



# 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 Catherine Johnson at [catherinej@esi-dc.com](mailto:catherinej@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, [dtac@esi-dc.com](mailto:dtac@esi-dc.com), and we will include your comments and queries in the next issue (Spring 2006). Help us make this an effective method of communication for the disaster behavioral health field.

**Our last discussion topic was:** What do you see as the intermediate and long-term mental health needs of the evacuees from Hurricanes Katrina and Rita?

### RESPONSE:

The psychological stress and trauma caused by the destruction of homes, loss of jobs, separation of families, evacuation from familiar settings, and loss of life in the areas hit by the 2005 hurricanes will lead to an increased need for mental health services. The discussion questions from the last issue of *The Dialogue* explored this issue. Readers were asked to predict what they thought would be the major mental health needs of evacuees in the coming months. The services that were iden-

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tified were care for trauma-related disorders, such as posttraumatic stress disorder or anxiety disorders; care for preexisting mental health disorders and alcohol or drug addictions; specialized care for children and adolescents; in-school counseling services; and assistance in reestablishing support networks for victims. Some of the Immediate Services Program (ISP) applications in the evacuee States focused, as would be expected, on immediate sheltering needs. This involved providing crisis counseling support in shelters, emergency housing, etc. However, as the ISPs move into the extension period and then into Regular Service Programs (RSPs), there will be a need to adopt an outreach approach to continue to serve people who move out of shelters and into temporary or permanent housing, and to continue to reach the many people who may have come to the State on their own or through nongovernmental relief organizations. There may also be opportunities to provide some services to first responders or other people from the State who went to the Gulf Coast States to assist.

From this discussion of mental health needs sprang questions on the differences between doing this work for evacuees from outside the

State versus working with in-State survivors. Strong communication between State Crisis Counseling Assistance and Training Programs (CCPs) is seen as essential when attempting to connect survivors with services as they return home. The CCP model, with its basic supportive, short-term interventions, lends itself well to assisting with referrals to other resources. For CCP services, the resources might be the CCP in another State. However, referral issues for people who are receiving traditional mental health or substance abuse services become more challenging as the people helping the survivor with a referral are not going to be as knowledgeable about the out-of-State system. The Substance Abuse and Mental Health Services Administration (SAMHSA) convened a conference call with the State CCP project directors on the topics of communication and hotlines to address these issues; a list of CCP hotline numbers is now available to help foster communication. The big question is, Will the survivors return to the gulf region or resettle in the States they evacuated to? The extent to which they remain or return will have a significant impact on program size and design, and it creates an unprecedented challenge for CCP program directors. Generally, one has an idea of the number of survivors in a disaster, and the chal-

lenge is how to reach them. In these CCPs the challenge is to reach a potentially moving target group. The RSP phase of the CCP is designed to allow for ongoing needs assessment and (negotiated) program adjustment in accordance with changing needs. Most often this is done in relation to quarterly reporting. We would imagine that States will need to work closely with their project officers to look at program needs as the RSP unfolds, then adjust accordingly.

**Our next discussion topic is: As numerous shelters were set up to house and assist evacuees from the 2005 hurricanes, what were the challenges and lessons learned in providing behavioral health services to individuals and families in such settings?**

## SAMHSA's Response to the 2005 Hurricanes



The behavioral health response to disasters as devastating as the 2005 hurricanes will continue for months and even years. The initial response of the Substance Abuse and Mental Health Services Administration (SAMHSA) and its partners was discussed in the Fall 2005 issue of *The Dialogue*. SAMHSA continues to work with States to ensure that mental health and substance abuse assessments and crisis counseling are readily available; longer term issues, such as posttraumatic stress disorder, are planned for; and people with serious mental illnesses or addictive disorders, as well as children with serious emotional disturbances, continue to receive ongoing treatment.

The crisis counseling response, in particular, has been extensive. SAMHSA's Center for Mental Health Services, via an interagency agreement, provides grant support and technical assistance to the Federal Emergency Management Agency's (FEMA) Crisis Counseling Assistance and Training Program (CCP). In addition to the hurricanes' direct toll on the Gulf Coast States, FEMA registrations show that every State and Territory in the country accepted hurricane evacuees. In fact, 29 States have received Immediate

Services Program CCP grants to provide services to hurricane victims or evacuees. In comparison, there were six simultaneous CCP grant awards following the events of 9/11.

Other important efforts are also ongoing. For example, SAMHSA continues to deploy mental health and substance abuse services professionals to the impacted Gulf Coast States to provide services to survivors, as well as consultation and training to State personnel. Also, the SAMHSA Suicide Prevention Hotline, 1-800-273-TALK, is a resource for hurricane survivors and their care providers. The hotline is connected to a network of local crisis centers and mental health and substance abuse providers across the country.

More recently, SAMHSA has launched a Hurricane Mental Health Awareness Campaign. A wealth of disaster behavioral health and hurricane-related information is available at <http://www.mentalhealth.samhsa.gov/disasterrelief/>. As part of the awareness campaign, a series of public service announcements (PSAs) have been designed to help adults, children, and first responders who have been impacted by the hurricanes and are in need of mental health services. The PSAs can be accessed on the Web at

<http://www.mentalhealth.samhsa.gov/disasterrelief/psa.aspx>.

SAMHSA has also created a series of video and Webcast presentations for disaster responders and relief workers. These may be viewed at <http://www.mentalhealth.samhsa.gov/disasterrelief/pubs/responder.asp>. To date, the series consists of the following topics:

- >> Key Concepts in Disaster Mental Health.
- >> Managing Your Stress in Crisis Response Work.
- >> Psychological First Aid Approaches.
- >> Posttraumatic Stress Disorder in Disasters.
- >> SAMHSA's Katrina Assistance Project—Publications for Responders and Relief Workers.

The tireless efforts of mental health and substance abuse services providers at the Federal, State, and local levels to provide assistance, support, and services to victims of the 2005 hurricanes are commendable. Thank you for all you have done and all you continue to do. Please remember that technical assistance to support your efforts is always available through the SAMHSA Disaster Technical Assistance Center.

# Mental Health Response to Mass Violence and Terrorism: A Field Guide

A *Field Guide* has been developed that draws from material contained in *Mental Health Response to Mass Violence and Terrorism: A Training Manual*. The Training Manual provides in-depth and comprehensive information and references for additional reading on the subject of mass violence and terrorism response. The *Field Guide* will serve as a companion piece to the *Training Manual*; it highlights practical approaches to mental health response.

The *Field Guide* is intended for mental health and disaster workers; first responders; Government agency employees; and crime victim assistance, faith-based, healthcare, and other service providers who assist survivors and families during the aftermath of mass violence and terrorism. All who come in contact with victims and families can contribute to restoring their dignity and sense of control by interacting with sensitivity, kindness, and respect. The *Field Guide* provides the basics of responding to those in crisis.

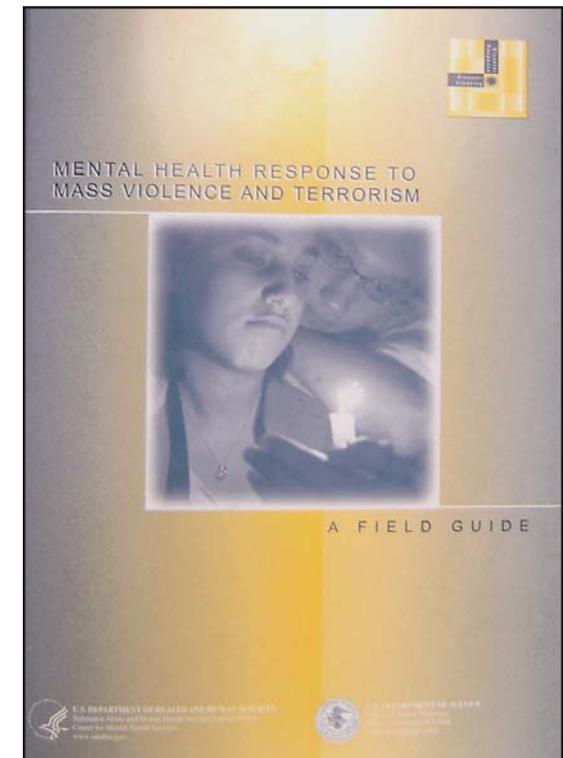
The *Field Guide* also includes essential information about survivors' and family members' reactions and needs, with specific suggestions for

assisting children, adolescents, adults, and older adults. It describes basic "helping" skills with indicators for when to refer someone to a licensed mental health professional. The last section presents stress prevention and management strategies for service providers or those who assist survivors and families.

This publication can be accessed electronically on the Web at [www.samhsa.gov](http://www.samhsa.gov) and [www.ncjrs.org](http://www.ncjrs.org). For additional free copies of this document, please contact SAMHSA's National Mental Health Information Center, and ask for Publication No. SMA 4025, at 1-800-789-2647, 1-866-889-2647 (TDD); or contact the Office for Victims of Crime Resource Center, and ask for Publication No. NCJ 205452, at 1-800-851-3420, 1-877-712-9279 (TTY).

#### CITATION

U.S. Department of Health and Human Services. *Mental Health Response to Mass Violence and Terrorism: A Field Guide*. DHHS Pub. No. SMA 4025. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005.



# Implementing a Crisis Counseling Program in a Large Rural Area: Iowa Recovers 2004-2005

## OVERVIEW

Iowa Recovers, a Crisis Counseling Program (CCP), was implemented in 75 of Iowa's 99 counties after 69 tornadoes and 110 flash floods damaged homes, businesses, and farmlands, affecting the lives of more than 4,000 Iowans in late May-early June, 2004. Implementing this Immediate Services Program (ISP) and Regular Services Program (RSP) in a large rural area posed several challenges:

- >> The affected individuals, families, and communities were widely dispersed across many locations throughout the State.
- >> The majority of the target population were involved in some form of agriculture (e.g., farmers, workers in food processing industries, businesspeople connected with farming, and the families of all these people), and they tended to be hardworking, self-reliant people who were reticent to discuss mental health and skeptical about Government-sponsored programs.
- >> Many special populations (e.g., Amish and Mennonite communities, Spanish-speaking immigrants, Iowans of African-American descent, the rural elderly, and rural chil-

dren), as well as the rural farm culture, made the delivery of services more complex.

This article describes how Iowa Recovers dealt with these issues and offers suggestions for implementation of ISPs and RSPs in other rural locations. A companion article "Structuring a Meaningful Program Evaluation: Iowa Recovers Experience" provides an independent evaluation of the CCP.

## DESCRIPTION OF THE DISASTERS

On May 19, 2004, heavy rains began to soak much of Iowa and other parts of the Midwest. The rains erased what was thought to be less than optimal soil moisture for good crop production. Iowa farmers were happy, as were the Iowa town businesspeople whose livelihoods depend heavily on Iowa's farmers. Agriculture is the major industry in Iowa.

Fortunes changed on Friday, May 21, 2004. Strong winds blew out of the South all day, with gusts reaching 60 miles per hour. Warm, humid air and steady high winds made people apprehensive. Severe thunderstorms rumbled across Iowa, dumping heavy rains of 2–6 inches in

northern Iowa and eastward to Wisconsin. Hail was common, mostly pea- to golf ball-sized, but hailstones as large as baseballs were reported in several central Iowa locations. At least 12 tornadoes were spotted in the late afternoon and evening at various Iowa locations. The worst tornado, an F2 twister estimated at a quarter of a mile wide, dropped to earth near Rolfe, in Pocahontas County in northwest Iowa, and moved directly through the town of Bradgate, in the adjoining Humboldt County. Over the course of the ensuing 5 weeks, many more tornadoes and heavy rains on already waterlogged ground caused property damage that was estimated to be \$28 million, excluding farm losses. Approximately 5 percent of Iowa's crops were destroyed. Remarkably, only one person died of storm-related causes, and five people were hospitalized with injuries.

## THE IOWA RECOVERS RESPONSE

Iowa Governor Tom Vilsack asked the Iowa Department of Human Services (DHS) Disaster Mental Health Coordinator, Lila P. M. Starr, LBSW, on May 21, 2004, to assess the need for a

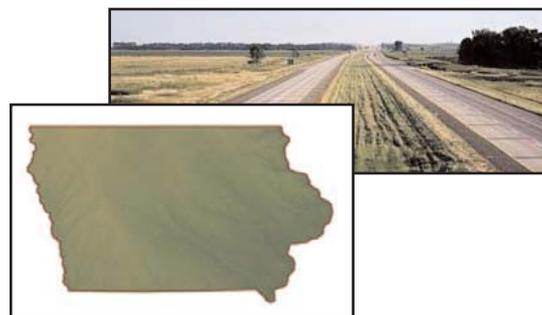
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CCP to assist the residents in several Iowa communities with recovery from the emotional toll of the severe tornadoes, flooding rains, and high winds. Ms. Starr contacted AgriWellness, Inc., a nonprofit organization that trains outreach workers and professionals to provide behavioral health supports primarily for rural populations. Earlier in May, DHS and AgriWellness completed training a group of first responders about behavioral health issues that accompany disasters, as part of a project funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to enhance Iowa's capacity for emergency mental health and substance abuse response to disasters of all types. By May 24, 2004, an initial assessment indicated the need for an immediate CCP. On May 25, 2004, President George W. Bush declared 25 counties eligible for Federal disaster assistance, including individual assistance. Using \$25,000 in Center for Mental Health Services Block Grant funds, DHS initiated an immediate CCP, while an ISP application was being prepared.

Twelve outreach workers, primarily from the group of first responders who had just completed the disaster behavioral health course, were trained June 3–4, 2004, and began offering services immediately in the most severely affected counties of Iowa. Following approval of the ISP, an additional 13 outreach workers were trained

June 29–30, 2004, to meet the increasing needs and to implement the federally funded CCP. Daniel Thompson, the Disaster Mental Health Coordinator for Texas, was recommended by the SAMHSA Disaster Technical Assistance Center to help with the training. The ISP was approved for \$194,535. By July 5, 2004, President Bush declared 75 of Iowa's 99 counties eligible for individual assistance, including crisis counseling from the Federal Emergency Management Agency. The ISP was extended until an RSP for \$253,507 was approved to begin September 24, 2004. Iowa Recovers ended June 19, 2005.

During the year-long Iowa Recovers CCP, the outreach workers completed 2,034 individual crisis counseling contacts, some of which were followup visits with the same service recipients. The staff reached 388 people in group crisis counseling sessions and 2,481 people in group educational services. Materials were distributed to 5,273 people.



#### REACHING A WIDELY DISPERSED TARGET POPULATION.

Damages from the tornadoes and flash floods were localized for the most part to the pathways of the tornadoes and the rivers and streams that overflowed their banks. The villages of Garber and Elkport, in Clayton County in northeast Iowa, were a notable exception; these communities were wiped out when a dam burst upstream and allowed a wall of water to surge over the towns. Both towns are being relocated.

To identify people in need of assistance scattered throughout much of the State, the Iowa Recovers CCP recruited outreach workers from all parts of the State to form four teams: (1) One team canvassed all the affected individuals, homes, and rural towns in the counties west of Interstate Highway 35 (I35); (2) another team canvassed all the rural locations in the counties east of I35; (3) a third team focused on the urban locations of Cedar Falls, Cedar Rapids, Des Moines, Marshalltown, and Mason City, where many homes in low-lying tracts experienced basement flooding; and (4) a roving team concentrated on the hardest hit farmsteads and rural towns, such as Garber and Elkport. All the teams were composed of four–five team members and a team leader who worked in pairs as they visited people at their homes, businesses, and other community sites. Often the outreach workers knew where to find people in need of

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CCP assistance because they were familiar with the locales by virtue of living nearby. To learn of people in need of CCP services, outreach workers on the four teams contacted the emergency management coordinators, law enforcement officials (e.g., county sheriff departments, city police), CPCs (i.e., officials in each county called Central Point of Coordination administrators, who are mandated by State law to coordinate mental health and substance abuse services in their respective counties and to ensure that all people with disabilities receive the social, behavioral, and other services they need), school officials in each district, DHS offices, and city clerks, when available, in all 75 counties that were declared eligible for disaster assistance.

Iowa Recovers coordinated with the Iowa Concern Hotline, a statewide telephone hotline and 211 service that operates 24/7, to take calls from people needing assistance of any kind in the entire State. The Iowa Concern Hotline was advertised widely via radio, television, and newspapers as the call center for Iowa Recovers. The outreach workers manned booths and distributed information at many county fairs and at all major statewide agricultural expositions such as the Iowa State Fair, the Farm Progress Show, and FarmFest. Radio and television programs and newspaper and farm magazine sto-

ries about Iowa Recovers were undertaken. County Emergency Management Coordinators and word of mouth among people affected by the disasters helped the outreach workers identify people in need of assistance. All these methods of outreach were effective in reaching the target population.

Although Iowa Recovers has ended, reconstruction projects are still underway. The citizens of Bradgate, Elkport, and Garber held anniversary celebrations in May 2005 and made sure that the Iowa Recovers staff were involved in these events.

#### **UNDERSTANDING IOWA'S RURAL CULTURE.**

From the beginning, the staff of the Iowa Recovers CCP were selected to match the demographic characteristics of Iowa's residents who were affected by the disasters. The staff of 25 outreach workers and team leaders (12 men and 13 women, ages 20-75) included 6 farmers, 2 teachers, 2 pastors, 2 nurses, 4 mental health and substance abuse professionals, 3 college students, 4 active or retired employees of the Iowa State University Extension Service, and 2 State employees. Matching the profile of Iowa residents affected by the disasters was a key to establishing credibility with the target population and providing CCP services in the "language" of the target population (e.g., farm talk,

the Spanish spoken by immigrants from Mexico and Central America working in meatpacking and industrial plants) helped break down negative stigma about mental health and substance abuse. The outreach workers avoided the term "mental health counseling" and described themselves as outreach workers connected with Iowa Recovers. They wore travel vests with a name tag and an Iowa Recovers decal.

AgriWellness developed Disaster Recovery Resource Guides for many of the hardest hit counties, and the outreach workers distributed the guides during their contacts. The guides contained information about farm disaster loans available through the county Farm Service Agencies of the U.S. Department of Agriculture (USDA), along with information on how to obtain a variety of behavioral health and other services. Information was also provided about how to apply for USDA rural development loans and credit and insurance services available to farmers through Farm Credit Services of America.

#### **ADDRESSING THE NEEDS OF SPECIAL POPULATIONS.**

To assess the need for CCP assistance by Iowa's many Amish and Mennonite farm communities, the project staff approached four spokespeople who belong to these communities about how Iowa Recovers could best serve the Amish

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and Mennonite populations. Project staff learned of several Amish families who lost farm buildings in floods. Following the spokespeople's advice, outreach workers visited these farm families.

When the outreach workers were selected and trained for the ISP in June 2004, not all the people and locations affected by the disasters were known. As it became clear during the summer that some of the people affected by the disasters were African-American and people of Hispanic/Latino backgrounds, one African-American man, an immigrant from Africa, and three people who speak Spanish fluently and are familiar with several variations of Hispanic/Latino culture were recruited to join the staff; they replaced five outreach workers who left the CCP to resume full-time jobs or who left for other reasons. AgriWellness furnished project brochures in Spanish and English and, with the assistance of a translator, published articles in Iowa's largest Spanish newspaper *El Heraldito Hispano*. Matching the racial heritage and cultures of these minority groups in the teams of outreach workers resulted in much better acceptance of CCP services than when the teams did not include individuals with these characteristics.

Iowa has many rural residents who are elderly. The outreach workers learned of the rural

elderly who were impacted by the disasters of 2004 by word of mouth, from the Area Agencies on Aging, and during visits to Senior Citizens Centers and meal sites for the elderly. The outreach workers contacted seniors in need of assistance at their homes and at educational events. Besides responding to the elderly's emotional needs, the outreach workers helped connect several individuals with resources they needed, such as help with pumping water from basements, acquiring new furnaces and water heaters, and connecting with the Iowa Disaster Human Resource Council for other unmet needs.

To address the needs of children for assistance, DHS and AgriWellness sent letters offering services to every school district in the 75 counties in the disaster area, announcing the availability of outreach workers to conduct inservice programs at schools and the availability of extensive packets of information containing brochures and information about addressing the needs of children coping with disasters, emergencies, or crises. Outreach workers responded to three requests for presentations at schools, and the AgriWellness staff sent out 187 packets of information to school districts that requested the information.



## RECOMMENDATIONS FOR CCPS IN RURAL AREAS

Iowa Recovers led to several suggestions for implementing CCPs in large rural areas:

- >> It is helpful to have a ready reserve of trained outreach workers geographically dispersed throughout a large rural area who can be available on short notice to provide immediate CCP services without having to travel long distances.
- >> Iowa Recovers requires that every outreach worker have a cellular telephone to connect with their team leaders for directions and with the Iowa Concern Hotline for referrals.
- >> The Iowa Recovers staff found weekly telephone conference calls among team leaders and biweekly telephone conference calls among team members particularly helpful.
- >> "Rural" has many cultures, and it is important to take these cultures into account to provide acceptable CCP services, such as selecting and training outreach workers who are of similar racial and cultural backgrounds as the target population.

The following article "Structuring a Meaningful Program Evaluation: Iowa Recovers Experience" provides additional information about this CCP obtained through an independent evaluation.

*This article was contributed by Michael R. Rosmann, Ph.D., and Lila P. M. Starr, LBSW.*

# Structuring a Meaningful Program Evaluation: Iowa Recovers Experience

Iowa Recovers provided an Immediate Services Program (ISP) in 2004 and a Regular Service Program (RSP) in 2004–2005 for survivors in 75 Iowa counties that were included in the Presidential declaration of disasters. Outreach workers provided emotional support to disaster survivors in their communities by using the Active Listening Practice Model. (For more details about the Iowa Recovers Crisis Counseling Program [CCP] see the accompanying article.) To gauge the effectiveness of the services provided, State Public Policy Group, Inc., was hired to perform a program evaluation.

Evaluation research requires evaluating a program in the environment in which it exists. This is much different than research in a controlled laboratory environment. Furthermore, what is discerned from the evaluation research must have value to a program's operation. To construct a research design that was both in a natural setting and valuable to a program's operation, a bifurcated tact was taken. First, the evaluation superimposed an evidence-based practices (EBPs) framework, currently being used by the Iowa Department of Human Services (DHS) in another mental health program

reform, on Iowa Recovers' activities. Second, triangulation, in which multiple techniques, both qualitative and quantitative, are used to discern the truth of the premises, was employed.

*“The program has the potential to be a great asset,” is a typical comment expressed by a community leader when discussing the delivery of the service.*

In 2004, Iowa passed a law that requires implementation of EBPs by Community Mental Health Centers and other mental health providers that receive a portion of Performance Partnership Block Grant funds through contracts with the Iowa DHS. To make the implementation of Iowa's statute workable, the term EBP had to be operationalized. Given Iowa's proclivity to grassroots initiatives and bottom-up thinking, Iowa operationalized EBPs as: (1) Using one of the six EBPs recognized by the Substance Abuse and Mental Health Services Administration or (2) "practicing in an evidence-based manner." Practicing in an

evidence-based manner means that the treatment practice is designed around the following rubric:

1. Clearly identified target population.
2. Clearly identified target symptoms or problems the program is designed to address.
3. Clearly identified desired outcomes of the program.
4. Reliable and valid methods to assess the degree to which the stated outcomes have been achieved.
5. Clearly identified core components of the treatment model in a manner that allows for replication across providers and sites.
6. Methods to assess fidelity to the model.

While Iowa Recovers outreach workers were not licensed mental health professionals, the Active Listening model they used with disaster survivors is a practice model. The origin of this practice can be traced back to the Federal Emergency Management Agency's basic course on CCP and its materials. Thus, Iowa Recovers was evaluated as to how well it practiced in an evidence-based manner.

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Practically, through several techniques and related activities, triangulation was undertaken to evaluate Iowa Recovers in this manner. Concisely, this was embodied in five activities: (1) A questionnaire for disaster survivors who received Iowa Recovers services; (2) training for outreach workers on how to disseminate the questionnaire; (3) focus groups with community leaders from communities where Iowa Recovers outreach workers had been operating prior to or at the time of the focus group; (4) a focus group with outreach workers; and (5) dissemination of evaluation findings for peer feedback.

Though not explicitly stated as part of practicing in an evidence-based manner or being an EBP, it was alluded to at the beginning of the article that the findings must inform the program such that improvements may be made. The desired outcomes for the program were fairly well operationalized by the Active Listening model and the job assignments explained in the disaster outreach workers handbook. (Having a manual is essential to standardizing the process for fidelity, as well as allowing replication.) Thus, to what extent and under what circumstances these outcomes were met became the metric to gauge Iowa Recovers' success and plot improvements. Following are some highlights:

#### **DISASTER SURVIVORS RATED OUTREACH WORKERS' JOB PERFORMANCE HIGHLY.**

- >> When asked how well outreach workers performed their job functions, more than 56 percent of respondents to the questionnaire said "very well" to all primary functions:
  - Assessed your situation (58 percent);
  - Provided information appropriate to the difficulties you were experiencing (57 percent); and
  - Provided emotional support (63 percent).
- >> Nearly half (47 percent) of respondents who answered the question recognized an improvement in their mental state as a result of the outreach workers.

#### **EVEN THOSE RESPONDENTS WHOSE SELF-PERCEPTION WAS THAT OUTREACH WORKERS DID NOT POSITIVELY IMPACT THEIR MENTAL STATE MAY HAVE, IN FACT, BEEN IMPACTED.**



The Active Listening model that the outreach workers used is designed to provide subtle, supportive services; it provides passive support by listening to and affirming individuals' feelings.

- >> Part of the outreach workers' job was to educate disaster survivors as to the resources available and help survivors develop plans to meet their goals. Apparently, many who did

not think their mental state had been positively affected did have their behavior impacted; they followed up with resource contacts left behind by outreach workers:

- 14 percent of this group called Iowa Concern Hotline; and
  - 15 percent contacted up to six organizations as a result of the information provided by outreach workers.
- >> A qualitative case study illustrates that point. One community leader at the focus group, who positively affirmed the value of the program for others but did not need psychiatric services, even after traumatic experiences earlier in life as a Vietnam veteran, spent many evenings talking with a disaster outreach worker.

#### **COMMUNITY LEADERS PRAISED IOWA RECOVERS IN PRACTICE AND IN THEORY BUT HAD SOME RESERVATIONS.**

- >> Community leaders felt going to survivors and not calling it "mental health" dealt effectively with the stigmas associated with mental illness, especially the rural cultural bias of being self-reliant and not needing to ask for help.
- >> "The program has the potential to be a great asset," is a typical comment expressed by a community leader when discussing the delivery of the service.

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- >> Community leaders worried, "now that it's running well, will the funding stop and the program be shut down?" They hoped some effort would be made to keep the program in a higher state of readiness so it could easily be rolled out after a disaster.

**PRACTICING IN AN EVIDENCE-BASED MANNER REQUIRES AN EVALUATIVE FEEDBACK LOOP SO THE PRACTICE CAN IMPROVE UPON ITSELF.**

- >> Continuity of the program needs to be addressed. There were initial difficulties during the ISP, and need is seen by many for a higher state of readiness in the future, given the regularity of the programmatic need.

- >> Some focus group attendees felt followup visits could have been more frequent. This may mean a programmatic evaluation of the optimal resource allocation for visits.
- >> Of those whose mental state was not positively affected by outreach workers, most wanted more information about and help with damage assessment and financial resources. The amount and type of referral information to provide is a programmatic consideration.
- >> This practice model, with its structure, had good outcomes, and it seems it could be replicated in similar sites with like outcomes.

*A complete report that expands on whether a program is practicing in an evidence-based manner, these evaluation findings, and a methodology section can be downloaded from [www.sppg.com/policy\\_work/policy\\_work.php?PHPSESSID=2643a04d07011f4300deda0f169be5d0](http://www.sppg.com/policy_work/policy_work.php?PHPSESSID=2643a04d07011f4300deda0f169be5d0).*

*Contributed by Jim Addy.*



# Massachusetts Department of Mental Health Article on the Enhanced Training Program

## INTRODUCTION

*As the State Mental Health Authority, the Massachusetts Department of Mental Health (DMH) promotes mental health through early intervention, treatment, education, policy, and regulation so that all residents of the Commonwealth may live full and productive lives.*

Although DMH's primary mission is to "provide services to citizens with long-term or serious mental illness, early and ongoing treatment for mental illness, and research into the causes of mental illness," DMH recognizes its responsibility to assist the public during major emergencies and disasters.

Operationally, DMH is divided into a Central Office, six Area Offices, and numerous local Site Offices that operate psychiatric inpatient facilities and community mental health centers and coordinate community mental health services for some 26,000 DMH clients. DMH also has hundreds of provider-operated programs across the State, providing community-based services, including residential, employment, and mental health outreach and treatment.

## ENHANCED TRAINING PROGRAM

The DMH crisis counseling program was developed to respond, when requested by the Massachusetts Emergency Management Agency (MEMA), Department of Public Health (DPH), or Red Cross, to large local emergency or catastrophic disaster events.

For close to 15 years, DMH has conducted formal disaster response and planning activities that include long-standing membership in MEMA; conducting agency emergency planning for clients, staff, facilities, and DMH-affiliated programs; acting as the lead support agency to DPH for Emergency Support Function 8 (Health and Medical Services); being the State agency authorized to apply for and administer the Federal Emergency Management Agency's (FEMA) Crisis Counseling Assistance and Training Program (CCP); and managing a disaster crisis counseling program.

After the events of 9/11, Massachusetts recognized the need to develop an enhanced training program. The fact that two of the 9/11 flights originated from Logan International Airport in

Boston had a significant impact on the State's people and government. The families and friends of passengers and airline staff, disaster responders, and airport workers connected to the event were more directly affected. Through FEMA's CCP, which DMH administered, approximately 80,000 individuals received 9/11-related assistance. Although FEMA Just-In-Time training sessions were conducted, and DMH called upon all available crisis counseling resources, the need for services exceeded the State's response capacity. Though much had been learned from the Oklahoma City Bombing and other more localized disaster events, nothing had truly prepared the State for the response it would be called on to perform.

As part of the response and recovery effort, Massachusetts was selected as one of six States to participate at the national level in a State-to-State dialogue with Federal agencies, such as the Substance Abuse and Mental Health Services Administration (SAMHSA), the Center for Mental Health Services, FEMA, and national partners like National Association of State Mental Health program directors. This opportunity afforded State planners the ability to

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evaluate, review, and suggest changes to their own programs that would better assist the response to future events. A new paradigm, which included disaster scenarios highlighted by the words "terrorism" or "bioterrorism" and included multiphase planning to include affected people from many States across the Nation, even worldwide, impressed upon Massachusetts the need to change its traditional standard of operating a crisis counseling program.

In Massachusetts, prior to 9/11, DMH had been providing annual crisis counseling training sessions throughout the State. The traditional training system was both developed and conducted by the Emergency Management Coordinators in each of the six DMH geographic areas. Coordinators were responsible for developing their own program materials and providing an annual Emergency and Disaster Preparedness and Response Orientation Training, with the goal of training new or recertifying crisis counselors for deployment as part of the statewide "on-call" Emergency Roster. All trained crisis counselors were classified as volunteers to the Department for an emergency response.

The State was fortunate to have the wonderful experience and expertise it did for the 9/11 response. Through the strong relationships DMH had built over the years with its cadre of

crisis counselors, vendors, and other organizations providing counseling services, Massachusetts was able to meet the needs of affected people. What was missing in the traditional CCP was strong, collaborative coordination within the State, integration into the public health and public safety infrastructure, and a model that embraced FEMA-accepted techniques and provided a single training curriculum. In addition, a formalized mechanism for including substance abuse services into the CCP did not exist. The goal became to utilize Health Resources and Services Administration funds awarded to the State to build a new and enhanced CCP.

Creation of the new program began in earnest in fall 2004. Not enough good can be said about the dedication of the DMH and DPH planners whose vision began the project just after 9/11. A vendor, Boston Medical Center's Center for Multicultural Mental Health (CMMH), headed by Dr. Kermit Crawford, a member of SAMHSA's crisis counseling cadre, was selected from a crop of organizations to provide logistical support, technical expertise, and day-to-day project oversight. From the beginning, a highly collaborative model was adopted between the DMH, DPH, and CMMH staff involved. Although the State's principal investigator at DMH, with input from DPH's Center for

Emergency Preparedness liaison, set core deliverables, the project has, from the outset, welcomed and included input from all voices involved in the project. The trainees themselves have helped inform and improve the training program.

This model has been highly successful in the ongoing development of the training program. A training committee, established at inception, includes representatives from CMMH, DMH's Central Office and Metro-Boston Area (whose representative has been a program trainer for more than 10 years), DPH's Center for Emergency Preparedness, the DPH Communicable Diseases Bureau, and the DPH Bureau for Substance Abuse Services. The committee has also been fortunate to have the input of experts from the National Center for Post Traumatic Stress Disorder and the National Center for Child Traumatic Stress. The committee includes a psychologist, a psychiatrist, a registered nurse, a specialist in substance abuse services, and several individuals with master's

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degrees in public administration. More than the titles, however, Massachusetts has assembled a committee that is working as a team and has a wealth of hands-on experience in providing disaster response. This, more than anything else, is driving the training committee to develop a program that gives crisis counselors the basic tools needed to be successful working a disaster event.

The enhanced program incorporates evidenced-informed best practices learned from recent human-caused and natural disasters. One of the new strengths of the program is evident in the name chosen for the project. The committee agreed to call State crisis counselors, "behavioral health disaster responders" (BHDRs), in recognition of the combined elements of emergency mental health and substance abuse services in disaster work. Substance abuse counselors, mental health providers, and others recognized as having natural helping skills are all encouraged to be trained and join the roster. In addition, there is no licensure requirement to complete the basic level of training and become a State volunteer BHDR. The program stresses that its BHDRs will be involved in crisis intervention during the initial phase and specialized services for the recovery phase of an emergency. It has chosen Psychological First Aid as the foundational technique of its training curricula, appealing to multiple learning styles. It includes

lectures, panel discussions, video presentations, experiential (hands-on) training simulations, and question and answer sessions. The training program has earned high marks, and there is a waiting list for each new training session.

*In order to understand what the BHDR training program has accomplished in the first year, it is important to note that the training goals, originally established for 12 months, were exceeded in 9 months.*

The basic program is offered in two 7½-hour sessions. Day 1, called BHDR–101, provides an educational overview of crisis intervention; mobilization of the State system by DMH, MEMA, and DPH; and unified response to disasters. Individuals having little or no prior experience as crisis counselors are asked to complete both days. Practitioners who have previous training as crisis counselors by DMH, FEMA, the Red Cross, or another accredited agency, are asked to complete only the second day of training, called BHDR–202. While day 1 is the more educational orientation, day 2 is modeled as the skill-building, hands-on experiential day when newly developed techniques and the personal experience of responders to past disasters are shared for training purposes. The goal of the

program is to recruit new crisis counselors into the emergency on-call cadre. The program is also strong in its presentation of the human impact of disasters and in promoting the importance of self-care.

The program has also been fortunate to include the training expertise of individuals from the American Red Cross, Logan International Airport's Fire Services, the Veteran's Administration, the Children's Trauma Recovery Foundation, CMMH, DPH, and DMH. This model has been central to the program's success because it provides trainees with the ability to meet and learn from the experiences of local responders. Overall evaluations have rated the program in the outstanding range. The average satisfaction rating for the four BHDR trainings was 4.3 out of a possible 5. By way of comparison, the Continuing Medical Education group, which conducted the evaluation process, reported that the average rating for other mental health-related courses they had assisted in for 2005 was 4.15. Evaluations have stressed the need for hands-on learning as opposed to a straight lecture style, and the program has worked to incorporate this into the format.

In order to understand what the BHDR training program has accomplished in the first year, it is important to note that the training goals,

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originally established for 12 months, were exceeded in 9 months. In other words, all trainings and other service deliverables were provided in a condensed 9-month contract year. The required number of participants trained, established originally at 75 people per quarter minimum for a total of 300 for the year, was exceeded as well. The actual number was 442 participants (47 percent more than the minimum). For year 1, 160 newly trained BHDRs elected to join the emergency on-call cadre, brining the total number of crisis counselors on the State's roster to nearly 1,000 volunteers.

For year 2 of the contract, the training program is running six training sessions: three BHDR-101 sessions and three BHDR-202 sessions. After completion of the first BHDR-202 session, November 30, 2005, in Northampton, MA, 66 individuals of the 101 attending signed up on the emergency roster. The State hopes this trend continues throughout the year, as the committee will be focusing on recruitment and retention initiatives. The trainings are being held regionally throughout the State, October 2005–May 2006. The

program is developing a train-the-trainer session, so the number of training sessions can be expanded into the third year of the program.

Goals for year 2 of the program also include the roll-out of a participant training manual/reference guide that will support the continued learning and information flow for participants/responders after the trainings. The committee is including modules on special needs populations and children in the training curricula. As mentioned earlier, the committee is developing a specialized training that will provide a train-the-trainer course using a participant-centered curriculum to prepare a selected group of specialists to become more effective trainers. For the second year, the committee has developed a plan to offer a regionally

*The strengths of the project lie in the level of expertise and dedication of its various members in developing a program that proves effective when tested during a response.*

based training formula to support growth within the State's regions and promote response capacity to all areas of the State.

The BHDR training committee in Massachusetts has set ambitious goals for itself in 2 short years. The strengths of the project lie in the level of expertise and dedication of its various members in developing a program that proves effective when tested during a response. The committee is continuously working on ways to improve the program and make it a better tool for training new volunteer crisis counselors. This collaboration has been successful to date because of its willingness to learn and grow—to promote the very flexibility that is the cornerstone of the training program.

*Ashley Pearson, MPA, Department of Mental Health (DMH) Emergency Management Director, Deputy Director of Community Systems. The article was written with assistance of text developed by DMH and the Behavioral Health Disaster Response Training Project.*

# *The Professional Quality of Life Scales: A Measurement for Caregivers to Assess the Positive and Negative Aspects of Work in the Field*

In the early days after the South Asian Tsunami, my colleagues and I scrambled to respond to our Indonesian colleagues' request for fast, on-the-ground training materials about how workers could protect themselves while working in such difficult conditions. It was not that we did not have available materials. But as we took in the scope and magnitude of the response, we realized that what we had was too complex and presumed a luxury of time that was not present. Consequently, we worked around the clock, taking advantage of our time-zone differences so that as our day ended (and sleep was needed!) in one part of the world, we passed the work on to those in the next time zone. The result, which has been used over and over in this past year of staggering natural disasters and humanitarian crises, was an aid worker support page with a plethora of one-page handouts and perhaps the most used bit, an aid worker pocket card that can be carried in a pocket or wallet for daily use. We have been told that the pocket cards were being handed out to onsite workers responding to Katrina, as well as at other disaster sites this year. In introducing the pocket card, we wrote—

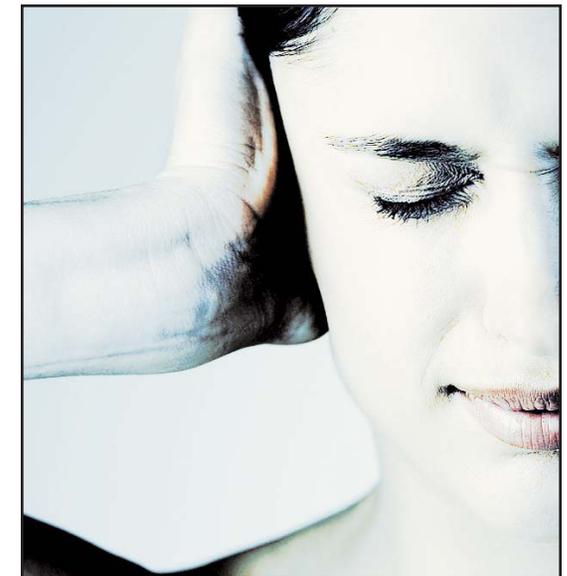
*Nothing ever quite prepares us for the amazing difficulties and joys that we find when responding to disasters and crises. Yet, over the past 15 years, we have learned a great deal about the psychosocial needs of communities in crisis and how we, as workers, can best help take care of ourselves while we try to help others*  
(<http://telida.isu.edu/telida/pocketcard.php>).

What calls us forward as helpers of all types to assist those in harms way, knowing that to help may well also place us in harms way? As administrators and supervisors, how do we respond to the needs of those we have sent into the field, knowing that to send them puts them at risk? How do we protect them? How do we sleep at night knowing that it is our job to send people into situations that may cause them physical and psychological harm? These are difficult questions that we have tried to address in some of our writings (Stamm, 1999; Stamm, Higson-Smith, & Hudnall, 2004). However, one thing is clear, ignoring the risks do not make them go away, not for the person who faces them directly, nor for the supervisors behind the scenes. How we are in relationships with others is a direct reflection of our relationship with our-

selves. How we are as helpers is critically important to those we help and to our ability to help.

These days, most people are aware of the potential risks to helpers and seek to respond to their mental health status. Even the new *Psychological First Aid Manual* ([www.ncptsd.va.gov/pfa/PFA.html](http://www.ncptsd.va.gov/pfa/PFA.html)), supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), includes a section on worker self-care. One evidence-based tool that can help with monitoring both

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short-term status and long-term program outcomes is the Professional Quality of Life Scales, or ProQOL ([www.isu.edu/~bhstamm/tests.htm](http://www.isu.edu/~bhstamm/tests.htm); Stamm, 2005). The ProQOL, which is available free, measures the positive and negative aspects of caregiving on those providing the care. The short measure is comprised of three 10-item Likert-rated scales: Compassion Satisfaction (CS), Burnout (BO), and Secondary Trauma/Compassion Fatigue (CF).

The ProQOL evolved from a series of earlier versions of a measure called the Compassion and Satisfaction Test (Figley, 1995; Stamm & Figley, 1996; Stamm, 2002). The original version was introduced to the literature by Figley in 1995. In 1996, the compassion satisfaction subscale was added by Stamm (2002). As the measure changed, it became long and cumbersome, and psychometric problems became evident (Stamm, 2005). The final outcome was the ProQOL, a shorter measure, sans the psychometric problems. This current version retains its overall positive focus. Earlier market testing showed that a positive focus made it easier to support any positive system change indicated by the measure, and it eased difficulties associated with the negative effects of caregiving.

Today, the ProQOL is one of the National Child Traumatic Stress Network's measures. It has been used worldwide in dozens of countries

and is available in six different languages with more translations emerging. The current translations include English, German, Russian, Japanese, Hebrew, and Spanish. Data has been collected across both time and geography. With 12 years of data collection and research from six countries on four continents, it was possible to create data banks that allowed substantial psychometric and norming work to be done. In addition, a ProQOL manual provides details about how to use the measure at [www.isu.edu/~bhstamm/documents/proqol/ProQOL\\_Manual\\_Oct05.pdf](http://www.isu.edu/~bhstamm/documents/proqol/ProQOL_Manual_Oct05.pdf). Should you prefer, you can obtain a test packet with the measure and manual through the Sidran Institute at <http://www.sidran.org/>.

*The ProQOL, which is available free, measures the positive and negative aspects of caregiving on those providing the care. The short measure is comprised of three 10-item Likert-rated scales:*

*Compassion Satisfaction (CS), Burnout (BO), and Secondary Trauma/Compassion Fatigue (CF).*

## OVERVIEW OF THE PSYCHOMETRIC PROPERTIES AND INDIVIDUAL INTERPRETATION OF THE PROQOL

As mentioned above, ProQOL is comprised of three 10-item scales, CS, BO, and CF, with alpha reliabilities ranging from .72 to .89. Items are scored on a Likert scale, in which 0 equals never, and 5 equals very often. Higher scores represent greater amounts of the characteristic being measured. The scales are generally unimodal and symmetric; there is minimal collinearity between the items or scales, and construct validity is established.

*Compassion Satisfaction* (CS, alpha = .89; norm mean 37, SD 7) measures the pleasure derived from being able to do one's work well. Workers may find pleasure in helping others through their work. They may feel positive about the work they jointly accomplish with their colleagues, the aid given to someone in need, or the changes they may make for their community. Higher scores on this scale indicate a greater satisfaction in their ability as caregivers.

*Burnout* (BO, alpha = .72; range 0-50; norm mean 22, SD 6) is associated with feelings of work-related hopelessness and inefficacy. It is

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generally intuitively understood, but for those experiencing it, the onset of the negative feelings may be so gradual that it is not obvious until the feelings become overwhelming. BO can reflect the feeling that the worker's efforts make no difference, or it can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale indicate one is at a higher risk for BO.

*Secondary Trauma/Compassion Fatigue (CF)* (CF, alpha = .80; range 0-50; norm mean 13, SD 6), also called secondary traumatic stress (STS) and related to vicarious trauma (VT), is about work-related secondary exposure to extremely stressful events similar to those that cause posttraumatic stress disorder. This generally happens when a worker is exposed to other people's traumatic experiences, such as through hearing their stories. In other words, the worker is on the periphery of the trauma. It becomes almost as if it is his or her trauma, but he or she is not directly in the path of danger. In this case, the exposure is not primary; one is not in physical danger like a soldier or a humanitarian aid worker. Nevertheless, it is a risk that should be monitored for those working in dangerous settings. STS/CF symptoms are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the event pop into your mind, or avoiding things that remind one of the event.

*Secondary Trauma/Compassion Fatigue (CF), also called secondary traumatic stress (STS) and related to vicarious trauma (VT), is about work-related secondary exposure to extremely stressful events similar to those that cause posttraumatic stress disorder.*

## INTERPRETING THE PROQOL AT A GROUP LEVEL

Years of data collection and practice-based evidence has provided useful information at systemwide and individual levels. For example, there appear to be no scale differences by gender. No differences have been observed by country, although this may be reflective of the type of workers and settings that are using westernized measures. There are differences based on the number of years a caregiver is in the field—more years in the field typically is associated with lower scores. While it is tempting to presume those with more experience do better, it is likely that those with greater exposure and low resiliency left the field, while those that remained were likely differentially resilient.

When looking across professions, such as mental health, physical health, and child protection workers, data indicates that physical health workers (e.g., nurses, primary care doctors) experience the least trauma, while teachers remain the most satisfied. As could be expected, those workers dealing with children and families in trauma tend to experience higher levels of BO than any other group.

## USING THE PROQOL FOR DECISION MAKING

Obviously, the "ideal" work environment in terms of managing stress and trauma is one that combines high CS with low BO and STS/CF. Practice-based evidence and preliminary quantitative evidence suggest interesting results in less than ideal work environments. Those who have high levels of STS/CF accompanied by high CS and, typically, a strong sense of altruism, may continue to be effective at their jobs and often respond well to a short STS/CF intervention. While it will be important for a worker's supervisor to make this type of decision individually, sometimes it is possible to accomplish intervention *in vivo*, without changing a work assignment. In contrast, those with high levels of both BO and STS/CF may be the most risky, both to themselves and in a work setting. In this situation, the caregivers are afraid and see no hope for change, which potentially ruins

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their effectiveness. Theoretically, this negative profile is associated with medical error, but because the data are not in on that concern, it is too soon to say for sure. Regardless of the system effects of people who are experiencing high levels of both BO and STS/CF, it is important that interventions be pursued for them as individuals. Supervisors should consider job reassignment during the intervention time.

## CONCLUSION

Providing good supervision and organizational support to workers who are responding to unthinkable tragedy is as important as it is difficult. A significant first step is to show workers that the organization cares about their well-being. Organizational approaches should include policy, good modeling, reflective supervision, and evaluation of the approach. While not the topic of this article, we recommend the methods of reflective supervision in addressing worker care. There are multiple resources on reflective supervision, including the proceedings from the SAMHSA-sponsored session “Reflective Supervision and Strengths-Based Tools: A Powerful Combination for Staff and Supervisors” at the 15<sup>th</sup> National Conference on Child Abuse and Neglect ([nccanch.acf.hhs.gov/profess/conferences/cbconference/fifteenth/program/skills\\_a.cfm](https://www.nccanch.acf.hhs.gov/profess/conferences/cbconference/fifteenth/program/skills_a.cfm)).

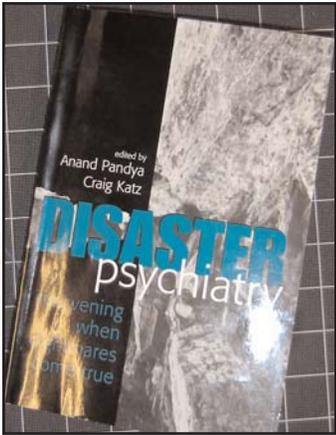
The ProQOL can be an important tool for both reflective supervision and evaluation. Workers can use the measure to monitor their own well-being and bring their concerns to supervision sessions. If the goal of supervision is a shared improvement for the worker and those they help, and the potential for positive and negative outcomes of helping to be seen as normal reactions to the work itself, then the risk of shaming or creating a "hunt to route out the bad people" is greatly reduced. Used as an outcome evaluation, the ProQOL can show program improvement, or at a minimum, provide evidence that workers are able to maintain an adequate level of psychological well-being. The data from the first 15 years and 3,000 people are in. Monitoring and respecting the effect of helping others is important if we wish to continue to respond to our oh-so-human desire to help in the face of disaster.

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For more information, see  
[www.isu.edu/irh](http://www.isu.edu/irh) or [contact irh@isu.edu](mailto:irh@isu.edu).

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## Book Review



**Disaster Psychiatry: Intervening When Nightmares Come True.** (2004). Anand Pandya, M.D., & Craig Katz, M.D. (Eds.).

Anand Pandya and Craig Katz's (Eds.) *Disaster Psychiatry: Intervening When Nightmares Come True* offers a unique selection of personal essays and firsthand accounts of psychiatrists deployed to the frontlines of man-made and natural disasters, both on American soil and abroad. From the 9/11 terrorist attacks and the Oklahoma City bombings to the brutal earthquake in Las Colinas, El Salvador, the authors of these essays draw on their years of experience and expertise, yet in their humility share their fears and anxiety over therapeutic interventions and often unfamiliar territory.

The testimonials show the way in which psychiatrists are often challenged to dramatically shift their thinking and roles from a traditional mental health perspective to a response that is one of assisting with the most basic human needs. In her essay "A Woman Named Katherine" Dr. Claudia Sickinger describes her role as psychiatrist at a disaster sight, noting, "On a typical day, I am sought out specifically as a physician to assess someone who is seeking treatment. In contrast, as a disaster psychiatrist, while keeping a watchful eye for signs of trauma, complicated grief, or other psychiatric symptoms warranting my concern, my only actual intervention might be to provide information, offer a chair, or lend a supportive ear." Such thoughts were reflected by the majority of contributors to this publication.

*Disaster Psychiatry* encourages the reader to stay attuned to the traumatic effects that a disaster has not only on the individual and families but also on the behavioral health consequences for first responders and communities. In his essay "The Other Ground Zero" Joseph Merlino details his work with the staff at the Office of the Chief Medical Examiner. His accounts of working with those whose jobs were to identify

and handle remains and personal possessions of the deceased, for what seemed like endless hours, is a reminder to behavioral health professionals in the disaster mental health field that intervention on this level is crucial. Also of significant importance in behavioral health response is the awareness and attunement to culture, ethnicity, and socioeconomic status. Such variables should also be attributed to subcultures as Mark Dembert describes in his essay on working with the Naval diving team who responded to the Swissair crash off the coast of Nova Scotia, September 2, 1998. Dembert describes the gruesome act of Navy divers who had the responsibility to recover an unforeseen amount of human remains, a task not ordinary in their daily lives. As Dembert describes, for those military personnel who have received specialized training, a psychiatric evaluation is often feared as a "black mark" in the individual's health record and may be grounds for removal from duty.

The last few essays in *Disaster Psychiatry* are dedicated to the grief and bereavement work done with children and adolescents after a disaster has occurred. The authors focus on developmental and age-appropriate interventions,

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specifically group work used with children, and advocate that creativity and play therapy are successful treatment modalities. In Margaret Thompsett's essay "Working with Fatherless Children After September 11<sup>th</sup>" she described the goal of group therapy with the children as to "help them develop a better cognitive understanding of death and its impact on them, to enable them to begin processing the traumatic and sad memories, and to acknowledge their feelings and find constructive ways of coping." Through artwork, building blocks, and even toy planes, the children in these essays were encouraged to create, reenact, and express their feelings about an event that would forever change their lives.

Psychiatrists, though rarely formally trained in disaster response, are crucial to any behavioral health team and can be invaluable resources in a crisis response. *Disaster Psychiatry* gives first-hand experiences of providers who, like any professional in this emerging field, were challenged to temporarily abandon their all too familiar treatment modalities and provide brief, supportive counseling. These compassionate and compelling stories address both the systemic and clinical challenges in disaster work and provide a lens through which any mental health professional can authentically empathize with both the authors and the victims.

## Upcoming Meetings

### AMERICAN PUBLIC HEALTH ASSOCIATION 2006 PUBLIC HEALTH SYSTEMS RESEARCH CONFERENCE

FEBRUARY 7-9, 2006  
WASHINGTON, DC

Join fellow researchers, practitioners, funders, policymakers, and others immediately following the Academy Health and Health Affairs 2006 National Health Policy Conference for a special dialogue on improving public health policy through research on the public health system. Participants will share their experiences as producers, users, and funders of public health systems research and participate in the development of strategies to build and advance public health systems research agendas. The following topics will be addressed at this groundbreaking meeting:

- Public Health Finance: Understanding the Costs, Who Pays Them, and Return on Investment.
- Public Health System Responses to Hurricane Katrina: Successes and Failures.
- The Quality Chasm in Public Health: Pathways to Improvement.

<http://www.apha.org/calendar/index.cfm?fuse-action=event&eventid=1426>

### 27TH ANNUAL INTERNATIONAL DISASTER MANAGEMENT CONFERENCE

FEBRUARY 9-12, 2006  
ORLANDO, FL

This conference has been designed to meet the educational needs of individuals and agencies involved with emergency preparedness, response, and disaster recovery, such as firefighters, emergency managers, hospital administrators, physicians, nurses, disaster planning coordinators, medical facility administrators, law enforcement officials, search and rescue responders, civil preparedness officials, mass fatality responders, and others who play important roles in critical incidents. This year's planning committee acknowledges the unique role that the myriad of first responders, response agencies, and communities play in planning for, responding to, and mitigating disasters.

<http://www.emlrc.org/disaster2006.htm>

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## MENTAL HEALTH RESPONSE TO MASS VIOLENCE AND TERRORISM

**MARCH 21–23, 2006**  
**HOUSTON, TX**

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

- Human Responses to Mass Violence and Terrorism.
- Mental Health Intervention.
- Organizational Response to Mass Violence and Terrorism and the Mental Health Role.
- Stress Prevention, Management, and Intervention.

<http://www.ovcttac.org/calendar/events.cfm?EventType=OVCTraining&FuseAction=ShowEvent&StartDate=03/21/2006&EventCity=Houston>

## ANXIETY DISORDERS ASSOCIATION OF AMERICA 26TH ANNUAL CONFERENCE

**MARCH 23–26, 2006**  
**MIAMI, FL**

The Anxiety Disorders Association of America Annual Conference is the only conference devoted exclusively to anxiety disorders. It provides education for health care professionals, individuals with anxiety disorders and their families, and the media about the nature and management of anxiety disorders.

The theme for the 26<sup>th</sup> Annual Conference is "Understanding Risk and Resilience in Anxiety Disorders: Implications for Research and Clinical Care." This year's theme will examine individuals at risk for the development of an anxiety disorder as a result of a variety of biological, psychological, or environmental factors, as well as those already manifesting difficulties, and in addition, it will explore factors that affect the response to treatment and chronicity of these disorders. Our invited keynote speaker will be Dennis Charney, M.D., Mount Sinai School of Medicine.

The Annual Conference provides a unique forum for clinicians, researchers, and anyone affiliated with mental health care to learn about scientific advances and current practices in the

diagnosis and treatment of anxiety disorders. In addition to the theme topic, the conference covers panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, social anxiety disorder, posttraumatic stress disorder, phobias, and comorbid conditions as part of the educational program.

<http://www.adaa.org/home.asp>

## NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE'S 36TH ANNUAL CONFERENCE

**APRIL 8–11, 2006**  
**ORLANDO, FL**

The National Council for Behavioral Healthcare is issuing a call to all who care about the future of mental health and substance abuse services to join us for our 36<sup>th</sup> Annual Training Conference, April 8–11, 2006.

The National Council's Annual Training Conference is the largest conference in the mental health and substance abuse industry, attended by nearly 1,500 leaders from the provider community each year. The conference is recognized for its focus on applying theory to real-world settings. Everyone—from CEOs to board members, from clinical and program directors to case managers and consumers, and from policy makers to researchers—comes together to

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explore new directions and challenges in the industry and share strategies for translating science to practice.

The 2006 Conference will feature more than 60 interactive institutes and workshops encompassing critical clinical, operational, governance, and policy issues ranging from workforce excellence to the financing of evidence-based practices. Conference tracks include the following:

- Best Practices in Children's Services.
- Coping with Disasters: Lessons From the Field.
- The Skills Executive Leaders Need for Peak Performance.
- Innovations in Recovery-Focused Services.
- Real World Examples of Cross-System Collaborations.
- Creating Cultures of Measurement: Data Driven Decision Making.
- The Electronic Health Record: Providers and Vendors Working Together.
- Successful Board Governance: What Matters Most.
- No Money, No Mission: The Business of Mental Health and Substance Abuse Services.
- What Science is Telling Us About the Future of Clinical Services.

<http://www.nccbh.org/orlando/index.htm>

