams, System Overview, and Veterinary/Animal Issues. The general sessions that will begin each day are designed to encourage networking and the building of communities of practice among groups sharing common interests and issues.

*continued*

The educational program will:

- >> Discuss the principles which underlie professional emergency health and medical service delivery;
- >> Describe the status of the profession as of 2005; and
- >> Develop a network with other colleagues for the further development of the Nation's life-saving systems.

For more information, go to  
<http://www.ndms.chepinc.org/index.html>.

## 4TH UCLA CONFERENCE ON PUBLIC HEALTH AND DISASTERS

**MAY 1-4, 2005**  
**WOODLAND HILLS, CA**

The conference is designed for public health professionals as well as individuals and organizations from both the public and private sectors involved in emergency public health preparedness and response. The diverse topics will be relevant to public health and medical practitioners, emergency medical services professionals, researchers, and managers involved in the wide range of emergency public health issues resulting from natural and manmade disasters. The public health

consequences of these disasters cut across many substantive areas.

This unique multidisciplinary conference will bring together academicians, researchers, practitioners, and policy-makers from public health, mental health, community disaster preparedness and response, social sciences, government, media, and non-governmental organizations.

By the end of this conference, participants should be able to:

- >> Describe the development of emergency health as a sub-discipline within public health;
- >> List three strategies and methods in emergency public health that link to overall public health outcomes;
- >> Describe the five ICS components necessary in a Departmental Operations Center;
- >> List at least two validation procedures used by the public when responding to risk communication from official sources; and
- >> Discuss the necessity of a public health workforce trained in the principles of emergency public health.

For more information, go to  
<http://www.cphd.ucla.edu/conf2005.html>.

## SAMHSA CADRE INITIATIVE ORIENTATION

**MAY 11-13, 2005**  
**BETHESDA, MD**

SAMHSA has selected a group of mental health and substance abuse professionals to participate in their Cadre of Consultants Initiative. May 11-13, 2005, the cadre will engage in an orientation to learn about SAMHSA's expectations of consultants and administrative processes, and to determine future training needs. Cadre recruitment is closed for 2005 and will reopen next year.

## READINESS, RESPONSE, AND RECOVERY: STRENGTHENING OUR BEHAVIORAL HEALTH ALL-HAZARDS CAPACITY

**MAY 18-20, 2005**  
**NEW ORLEANS**

This conference will provide specialized intervention skills and planning knowledge for mental health and addiction disorder professionals to utilize in their work as public sector providers of disaster behavioral health services. The conference is structured within three training tracks:

- >> The Administrative and Planning Track will focus in great detail on administrative and planning issues associated with readiness and response activities. Topics include risk assessment, risk communication, plan development, and ongoing preparedness activities.
- >> The Disaster Response Interventions with Special Populations Track will focus on response and recovery issues unique to vulnerable populations. Topics include children, older adults, previously traumatized individuals, and culturally diverse groups with vulnerabilities that impact recovery.
- >> The Immediate Response to Mass Casualty Incidents Track participants will acquire skill sets specific to working within the context of mass casualty disaster sites. This includes family reception centers, providing psychological first aid to survivors, assisting the first-responder community with incident debriefings and stress management, and assisting with communication and support to the larger community in a variety of settings.

## NATIONAL MENTAL HEALTH ASSOCIATION ANNUAL CONFERENCE: JUSTICE FOR ALL

**JUNE 9–11, 2005  
WASHINGTON, DC**

For more information, go to <http://www.nmha.org/annualconference/index.cfm>.

## 9TH EUROPEAN CONFERENCE ON TRAUMATIC STRESS

**JUNE 18–21, 2005  
STOCKHOLM, SWEDEN**

Every two years the European Conference on Traumatic Stress (ECOTS) provides a unique opportunity for professional and informal exchange between researchers and practitioners in the field of trauma from across Europe and other continents. Over the past decade, the European Society for Traumatic Stress Studies (ESTSS) has continued to develop into the leading European organization in this field. It brings together colleagues from different professional backgrounds and geographic areas, who are searching for new methods of treating people who suffer because of trauma, discovering facts about the bio-psychological effects of trauma,

or helping communities heal after large-scale traumatization. ECOTS has become the main vehicle for ESTSS to fulfill its mission at a time when exposure to trauma seems to be increasingly universal and affecting more and more people through terrorist attacks, natural disasters, and wars.

The conference will be interdisciplinary and is open to anyone who might have an interest in psychotraumatology. Examples of professions that could benefit from it are those who in their work will be confronted with individuals suffering from traumatic experiences. This could be clinicians, forensic personnel, journalists, lawyers and other personnel from the judicial system, psychiatrists, psychologists, others working within the field of psychiatry, researchers, and social workers.

For more information, go to <http://www1.stocon.se/ecots2005/9/12734.asp>.

## THE BEHAVIORAL HEALTH RESPONSE TO MAJOR DISASTERS

OCTOBER 18, 2005  
WALTHAM, MA

Do you know what a behavioral health responder does during a natural or manmade disaster? In the aftermath of the 9/11 terrorist attacks, it is clear that, as part of all-hazards disaster preparedness, each State needs an integrated disaster behavioral health response. This skill-based training for professionals is a followup to the statewide overview in February 2005. This

training is offered to administrators/managers and other professionals in Massachusetts to develop a working knowledge of Evidence-Based Practices (EBP) to help communities cope in the aftermath of disasters.

At the conclusion of the training, participants will be able to:

- >> Recognize the important role administrators/managers play in ensuring that behavioral health staff are trained in disaster response;
- >> Recognize the various disaster types, phases, and responses;
- >> Recognize the human impact of disaster;
- >> Identify best practices and evidence-based interventions related to behavioral health disaster response;
- >> Identify best practices for addressing populations with specific characteristics and needs; and
- >> Understand the stress inherent in disaster work for behavioral health responders.