



The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER BEHAVIORAL HEALTH

ASK THE FIELD

The Dialogue: Given the public health emphasis on and concern about the possibility of pandemic flu, what is the most important thing disaster behavioral health workers can do to prepare?

Steve Crimando: It is anticipated that an influenza pandemic would be a very long and complex emergency. The concepts of behavioral health that we use today did not exist during the last great pandemic in 1918, so there are many unknowns. To some degree, addressing the behavioral health needs created by this type of event requires creating a new paradigm for understanding impact and intervention, but there are a few things that we can

safely assume. For example, a pandemic would have the same health impact on behavioral health workers as the general public. That means that perhaps 40 percent or more of the behavioral healthcare workforce might be "offline" at any one time dealing with the impact of the disease on themselves and their families. To enable behavioral healthcare workers to respond to such a long and complex emergency, the individual worker and the systems in which they work need to take advantage of the current window of opportunity and begin to plan and prepare now.

"Preparing now" means working in close collaboration with public health and emergency management officials to ensure that roles, responsibilities, and expectations are clear

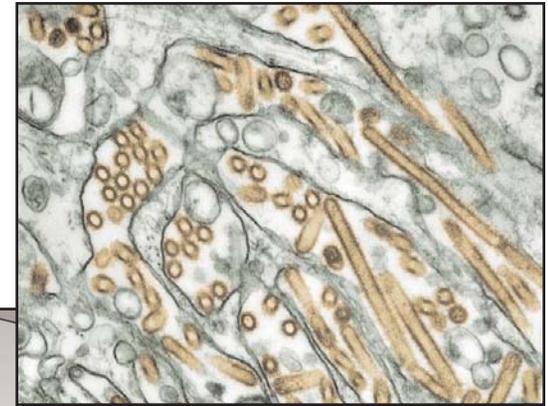
about how and when behavioral health resources will be used. It also means that behavioral healthcare workers must assess their "toolkits" and make sure that the intervention skills they already possess are appropriate for this sort of crisis. I think the four essential skill sets for this scenario will be psychological first aid, hostility and rage management (verbal deescalation, personal safety, etc.), stress management and self-care, and assisting people with complicated grief and loss reactions.

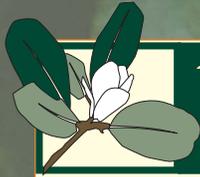
Because of the prolonged and complex nature of this crisis, people may not be able to follow their normal rituals, such as burials and other ceremonies. They may also be separated from their natural support networks, such as family, friends, neighbors, and spiritual helpers, and

these factors will interrupt the type of community cohesion that we typically count on for healing during other types of disasters. Another planning consideration is that it will be important to protect the health and safety of the behavioral health workforce to ensure their availability once the crisis has passed. Disaster behavioral health delivery systems can also prepare by exploring alternative ways of reaching people, such as telecounseling, voice and video messaging, and online forums. Communication can be facilitated using these methods to help create community connectivity even in the absence of direct, face-to-face contact. These methods were useful during the SARS outbreak in Hong Kong and may be useful in this situation as well.

President Kennedy once said, "The time to repair the roof is while the sun is shining." I believe that behavioral health workers should apply that same spirit of preparedness to readying themselves, their families, and communities, as well as in developing the appropriate skills to help others through a potentially devastating event."

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The Spirit of Recovery

The Spirit of Recovery: All-Hazards Behavioral Health Preparedness and Response—Building on the Lessons of Hurricanes Katrina, Rita, and Wilma

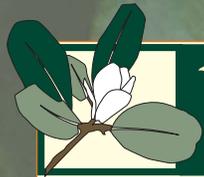
During the past year, the United States of America has experienced an unprecedented number of disasters and emergencies, including the hurricanes that devastated the gulf coast States, school shootings, and suicide clusters. SAMHSA continues to emphasize the importance of all-hazards disaster behavioral health preparedness. To that end, SAMHSA recently convened a national summit, *The Spirit of Recovery: All-Hazards Behavioral Health Preparedness and Response—Building on the Lessons of Hurricanes Katrina, Rita, and Wilma*, May 22–24, 2006, in New Orleans. Teams from 46 States, 7 Territories, and the District of Columbia came together to assess the progress made on disaster behavioral health plans and to help address existing problems and continued needs, particularly around regional collaboration.

The teams consisted of mental health and substance abuse commissioners, disaster behavioral health coordinators, health department staff, and emergency management representatives. Other key participants included voluntary agency leads, consumers and survivors, and members of faith-based and community organizations. Leading organizations, such as the National Association of State Alcohol/Drug Abuse Directors and the National Association of State Mental Health Program Directors, were in attendance, which led to networking opportunities and peer-to-peer communication that had not been previously accomplished. Stake holders from other national associations and SAMHSA's Federal partners also attended to establish collaboration on all levels. A total of 602 people were in attendance.

Through plenary sessions, topical break-outs, and regional workgroups, participants reviewed lessons learned from the 2005 hurricane season and identified opportunities to work more closely together to resolve unmet behavioral health needs. While looking back at past efforts, tasks completed, and remaining work to be done as a result of the 2005 hurricanes was a critical component of the summit, looking ahead and preparing for future disasters through coordinated

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The Spirit of Recovery

all-hazards preparedness was also key. To reinforce the importance of these efforts, the voices of survivors were shared each day. Through presentations and multimedia exhibits, their personal experiences, individual roads to recovery, and thoughtful feedback to those charged with addressing their behavioral health needs resonated throughout the conference.

Among focus areas were the issues surrounding substance abuse and mental health treatment capacity, populations with special considerations, evacuation and displacement, emergency response centers, research and clinical experience, partnership and coalition building, public safety workers, disaster-related suicide,

methadone treatment, and regional collaboration. Topics were addressed through plenary sessions and targeted breakout sessions, and were further explored in regional workshops that enabled dialogue about lessons learned and technical assistance needs.

While the potentially devastating consequences of future hurricane seasons remain unknown, the Nation is now better equipped to respond quickly, communicate effectively, leverage resources, and better serve Americans from an early disaster response phase to the completion of a recovery-oriented response phase. Americans have proven throughout history that they are a resilient people.

However, in the face of tragedy and its aftermath, many citizens will need assistance with attaining and sustaining recovery from resulting substance abuse disorders and mental health problems. Research reinforces this important fact, and the national summit was a rare opportunity to glean knowledge from that research and share it among participants. Ultimately this will lead to a Nation that has a well-prepared behavioral health treatment field that remains ready to facilitate recovery in calm or crisis.

For more information, and to view a selection of summit presentations, go to <http://www.spiritofrecoverysummit.com>.



Spirit of Recovery Summit Highlights

Listening to the Voices of Survivors, Family Members, and Responders

An important focus of the Spirit of Recovery summit was hearing the stories of the survivors of the gulf coast hurricanes. Each day of the summit began with a Voices of Survivors session. Their stories of perseverance, resilience, and recovery were inspirational as well as educational. Through the first-hand accounts of these survivors, disaster behavioral health professionals heard how their efforts helped those in crisis as well as how those efforts can be improved in the future.

The first day of the summit opened with the compelling stories of four survivors of the gulf coast hurricanes. The session was moderated by Anne Mathews-Younes, Ed.D., director, Division of Prevention, Traumatic Stress, and Special Programs for the Center for Mental Health Services (CMHS), SAMHSA, and Anne Herron, director, Division of State and Community Assistance for the Center for Substance Abuse Treatment (CSAT), SAMHSA. Before introducing the survivors, Dr. Mathews-Younes began by highlighting the groundbreaking work of Michael Nye. Mr. Nye created a moving presentation of photographs of eight survivors with stories that were told in their own words.

Participants could hear the stories through earphones while looking at the pictures of the survivors. As Mr. Nye put it, "Each individual story of suffering and loss is precious and painful in its particularity. Perhaps simply telling one's story is an act of healing—the first step toward recovery is being able to express what one has experienced."

DAY 1

MICHAEL PATRICK

During the opening plenary, the first survivor to speak was Michael Patrick. Michael now works with SAMHSA's Project Recovery in Mississippi and helps other survivors of the hurricanes. He is a native of New Orleans and described his life before Hurricane Katrina as disappointing. He



was not doing well in school, he was financially strapped, and his social life was suffering. Things were bad, but then the hurricane hit. He evacuated to Memphis, TN, with his mother and suffered a series of setbacks trying to access aid from government organizations. He described his state after Hurricane Katrina with the acronym DAMN, which stands for depression, anger, mentally beat, and no drive. In his desperation, he called his sister and asked her to help him figure out what to do next. With her help, he relocated to Mississippi and got in touch with Project Recovery. His work with that organization gave him a sense of pride and a sense of giving back to others who were affected by the disaster. He credits his work with Project Recovery as instrumental in finding the resilience to bounce back from adversity. He has also used his experience to better his life after Hurricane Katrina. As he described it, in the tree of life, there are many branches representing the different classes of existence. In his life before Hurricane Katrina, he was on one of the lower branches, and so when he fell out of the tree of life, he did not injure himself too badly; it was as if he only sprained his ankle. He now

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has plans to enter nursing school and looks forward to a life of independence and service to the community. This experience has transformed him, taught him ways to deal with his anger effectively, and shown him how to help those who are in greater need. He says that he has learned from his leaders at Project Recovery to live by three ideals: Be safe; be careful; and make a difference.



MARYANN POWELL

The second survivor to tell her story was Maryann Powell. Maryann is a single mother of five children who also takes care of her ailing father. Before Hurricane Katrina, she owned her own business in New Orleans and was studying criminal justice. As the hurricane threatened New Orleans, Maryann knew she had to evacuate but could not convince her father to go. So, she made the very difficult decision to leave her

father and one of her children in New Orleans and evacuate with the rest of her children to Mississippi. The devastation she witnessed in both Mississippi and Louisiana broke her heart. She knew she could always rebuild, but the first challenge was where to start. She said the idea of where to start was one of the hardest hurdles to face.

During her evacuation, she lived through Hurricane Wilma and came out of her hotel room the next day to find a tree on her one remaining possession—her truck. She began to laugh at the situation, and a passerby questioned why she would laugh at someone else's misfortune. One of the hotel workers told the man that it was her truck and she was laughing at her own misfortune. A sense of humor was one of the many ways she found the resilience to withstand her situation. Fate was merciful in this case, and except for a few scratches, her truck was fine.

Maryann found that her hotel room had become a haven for other survivors and a center for comfort and mental support. She said being a solid rock for other survivors helped her make it through the experience herself. The word got out about her work with the evacuees in her hotel, and she got an interview with Project Hope, Florida's Crisis Counseling Assistance and Training Program



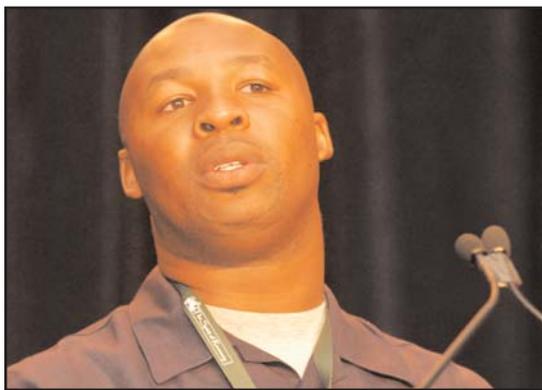
(CCP). She is now working with Project Hope and said that she wished something like Project Hope would have been available at the hotel during her evacuation. She expressed her gratitude to FEMA and the American Red Cross and said that what helps in these situations are prayer and people like SAMHSA's crisis counselors.

Her job as a crisis counselor gave her another boost of resilience and hope for the future. She said the proudest moment came when she was given her identification badge. It was better than any credit card or driver's license. She wore that badge everywhere because it gave her pride, identity, and resilience and was her way to reach out to other evacuees with support and encouragement. Maryann continues to work with Project Hope and has set up a nonprofit organization to help survivors with the things they need to rebuild their lives.

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HUBERT JACKSON, JR.

Hubert Jackson, Jr. is his given name, but his friends are invited to call him Burt. After the devastation of the gulf coast hurricanes, he says that many more people are calling him Burt. For Burt, and others like him, Hurricane Katrina changed everything. Prior to the hurricane, Burt was employed as a grief counselor and was used to dealing with the emotional issues of others. As he explained, he also comes from a long line of southern preachers, and so he knows how to talk to and engage an audience, however, Hurricane Katrina put him back in touch with his empathy in ways that he never expected.



He evacuated with his wife, who was 12-weeks pregnant with their first child, and their four dogs. As they traveled back to their house after the hurricane, he said he never believed he would witness such devastation. Miles of houses

and other buildings along the Mississippi coastline were simply gone—wiped away. When they returned to their home, they initially thought that their house had escaped with only minor damage that could be repaired. However, his wife knew something was very wrong. When they went inside their house, everything was destroyed. The storm had ripped the two ridge vents, the chimney, and the south side of the roof from their home. Burt found himself with no house, no job, and a baby on the way. He said that it does not matter how you lose your home or your livelihood, "Whatever you lost, however you lost it, it's still gone." So, the next step was figuring out how to bounce back and rebuild.

Burt now works with Project Recovery and is able to use his expertise to help others. He thanked SAMHSA for channeling the talents of people in the CCPs and for communicating the idea that mental health matters. His work with Project Recovery has given him hope, and that hope has allowed him to help himself and others. He finished his remarks by asking the summit participants not to rely solely on media accounts, but to survey the damage for themselves and to always do as he tries to do when helping others—focus on the strengths; reassess; and improve.



RO'BIN WHITE-MORTON

Ro'Bin White-Morton began her remarks by singing a stirring rendition of "Walk on by Faith," a song that sustained her during the harrowing events she experienced during her evacuation from the aftermath of the floods in New Orleans. Ro'Bin is an artist, poet, and native of New Orleans. Just before Hurricane Katrina, she traveled to Philadelphia to drop off her son at the Curtis Institute of Music. Hearing that the hurricane was coming, her son urged her to stay in Philadelphia, but she returned to New Orleans to rejoin her husband.

By the time she got back, it was too late to evacuate, and she and her husband found themselves in the middle of the floods, devastation, and chaos that followed Hurricane Katrina. They both waded through water that was often neck deep, and fended off attacks by fire ants as they made their way to the Superdome. As she

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can attest, the events that took place in the Superdome were terrible. However, she said as she saw children playing and families coping, she realized that God's plan would prevail.

What Ro'Bin learned from her experience was that in times of disaster, what you were, what you did, and what you had do not matter. All of the evacuees were in the same situation. For her, the healing began when she evacuated to Texas and was able to help families reconnect with one another. Bringing families together after they were separated was a joyous experience. She lived by the philosophy of Leo Buscaglia, who talks about living, loving, and taking in the good energy that life has to offer. She said that philosophy and her art sustained her during the hardest times.

Ro'Bin now works with Project Thrive in Philadelphia, helping survivors in that area. She says, "If you give your goodness, your greatness will come." Her words of wisdom to the mental health professionals were that it is important to understand the folklore and folkways of the populations you are serving, and to understand that people are still hurting and still need help. Survivors are everywhere.

DAYS 2 AND 3

The theme of listening to the voices of survivors continued on the second day as participants heard from Dr. Eartha Johnson and her work with SAMHSA's Katrina Assistance Project.

On the third day, participants had the chance to preview the work of David Lee, Josh Goldblum, and Joshua Cogan. Their documentary project, *Yearbook 2006*, follows the lives of young Hurricane Katrina survivors and evacuees from Benjamin Franklin High School as they adjust to lives that are culturally and geographically miles from New Orleans. They were eventually able to return to Benjamin Franklin High to attend prom and graduate with their friends. The online interactive documentary will be launched at the end of the summer to coincide with the anniversary of the hurricane.

Where Does the Sun Go in a Storm?

By Ro'Bin White-Morton

Where does the sun go in a storm?
When darkness hits the sky
And the shadows of the old are now slate blue
When the winding winds do roar
As the pressure hit the floor
Of the ground ending each morning's dew.
While the trees which once stood still
Topple down as sidling hills
When the tides of all says adieu
Does it settle in itself
Upon a mantle of life's wealth?
Or does it rest in the depth of God's truth?

Spirit of Recovery Summit Highlights Featured Plenary

VALUABLE PARTNERSHIPS

*Cheri Nolan, Senior Policy Advisor to the
Administrator, SAMHSA—Moderator*

*Herbert Jones, Vice President, External Affairs,
National Center for Missing and Exploited
Children (NCMEC)*

*Warren Harrity, M.A., Executive Director,
Katrina Aid Today (KAT), United Methodist
Committee on Relief (UMCOR)*

*Mark Farr, Senior Director, Outreach, Volunteer
Centers and Community-Based Strategies,
Points of Light Foundation*

*Mona Johnson, Executive Director, Institute for
Therapeutic Wellness*

Herbert Jones shared a moving video produced by NCMEC, the focus of which was the extraordinary efforts of NCMEC staff and volunteers to reunite displaced children with their families in the wake of Hurricane Katrina. Following the conclusion of the video, Mr. Jones spoke in more detail about the partnerships that made this effort successful. In the weeks following Hurricane Katrina's landfall, NCMEC fielded reports of 5,129 missing children. The media was

immediately responsive to this overwhelming need and partnered with NCMEC to begin airing pictures of these missing children on the various cable news channels.

In the wake of this effort, however, call volume on the NCMEC hotline increased beyond capacity, from an average of 700 calls per day to 700 calls per hour, and staff became concerned that the NCMEC Web site might crash under the stress of the high volume of hits. Corporate partners stepped in to establish overflow hotlines and enhance server support to their Web site. Law enforcement and other partner agencies provided extra volunteer help to staff the hotlines and coordinate with field volunteers. The happy conclusion of this herculean effort, Mr. Jones reported, was that every missing child reported to NCMEC following Hurricane Katrina has been reunited with their family.

Warren Harrity followed Mr. Jones with a presentation on the work of KAT, a case management consortium of nine member agencies, headed by UMCOR. Mr. Harrity reported that the bulk of funding for KAT originated in international donations to the U.S. Government



that were earmarked for the recovery effort for Hurricane Katrina. After deciding that the money should go toward funding long-term recovery efforts, FEMA selected UMCOR to act as the grant manager. Nine member agencies were then picked from a request for proposals process, and KAT officially began operations in January 2006. According to Mr. Harrity, KAT is

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composed of approximately 2,500 paid and volunteer case managers working from 110 offices in 33 States. The overall goal of KAT is to serve at least 100,000 cases by identifying unmet needs of families and individuals, developing a plan of recovery with them, and advocating on their behalf. In addition to the nine KAT partner agencies, UMCOR also provides funding for 16 grassroots organizations to assist another 8,000 families and individuals with case management services.

Following Mr. Harrity was Mark Farr, who offered some guidance on partnering with faith-based groups in disaster recovery. Rev. Farr began by noting that 44 percent of all volunteer work in the United States is done by faith-based groups, and that they tend to have strong communication networks that can activate rapidly in times of crisis. He stated that a tip for using them effectively is to think of them not in terms of theology, but rather in terms of service and as conduits for healing. Rev. Farr advised that clergy can be very sensitive to motivations, and that in seeking to partner with faith-based groups, it is best to frame the crisis as something to be worked on together in a collaborative effort. Rev. Farr stated that the Points of Light Foundation has well-established partnerships throughout faith-based communities as well as the corporate and Federal worlds,

and that in the weeks following the devastation of Hurricane Katrina, they were able to successfully rally funds and volunteer groups to help with the immediate recovery efforts.

Mona Johnson concluded the plenary session with a presentation on the partnering efforts of the Institute for Therapeutic Wellness in the immediate wake of Hurricane Katrina. Following the diaspora of gulf coast residents, the Institute worked with other grassroots agencies to provide an array of services to evacuees, including transportation, housing, food, clothing, and spiritual outreach ministries. They consulted with the Physicians' Network to arrange for continued prescription medications for those who needed them. They instituted a "telephone grapevine" for information dissemination to rural areas

and partnered with faith-based and voluntary organizations to distribute relief supplies to those areas as well. Pastor Johnson reported that in the first 14 days following the disaster, grassroots organizations were able to take the lead in caring for people in their communities. Through the partnerships that they established, they were able to work together to meet the needs to the best of their combined abilities.



Spirit of Recovery Summit Highlights Featured Breakout Sessions

SUICIDE PREVENTION IN THE WAKE OF DISASTER

Seth Hassett, M.S.W., Chief, Emergency Mental Health and Traumatic Stress Services Branch (EMHTSSB), Center for Mental Health Services (CMHS), SAMHSA—Facilitator
L. Lee Tynes, M.D., Ph.D., Medical Director, Jefferson Parish Human Services Authority
April Naturale, M.S.W., L.C.S.W., A.C.S.W., Director, Network Development, SAMHSA's National Suicide Prevention Lifeline
Lloyd Potter, Ph.D., M.P.H., M.S., Director, Suicide Prevention Resource Center, Education Development Center

Seth Hassett opened the panel discussion by introducing the panel members and offering a brief overview of the topics to be covered, "What do we know about suicide and disaster, and based on that knowledge, what is our best practice for assessing risk and preventing loss?"

Lee Tynes was first on the panel to speak and began his presentation with some personal slides of Hurricane Katrina-related damage to his own house in Jefferson Parish, LA. Dr. Tynes reported that the rough data he was able to

collect from the Jefferson Parish Coroner's Office and the New Orleans Police Department indicated that the New Orleans area saw an increase in the number of completed suicides in the wake of Hurricane Katrina. According to the numbers he obtained, suicide rates for the area in the aftermath of Hurricane Katrina through the end of 2005 were double the average number (8.9/100,000 per year on average versus 17.58/100,000 per year post-Hurricane Katrina). He acknowledged, however, that the limitations to this information included population percentages being skewed by the large number of evacuees from the area, and that suicides are believed to be frequently underreported or attributed to other causes.

April Naturale followed Dr. Tynes with a discussion of empirical evidence related to suicide and disaster, as well as high-risk indicators for suicidal behavior. Ms. Naturale reported that the current literature relates only to single-event disasters, and is therefore difficult to apply to a multiple-hurricane disaster like Hurricanes Katrina, Rita, and Wilma. In addition, she found no longitudinal studies that followed post-disaster suicide rates beyond 48 months.

After acknowledging the significant lack of research in the field, Ms. Naturale went on to identify some common suicide-risk variables that overlap with disaster-risk variables. These included having a history of depression, anxiety, and/or substance abuse or dependence; being physically isolated; and having a lack of social support. She also noted that people who recover bodies from water are the highest exposure group in risk factor, and that this population group can include first responders as well as civilian volunteers. Ms. Naturale observed that the catastrophic scope of Hurricanes Katrina, Rita,



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and Wilma created a situation in which an unusually large number of people were vulnerable to these risk variables due to sudden homelessness, multiple moves, loss of community and routine, and loss of mental health and substance abuse services and care.

Lloyd Potter finished the panel discussion with a presentation on advances in the field of suicide prevention. Effective intervention methods for preventing suicide must be based on an understanding of the behavior, and to that end Dr. Potter gave an overview of the Suicide Model developed by Dr. David Schaffer. This model follows a linear path from an individual's underlying psychological disorder to a stress event, which then causes a change in mood. At this point, an appropriate intervention could facilitate survival; whereas lack of intervention could lead to suicide.

Dr. Potter went on to review the risk factors associated with suicide and discuss the spheres of influence wherein response can exist: Society,



community, family, peers, and the individual. In a post-disaster situation, the community sphere is crucial. Dr. Potter reported that a community's social capital, or its levels of collective competence and shared responsibility, is typically a good indicator of its resilience and ability to respond to populations at risk for suicide. The keys to prevention on the community level, according to Dr. Potter, include creating and maintaining an organized response in a post-disaster situation, developing and implementing a data-driven plan, and evaluating and reporting response efforts in order to further inform future plans.

SELECTED ASPECTS OF SUBSTANCE ABUSE AND MENTAL HEALTH SCREENING IN DISASTER SITUATIONS: EXPERIENCES, LESSONS WE ARE LEARNING, AND REMAINING CHALLENGES

*Robert Stephenson II, M.P.H., Director,
Division of Workplace Programs, Center for
Substance Abuse Prevention (CSAP),
SAMHSA—Facilitator*

*Laura House, Ph.D., M.S.W., Public Health
Advisor, Division of Service Improvement,
CSAT, SAMHSA*

*Susan Hamilton, Ph.D., Senior Associate,
Disaster Mental Health, American Red Cross
(ARC)*

*Ashley Pearson, M.P.A., Emergency
Management Director, Massachusetts
Department of Mental Health*

Laura House reviewed research regarding substance abuse and disasters and described how the SAMHSA-funded Screening, Brief Intervention, Referral, and Treatment (SBIRT) model can be adapted to post-disaster settings. After Hurricane Hugo, beer consumption in the affected areas rose by 25 percent. Also, after the September 11, 2001, terrorist attacks, consumption of cigarettes, alcohol, and marijuana rose by 3.3 percent, 19 percent, and 2.5 percent respectively. More studies need to be done, but it appears that alcohol and drug use increased significantly after Hurricane Katrina as well.

After Hurricane Katrina, SAMHSA formed State partnerships to assist the State substance abuse authorities in the gulf region. Collaboration and support were provided to State offices, and their staff were provided with consultation and expertise. In addition, direct substance abuse service providers were sent to the gulf region for 2-week deployments, and staff in Louisiana were supported with disaster and crisis counseling training. A substance abuse training module was developed for crisis counselors in Louisiana

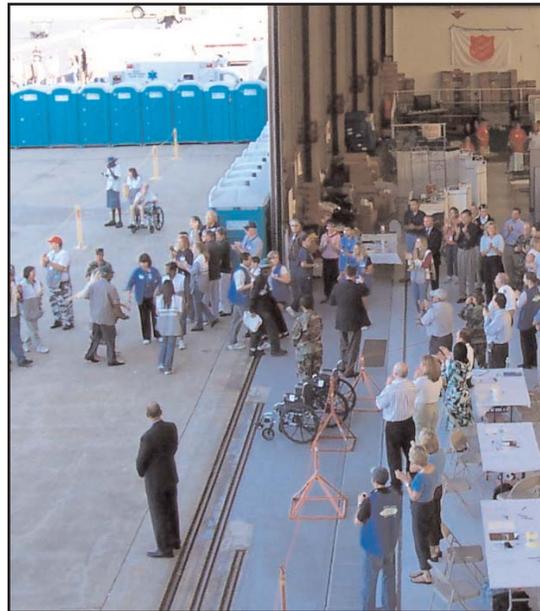
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who had limited knowledge of substance abuse counseling. Traditional treatment models emphasize universal prevention and specialty treatment. However, the Screening and Brief Intervention (SBI) models may be particularly useful in post-disaster situations. These models focus on early intervention for nondependent users. Screening, feedback, and immediate intervention are provided to nondependent users, as well as referral and support to dependent users.

After a disaster, many people may develop short-term patterns of binge drinking and other substance abuse. Such use may or may not progress into substance dependence. The SBIRT model focuses first on rapid screening. A variety of readily available screening tools can be used, such as the CAGE (for adults) and CRAFFT (for adolescents). These tools are easy to administer and can be used in shelter settings by substance abuse counselors or paraprofessionals. Brief intervention uses motivational interviewing and short counseling sessions, typically in medical primary care settings. Feedback, responsibility, advice, a menu of options, and empathy (FRAME) are used in this portion of the model. Brief treatment is a structured approach of two to nine sessions involving cognitive behavioral therapy, motivational enhancement therapy, client engagement, and rapid implementation of client change strategies. Referrals are made for people who need a higher level of care. Using

this approach, an SBIRT team operated successfully in the Houston Astrodome by integrating its services within the health clinics that were set up around the Astrodome.

During the first 2 weeks following Hurricane Katrina, ARC conducted a rapid public health assessment of disaster mental health needs on a sample of ARC shelters in the southern region of Louisiana. Susan Hamilton described the focus of the assessment and the recommendations made. During the period of September 2–11, a total of 18 shelters were visited, and 85 contacts were made with shelter residents. In addition, ARC shelter staff, volunteers, and community leaders were interviewed.



Vulnerable populations were assessed for a variety of medical, psychiatric, substance abuse, cognitive, and other psychosocial problems. Assessment also focused on the hurricane rescue experience, shelter experience, and coping strategies employed by the shelter residents. Mental health and substance abuse services at the shelters were found to be highly variable. In addition, numerous overlapping vulnerable groups were found with a high profile of economically disadvantaged people with medical and psychiatric illnesses. To meet the long-term psychosocial needs of the community, a model was proposed based on a population health perspective and a community participatory approach. Elements of this proposal included prioritizing the reestablishment of communal and social activities, supporting self-help groups, supporting structured activities for children and youth, and continuing outreach to vulnerable individuals. Recommendations included recruiting more ARC minority staff and volunteers, improving communications by ARC leadership, linking such communications with field events, and repairing damage to ARC's reputation.

Ashley Pearson detailed the behavioral health component of Massachusetts' Hurricane Katrina evacuee operation. Operation Helping Hand (OHH) was located at the Otis Air National Guard base in Bourne, MA. A total of

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208 evacuees were sheltered by OHH September 8–October 24, 2005. For the first 72 hours, Department of Mental Health staff and behavioral health disaster responder (BHDR) teams provided crisis counseling and immediate brief interventions. Volunteer psychiatrists also offered assistance. For the first 2 weeks, behavioral health staff coverage was available 24/7. An initial needs assessment identified 62 evacuees who had a variety of pressing mental health needs, such as followup evaluation, medication assessment, and triage for hospitalization or substance abuse services. An additional 19 evacuees were identified as needing immediate hospitalizations relating to depression, psychosis, substance abuse, or posttraumatic stress disorder (PTSD). Further assessment of the evacuees revealed an estimated 40 people with chronic mental illnesses; 35–40 people with a history of depression, substance use, or PTSD who may need short-term services; and 120 people who were not identified as having any recent mental health (including acute stress disorder) or substance abuse impairments. The Bureau of Substance Abuse Services was an integral part of OHH, providing four substance abuse counselors onsite daily who conducted screening, triage to inpatient services, groups, outreach, and crisis counseling. Alcoholics Anonymous meetings were also held onsite. OHH emphasized the need for effective

interagency communication, further development of emergency management awareness, and the importance of disaster behavioral health services in a shelter setting. Finally, OHH also demonstrated the importance of the Incident Command System (ICS), as well as a rapid-alert system for the BHDR teams.

THE BIOLOGY BEHIND BEHAVIOR: UNDERSTANDING THE HUMAN RESPONSE TO STRESS

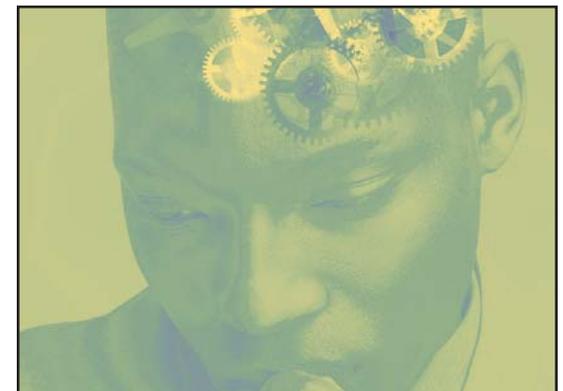
Samia Dawud Noursi, Ph.D., Health Scientist Administrator, Division of Epidemiology Services and Prevention Research, (DESPR) National Institute on Drug Abuse (NIDA)-Facilitator

Richard Nakamura, Ph.D., Deputy Director, National Institute of Mental Health (NIMH)

Richard Nakamura opened the session with a few statistics that illustrate how widespread mental illnesses are. He explained that mental illness ranks fourth when looking at the burden of disease for all age groups worldwide. He also noted that suicide is the 11th leading cause of death, that suicide outnumbers homicide by 3 to 2, and that 90 percent of suicides are completed by people who have a diagnosable mental illness.

Dr. Nakamura then talked about the specific ways humans respond to stress and how those responses affect behavior. He began this discussion by describing the plasticity of the human brain. He described how new neurons are constantly growing and forming new connections, even in very old people. While genes guide the general structure of the brain, it is also significantly affected by our behavior. Research has found that activities such as exercise increase the number of new neurons; while stress on a person decreases the number. Stress has been found to simplify neurons, making them less able to make connections.

The affects of stress on the brain are of particular concern to individuals who have been diagnosed with PTSD, which is a mental illness that can occur after a person experiences or witnesses an extremely stressful event. Generally, survivors of such an event recover



continued

and return to normal after a period of time, however, there are some individuals for whom this is not the case. The stress reactions that they experienced during the traumatic event do not go away on their own, and in some cases the stress reactions get worse over time.

The goal of PTSD treatment is to "extinguish" the fear response that sufferers continue to experience. Extinction of this response allows patients to recover from fear and feel safe again. There are some medications that assist in this process. There are also early interventions, such as psychological first aid, that are thought to help prevent PTSD.

Talk of extinction led to a group discussion about how to help disaster survivors extinguish

their fear responses when they are constantly faced with additional stressors (such as need for housing and food, or separation from loved ones). These additional stressors keep disaster survivors in a longer state of stress and slow the recovery process. The first suggestion from the group focused on the need for governmental agencies to better coordinate with one another. It was thought that the agencies dealing with the physical needs of disaster survivors (such as housing), need to be educated on the idea that the longer people are left without resources, the longer it will take for those people to recover.

The group then began discussion on more individualized ways to help disaster survivors manage their stress levels. A plan was offered in

which crisis counselors would help people to compartmentalize and organize the many needs with which they are faced. Building on that idea, a group member suggested that if survivors receive assistance in meeting their most immediate needs, then they will be better equipped to deal with other issues. Another group member said that sometimes people are overwhelmed at first, but after talking with someone about their worries, they realize that they will be okay. This person also reminded the group that people are naturally resilient and that PTSD is not the normal reaction to a disaster. It was agreed that coordinated efforts of crisis counselors, behavioral health professionals, and State and local officials can help disaster survivors deal with stress more effectively.

MARRIOTT'S "SPIRIT TO SERVE"



On the closing day of the Spirit of Recovery summit, SAMHSA recognized organizations and individuals who exemplified the tremendous efforts of everyone who has been involved in the recovery from the 2005 gulf coast hurricanes. Among the organizations and individuals honored was the New Orleans Marriott, which was instrumental in the success of the summit and, as they say in their slogan, the "Spirit to Serve" in the face of disaster.

The Marriott Corporation led the industry in disaster preparedness during Hurricane Katrina. The New Orleans-area Marriott hotels had an organized and comprehensive plan for their guests and associates which included twice-daily briefings and adequate emergency supplies. Evacuations of guests and associates were planned and executed efficiently before and after the storm. The management of Marriott worked on a State, regional, and national level to ensure the safety of their guests and associates and helped other New Orleans hotels as well. After the storm and the subsequent flooding, Marriott offered complimentary housing to their associates who sustained loss and damage. In addition, the company offered incentives for associates to stay in New Orleans and paid for leaves of absence through September 30, 2005, no questions asked. Mental health counselors were brought onsite for a month after the storms, and a 24-hour life-service help line and Web site are still in operation. During and after this disaster, Marriott took a leadership role in risk communications, employee assistance, and guest relations.

Spirit of Recovery Summit Highlights Regional Workgroups Summary

On the second day of the summit, participants engaged in workgroup sessions to share recent experiences and identify disaster behavioral health planning priority areas on a number of levels. Participants were grouped into teams by public health service region and worked together to achieve two goals: Establish a priority related to strengthening regional collaboration, and identify the first step toward addressing the priority. The purpose of this exchange was for the groups to learn from one another and begin a regional dialogue that would continue long after the conclusion of the summit.

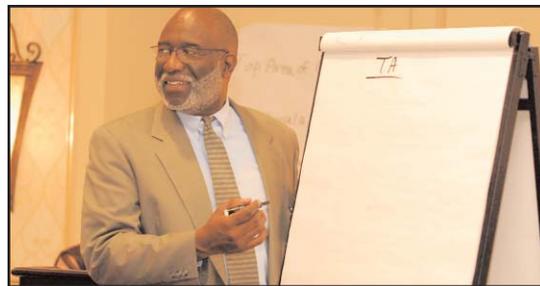
Group facilitators kicked off discussions by having team members share their top lessons learned from the 2005 gulf coast hurricanes or other recent disasters, their top challenges faced in regional collaboration, and the top technical assistance needs they felt could be met by the Federal Government. Although lessons and challenges varied from State to State and from region to region, there were a number of common themes and action steps that emerged, particularly in relation to what States and Territories can do to expand their capacity and move forward with planning efforts. Such activities include the following:

>> Evacuation Planning:

- Develop comprehensive evacuee tracking systems;
- Plan for special-needs shelters and the services they must provide;
- Develop plans to address evacuations that cross multiple jurisdictional lines; and
- Prioritize identifying shelter sites that are geographically close or accessible to other social and health resources.

>> Training:

- Train staff and community providers on interventions;
- Provide technical training for behavioral health staff on systems, including emergency management assistance compacts and ICS; and
- Regularly conduct drills and exercises to test plans for ICS implementation.



>> Partnerships:

- Establish and maintain both formal and informal partnerships;
- Develop tracking systems to help manage volunteers; and
- Proactively include substance abuse partners during the planning and response phases.

>> Documentation and Reporting:

- Determine in advance who can and will write grant applications when the need arises; and
- Develop systems and protocols for generating situation reports and thorough after-action reports to glean lessons learned and modify plans.

>> Cultural Competence:

- Acknowledge, understand, and anticipate issues of culture and heritage in all aspects of behavioral health planning.

>> Care for Behavioral Health Staff and Responders:

- Provide stress management support; and
- Reinforce the importance of family and personal disaster planning.

continued

Participants also openly discussed their technical assistance needs and cited issues for their Federal partners to consider on both programmatic and policy levels, specifically around strengthening regional collaboration and planning. Many States and Territories agreed that their needs include the following:

- >> Systems that support and shepherd ongoing face-to-face collaboration and interaction.
- >> Improved systems for managing accessibility of medications and medical supplies during the response phase.
- >> Additional technical assistance and training on the parameters and characteristics of available funding sources.
- >> Funding sources that programmatically address a wider range of behavioral health needs and provide further support for full-time disaster behavioral health staff.
- >> Standardized systems for behavioral health deployment that would streamline cross-State credentialing, mutual assistance systems, and standardized trainings.

On the third day of the event, A. Kathryn Power, M.Ed., director, CMHS, SAMHSA, and H. Westley Clark, M.D., J.D., M.P.H., C.A.S., F.A.S.A.M., director, CSAT, SAMHSA, addressed the attendees and reviewed the workgroup outcomes. Ms. Power and Dr. Clark reinforced the

importance and advantages of each of the State and Territory action steps and provided additional guidance from the Federal perspective. They also listened to additional remarks from the participants regarding policy and programmatic challenges, which will be included in the event's final report for submission to SAMHSA leadership.

Note: SAMHSA DTAC is working diligently on establishing mechanisms to continue the dialogue

among States and Territories, regional groups, and current Federal grantees. Such efforts include the implementation of a nationwide discussion board, topic-based regional trainings, and new technical assistance resources. More detailed information is forthcoming. And, as always, SAMHSA DTAC invites you to submit ideas and suggestions on how we can better serve you. Feel free to contact SAMHSA DTAC with your feedback at dtac@esi-dc.com or 1-800-308-3515.



Interaction with Families and Communities Who Have Missing and Deceased People Following Mass Disasters

In order to provide a context for the post-disaster reactions and needs of families and communities with missing and deceased family members, and the reactions of forensic and mental health professionals, it is important to understand the ways in which mass disasters affect survivors and impact the ante mortem data (AMD) and identification process. Family members will have a need for information about their missing or deceased family member. For example, they will ask to see the body, wish to retrieve the remains, ask how they can get a coffin, or ask where they may get a death certificate. These issues will have been clarified prior to any data collection and identification, and at least one or two members of the forensic or family support team should be prepared to convey the needed information in both written and verbal formats, when possible.

In natural and manmade mass disaster events, worrying about a missing loved one is an extraordinarily distressing experience. Individuals, families, and communities may go through a number of different feelings: Worry, hope, anger, turmoil, gratitude, shock, or guilt.

They may alternate between certainty that the person is alive—even in the face of contradictory evidence—and hopelessness and despair. They may blame authorities for perceived ineptitude or delays. They may also feel vengeful against those they consider responsible for their presumed loss, and be frustrated with what they feel are inadequate efforts or resources devoted to locating their missing relative or friend.

Traumatic events generally involve threats of personal death or injury or of close encounters with violence and death, including witnessing the death of others. The common denominator of psychological trauma is the feeling of intense fear, helplessness, loss of control, and threat of annihilation.

Mental health professionals can be a bridge to the forensic/exhumation teams and will assist families with the process. Psychosocial professionals are in a good position to collect and record ante mortem information, and let families know how they can help identify bodies by providing detailed information about their loved ones. Families will have many questions that must be addressed. The forensic team is

often the first in the area, and there is a need to offer a supportive intervention.

Helping professionals may need to both offer and provide support to people with missing family members. In one example, such a professional learned from a group of family members waiting at a morgue that they were all worried about one particular man who had lost both a brother and a son. The worker sat beside the man and asked about who he had lost and how it happened. For the next 2 hours, the worker listened as the man told his story. As he talked, the worker gently urged him to continue, and when he cried, the worker held his hand but did not attempt to stop the tears.

AIDING IN THE IDENTIFICATION OF FAMILY MEMBERS

AMD is detailed information describing a missing person or a person believed to be dead. Those family members who were the last to see the missing person may be asked questions about that person during his or her life and at the time of disappearance. This information

continued

will be compared with findings from the recovered bodies (post mortem data collected by forensic pathologists and anthropologists). Families with a missing person must be assisted in understanding the purposes of the AMD collection and how it relates to possible identification. Community education, including town hall meetings, and information on television and in the print media are helpful prior to actually collecting data.

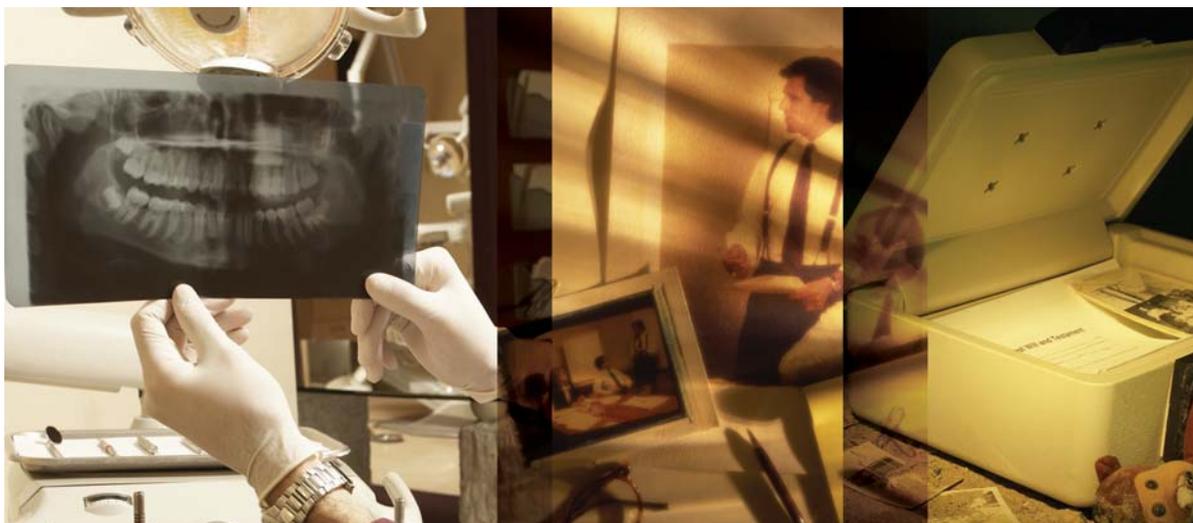
Sometimes families may have difficulty starting their story or organizing their thoughts. It is helpful to ask orienting questions and gradually ask them about the missing or deceased. Remember that survivors need to talk about these topics but may avoid discussing them with their family members. Remember to empathize

with the client. Do not force them to talk about things they do not want to discuss or force them to talk at all if they would rather be quiet.

AMD questionnaires are designed to collect the most useful information from informants to aid in identifying mortal remains recovered as a result of exhumations. These questions help obtain detailed information on clothing, jewelry, medical details, age, physical characteristics, etc. DNA samples should be obtained through the closest maternal relatives of the missing person. All possible living maternal relatives should be recorded, with their contact information to assist in followup should DNA samples become necessary. Maternal relatives include the missing person's mother, any siblings with the same mother, and the mother's siblings.

Eventually, some families may want to see clothes or pictures of clothes to assist with identification. It is important to warn family members that clothes will not look precisely as they had in life. The clothes themselves may give off a strong odor, and families need to know what to expect. Typically, families have mixed feelings about the pending identification—they want and they do not want the final answer. Even when they say they know the loved one is dead and hope to find clothing they recognize, it will be difficult for them to confront the truth. The moment of recognition is typically the acknowledged "moment of death." Sometimes, family members want to touch the clothes, some want to take pictures. Helping professionals may need to advocate for the family's wishes.

If the family wishes to see the body or what remains of a body, it is usually advisable that some support work is done prior to a viewing. Families must know that their loved one will not look the same as he or she did in life. They may be decomposed and be virtually unrecognizable. Often this process must be established prior to the start of the exhumation so that there is no confusion for team members or families. Showing photos to family members prior to viewing remains may be helpful.



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Suspecting or even knowing rationally that a missing family member is dead is very different from being confronted with the actual fact of the body. The body puts an end to hope. The body, often deteriorated by the effects of time, may uproot any hopeful images of the person the family member was holding. Often a family does not fully grieve until they see the body. Even if years transpire between the time of the person's disappearance and the discovery of the body, and if the family appears to have gone through a grieving process, they may go through it all over again and with greater intensity when the body is actually found. In mass casualty events, actual physical confirmation of death through the recovery of remains may be protracted or may never occur.

Not being able to perform burial and other religious rituals can complicate the grief process and increase a family's distress. When there is no body to bury, it is important for families and communities to create other kinds of memorial observances. People may also need a place to go. This is especially a problem in areas so ravaged by natural disasters that even cemeteries have been flooded. Although cultural practices differ, in all cultures there are formalized ways to express grief and to honor and memorialize the dead. Without exposing children to overly disturbing images, they should be included in these rituals.



TRAUMATIC EVENTS AND REACTIONS

Traumatic events, such as witnessing the death of family members, being threatened with bodily harm, and losing one's home, affect the entire family. Children and older adults are particularly vulnerable. Because children, especially younger children, do not have the language skills to enable them to speak about what happened to them, they may hold feelings inside. This can result in poor concentration in school, nightmares, sleep problems, bedwetting, and other behaviors that are normal in much younger children. Children affected by trauma and grief may also act out their feelings through aggressive behavior. Traumatic events and traumatic grief may also be particularly stressful for older adults, who are at a stage in life where they may be feeling vulnerable, or their physical health may be failing. Children and older adults will be present in the field when forensic professionals conduct their work. It is important to know how the events of the disaster and the events of identifications impact them. Adults often need reminders that children are taking everything

in and have witnessed events along with the adults. Children's feelings and fears should be validated, and their courage in the face of such danger should be acknowledged.

WHAT A HELPING PROFESSIONAL CAN DO

In the short term, a supportive response from other people may mitigate the impact of the event, while a hostile or negative response may compound the damage and aggravate the traumatic syndrome. In the immediate aftermath of the trauma, rebuilding some minimal form of trust is the primary task. Restoration of a sense of personal control and self-esteem is also vital. Preserving connections to the community and stimulating an individual's ability to cope may protect them against the development of posttraumatic stress disorder.

Forensic teams and psychosocial professionals cannot run away or gasp in horror. They should not say, "Stop crying," or "Don't worry." Professionals should always allow a full expression of the survivor's feelings. A survivor's courage should be recognized, and they should not feel judged. Forensic and mental health professionals should set the stage for healing. Professionals can provide the answers and structure necessary to allow family members to grieve.

THE PROFESSIONAL'S PERSONAL REACTIONS

This work can also be a very stressful process for psychosocial and forensic professionals. Professionals want to help. This can be very frustrating at times when little can be done. There is a gap between desire to help and the realities of how much a psychosocial professional can actually do. It is important for professionals to be aware of their own feelings about death and grieving. Those who are assisting in the forensic effort must be aware of this impact, so that they can be helpful to others in a professional role. Forensic and mental health professionals must take time to care for themselves, including eating and sleeping properly, taking breaks during long workdays, and talking to someone if they are experiencing any symptoms of trauma or stress.

This article was contributed by Margaret Samuels, M.S.W., LCSW, deputy director and clinical associate, Center for Child and Family Health, Duke University, Department of Psychiatry. Ms. Samuels has spent many years working with traumatized children and families in the United States, Bosnia, Kosovo, Iraq, and Romania.

Complications of Mass Disaster Displacements

Mass disasters that cause numerous missing persons and deaths are compounded by displacement of thousands of people. This presents challenges that may have long-term psychological effects. Attention should be paid to the following areas:

- >> Have all living missing persons been found?
- >> What is the process for giving information about a missing/deceased family member?
- >> How will the information be centralized if families are spread throughout the United States?
- >> Who will take the data and DNA samples from families, and how will they be trained to do so? If mental health professionals can be trained to do so, psychological support should be built in automatically.
- >> If there is a tentative identification (driver's license found with body, body found in own home) who will contact the families, and how will they do so? How will families view bodies and meet with forensic professionals? How and where will they be buried, and who will pay?
- >>> Print materials explaining the process, where to go, and what to do should be disseminated at informational meetings in shelters and communities.
- >>> Special guidelines on how to explain the process to and provide support for children in these situations also should be disseminated.
- >>> Mental health professionals can be a bridge from forensic professionals to family members and can provide supportive help through the entire identification process.
- >>> A small team of mental health and forensic professionals at each morgue or data collection area can provide sensitive technical understanding, data collection, and support.
- >>> Families should have a trained, supportive mental health professional available through the entire identification process.

Book Review



Rosman, E. A., Perry, D. F., & Hepburn, K. S. (2005). *The best beginning: Partnerships between primary health care and mental health and substance abuse services for young children and their families*. Washington, DC: Georgetown University National Technical Assistance Center for Children's Mental Health.

THE BEST BEGINNING: PARTNERSHIPS BETWEEN PRIMARY HEALTH CARE AND MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES FOR YOUNG CHILDREN AND THEIR FAMILIES

This 92-page report, written in August 2005, was developed under a cooperative agreement between SAMHSA and the Georgetown University National Technical Assistance Center for Children's Mental Health, and is an outgrowth of SAMHSA's intra-agency Children and Families Matrix Workgroup. It is divided into five main sections: Background; Methodology; Case Studies; Innovative Approaches Used by Sites: A Synthesis; and What Practitioners Need to Know: Lessons Learned from the Field. It also includes appendices that list the members of the expert workgroup, share the interview protocol, outline the screening tools, and list the members of the Federal team involved in the project.

This document was developed as a resource to give healthcare providers and policymakers at all levels an overview of a range of innovative

efforts across the country, including examples where healthcare providers have attempted to treat families as a whole, provide care in the context of a medical home, identify mental health and substance abuse disorders earlier, and make successful referrals and linkages to community-based mental health and substance abuse services and supports.

Primary healthcare providers represent a significant and natural point of contact for young children and their families. Being able to intervene early with caregivers of infants and toddlers through primary health care providers can promote children's mental health and well-being, prevent or delay later negative outcomes, promote protective factors and decrease risk factors associated with negative child outcomes, and may prevent the need for intensive and expensive care later in life.

The report identifies pediatric settings that incorporate innovative approaches to primary care, including the following:

- >> Creating a medical home.
- >> Providing comprehensive mental health, substance abuse, and developmental screening.

continued

- >> Providing facilitated referrals.
- >> Providing family-centered care.
- >> Providing mental health and substance abuse services.
- >> Demonstrating cultural and linguistic competence.

The report highlights national efforts to integrate behavioral health and primary care, including the following:

- >> Starting Early Starting Smart (SESS).
- >> Early Head Start (EHS).
- >> Healthy Steps for Young Children.
- >> Assuring Better Child Health and Development.
- >> Medical Home.
- >> Bright Futures Mental Health.

The report gives detailed case studies that provide a variety of examples of the integrative strategies addressed in the report and focuses on issues including the history and mission of each facility, the setting and populations served, staffing and staff development, and financing.

The final section outlines lessons learned from the field for practitioners, including the following:

- >> Make comprehensive screening routine in primary care settings.
- >> Be innovative in billing.
- >> Ensure that an array of referral sources is available for children and families that screen "high" on developmental or behavioral health screens.
- >> Implement a medical home model.
- >> Whenever feasible, collocate services.

- >> Do not forget substance abuse.
- >> Move from individual-centered care to serving the family as a whole.
- >> Increase cultural awareness and cultural competence.
- >> Be aware of what is happening at the macro-level policy climate.
- >> Use data to advocate for services.
- >> Take chances, and experiment with new approaches.
- >> Be flexible.
- >> Be a leader with a vision.

This report is available online as an Adobe PDF file on the Georgetown University Center for Child and Human Development Web site. Go to http://gucchd.georgetown.edu/products_publications.html.

CALL FOR INFORMATION

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

Upcoming Meetings

DISASTER PLANNING FOR HOSPITALS

AUGUST 9–11, 2006
WASHINGTON, DC

Participants in this conference, organized by World Research Group, will learn strategies to prepare hospital staff and facilities for a large-scale disaster or pandemic, collaborate with partner hospitals, meet surge capacity, and respond to a disaster situation. For more information, contact World Research Group at 800-647-7600, info@worldrg.com, or <http://www.worldrg.com/showConference.cfm?confCode=HW675>.

AMERICAN PSYCHOLOGICAL ASSOCIATION 2006 ANNUAL CONVENTION

AUGUST 10–13, 2006
NEW ORLEANS

Topics to be addressed in this year's cross-cutting programs include assessing capacity in older adults, psychological perspectives on natural and social disasters, and infusing diversity into psychology. For more information, go to <http://www.apa.org/convention06/homepage.html>.

UNIVERSITY OF SOUTH DAKOTA DISASTER MENTAL HEALTH INSTITUTE— INNOVATIONS IN DISASTER PSYCHOLOGY 2006: CULTURALLY RESPONSIVE DISASTER MENTAL HEALTH

SEPTEMBER 7–9, 2006
RAPID CITY, SD

This conference is intended for disaster mental health, health, and mental health professionals. The overall objective is for participants to learn more about cultural responsiveness and sensitivity in disaster psychology. For more information, contact the Disaster Mental Health Institute, University of South Dakota at (605) 677-6575, dmhi@usd.edu, or <http://www.usd.edu/dmhi/conference.cfm>.

NATIONAL EMERGENCY MANAGEMENT ASSOCIATION (NEMA) 2006 ANNUAL CONFERENCE

SEPTEMBER 18–22, 2006
ORANGE BEACH, AL

This conference provides an opportunity for emergency managers to come together to discuss the many challenges that face the

community today, share solutions, grow professionally, and network with peers. Attendees will hear from those involved in shaping the future of homeland security and emergency management, strengthen relationships with partner organizations, and discuss NEMA's views on all-hazards emergency preparedness with the leadership in Washington, DC. For more information, go to <http://www.nemaweb.org/?1590>.

PREPARING FOR PANDEMIC INFLUENZA

OCTOBER 11–12, 2006
ARLINGTON, VA

This conference will bring together an influential gathering of medical and public health leaders to review and discuss the National Pandemic Influenza Preparedness Plan and the Nation's preparedness and response efforts and goals. Medical, clinical, and epidemiological experts will present the most current information related to surveillance, specific contingency plans, vaccine and drug production and stockpiling, risk communication, and the role of Federal, State, and local governments in responding to a new influenza pandemic. For more information, go to http://www.homelanddefensejournal.com/hdl/co nf_influenza.htm.

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INTERNATIONAL SOCIETY FOR TRAUMATIC STRESS STUDIES 2006 ANNUAL MEETING: THE PSYCHOBIOLOGY OF TRAUMA AND RESILIENCE ACROSS THE LIFESPAN

**NOVEMBER 4–7, 2006
HOLLYWOOD, CA**

Mark your calendar now for the largest gathering of professionals dedicated to trauma treatment, education, research, and prevention. More than 100 symposia, workshops, panel discussions, cases, and media presentations will be presented on a wide variety of topics related to traumatic stress. The conference will focus on the following: A lifespan perspective regarding the risk of trauma and its consequences; perspectives on resilience and trauma, given exposure to potentially traumatic events; and the relationships among genetic, biological, and psychosocial factors predicting traumatic stress, resilience, and treatment of trauma-related problems. For more information, go to <http://www.istss.org>.

AMERICAN PUBLIC HEALTH ASSOCIATION 134TH ANNUAL MEETING

**NOVEMBER 4–8, 2006
BOSTON**

This meeting consists of more than 900 scientific sessions, roundtables, poster sessions, institutes, and panel discussions at which more than 4,000 scientific papers will be presented. Sessions include mental health issues in mass care settings and substance abuse after disasters. For more information, go to <http://apha.org/meetings>.

2006 ROCKY MOUNTAIN REGION ANNUAL DISASTER MENTAL HEALTH CONFERENCE—TAKING CHARGE IN TROUBLED TIMES: RESPONSE, RESILIENCE, RECOVERY, AND FOLLOW-UP

**NOVEMBER 8–11, 2006
CASPER, WY**

This conference is presented by the Rocky Mountain Region Disaster Mental Health

Institute. Topics will include cultural concerns, ethnicity, political concerns, religious considerations, children, and mitigation. For more information, contact Rocky Mountain Region Disaster Mental Health Institute, (307) 399-4818, rockymountain@mail2emergency.com, or <http://www.rmrinstitute.org>.

THIRD ANNUAL SYMPOSIUM ON CRISIS INTERVENTION: BRIDGING THE GAP TO MENTAL HEALTH TREATMENT

**NOVEMBER 14, 2006
BALTIMORE/WASHINGTON, DC AREA—TBD**

The Affiliated Sante Group will host this symposium and has issued a call for papers. Proposals are encouraged from those in the fields of psychology, social work, crisis intervention, and emergency services. For more information, or to download a copy of the call for papers submission form, go to <http://www.thesantegroup.org> or send an e-mail to crsconference@santegroup.org.