



The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER BEHAVIORAL HEALTH

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.

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 (Fall 2005).

Our last discussion topic was: Does behavioral health participate in your State's homeland security exercises and simulations?

RESPONSE:

"Yes. The Massachusetts Department of Mental Health (MDMH) is taking part, as a

support to the American Red Cross (ARC) (MassCare-ESF6), at a MassPort/Homeland Security drill. Our MDMH group will be:

1. Area Emergency Management Coordinator—Metro Boston at Logan Airport (lead);
2. Emergency Management Coordinator—Central Office (shadow at Logan);
3. Area Emergency Management Coordinator—Central Mass. (shadow at Logan); and
4. Area Emergency Management Coordinator—Metro Suburban (lead support to Waltham ARC for screening of volunteers).

continued

Reflections from the Project Director: KY Project Recovery (FEMA 1523): Keys to Success

We will be drilling the newly trained Behavioral Health Disaster Responders who took the training in March and April (approximately 100 people). We are very excited to be active participants in this event.”
Ashley Pearson, Massachusetts disaster mental health coordinator

RESPONSE:

“In Washington State, behavioral health will be included in planning for a statewide emergency exercise in 2006. It would be very helpful to see/talk about effective approaches other States have used.” *Margaret A. Hanson, Washington Public Health Preparedness.*

NOTE: If others are interested in discussing effective approaches, SAMHSA DTAC would be happy to arrange a conference call. Please contact Kerry Crawford at 240-744-7050, kerrydc@esi-dc.com.

Our next discussion topic question is: How have you collaborated or provided disaster behavioral health services to tribal communities in your State/ Territory? What have been some of your successes or challenges?

INTRODUCTION

On May 26, 2004, severe thunderstorms moved across the Commonwealth of Kentucky, producing damaging winds, heavy rainfall, tornadoes, mudslides, hail, flash flooding, and floods. Much of the State was severely affected, particularly the eastern and central portions. This severe weather system resulted in widespread damage to homes, businesses, agriculture, roads, trees, and bridges. The National Weather Service reported 19 tornadoes. Touchdowns were reported in Fayette, Henry, and Montgomery counties. On May 28, 2004 Governor Ernie Fletch signed an Executive Order of State of Emergency. Another line of severe thunderstorms passed through May 30, 2004. On June 4, 2004, the Governor submitted a request for a Presidential Disaster Declaration, which was granted June 10, 2004.

In eastern Kentucky, the severe storms, flooding, and flash flooding resulted in five deaths and numerous injuries. The affected counties are economically distressed and a very high percentage of the population is living below the poverty level (30.5 percent). Only 32 of the

initial 1,043 homes surveyed had flood insurance and only four of the 1,043 homeowners had homeowner’s insurance. Since the rain continued almost daily in the impacted areas, mudslides affected secondary roads, homes, and communities.

Ninety percent of the heaviest-hit counties have unemployment rates above the national level and a large percentage of impacted survivors were more than 65 years old and living on fixed incomes. Outreach challenges included people with limited financial resources, older adults, and families with children living in the remote, isolated regions of eastern Kentucky. Many survivors rely on home-canned produce from their summer vegetable gardens to help feed their families during the winter months. All gardens were contaminated by floodwater.

Large numbers of families were displaced in communities with limited rental property. The Federal Emergency Management Agency (FEMA) provided travel trailers for short-term housing until more permanent housing could be acquired. This underscored the psychosocial long-term recovery faced by survivors.

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On June 22, 2004, the Kentucky Community Crisis Response Board (KCCRB) submitted an Immediate Services Program (ISP) application on behalf of the Commonwealth of Kentucky, and FEMA DR-1523-KY Project Recovery was approved July 8, 2004.

Beginning the morning of May 28, 2004, The Kentucky Community Crisis Response Team (KCCRT) and KCCRB staff partnered with mental health center staff to provide outreach to 841 survivors. By July 23, Project Recovery had provided outreach and service linkage to 3,590 survivors. Trained disaster outreach workers from Pathways Mental Health Center, Seven Counties Services, and Kentucky River Community Mental Health Center responded to the most impacted communities. Kentucky Emergency Management (KEM) and local fire and police departments assisted in locating people impacted by the disaster.

The KCCRB Executive Director served as State-level Manager of Project Recovery and is Disaster Mental Health Coordinator for the Commonwealth of Kentucky. KCCRB, the lead disaster behavioral health agency in Kentucky, coordinated initial assessment through outreach teams and provided administrative, fiscal, and training support to Project Recovery, beginning September 27, 2004.

Project Recovery Coordinator Rebecca Bauder managed all aspects of the ISP and the Regular Services Program (RSP). The ISP served 6,723 survivors through individual crisis counseling and 1,852 survivors through 72 group psycho-educational programs that ended September 26, 2004. The RSP ended June 26, 2005. Project Recovery has served 8,157 survivors through individual crisis counseling and 22,570 survivors through 754 group psychoeducational presentations.

PROJECT RECOVERY KEYS TO SUCCESS

HISTORY OF DISASTER RESPONSE IN KENTUCKY

In the past, the Kentucky Department of Mental Health and Mental Retardation Services (KDMHMRS) had worked along with 14 community mental health and mental retardation centers to mitigate the effects of disasters. Unfortunately, Kentucky experienced many disasters in the late 1980s that demonstrated a clear need for an organized mental health response to community-wide crises. In the 1990s, the State's efforts to provide such responses evolved into KCCRB, a unique agency that was developed and established by the State Mental Health Authority (SMHA). During the evolution of KCCRB, a conscious choice was

made to administratively attach KCCRB to State government, where it could best work with other organizations and agencies to mitigate the effects of natural and human-caused disasters. The Kentucky Department of Military Affairs (KDMA) was chosen because it also has purview over the National Guard, the Emergency Operations Center, and KEM. KCCRB was legislatively defined in Kentucky statute (KRS 36.250 to 36.270) in 1996 and administratively attached to KDMA in 1998.

As the mental health authority, KDMHMRS staff have served in the role of Disaster Mental Health Coordinator and worked with KCCRB and the Governor's Authorized Representative (GAR) to apply for FEMA Crisis Counseling Assistance and Training Program (CCP) grants. KCCRB, which is composed of all agencies in Kentucky involved in disaster response, recommended that KCCRB become the lead State agency designated to coordinate disaster mental health services and submit FEMA CCP grant applications.

When a disaster strikes, KCCRB is activated through Kentucky's Emergency Operations Center (EOC) and plans in collaboration with KEM, American Red Cross (ARC), Salvation Army, and other organizations active in disaster.

KCCRB mobilizes disaster behavioral health assessments and outreach teams after disaster through its network of team members and trained disaster mental health staff from the regional behavioral health centers in the impacted regions of the State. This ensures an aggressive outreach and immediate coordinated response by local, regional, and State resources.

Collaborative efforts between KCCRT regional resources, regional mental health centers, KEM, county-based emergency management, first responders, and other local authorities ensure timely and effective outreach during the initial 30 days prior to a FEMA CCP.

CCP OVERSIGHT AND FUNDING

KCCRB staff and representatives of the regional mental health centers in the impacted areas collaborated and submitted the CCP ISP grant application. An advisory committee was formed among participating providers and served as an advisory body to Project Recovery. Once the CCP grant was approved, the funding flowed from KEM to KCCRB. KCCRB reimbursed the centers for allowable costs in the ISP. Once the CCP RSP was approved, the funding flowed from KEM to KCCRB and KCCRB subcontracts with mental health centers and reimbursed the centers for allowable costs. This has greatly increased timely reimbursement for services.

OUTREACH STAFF INDIGENOUS TO THE REGION

Hiring outreach workers indigenous to the affected regions of the State has proven to be one of the most successful aspects of Project Recovery. These individuals are dedicated, energetic, and passionate about wanting to make a difference in their communities.

Indigenous outreach teams are most effective in rural communities that tend to be remote and isolated. Often these survivors are distrustful of outsiders, reluctant to seek assistance for themselves and their families, and more likely to be receptive to local community members for support and networking.

UNIQUE APPROACHES

>> Resiliency Presentations

Combining outreach services of one-on-one contact and group presentations during the first quarter allowed the Project Recovery team to impact more survivors. The outreach teams delivered three basic presentations focused on resiliency and other topics related to the changing needs of survivors. In addition, Project Recovery teams set up information booths during community events to provide educational materials and promote resiliency awareness.

>> Worry Stones

“Worry stones” are small, polished rocks,

about the size of a quarter, that Project Recovery outreach staff distributed when making outreach visits and community presentations. The worry stones came with the following information: *“Keep this stone in your pocket or somewhere nearby. When you start to worry or have uncomfortable thoughts about an event, you can hold the stone in your hand. Rubbing the stone between the thumb and forefinger is relaxing and can take the worries away. Many people all over the world believe that rubbing the stone can relieve physical and emotional pain, anxiety, and stress.”*

Distributing worry stones has been an innovative addition to outreach. On several occasions, youth who had received them in a prior disaster (FEMA-DR-1475) and were reaffected in DR-1523, reported to outreach staff that they still have their stones and carry them all the time. One girl gave her worry stone to her younger sibling who was worried when it rained. Older survivors also reported that worry stones help decrease the physical and emotional stress they experience when it rains and when rain is predicted for their area.

>> Assessment and Referral Tool

An assessment and referral tool was developed by Project Recovery outreach staff during the mid-phase training to assist outreach workers in determining when a behavioral health referral is needed in phasedown of the program.

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CUSTOMER SERVICE SURVEY

Project Recovery management designed a customer satisfaction survey utilizing technical assistance from SAMHSA Disaster Technical Assistance Center (DTAC) staff. The goal of the survey was to gain survivors' perception of Project Recovery in terms of service delivery, symptom reduction, and service support. A sample of 100 disaster survivors was randomly selected 6 months after the disaster. Surveys were conducted over the telephone and took approximately 10-30 minutes to complete.

The first area assessed was participant demographics. The largest percentage of consumers served by Project Recovery were between the ages of 26 and 30 (12.2 percent). This population was followed closely by consumers 56-60 years of age (11.1 percent). All consumers (100 percent) were Caucasian. The majority of consumers were female (60 percent).

The most frequent post-disaster stress reaction reported by consumers was hyper-vigilance (92.2 percent). Worry (84.4 percent), watchfulness (84.4 percent), anxiety (67.8 percent), fatigue (68.9 percent), and sadness (52.2 percent) were also reported.

On a four-point scale, consumers felt strongly that they would recommend Project Recovery

services to others (3.788), necessary referrals to other supportive services were made (3.766), and services overall were helpful/positive (3.74).

Consumers also felt strongly that services aided them in understanding that stress reactions are normal (3.92), they were given necessary referral contact information (3.88), services eased emotional stress reactions (3.66), services aided in reducing stress (3.6), and services helped them feel less overwhelmed (3.5).

Project Recovery will use this data to inform future disaster outreach practice. Findings to consider include population demographics, most frequently reported stress reactions, differences in stress reactions for gender, areas of strengths and weaknesses in service delivery, and service effectiveness.

In eastern Kentucky, a consumer is most likely to be 26-30 years of age, female, and Caucasian. Most frequently consumers will report being hyper-vigilant, watchful, worried, fatigued, and anxious. These areas will be important to assess and focus on in future disasters. Survey results indicate that providers will need to focus primarily on strategies that ease emotional stress.

ONGOING COLLABORATION IN REGIONAL PLANNING, PREPAREDNESS, RESPONSE, AND RECOVERY

In 1998, following the school shooting in western Kentucky, KCCRB, in collaboration with the Center for School Safety and the Department of Education, conducted a survey of all public school districts. From this data, a school-centered emergency management guide was developed. Regional trainings were provided and the guide was distributed to assist in all-hazards planning, preparedness, response, and recovery.

From 2002 to the present, KCCRB, in collaboration with the Department for Public Health via the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) funds, designed and developed a 21-hour train-the-trainer course, titled *The Psychology of Disaster and Terrorism*. A statewide training pool of 65 trainers from public health, regional mental health centers, and KCCRB regional coordinators deliver a 14-hour course for local community workforces. The training is designed to teach psychological resilience techniques to support the provision of self-care and peer-care following disasters and terrorism.

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Beginning in FY 2004, the SMHA and the Kentucky Association of Regional Programs, utilizing SAMHSA Targeted Capacity Expansion Grant, CDC, and HRSA funding, have overseen the regional development of all-hazards planning, preparedness, response, and recovery by the 14 regional behavioral health centers. Each center participates in planning, exercises, and regional preparedness and response through a designated Disaster Coordinator.

These three initiatives have increased local and regional planning and preparedness and assisted in promoting partnerships among all disaster response agencies across the Commonwealth of Kentucky.

This article was contributed by Renelle Grubbs, LCSW, Kentucky disaster mental health coordinator, executive director, Office of KCCRB.

TOPOFF 3: April 4–8, 2005

Imagine your State hospital is reporting an influx of thousands of patients with flu-like symptoms. Within days, tens of thousands of people have been diagnosed with pneumonic plague as emergency rooms, hospitals, and mortuaries are overwhelmed. In a separate incident, a chemical attack at a local fair results in hundreds of additional casualties. As unimaginable as these events seem, they could happen. For this reason, these two scenarios were the basis for the Top Officials Three (TOPOFF 3) Exercise recently conducted by the U.S. Department of Homeland Security (DHS). The full-scale exercises involved five venues: Interagency, Connecticut, New Jersey, United Kingdom, and Canada. For more information on the role of behavioral health in this exercise, see the following four articles in this issue:

- >> [TOPOFF 3 Exercise: SAMHSA's Participation;](#)
- >> [TOPOFF 3 Exercise: The Connecticut Experience;](#)
- >> [TOPOFF 3 Exercise: New Jersey's Disaster Mental Health Response System; and](#)
- >> [PsySTART Rapid Mental Health Triage and Incident Management System.](#)



TOPOFF 3 Exercise: SAMHSA's Participation

The U.S. Department of Homeland Security (DHS) recently completed the third congressionally mandated Top Officials (TOPOFF) full-scale exercise April 4–8, 2005. TOPOFF 3 involved Federal entities ranging from the Department of Defense (DoD) to the Department of Agriculture, with the Department of Health and Human Services (HHS) leading Emergency Support Function (ESF) #8, Public Health and Medical. As outlined in the recently released National Response Plan, ESF #8 partners include the Department of Veterans Affairs, DoD, the Environmental Protection Agency, American Red Cross (ARC), and HHS Operational Divisions such as SAMHSA and the Centers for Disease Control and Prevention (CDC). TOPOFF 3 was a large, multinational event involving thousands of individual participants from the United States and partners in Europe and Canada. Participants included Federal, State, and local “players” and exercise controllers, as well as civilian volunteers portraying victims.

SAMHSA provided behavioral health consultation at the State venues, as well as other key response locations. Mikisha Brown, M.P.H.,

The National Response Plan, including roles and responsibilities related to ESFs, can be obtained from the DHS Web site: http://www.dhs.gov/dhspublic/interapp/editorial/editorial_0566.xml.

For more information about the TOPOFF Exercise Program and TOPOFF 3, go to: http://www.dhs.gov/dhspublic/interapp/editorial/editorial_0588.xml.

was the SAMHSA liaison to the Secretary's Emergency Response Team (SERT) in Connecticut, and Robert DeMartino, M.D., was the SAMHSA liaison to the SERT in New Jersey. Both Ms. Brown and Dr. DeMartino advised the SERTs on behavioral health matters, and consulted directly with the mental health and substance abuse departments in Connecticut and New Jersey to help address emerging behavioral health needs. Seth Hassett, M.S.W., was present in the Secretary's Operations Center in Washington, DC, and Carol Rest-Minberg, M.P.H., was deployed to the CDC Director's

Emergency Operations Center (EOC) in Atlanta. All of the deployed SAMHSA personnel are involved in the SAMHSA Disaster Readiness and Response matrix area.

From SAMHSA's perspective, participation in TOPOFF 3 represented a significant step forward for behavioral health in the disaster response arena. Mental health and substance abuse concerns, largely downplayed or ignored in past exercises, were given a higher profile during TOPOFF 3. Relevant issues that were raised included deployment of mental health clinicians to disaster sites, availability of trained substance abuse and mental health providers, and development of public messages. The simulated television news network used during the exercise featured multiple stories on behavioral health, including an interview with Kathryn Power, M.Ed., director of SAMHSA's Center for Mental Health Services.

SAMHSA will continue to work to promote the inclusion of behavioral health in disaster and terrorism exercises and to support substance abuse and mental health involvement in planning and exercises at all levels.

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TOPOFF 3 Exercise: The Connecticut Experience

As part of the TOPOFF 3 exercise, SAMHSA inaugurated the SAMHSA Emergency Response Center (SERC). Although the Center is still under development, the exercise provided an opportunity to begin testing equipment and Incident Command System (ICS) protocols while identifying areas that need continued development. SAMHSA expects the SERC to play a growing role in emergency response activities over time.

INTRODUCTION

TOPOFF 3 was the largest DHS exercise conducted to date with the participation of more than 10,000 individuals and more than 200 Federal, State, local, tribal, private sector, and international agencies and organizations, and volunteer groups. The exercise culminated in a simulated terrorist attack involving a biological agent (plague) in New Jersey, while Connecticut experienced an explosion and the release of mustard gas, a deadly chemical agent.

TOPOFF 3 was noteworthy in that it was the first time that behavioral health was incorporated into the exercise series. This signifies the growing recognition on the part of Federal and State authorities of the importance of mental health interventions following a disaster. The State of Connecticut Department of Mental Health and Addiction Services (DMHAS), the Department of Children and Families (DCF), and the American Red Cross (ARC) were invited to participate in TOPOFF 3 to address the psychological needs of Connecticut's citizens following the simulated terrorist attack. One of the major goals of the overall exercise involved testing the State's capacity to coordinate the

behavioral health response following a major disaster.

PLANNING EFFORTS

While DMHAS and DCF had conducted more than 15 disaster simulations during the past 3 years, TOPOFF 3 planning went beyond any previous preparations. Involvement in the planning process began in June 2004 and resulted in extensive preparations. It was necessary to develop a team of behavioral health professionals to serve in a variety of roles including planners, controllers, and evaluators. Throughout the planning process, staff attended various trainings focused on chemical weapons, public information and risk communication, and tabletop exercises designed to strengthen leadership capacities. The planning team developed behavioral health goals for the exercise and specific details regarding DMHAS's and DCF's roles in the exercise. Script cards for role players who functioned as psychological casualties were written. In order to ensure sufficient numbers of victims and family members, DMHAS and DCF recruited volunteer role players.

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OVERVIEW OF THE DISASTER

The simulated disaster began in Connecticut April 4 at approximately 1:25 p.m., when an explosion occurred at a family festival in a park in New London. The attack occurred several hours after the initial terrorist attack in New Jersey where plague was released. The explosion dispersed mustard gas over an area of New London and killed and injured a number of individuals. Thousands of psychological casualties were designed to test the capacities of hospital emergency departments throughout the State.

SCOPE OF INVOLVEMENT

The behavioral health response was coordinated under the leadership of DMHAS Commissioner Thomas A. Kirk, Jr., Ph.D., and DCF Commissioner Darlene Dunbar. DCF Chief of Staff Brian Mattiello and DMHAS Deputy Commissioner Pat Rehmer also played key roles throughout the response. DMHAS and DCF activated crisis response teams that provided psychological first aid (PFA) at a Family Assistance Center, in local hospitals, and at the actual disaster scene in New London where first responders were debriefed. Psychological supports were provided in tandem with mental health workers from ARC. Approximately 90

members of the DMHAS/DCF Behavioral Health Crisis Response Teams participated in TOPOFF 3.

In addition to the direct services offered by team members, DMHAS and DCF participated within a unified command structure at the State's Office of Emergency Management and opened a joint DMHAS/DCF Command Center to manage the behavioral health response. The management team supported real-life and mock media at the Joint Information Center, and coordinated with other State and Federal agencies throughout the exercise. The agency's behavioral health disaster coordinators worked collaboratively with SAMHSA designated liaison Mikisha Brown throughout the exercise in order to secure Federal behavioral health resources.

The simulated incident became a federally declared disaster. This prompted a "nationalized" application for the FEMA Crisis Counseling Assistance and Training Program (CCP) Immediate Services Program (ISP) grant. In addition, the exercise provided DMHAS/DCF an opportunity to test major aspects of its Behavioral Health Disaster Response Plan including activation and alert, command and control, as well as the provision of PFA. As a followup to TOPOFF 3, Connecticut was invited to participate in a series of meetings designed to

examine the long-term impact of behavioral health issues on recovery following a major terrorist attack. This provided additional insights for future planning.

LESSONS LEARNED

The exercise was instrumental in identifying aspects of the plan that worked effectively and also highlighting areas that could be enhanced. While a number of lessons were learned through involvement in TOPOFF 3, the primary areas requiring additional attention are:

- >> Surge capacity and medical and psychological triage issues in hospital settings;
- >> The mental health role in mass mortuary and death notification;
- >> Coordination of State and ARC behavioral health resources; and
- >> The role of mental health issues in risk communication and public information.

For more information on the Connecticut experience, contact Jim Siemianowski at (860) 418-6810, james.siemianowski@po.state.ct.us.

This article was contributed by Jim Siemianowski, LICSW; Kathy Dean, M.S.S.W.; Liz Mercer, M.S.W.; Wayne Dailey, Ph.D.; Michelle Ufner, Ph.D.; and Alicia Woodsby, M.S.W.

TOPOFF 3 Exercise: New Jersey's Disaster Mental Health Response System

BACKGROUND

Mental health disaster preparedness in New Jersey has been evolving for 16 years. In 1989, in collaboration with the New Jersey Office of Emergency Management (OEM), the New Jersey Division of Mental Health Services (DMHS) developed its first mental health emergency response plan. Since the early 1990s, New Jersey has responded to several declared disasters as well as many undeclared community incidents including: Coastal storms, the 1993 World Trade Center bombing, the repatriation of gulf war military personnel, urban fires, air-plane crashes, a massive gas explosion, the repatriation of Kosovo's citizens to New Jersey, hurricanes, incidents affecting schools, floods, the September 11, 2001 terrorist attacks, and a bioterrorism incident originating from postal facilities in New Jersey.

The September 11, 2001 disaster brought nationwide focus to the importance of mental health disaster planning and response. Following the 9-11 tragedy and the anthrax crisis, New Jersey's public mental health system

provided substantial crisis counseling, clinical services, information and referral, and specialized interventions. Many of these services were provided for 3½ years following the disaster.

DISASTER AND TERRORISM BRANCH

As part of its evolutionary disaster mental health planning process, DMHS, which is within the New Jersey Department of Human Services, houses a highly specialized mental health Disaster and Terrorism Branch. The Disaster and Terrorism Branch is home to a multidisciplinary Training and Technical Assistance Team which has the capacity to provide ongoing as well as on-demand training for mental health professionals in the wake of disaster to further increase the State's capacity to address the psychosocial needs of the community. The services available through the Disaster and Terrorism Branch include: Individual crisis counseling, psychological first aid (PFA), written or verbal psychoeducational information on disaster stress management, group crisis counseling, consultation and training, information and referral services, and toll-free helpline services. In addition, technical

assistance is available to counties to assist with revision of mental health emergency response plans to integrate an all-hazards planning approach (based on Federal guidelines and incorporating lessons learned from the response to 9-11) in the revision of their plans.

The Disaster and Terrorism Branch also maintains a disaster mental health Web site (<http://www.disastermentalhealthnj.com>) to share relevant information with the public and with mental health professionals, and publishes the bimonthly e-newsletter, *New Jersey Crisis Counselor*. The Disaster and Terrorism Branch works in close collaboration with representatives from public health, law enforcement, emergency management, and other professionals at the local, State, and Federal levels to coordinate mitigation, planning, response, and recovery efforts. The Branch also actively promotes the participation of mental health professionals in emergency response exercises and ongoing professional development activities.

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Other States maintain disaster behavioral health Web sites, and some are included below. Please contact SAMHSA DTAC with your State site!

Connecticut: <http://www.dmhas.state.ct.us/disasterbh.htm>

Kentucky: <http://kccrb.ky.gov/about>

Massachusetts: <http://www.mass.gov/samh>

Nebraska: <http://www.disastermh.nebraska.edu>

Nevada: <http://mhds.state.nv.us/admin/disaster.shtml>

New Hampshire: http://www.nhoem.state.nh.us/BehavioralHealth/behav_home.html

North Carolina: <http://www.dhhs.state.nc.us/mhddsas/disasterpreparedness/index.html>

South Carolina: <http://www.sph.sc.edu/cdrs/index.html>

Texas: <http://www.dshs.state.tx.us/compred/dmh/default.shtm>

Virginia: <http://www.communityresilience.com>

ALL-HAZARDS PLANNING

New Jersey's mental health disaster plan and its county counterparts are now undergoing revisions to incorporate recently promulgated Federal guidelines for all-hazards planning. The State's plan is a framework for county-specific plans that help ensure rapid and effective response. In coordination with the New Jersey OEM, the plan facilitates the deployment of mental health counselors to assist people impacted by disasters. In response to a push for an all-hazards planning approach by SAMHSA, New Jersey has spent the past 2 years continuing to improve its disaster mental health emergency

response system. These activities have been supported by grants from SAMHSA and HRSA through the New Jersey Department of Health and Senior Services.

To support the planning process, a Mental Health All-Hazards Preparedness Advisory Committee was formed. This committee oversees a county-based planning process for emergency preparedness focused on coordination of mental health, substance abuse, and other human services. It also improves communication and collaboration among many organizations that respond to disasters.

Chaired by DMHS, the Advisory Committee has been made a working subcommittee of the Governor's Domestic Security Preparedness Task Force Planning Group. In addition, a few people selected from the Planning Group formed a subcommittee to address the needs of first responders within the planning process. This subcommittee includes representation from all departments of State government involved in disaster planning and response, as well as community-based emergency response organizations. Included are representatives from human services; addiction services; law enforcement; victims assistance; local, volunteer, and private emergency response organizations; State and county emergency management; and State health, education, and agricultural agencies.

The mission of the Advisory Committee is to strengthen the State's ability to respond to the mental health needs of New Jersey's citizens in times of disaster or traumatic community incidents; and to support mental health providers and administrators in each county in the development of their respective emergency mental health response systems using the SAMHSA all-hazards planning approach.

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TOPOFF 3

The strength of New Jersey's mental health emergency response system is due in part to the support it has enjoyed from its partners in law enforcement including the New Jersey OEM and the New Jersey Department of Law and Public Safety, as well as its continued collaboration with other law enforcement components of State and local government. It is because of these partnerships that mental health stakeholders are invited to participate in emergency response planning and preparedness activities on a regular basis. A clear example of this is the prominent role that mental health played in the TOPOFF 3 Exercise.

In preparation for TOPOFF 3, mental health input was provided in the development of the exercise to ensure that the mental health impact and response to this type of event were addressed and would provide lessons learned toward improving the mental health response system. Specific objectives were developed to test the State and county disaster mental health plans and responses. Since the September 11, 2001 terrorist attacks, there has been movement toward an all-hazards planning process and redefining of procedures. This exercise tested those processes and identified strengths and areas for improvement. During the exercise, DMHS's role was to activate the State disaster

mental health plan, provide the mental health response that would be required in this type of event, and begin to identify needs for the recovery phase. Staff participated at all levels of the exercise.

During the actual play, a mental health planner was situated at the control center. Staff members were assigned in the field in various roles and were also assigned as data collectors. The data collectors specialized in mental health issues and were able to collect data specifically for mental health planning. The State's toll-free disaster helpline increased its hours of operation to 24/7, as it does during every disaster, and was quite active during the play.

Each County Mental Health Administrator participated at some level in the exercise, and most of them followed their disaster plans and worked within their incident command systems. There were more than 100 crisis counselors statewide at Points of Dispensing (PODS) filling crisis counseling roles during the simulated bio-hazard exercise. Daily communication between the staff of the Disaster and Terrorism Branch and county mental health administrators ensured that up-to-date information was flowing between both levels of government.

Information from the exercise will be used to improve the State's mental health disaster response planning process.

TRAINING AND CREDENTIALING

Disaster mental health training and credentialing is another important issue for planners that must include participation from public and private providers of mental health services.

TRAINING

The Disaster and Terrorism Branch has designated a person to spearhead its training initiative and address specialized training issues as they emerge. Continuous training efforts have been directed toward building and maintaining a sustainable disaster mental health workforce as a psychosocial reserve corps. Over the past 2 years, an average of three training events have been held each month. Training topics range from the basic FEMA CCP model, to psychological first aid (PFA). The PFA training was recently developed to enhance the counselor's ability to provide supportive communication, assist with coping and verbal de-escalation during and immediately following disasters and other traumatic events. This training was developed in response to feedback from trainees expressing a need for more concrete, skill-based instruction. There are a total of 16 different training programs including: Managing the psychosocial consequences of chemical, biological, nuclear, and radiological events; and a disaster mental health logistics and operations course.

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The training initiative is a three-pronged program. The first prong is designed to address attrition in New Jersey's disaster mental health workforce by frequently offering basic training and then incorporating people with minimum competency into the overall State database of ready crisis counselors. The second prong involves advanced training on hazard-specific, skill-specific, and phase-specific issues. The third prong involves advanced training in population-specific and geography-specific issues. Since this training has begun, more than 3,500 counselors have received specialized training.

CREDENTIALING

New Jersey's response to the September 11, 2001 terrorist attacks reflected substantial commitment to disaster work from public agencies and individual professionals. That commitment and interest has remained strong in New Jersey, resulting in more than 3,500 professionals identified in the DMHS database as potential disaster mental health workers. Although these numbers are encouraging, the total number alone provides little information regarding the competency of this potential workforce. In order to assess the competency of this workforce, a plan for credentialing has been initiated.

The credentialing application is composed of three parts: Part I is a detailed review of

professional qualifications, Part II is a disaster response readiness self-assessment, and Part III is a structured interview protocol. Part I was created as a composite of the current DMHS Emergency Response Network form as well as elements from screening applications used by other disaster relief and humanitarian aid agencies, such as the American Red Cross (ARC), Doctors of the World, and Mental Health Workers Without Borders. Part II is adapted from a self-assessment tool utilized by the United Nations for staff assigned in various countries to assist with humanitarian aid and disaster relief. The self-assessment includes a scoring guide where professionals are able to score their responses and compare them to a profile of individuals who have performed successfully. Part III, the structured interview protocol, will be piloted later this fall. This structured interview is designed to assess specific competencies identified as critical to effective performance as a disaster mental health worker. Competencies are defined as knowledge, skills, and attitudes/personal characteristics.

RAPID ASSESSMENT, DEPLOYMENT, AND RESPONSE TEAM

In response to concerns about the Republican National Convention last year, the Disaster and Terrorism branch developed a Rapid

Assessment, Deployment, and Response (RADAR) Team. The purpose of the RADAR Team is to provide a coordinated response to the mental health needs of all affected populations in the wake of a disaster or terrorist event.

The RADAR Team is a resource for emergency managers, human services managers, mental health administrators, and other officials interested in quickly and accurately assessing the immediate mental health impact of an event, and accessing the appropriate mental health support services. Upon notification of deployment, the RADAR team responds as soon as possible to Emergency Operations Centers (EOCs) to provide technical assistance to decision makers in assessing the need for disaster mental health services and in coordinating the deployment of crisis counselors, peer-support personnel, and other specialized disaster mental health resources.

The RADAR Team serves as a forward response group composed of representatives from the mental health and first responder communities. RADAR Team assessments consider all affected populations, including civilians and first responders. They provide disaster mental health guidance and support to the emergency command structure, help mobilize a rapid and integrated mental health response, and initiate mental health intervention services.

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PsySTART Rapid Mental Health Triage and Incident Management System

CONCLUSION

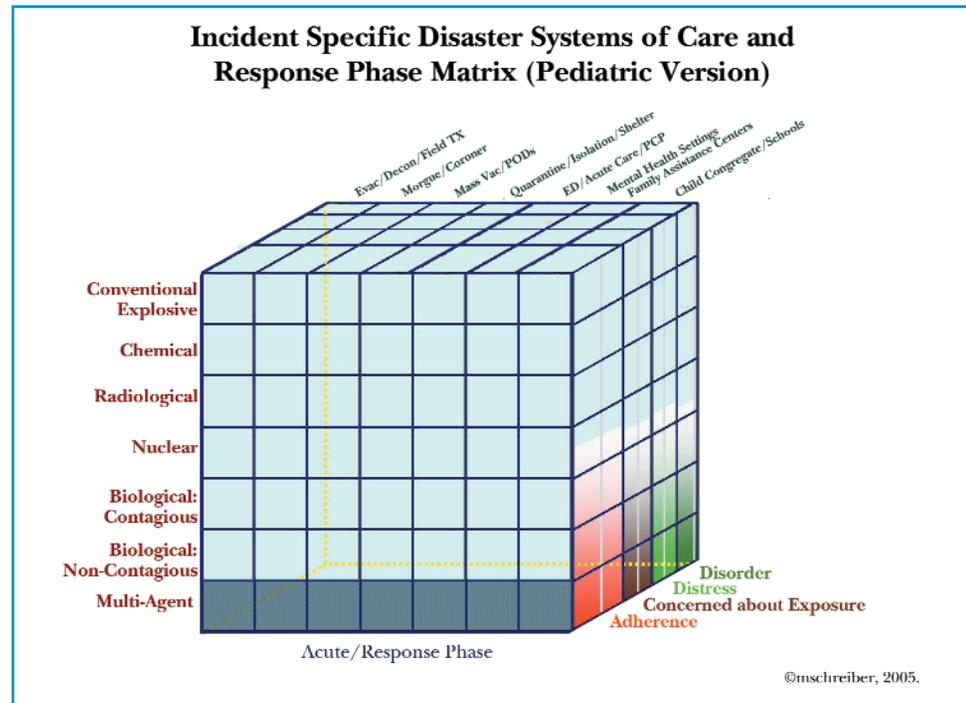
Because the ability to meet the mental health needs of New Jersey’s citizens during a disaster is of high importance—and even more critical during a terrorist-related disaster—the full inclusion of mental health services into the State’s emergency response system has already proven itself to be essential. New Jersey is proud of the progress that has been made in its efforts to continuously refine its disaster mental health response system, but also recognizes that there is still much work to be done, especially in light of the increasing challenges and ongoing threats to safety faced by the public each day. There also continues to be an acknowledgment that collaboration with other disaster responders and stakeholders is crucial to sustaining a viable all-hazards planning process.

This article was contributed by Gladys Padro, M.S.W., LSW, director of the Disaster and Terrorism Branch, New Jersey DMHS.

Efforts to build a comprehensive model for the impact of mass casualty disasters and terrorism on children are now underway, informed by diverse events such as California wildfires, the Oklahoma City Bombing, anthrax attacks, and the SARS virus.

One component in the effort to mitigate the impact of mass casualty events on children is

the development of a model children’s disaster system of care and an integrated rapid triage/behavioral health incident management system, known as PsySTART. In order to rapidly assess and provide for the needs of a large “surge” pediatric population, a model for evidence-based rapid triage linking disaster systems of care has been proposed (see Figure). This approach would permit local communities



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to integrate mental health response in the various levels of the National Incident Management System (NIMS) and local incident command systems (ICS). This would enable synchronization and a common operational picture of behavioral/mental health services across the continuum of response and recovery and within/between defined disaster systems of care.

This model would also provide seamless, real-time integration of cross-system triage data including emergency medical services/hospitals, primary care providers, mental health (and later FEMA Crisis Counseling Assistance and Training Program Immediate Services Program services), public health, medical examiner, schools/child care, and specialized disaster medical (e.g. National Disaster Medical System and disaster relief, American Red Cross [ARC], etc.) into a common operational picture. This system premise forms the cornerstone of PsySTART.

In this model, various disaster and terrorism scenarios are being developed into incident-specific triage/systems of care and “playbooks.” The model incorporates terrorism/pandemic incident-specific response settings or systems of care such as mass prophylaxis/vaccination tied to the Strategic National Stockpile/Points of Dispensing (PODs), shelter in place, isolation/quarantine, and evacuation strategies. The system could also enable parents/caregivers to

voluntarily enter information into the triage system if they desire followup services.

The PsySTART pilot system could rapidly estimate real-time population mental health needs on a graphical information system (GIS) backbone and establish an evidence-based strategy to manage mental health incident response in the acute response and recovery phase. In the immediate aftermath of an event, limited mental health resources could be aligned on a rational-need basis in near real-time. Both behavioral/mental health incident management and collaborating systems of care would have a common operational picture. The pilot system is now operational via a secure Web site, and the triage tag and information technology systems have been piloted in Oklahoma tornadoes, California wildfires, Southeast Asia tsunami, and TOPOFF 3 (in the ARC/National Headquarters Disaster Operations Center). Although data analysis is still incomplete, early evidence suggests that the system may be useful in identifying immediate need and sustained risk.

In the absence of standardized, rapid triage such as PsySTART in mass casualty events, those in need may not be located or treated until some time after clinical levels of distress and impairment have become entrenched. For example, in a study of children following the Northridge earthquake, many children with the worst event

exposures (and subsequent risk from traumatic stress), including those injured and/or trapped, were not identified until months and sometimes years later. Recent evidence from New York City found that only 27 percent of children with severe or very severe posttraumatic reactions received mental health care in the period 4-5 months after the September 11, 2001 terrorist attacks.

There is now emerging evidence that prompt provision of brief, acute-phase services in the first weeks after an event can lead to sustained reduction in morbidity years later, reducing the burden of secondary functional impairment, presumed daily average life years lost (DALYS), and costs to both the individual and the public. Given the increasingly clear behavioral health costs of terrorism, efforts such as these might require equal levels of support and commitment as other homeland security efforts. Rapid triage of those in need of immediate psychological first aid and linkage between systems of care in real-time with GIS may lead to more efficient and effective delivery of care across phases of response and recovery and holds the promise to significantly change the way mental health services are provided after mass-casualty events.

This article was contributed by Merritt Schreiber, Ph.D., coordinator, Terrorism and Disaster Branch, National Center for Child Traumatic Stress.

National Volunteer Organizations Active in Disaster: Successful Strategies for Collaboration During the Historic 2004 Hurricane Season

Four powerful hurricanes—Charley, Frances, Ivan, and Jeanne—decimated eastern U.S. communities in 2004, causing 27 declared major disasters in 15 States. The Federal Emergency Management Agency (FEMA) mobilized a record-setting emergency response force, exceeding operational response to the 1994 Northridge earthquake in California, and the September 11, 2001 terrorist attacks. The National Volunteer Organizations Active in Disaster (NVOAD), a consortium of 40 organizations that collaborate to avoid duplication of service and effort, responded to the crisis counseling needs of the hurricane-impacted areas of Florida. In addition, NVOAD activated an Early Psychological Intervention (EPI) subcommittee whose pre-disaster planning informed response to the immediate mental health needs of hurricane survivors.

As Hurricane Charley swept through Florida in August 2004, NVOAD began collaborating with 12–15 voluntary and State agencies in a series of daily conference calls on crisis counseling needs of affected regions. The conference calls continued throughout the subsequent 6 weeks and

three additional hurricanes. To create an effective plan for collaboration, the facilitators of the calls asked the following questions after each hurricane: What shelters or comfort centers and/or disaster field offices are in need of mental health services? Are there any areas being overlooked? Are there available agency updates?

These daily conference calls proved to be the most effective link during the disaster response. Participants at different levels of involvement shared a breadth of perspectives as they discussed their organizations' methods of providing service, locations of services, and types of emerging needs. The calls fostered collegiality and trust—building a forum for awareness, communication, and consensus—which appear as a continuum of care to those impacted by disaster.

Coordinated agency response took further shape in the emergency and relief stages of the disaster. Organizations partnered and worked in each other's delivery systems, attended other organizations' trainings, and shared intervention strategies. The hurricane-response effort

seemed to strengthen pre-existing relationships, in addition to creating partnerships between organizations that had not previously worked together.

Building consensus is particularly critical in developing early psychological care. In 2003, four members of NVOAD who consistently provide psychological first aid, crisis counseling, and training—American Red Cross (ARC), International Critical Incident Stress Foundation (ICISF), National Organization for Victim Assistance (NOVA), and Salvation Army—convened to share practices and increase collaboration throughout networks of stakeholders. The group formulated the term “Early Psychological Intervention” to inclusively identify the services provided by the four agencies. This term became the eventual name of the subcommittee that was established to create a sustainable, cooperative linkage between the aforementioned members.

The EPI Subcommittee developed five points of consensus: EPI is valued; EPI is a multi-component system to meet the needs of impacted people; specialized training in EPI is

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necessary; EPI is one point on a continuum of psychological care that ranges from pre-incident preparedness to post-incident psychotherapy; and cooperation, communication, coordination, and collaboration are essential to EPI delivery.

Regarding value, consensus formed around the concept that where there is a need for physical disaster response services, there may be a need for psychological disaster services, though EPI is not a substitute for psychotherapy. Also, specific EPIs should be included in any disaster response initiative, including: Pre-incident training and post-incident evaluation based on lessons learned; incident assessment and strategic planning; risk and crisis communications; crisis intervention with large groups, small groups, and individuals; spiritual assessment and care; and acute psychological assessment and triage. Training in all of these areas, in addition to training in local, State, and Federal

emergency management protocols and practices, will enable organizations to provide the highest quality of service.

Ultimately, organizations that provide EPI agreed to cooperate to encourage the formation and utilization of functional partnerships, communicate regularly to share information, coordinate to maximize resources and minimize redundancy in a noncompetitive atmosphere, and work together to achieve the best outcomes for the people impacted by disaster.

The consensus points developed in the 2003 meeting informed the NVOAD 2004 hurricane-season response, and created a pre-disaster framework for successful cooperation. In the future, the broader behavioral health community must work to remove barriers between voluntary organizations and government agencies, and provide comprehensive collaboration.

Forecasters predict an above-normal hurricane season for 2005, making the work of the EPI Subcommittee and those who responded to the 2004 hurricanes an excellent resource for establishing proven frameworks for collaboration between service providers, and providing the highest-quality care possible for individuals on the road to recovery.

To learn more about voluntary organizations, go to www.nvoad.org.

This article was contributed by Johanna Olson, Lutheran Disaster Response, outgoing chair for both the NVOAD Emotional and Spiritual Care Committee (ESCC), and the EPI Subcommittee. For more information on EPI, please contact the new ESCC chair, Tom Davis, Church World Service, at tdavis@churchworldservice.org.

RESOURCE CENTER: 2004 HISTORIC HURRICANE SEASON

Four hurricanes struck the United States during the 2004 hurricane season—Charley, Frances, Ivan, and Jeanne. (The hurricane season runs from June 1 to November 1.) A record-setting 27 major disasters were declared for hurricane-related damage last year in 15 states, Puerto Rico, and the U.S. Virgin Islands. Forecasters have predicted an above-normal hurricane season for 2005. The following Web sites contain preparedness resources and tips for preparing for the season.

- >> **Hurricane Season 2005: Building on Success**
FEMA Evolutions for the 2005 Hurricane Season and Beyond
<http://www.fema.gov/news/newsrelease.fema?id=17324>.
- >> **Building On Success—By The Numbers**
FEMA's Response to The Historic 2004 Hurricane Season
<http://www.fema.gov/news/newsrelease.fema?id=17325>.
- >> **Hazards: Hurricanes**
FEMA: Informing the Public about Hazards
<http://www.fema.gov/hazards/hurricanes>.
- >> **Hurricane Preparedness**
Florida Division of Emergency Management
http://www.floridadisaster.org/hurricane_aware/english/intro.shtml.
- >> **Hurricanes**
National Oceanic and Atmospheric Administration
<http://hurricanes.noaa.gov>.
- >> **Hurricanes**
American Red Cross
http://www.redcross.org/services/disaster/0,1082,0_587_,00.html.
- >> **Key Facts About Hurricane Recovery**
Centers for Disease Control and Prevention: Emergency Preparedness and Response
<http://www.bt.cdc.gov/disasters/hurricanes/recovery.asp>.
- >> **Hurricanes**
National Child Traumatic Stress Network
http://www.ncetsnet.org/nccts/nav.do?pid=ctr_terr_hurr_desc.
- >> **Cómo ayudar a los niños a vérselas con el miedo y la ansiedad**
(Helping Children Cope with Fear and Anxiety, SAMHSA, CMHS)
<http://www.mentalhealth.samhsa.gov/publications/allpubs/KEN-01-0099/default.asp>.
- >> **Los huracanes y su salud y seguridad**
(Health and Safety After a Hurricane, Centers for Disease Control and Prevention)
<http://www.bt.cdc.gov/disasters/hurricanes/espanol/pdf/seguridad.pdf>.
- >> **¿Está preparado para un huracán?**
(Hurricane Preparedness Information, American Red Cross)
<http://www.redcross.org/services/disaster/foreignmat/hurrspn.html>.

SAMHSA Cadre of Consultants Initiative Launched!

On May 11, 2005, 39 professionals from across the country joined SAMHSA staff for an orientation to the SAMHSA Cadre of Consultants Initiative in Bethesda, MD. The purpose of the orientation was to inform the consultants of the Initiative's purpose, mission, and service areas; SAMHSA's expectations; the roles that consultants may be assigned; and the administrative process. The meeting was interactive, giving consultants the opportunity to share ideas to help shape the future of the Initiative.

On hand to provide the welcome and opening remarks were: Dan Dodgen, Ph. D., emergency coordinator, SAMHSA; Seth Hassett, M.S.W., chief, Emergency Mental Health and Traumatic Stress Services Branch (EMHTSSB), Center for Mental Health Services (CMHS); Steven Shapiro, public health advisor, Division of State and Community Assistance, Center for Substance Abuse Treatment (CSAT); and Charlie Williams, M.H.S., CEAP, senior public health advisor, Division of State and Community Assistance, Center for Substance Abuse Prevention (CSAP). SAMHSA DTAC Project Officer Maria Baldi, EMHTSSB, CMHS,

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State Training: Ohio

provided an overview of the Center and SAMHSA DTAC Director Ian Gordon provided an overview of the Cadre Initiative. Through a number of small-group discussions, brainstorming sessions, and scenario-based exercises, consultants were guided through several topics over 2½ days. Topics included: Representing SAMHSA (ethical boundaries to consider), managing and balancing roles and expectations, scope of consultant services, methods for providing effective technical assistance (TA), and management and administration of the Cadre.

SAMHSA recognizes that States and Territories have growing TA needs for consultation related to disaster preparedness, response, and recovery. Historically, SAMHSA's pool of resources to provide such TA has consisted of SAMHSA staff and a few members of the field with disaster

behavioral health experience. In an effort to build field capacity and ensure consistent TA delivery, SAMHSA established the Cadre of Consultants Initiative. Its goals are to:

1. Increase overall field capacity through an expanded and strengthened resource base for TA delivery/consultation;
2. Ensure that requests for consultation and training are addressed by consultants who possess appropriate expertise through a formalized selection and deployment process; and
3. Promote consistency, quality, and continuous improvement of TA delivery efforts through established guidelines for consultation delivered on behalf of SAMHSA.

This article was contributed by Ian N. D. Gordon, M.S., director, SAMHSA DTAC.

More than 400 behavioral health professionals, first responders, consumers and families, members of law enforcement, and victim advocates were cross-trained April 14–15 at the Joining Forces: Preparing Communities for the Behavioral Health Impact of Terrorism or Disaster. The Ohio Departments of Mental Health (ODMH) and Alcohol and Drug Addiction Services hosted the conference to provide training on the psychosocial effects of terrorism and disaster.

The conference, cosponsored by 21 other organizations, included keynote addresses and workshop presentations to demonstrate the behavioral health effects of terrorism or disaster on individuals and communities. Simultaneously, the conference educated behavioral health service providers on the roles of first responders and recovery workers.

The National Association of State Mental Health Program Directors has estimated that after a terrorist attack, psychological casualties will outnumber physical casualties by four to one. The Joining Forces conference encouraged increased integration of behavioral health services to victims, families, older adults,

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children, and first responders in the existing response system during the weeks, months, and years following a terrorism or disaster event. The opening session included remarks from Ohio Attorney General Jim Petro, who also provided funding for the conference, and Ohio Emergency Management Agency Director Nancy Dragani. Former Oklahoma City Assistant Chief of Police Lawrence Johnson, Jr., and Dr. Kermit Crawford of the Boston College of Medicine delivered keynote addresses. The 36 workshops covered all aspects of behavioral health and disaster response. Some of the presentations are available on the ODMH Web site so that conference participants and others can continue learning about the role of behavioral health services in terrorism or disaster. The presentations are available at <http://www.mh.state.oh.us/ibhs/centraloffice/allhazards.jfpresentations.html>.

For more information about Ohio's behavioral health response to terrorism or disaster, contact Joseph Hill, manager of risk administration at 614-644-6996, hillj@mh.state.oh.us.

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:

- >> **Centers for Disease Control and Prevention, Office of Communication. (2005).** *Crisis and Emergency Risk Communication Course (CERC)*. This is a fast-paced, interactive course that gives participants essential knowledge and tools to navigate the harsh realities of communicating to the public, media, partners, and stakeholders during an intense public health emergency, including terrorism. The course consists of 12 self-contained modules that can be arranged to meet the crisis communication training needs of distinct groups (e.g., public health professionals, medical and health professionals, first responders, community and civic leaders, and volunteer organizations) at the local, State, and Federal levels. <http://www.cdc.gov/communication/emergency/cerc.htm>.
- >> **National Child Traumatic Stress Network . (2005).** *National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices*. http://www.nctsn.org/nccts/nav.do?pid=nws_main.
- >> **Pole, N., Best, S., Metzler, T., & Marmar, C. (2005).** Why are Hispanics at greater risk for PTSD? *Cultural Diversity and Ethnic Minority Psychology*. 11(2), 144–161. Viewed June 14, 2005 at <http://www.apa.org/journals/features/cdp112144.pdf>.

Upcoming Meetings

2005 AMERICAN PSYCHOLOGICAL ASSOCIATION (APA) ANNUAL CONVENTION

AUGUST 18–21, 2005
WASHINGTON, DC

The purposes of the annual convention are to: Provide a forum in which members may present their scientific and scholarly work, present a general program that will be informative and of interest to all members of the association, facilitate the exchange of experience relating to the applications of psychology, and provide a place where the business of the association can be conducted efficiently.

The convention program was developed by several APA divisions, and include symposia, paper and poster sessions, invited addresses, discussions, and workshops. Meetings for the 113th convention will be held in the Washington Convention Center, the Grand Hyatt Washington, the JW Marriott Pennsylvania Avenue, and the Renaissance Washington, DC Hotel.

Disaster behavioral health-related sessions include:

- >> American Red Cross Disaster Mental Health Training;
- >> APA's Response to the Tsunami Disaster;
- >> Changes to Disaster Services—Implications for State Disaster Response Networks;
- >> Hurricanes 2004—Disaster Impact on Residents, Providers, and Residential Healthcare Facilities;
- >> Innovations and Best Practices in Violence and Disaster Intervention;
- >> Planning for the Unthinkable—Developing a Behavioral Health Disaster Response; and
- >> Training Counseling Psychologists as Early Responders in Disaster Mental Health.

For more information, go to:

<http://www.apa.org/convention05>.

EIGHTH ANNUAL CONFERENCE ON INNOVATIONS IN DISASTER MENTAL HEALTH

SEPTEMBER 22–24, 2005
RAPID CITY, SD

This conference will examine research strategies and methodology in disaster psychology in an effort to promote innovative approaches and

collaborative agreements that will yield more definitive results. Its goal is to assemble a group of experts in the field of disaster and trauma research to discuss the ways in which they have successfully implemented their research protocols. Poster abstracts are due by August 19, 2005. For more information, contact the Disaster Mental Health Institute, The University of South Dakota at <http://www.usd.edu/dmhi/conference.cfm>.

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 human-caused 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 offered in February 2005. This training is offered to administrators/managers and other professionals in Massachusetts to develop a working

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knowledge of evidence-based practices (EBP) to help communities cope in the aftermath of disasters.

At the conclusion of the training, you 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.

AMERICAN PUBLIC HEALTH ASSOCIATION (APHA) 133RD ANNUAL MEETING & EXPOSITION

NOVEMBER 5–9, 2005
NEW ORLEANS

The APHA Annual Meeting & Exposition is the premier public health educational forum. Learn from experts in the field, hear about cutting-edge research and exceptional best practices, discover the latest public health products and services, and share public health experiences with peers. The world of public health is in continual motion, and there is no better time to stay abreast of the research and learn about emerging issues.

The APHA Annual Meeting & Exposition is the oldest and largest gathering of public health professionals in the world, attracting more than 13,000 national and international physicians,

administrators, nurses, educators, researchers, epidemiologists, and related health specialists. APHA's meeting program addresses current and emerging health science, policy, and practice issues in an effort to prevent disease and promote health.

The 2005 APHA Annual Meeting & Exposition theme, Evidence-based Policy and Practice, explores the processes of systematically finding, appraising, and using scientific research as the basis for developing sound practices. The knowledge gleaned from this research is used to develop policies and practices that improve health outcomes and performance as well as allowing for more efficient use of resources. Policy makers are also provided with a better understanding of the science, ensuring that policy decisions are based on the best information available. For more information, go to <http://www.apha.org/meetings/index.htm>.