



The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER BEHAVIORAL HEALTH

ASK THE FIELD

The Dialogue: Disaster anniversaries are difficult and can trigger the recurrence or onset of disaster reactions in those affected. This is especially true with the recent 5-year anniversary of the September 11, 2001, terrorist attacks and the 1-year anniversary of Hurricane Katrina. In addition, the increased media attention surrounding Hurricane Katrina and the release of movies about 9/11/01, such as *United 93* and *World Trade Center*, can add to the stress and trauma. In relation to disaster anniversaries and the reactions they can trigger, what are some of the ways disaster behavioral health practitioners can help people who might be struggling with these reactions?

April Naturale: For disaster survivors, the date the event occurs often becomes a historical marker in their lives for years to come. They recall the activities they were engaged in before they learned of the incident, how they felt when the disaster hit, and how they responded in the immediate aftermath. This is also true for other traumatic or significant events that inevitably take place through the course of a human lifetime. For example, we lose loved ones, sustain physical injuries by accident, or become a victim of crime. We quickly begin to fold the events into our daily thinking and develop timeframes using these events as a reference point. For example, it is not unusual to hear someone say, "Before my father died..." or "After Katrina..." as an opening

statement. I found this to be a stark reality in the years after 9/11/01 in New York City. Although I expected people to be talking about the World Trade Center disaster well into the first year after it happened, I was surprised that the references continued until I stopped noting the phenomenon 2½ years later. Throughout that entire timeframe, not 1 day had gone by that I did not hear a minimum of two or three people say, "Before 9/11..." or "On 9/11, I was..."

It stands to reason that the anniversary dates of these events would also trigger our memories. Our memories are the recall of images, sounds, smells, and emotions all attached to the same brain cells. At the same time that we recall an image, all the other sensory memories accompany that image. When we are unable to

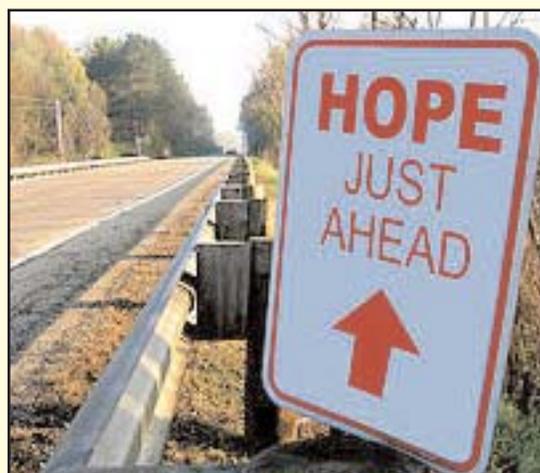
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distinguish the memory from the current reality and the recall disturbs us emotionally to the extent that we suffer and cannot function normally, we identify this as posttraumatic stress disorder.

For most of us the memories are containable, and while some recall might disturb or upset us momentarily, we continue to function and the distress is time-limited. That is what we call "recovery." So, an important intervention in addressing anniversary events closely follows the main tenets of crisis counseling which indicate that education around disaster responses is important to help people recognize their responses are generally "normal." Tell disaster survivors that having some emotional distress responses as the disaster anniversary approaches is very common. Some people report an increase in anxiety, sadness, or other distress symptoms that seem as severe as they were in the immediate days after the event. Then, as if the anniversary is some type of hurdle that gets crossed psychologically, their symptoms recede afterward. Many people even report feeling that they move back to their predisaster emotional state after they get through the anniversary.

This phenomenon also seems to apply to individual trigger events such as the birth date of a loved one who has died, or the marital anniversary of a widow or widower. One 9/11/01 survivor who barely escaped injury during her

building evacuation told me she saw the entire first year as a year of firsts—the first Christmas after 9/11, the first birthday, the first summer—every day, all the way through until 9/12/02 when she reported that she finally woke up that morning and did not think of it as one of the first days post 9/11.



Human beings have a gift for learning by recall and repetition. These learned behaviors and responses are what become known to us as habit. We do not like change. We fall into routines that we reapply over and over, often year after year. We build into those routines the rituals that bring us comfort in their familiarity and their ability to decrease our anxiety because they are known ways of being and doing. In the United States, we have all kinds of annual acknowledgments and rituals, old and new. Many people

cannot recall the original meaning of the Maypole celebration, but are eager to participate every year. And I am not sure if anyone really knows why we celebrate Groundhog Day.

Knowing that these memories and some accompanying emotions are inevitably going to resurface around anniversaries may help people understand why they feel as they do and not become more distressed by the occurrence.

Another tenet of post-disaster crisis counseling is to help survivors recognize what coping skills may assist in diminishing the distress symptoms they might feel around anniversary and trigger events. As we know from disaster research, social supports can be most helpful and it is recommended that disaster survivors not isolate themselves on the anniversary. Participation in community rituals that mark the day in a respectful and supportive manner can be a most effective way to get through tough times.

Some people choose individual or family rituals such as visiting a grave site, lighting a candle, saying a prayer, or a silent moment as a way to mark the importance of an anniversary. In the words of A. Kathryn Power, director of the SAMHSA Center for Mental Health Services, we can give people permission to celebrate even in the face of disaster. This can help communities who are working toward recovery come together in their efforts.

The connectivity of individuals, families, and groups is the fabric of our community lives and the essence of resilience. Anything people choose to do that will help decrease their symptoms and avoid isolation should be encouraged.

It may be particularly important to reach out to friends and family members who are at high risk for suffering from an increase in disaster distress symptoms because they are more vulnerable or frail. Family members and children who lost a loved one may need special attention, support, and caring from others. Isolated older adults who are not well physically or who lack transportation may benefit from the outreach efforts of concerned others. People who have suffered with previous trauma, are managing a mental illness, or are struggling with substance abuse issues would benefit from a caring individual and from participating in an anniversary ritual that helps them feel connected to the community. These are just a few examples of people in the affected communities who may benefit from the attention of others during stressful times.

In summary, when anticipating an anniversary, special days like holidays, or other trigger events, the following tools may help survivors and communities recovering from disaster and trauma:

>> Educate people about expected anniversary and trigger event symptoms such as thoughts, feelings, dreams, and memories

that reoccur; grief and sadness related to their losses; fear and anxiety; and frustration, anger, or guilt about the event.

- >> Encourage the use of coping skills such as exercise, meditation, and talking.
- >> Decrease isolation and increase socialization.
- >> Increase connectivity by reaching out to family and friends.
- >> Use individual and community rituals and practice religious or spiritual beliefs.
- >> Acknowledge and pay reverence to losses.
- >> Give permission to celebrate.

Additionally, while most recognize the need to give reverence to those who died and the losses sustained as a result of tragedy, many people discuss the need to frame the anniversary as a time to acknowledge the thankfulness for their own lives, good health, and the love of family and friends.

Anniversaries, holidays, and other special days may be times of sad memories mixed with joy and new reasons to celebrate. Know that these times may be more difficult and renew some distress symptoms such as those felt right after the disaster. This is not unusual, and most people are able to get through these special times and get back to feeling better once the anniversary or special day passes, especially with help from friends and family

Be aware that special days may be difficult. This is normal, and recognizing it as such may help you to not be so hard on yourself. For many people, special days remind them of their losses. They may start anticipating the anniversary, birthday, or holiday several days in advance. Not having your loved one to share the day; not having your old home; not having your old neighborhood; not having your old job—it is difficult to imagine what has happened and hard to believe the current reality. It is normal to have fears and concerns about how the special day will make you feel.

Be gentle with yourself during "trigger" events. These trigger events include not only the anniversary of the disaster itself, but also other special events such as birthdays and wedding anniversaries. Treat yourself with the same kindness you show others.

Participate in rituals that may provide comfort. These rituals include singing, praying, going to the beach or a movie, sharing a meal, and going to a spiritual service.

Plan activities. It will be more helpful to plan what you are going to do and who you are going to do it with before the special date arrives. Plan your activities so that you know what to anticipate and are not disappointed if something you wanted to do is not possible. Do not set yourself up for disappointment.

Reach out to family and friends. There is no need to be alone, and isolation is not helpful. Invite others or accept invitations to participate in rituals or social events, or just be together.

Talk about your losses. Most people have a need to talk about their losses. This is normal and may continue beyond the anniversary and special days. Find someone who will listen and understand.

Do things that might help you with overwhelming emotions. If you are the type of person who likes to exercise or take a walk, make sure to do so in the days before and on the special days themselves. Try writing in a notebook as if you are telling someone a story, or just write



down your thoughts. Write a letter to your loved one telling them that you miss them, or just telling them how you are doing. Talk to others you trust to understand. Think about

what may help you to cope with your heightened feelings during anniversaries, holidays, and other special events.

Do what you would like to do rather than what you think you should do. Loss is likely to change the way you spend your holidays and other special days. While there may be a desire to keep things the same, trying to do so may make the losses more evident and distressing. Things are different. Know that you can create new ways to acknowledge and celebrate special days. Do not feel like you have to try to make things look or feel exactly the same as they were. Try not to put the needs of others before your own needs. Each person should spend these days in the ways that will be most helpful to them. Trying to make things better for others may result in misunderstandings and may not allow for self-care (I thought that is what they wanted to do, they thought it was what I wanted to do, and no one felt comfortable saying what they REALLY wanted to do.).

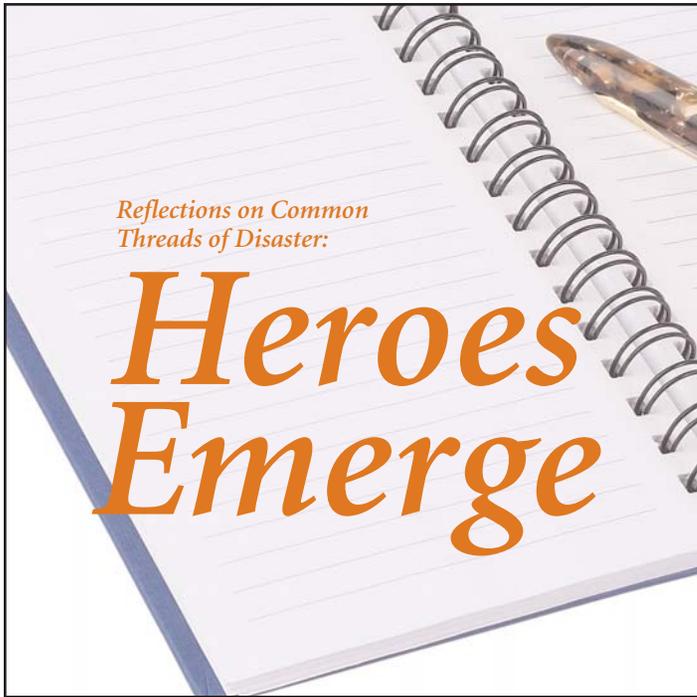
Know that it is natural to feel sad or angry. You may feel bitter and angry that others seem to be enjoying themselves when you are having a difficult time. Good wishes and holiday greetings may just remind you of your losses. This is a normal reaction. Try not to fight the feelings, but be aware that they are likely connected to your losses and may not be aimed at anyone in particular.

Draw on your faith and spirituality. For many, faith is a source of strength and comfort every day and especially during difficult times. Reach out to your faith advisor and your spiritual community to support and console you.

Accept kindness and help from others. Support makes difficult times more bearable. There is often a tendency to resist help from others, or to believe that we do not need help as much as our neighbor and therefore should not accept it. This is common in many cultures and ethnicities across the country and around the world. Difficult times like anniversaries, birthdays, and holidays may be important times to open up and let in others. Accept their support. Be gracious and allow them the opportunity to share their caring with you.

Helping others may actually be a form of helping yourself. If you are the type of person who gets satisfaction from helping others, you might want to think of small ways that you can be of help to others in need during difficult times. Helping can be as simple as going through your closet to find gently used clothing that might be of use to someone else.

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Note: Warren Harrity, M.A., is currently the executive director of Katrina Aid Today, a national program for Hurricane Katrina survivors, managed by the United Methodist Committee on Relief. Katrina Aid Today is a coalition of groups using public funds to assist families hardest hit by the hurricane through case management. In this article, Mr. Harrity shares his personal experience on the common threads of disaster that people share around the world.

Most disasters are swift and sudden. Some disasters provide time for preparation and an organized departure. Whether the disaster is natural or human-caused, the end result for many families and individuals affected by it is the loss of all that was common to them. Many families that I have met; whether in Bosnia, Afghanistan, Armenia, or here in the United States; have lost family members, households, jobs, neighbors, and neighborhoods. Many have lost all hope of ever recovering from the disaster they have experienced. In these disparate regions of the world there are different cultures, various religions, myriad ethnicities, and distinct ways of life. Yet given these various differences, there are many commonalities; not the least of which is the emotional response to the loss of all that is dear to them. The tears of a mother, the bewilderment of a child, the struggles of a father seeking to provide for the family's daily bread are reactions that cross all borders, cultures, and religions. Equally compelling is the similarity among people regarding the will of the human spirit to survive, rebuild, and recover.

I have witnessed heart-wrenching emotional upheavals and heroic acts of courage as a result of disasters and their aftermath. I am moved by the knowledge that despite the apparent differences among people on the surface, there is much that we share in common.

THE COMMONALITIES OF LOSS

Most striking in a disaster is the loss of life. The world watches in horror the anguish of families who have lost their loved ones. Our glimpse of this is often momentary in snapshots on the news. Yet the loss of loved ones is life changing and the recovery from this is lengthy and sometimes life-long. The loss of homes and possessions is also quite striking as we have witnessed most recently with Hurricane Katrina as splinters of timbers and piles of bricks are all that is left of towns on the gulf coast of Mississippi and Alabama and in New Orleans. Plumes of smoke and other signs of carnage caught our attention as we witnessed the bombed-out remains of villages in Bosnia in years past and in Afghanistan and Iraq today.

The destruction of these homes represents, in many cases, a lifetime of effort suddenly vanished. Years of savings wrought by daily hard work in gainful employment and labor are suddenly stripped away. The homes we see destroyed were in established communities that have been dispersed far and wide, changed in ways that will never be the same. Suddenly, family members and friends, shopkeepers and acquaintances, teachers and physicians that make up the fabric of people's lives are no longer there, leaving a void in the lives of families and individuals within these communities.

The people in disaster areas suffer from the loss of trust; trust in God perhaps, trust in others, or themselves. They suffer from the loss of dignity, respect, and self-esteem, which are replaced by despair, hopelessness, self-doubt, and fatigue. We get occasional reminders of past suffering in the news as anniversaries are marked or new struggles become apparent. For the families, the event that caused the destruction is a constant presence in their minds and hearts. The recovery from the event is present in the daily struggle to regain normalcy. In some cases, full recovery never happens and the plight of those who suffer is forgotten as individuals suffer anguish in quiet desperation.

BOSNIA: A COUNTRY DIVIDED SEEKS TO HEAL

Ethnic conflicts 1992–1995 led to the forcible displacement of an estimated 2.2 million people from what is now Bosnia and Herzegovina. Since the signing of the Dayton Peace Agreement (GFAP) in 1995, real and tangible progress on the return of Bosnian refugees and internally displaced persons (IDPs) has been made: More than 1 million refugees and IDPs have returned to their pre-war homes. Yet the plight of Croats (Catholics), Serbs (Orthodox Christians), Bosniaks (Muslims), and Roma populations continues as the country remains supervised by the international community,

which seeks to ensure a lasting peace in a viable state.

During a 5-year period in Bosnia and Herzegovina (1998–2003), I witnessed and took part in the beginnings of a recovery that will take decades of healing. As a project manager for a German nongovernmental organization known as *Hilfe zur Selbsthilfe* or Help for Self Help and known by the acronym HELP, and later as a refugee coordinator based in Embassy Sarajevo, I had many opportunities to meet families, get to know them, and hear their stories of the loss that occurred due to a genocidal war in that country. The tragedy of that war affected virtually every family in a country of 4 million people. The severity of the tragedies that befell this country and its people was such that for many, the events were impossible to convey without a tremendous outburst of emotions. Families had suffered untold losses of homes that were bombed or burned to the ground, family members who were found in mass graves or not found at all, savings that were lost, lands that were lost, and communities that were thrown to the four winds. In the early years of reconstruction, security was not guaranteed for families returning to their pre-war homes. Houses that were constructed were bombed or set on fire in the middle of the night, and shootings aimed

at returning individuals occurred quite often. Our response was to rebuild the houses that were destroyed, and communities were encouraged by this support.

Despite the travesty experienced in this country, the people of Bosnia are looking forward to a future. Most striking to me was their sense of humor that seemed to carry them through the worst of the post-war days. Black humor as dark as the days from which they were recovering stirred them into hearty laughter; they seemed healed of their ailments in the moments that they shared. Always ready with a cup of coffee and insistent with a dinner invitation, they welcomed the time of companionship and cheer as they trudged the road to recovery.

AFGHANISTAN: THE URGE TO RETURN HOME

Afghanistan remains a nation in crisis. More than 24 years of wars, ethnic conflict, repressive regimes, drought, famine, and earthquakes have forced millions of people to seek refuge in neighboring countries such as Pakistan and Iran or to become displaced within their own country. Land that was once traditionally farmed is now heavily laden with land mines. Irrigation systems and homes have been destroyed. Houses have been turned to rubble. Following the demise of the Taliban regime in

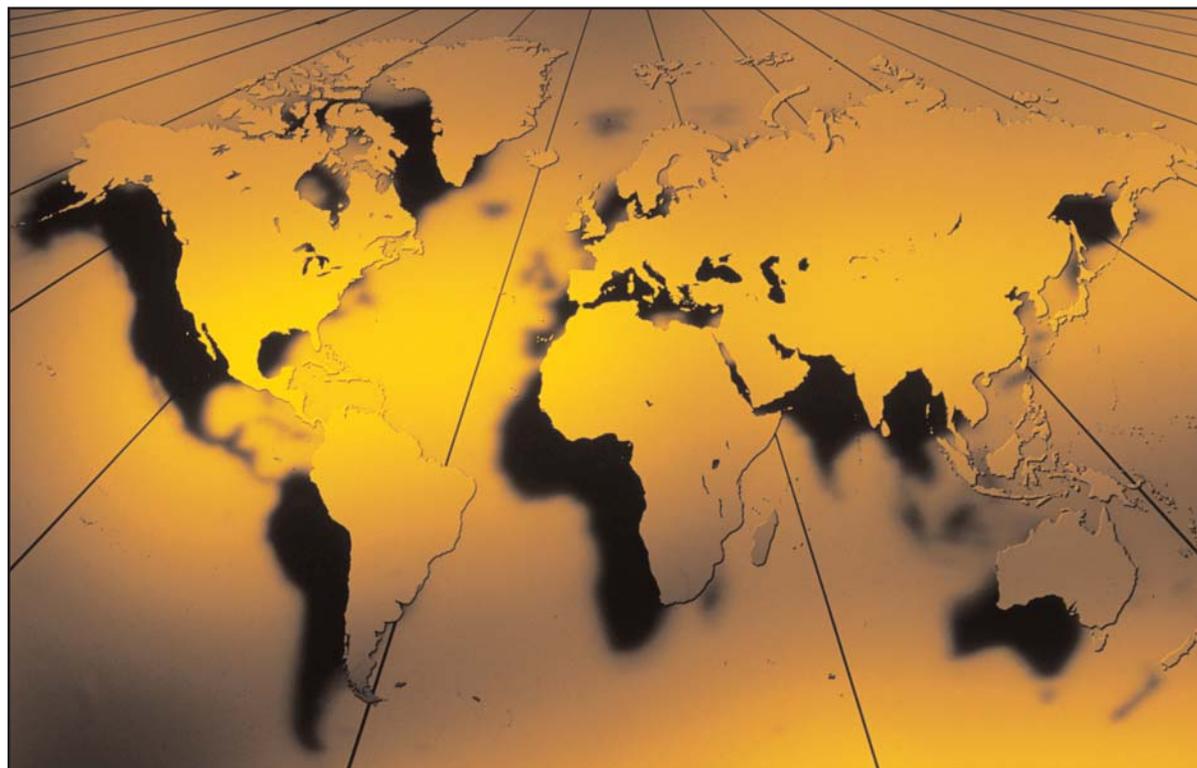
2001, refugees and IDPs tried to return to their homeland. They gave a vote of confidence in their future by returning to devastated communities in numbers that far exceeded expectations. Since the fall of the Taliban regime, nearly 5 million people have returned to their pre-war homes. These families have returned despite continued violence among war lords and the Taliban.

During the year that I worked there (2003–2004) as head of mission for the United Methodist Committee on Relief (UMCOR), an increase in violence aimed at humanitarian workers began. This trend has continued and many Afghan nationals as well as expatriate humanitarian staff have lost their lives in the effort to rebuild the country. Afghanistan remains a country embroiled in conflict as Taliban forces continue to try and stem the advent of progress. Through open-armed conflict and internal terrorist attacks on the people of Afghanistan and the international community trying to help them, a lasting peace seems elusive. I saw hundreds of destroyed properties and ravaged lives due to the war. This sight was all too common and I witnessed even worse destruction as I traveled north of Kabul through the Samali plain, which stretches through the mountainous desert for 20 miles. The Taliban "scorch the

earth" policy cleansed the population from their homes, destroying tens of thousands of houses, schools, and medical facilities while claiming thousands of lives and forcing additional thousands to become refugees. The losses were enormous and the difficulties protracted as years of war led to situations in which children were born and raised in refugee camps and the quality of life deteriorated dramatically for those displaced.

Yet, in both urban and rural areas where I traveled and worked I saw an eager, vivacious productivity among those seeking to return. Acquaintances and strangers alike broke into a smile and a warm greeting of Al Salam Alaikum (God be with you) when they saw you. I had enjoyed a warm and friendly welcome from courageous people reeling out of 24 years of war, eager to rebuild their lives, achieve some stability and normalcy in their families, and anxious for a lasting peace.

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ARMENIA: PROTRACTED DIFFICULTIES

In December 1988, one of the most devastating earthquakes on record occurred in Armenia, killing more than 25,000 people. At the same time, Armenia and Azerbaijan started a 3-year war over the disputed enclave of Nagorno Karabakh. This dispute cost more than 30,000 lives. These devastating events, compounded by economic collapse due to the dissolution of the Soviet Union, resulted in drastic hardship for countless Armenians.

When I had arrived in Yerevan, the capital city in 2004, I was impressed that it was vibrant and alive. I was concerned during my travels through the country that the effects of the destruction and deterioration remained apparent throughout much of the area outside of the capital city. During that year, records show that 52 percent of the population lived below the poverty line, 16 percent of which lived below what is considered severe poverty. The World Food Program (WFP) announced figures that year that some 800 million people in the world suffered from malnutrition. Armenia was ranked in the top 22 countries whose populations were suffering from malnutrition. According to the WFP, hunger and malnutrition kill more people every year than AIDS, malaria, and tuberculosis combined.

While many startling incidents of malnutrition and hunger come to the world's attention due to the severity of the cases and the mounting death tolls, incidents of malnutrition in countries such as Armenia go unnoticed. Families continued to suffer as many were unable to recoup what they once had. I met many families who were living in communal centers and "domics" or metal temporary shelters for 12 years after the earthquake that destroyed their homes. Life for these families was abysmal.

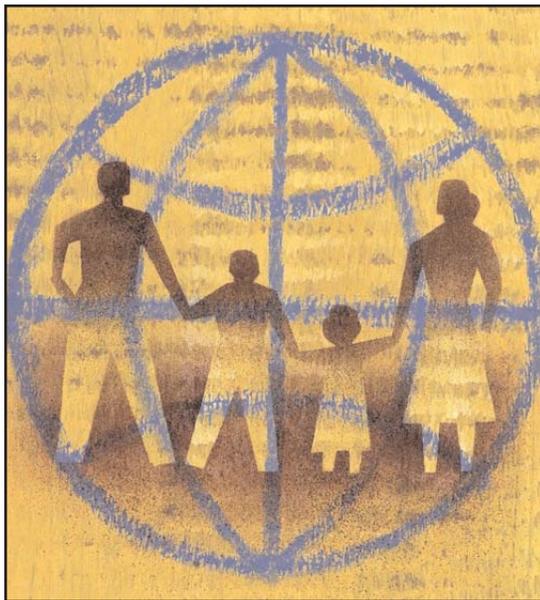
Despite the desperate situations in which they lived, families I met were welcoming, and often would not let me depart without an offer of a meal.

However, meeting the people of Armenia was a pure joy. Despite the desperate situations in which they lived, families I met were welcoming, and often would not let me depart without an offer of a meal. I was encouraged by this generosity of spirit and was impressed by the kindness of a people who had suffered tremendously. Those who had the opportunity were eager to make progress in their lives and worked steadily toward goals that would lift them out of their dire situation.

RECOVERY IS A PROCESS

Programs I have worked on in these parts of the world were often viewed as difficult undertakings. In Afghanistan and Bosnia, for example, due to the hostile nature of the relationships among the ethnic groups throughout and after the wars, a climate of fear, distrust, and hostility remained. Projects implemented in all of these countries provided an environment that nurtured the development of communal ties and the rebuilding of relationships. Families and neighbors assisted one another within their ethnic groups in the reconstruction and recovery process thus reestablishing social relations formerly enjoyed before the disasters that changed their lives. Rebuilding these relations enabled the beneficiaries to lead normal, healthy, productive lives again. Programs were aimed at developing close collaboration between community leaders and the beneficiaries. The people in these communities proved to be the key ingredient to the success of these programs as they walked the road to recovery with other families. Leaders of the ethnic groups were encouraged to meet together to discuss overall project objectives and overcome obstacles to community building and recovery. Painstakingly, progress has been made in some areas of these countries.

The importance of one person walking the road to recovery with another is enormous. Beneficiaries in these countries expressed gratitude for the support they received from the personal contact with agencies providing a helping hand so that they could help themselves. During my visits to towns and villages, I have had the honor of witnessing the healing of men and women who have openly expressed their sorrow, their tears, and their joy in the process of recovery. In Bosnia, I stood with a man named Mahmed as we surveyed his home that was nearly completed after many months of construction. Standing inside the house, he began to point at places where memories had been made; a child's first steps, a brother's



proud moment, holidays that had been celebrated. He then began to speak about the war, the destruction, the moment they fled for their lives, the screaming, and the terror. He began to sob while still trying to speak of all that had been lost. We stood for a long time before he was able to collect himself and finally speak solemnly about his gratitude for the home being rebuilt and for the changes and improvements he saw slowly occurring in his village as it came back to life. He knew that life would never be the same, but he was making a beginning, a start at something new.

I have met many such people making a new beginning, never thinking that they would ever need to do so in this lifetime. These individuals are heroes to me; they have courageously overcome obstacles to recovery. Through their heroic efforts, widows have fed children, fathers have raised roofs, children have attended newly reconstructed schools, and doctors have provided medical attention in clinics. This is one of the greatest commonalities among those who have recovered; the courage to heal.

KATRINA: A DISASTER AT HOME

Hurricane Katrina and its devastating destruction created a mass migration of people at a level previously unknown in the United States

of America. In so doing, families have been scattered throughout the country and are now displaced people. I never imagined that I would ever work on a disaster of this magnitude in the United States. Tens of thousands of families remain without a durable solution more than 1 year after the disaster. The effect of the disaster is quite similar to those that I have witnessed overseas in that the storm has left families utterly with a myriad of losses. Many of those displaced disaster survivors will require long-term assistance and social support in order to achieve self-sufficiency and a lasting recovery. Many families cannot do this on their own; many families now struggle with grave emotional upheaval and are trying to grapple with all that recovery entails.

In October 2005, the Federal Emergency Management Agency granted \$66 million to UMCOR which in turn created Katrina Aid Today, a national case management consortium. This unique initiative brings together a consortium of nine national social service and voluntary organizations and 16 local service agencies working as a team to provide case management services to the most vulnerable survivors and evacuees of the hurricane. It is designed to provide assistance to 100,000 families displaced by Hurricane Katrina. These case managers are assisting those people considered

among the most vulnerable after suffering the impact of Hurricane Katrina. These people may have disabilities, may be older adults, single heads of family households, pre-disaster impoverished, newly impoverished, working poor, and those with health problems. Case managers assist survivors by facilitating the creation of recovery plans, identifying unmet needs, and facilitating access to necessary resources; they are allies in recovery. Case management services function as an advocacy tool for survivors in long-term and unmet needs tables.

The survivors of Hurricane Katrina have much in common with those who have suffered from

disasters around the globe. The recovery process is happening slowly and in staggered steps as families seek to get their legs under them to take the courageous steps ahead. The heroes in recovery are already emerging as rebuilding begins along the gulf coast of Mississippi and Alabama and in New Orleans. It is estimated that recovery may take 6–10 years before results can be seen. These families will need support every inch of the way as they recover from this country's worst disaster in memory.

I look forward to more of the heroes who survived Hurricane Katrina coming to the fore as the recovery process takes shape. I am sure that

our friends in the gulf States will conquer obstacles to rebuilding their lives and emerge victorious. They will encounter many hurdles along the way to recovery, but with good fortune they will not have to go through the process alone. I am encouraged that those individuals called case managers will join the many teams of volunteers and professionals to aid in the recovery process. I am most encouraged that the will to survive is strong and that despite setbacks, these families will one day achieve stability once again.



Disaster Mental Health Training: Guidelines and Considerations

"Everything is complex and everything is simple...the complexity of thinking, the simplicity of beholding." Andre Comte-Sponville

The paradox of understanding that things are simpler than we can imagine and more complex than we can conceive is fully at play in most things associated with disaster mental health (DMH) training. In view of this paradox, finding balance is key. Weighing the importance of describing simple, but unimagined roles for mental health professionals, while describing the complex range of factors associated with multi-cultural community empowerment, public and mental health surveillance, intervention, and recovery planning is a tightrope walk. Trainees may struggle with new conceptualizations of helping behaviors, the anxiety of working in unconventional environments, and engaging non-mental health treatment-seeking individuals of all ages and demographics. Helping trainees shift from complex clinical orientations to fundamental helping behaviors, from an inpatient/outpatient clinical-oriented paradigm to an outreach pragmatic needs-shaped paradigm, and from micropathology-based

models to macrocommunity recovery models can be difficult. While there is a place for conventional clinical training related to early intervention and tertiary treatment, generally survivors in need of such services compose about 11–15 percent of a disaster population.

Having been invited to briefly write about DMH training guidelines and considerations for *The Dialogue*, I hope to achieve the balance of, let us say, a tightrope walker who lives to see another day.

TRAINING GUIDELINES

DMH training is shaped primarily by seven factors: 1) trainees' credentials, roles, and experience; 2) when training is delivered; 3) topics and learning objectives; 4) the training process; 5) the time available for training; 6) background and teaching experience of the trainer; and 7) available funding.

Trainees: Trainees should be sanctioned to operate within officially recognized structures. Trainees may include: Mental health professionals (e.g., social workers, psychologists, marriage and family therapists, psychiatric

nurses, psychiatrists); medical professionals (e.g., physicians, physician's assistants, nurses working in primary care, family practice, and pediatrics); clergy; fire department and police personnel; school personnel; and, paraprofessionals (e.g., staff of helping organizations, community volunteers, graduate students).

Dr. Marlene Wong, director of crisis counseling and intervention services for the National Center for Child Traumatic Stress, advocates training school personnel using evidence-based programs that have demonstrated benefits to children's health, mental health, and learning as well as enhanced classroom management in the post-disaster environment. Programs with successful outcomes were designed to have minimal disruption to the work of the classroom and the routines of the school day. Of note is the preparation required before training. Preparing school and district staffs to participate in DMH-related programs requires increasing their level of information and awareness and building skills necessary to develop disaster-related roles and responsibilities.

When training is delivered: Pre-disaster training is optimal. It can serve to coordinate and integrate system-level response as well as provide professional trainees with opportunities to learn about the significant differences between DMH services and conventional clinical services. Ideally, pre-disaster training and drills involve numerous community emergency services. Combining classroom teaching with participation in disaster simulations yields opportunities for operating within an incident command system, networking, operational testing, and team and skill building. In lieu of more comprehensive training, a series of focused and specialized trainings can address a wide range of topics specific to DMH service delivery.

When training takes place in the aftermath of disaster, content is shaped by the temporal phase of the disaster and the topics associated with relevant learning objectives. For example, topics specific to "just-in-time" training given in the immediate aftermath may include psychological first aid, common stress reactions, navigational and engagement strategies, grief work, and identification of high-risk individuals. Training given in the second to fourth week might include topics of acute stress disorder, early intervention modalities, working in the schools, outreach strategies, brief education delivery, and cross-cultural issues. Training in

the later stages following disaster might include topics of posttraumatic stress disorder and other chronic reactions to trauma, comorbidities (e.g. depression, substance abuse), treatment protocols, vicarious traumatization, outreach strategies, and helper self-care.

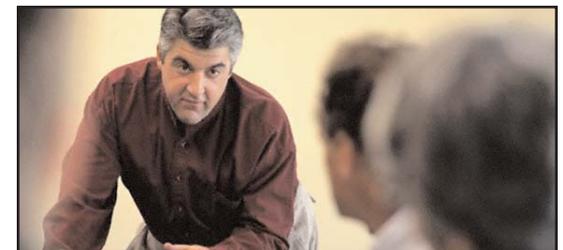
Training topics and learning objectives: Much of the disaster-related research during the past two decades has focused on the impact of disasters, with relatively little research on interventions. Until specific DMH interventions are examined, the existing literature can be used to inform and guide training in disaster-related assessment with regard to individuals at risk for adverse mental health outcomes. Findings in other areas of research (e.g., early intervention) can be reasonably generalized and applied to DMH training.

Specific learning objectives are determined by who is being trained, the identified learning needs, and when the training is delivered. The trainer must often make this judgment, informed by his or her own professional experience.

Processes of training: In addition to content, it is important to consider the process of training. Much of the material in the existing training manuals is dedicated to explaining their topics or content. The complexity of the skills involved in delivering DMH services

suggests that the best training must go beyond simply describing the array of disaster reactions, coping behaviors, and various methods of intervention. Two recent inquiries found that the majority of practitioners preferred to observe the demonstration of helping interventions. Allowing trainees to rehearse interventions and receive feedback is helpful in gaining mastery of essential helping skills. Videotapes can be used to enable trainees to see and hear disaster-related stories, survivor and responder reactions and coping efforts, and examples of helping behaviors. Using improvised vignettes, helping skills can be demonstrated with opportunities to practice them and receive performance feedback.

Time allotted for training: The amount of time allotted for training is determined by many variables, however, most training falls into 4, 8, 12, or 16-hour programs. Longer programs can utilize the extended time to create opportunities for planning, team building, networking among participants, role-playing, exercises, and demonstrations of helping behaviors.



Trainers: Generally speaking, most trainers are licensed mental health clinicians or administrators who have disaster experience that includes responding to a range of disasters (natural, human-caused, mass casualties) and communities (urban, rural, ethnic diversity). Exceptions to this rule are speakers who can address specific topics (e.g., resources, administrative methods, cultural characteristics of the community, spirituality, bereavement,



treatment modalities). The characteristics of an effective instructor include possessing good communication skills, in-depth knowledge of the subject, a positive attitude, patience and flexibility in responding to trainees' learning needs, and skills to manage the class and motivate trainees. In addition, having a conceptual and practiced understanding of the learning process is essential. From classroom setup to conducting a course, skills such as good climate setting, bridging ideas from one section of training to another, facilitating discussion, guiding student practice, clarifying, using interactive learning, and knowing current media presentation technology are important instructor qualities for achieving learning objectives.

Funding: Funding for DMH training may come from many sources, depending on whether the program is sponsored by a government, nonprofit, or private sector agency. Funding from the Federal Government is overseen primarily by the Federal Emergency Management Agency, the Substance Abuse and Mental Health Services Administration, and its Center for Mental Health Services, through various grant mechanisms. Nonprofit funding and private sector funding may involve pharmaceutical companies or local institutional support.

TRAINING CONSIDERATIONS

Simplicity of beholding: Whether we query DMH workers or read anecdotal accounts of their helping experiences (see the Summer 2006 issue of *The Dialogue*), we are often impressed with descriptions of the restorative power of simple attentive behaviors. Reflective listening and nonverbal behaviors such as degree of eye contact, touch, attentive silence, posture, and vocal tone, serve to increase survivors' sense of being understood, supported, and cared for, while reducing alienation that trauma may have caused. Another set of helpful behaviors commonly described by workers and trainers are those related to responding constructively to survivors' pragmatic needs. Such help may be in the form of arranging transportation, child care, obtaining needed supplies, locating missing persons, or help with obtaining food and clothing. These intervention behaviors are not typically addressed in graduate clinical training programs. Because all psychological care begins with physical care, addressing these behaviors is, however, a significant component of disaster mental health training.

Historically, the simplicity of these behavioral interventions has been met with resistance by mental health professionals holding preconceived ideas that DMH training is limited to

continued

differential diagnosis, screening tools, and clinical therapy options. If the shift to an outreach pragmatic-needs paradigm cannot be made, such trainees may be better suited for later-stage interventions.

The rejection of an outreach pragmatic-needs paradigm, has in some cases, led to dismissing the important role of paraprofessionals. Many paraprofessionals may arrive at a DMH training already possessing the set of attentive behaviors helpful to survivors. Many obviously learn how to respond appropriately and attentively. Given the shortage of prepared DMH workers in virtually every city and town in the United States, utilization of thoughtful, resourceful, simple care administered by professionals and paraprofessionals alike could ultimately account for a significant increase in the support received and valued by survivors.

Complexity of thought: Mathematician Leslie Lamport observed, "There is a race between the increasing complexity of the systems we build and our ability to develop intellectual tools for understanding that complexity." Under ordinary circumstances, human services are complex and challenging. Disasters are particularly characterized by multiple system failures that, in turn, create unmanageable problems. In the wake of disaster, there is always a sense of the race to understand

complexity. DMH training must take into account the complexity of service delivery within view of acutely activated and culturally diverse economic, political, and historical forces.

Training content is dependent on the unfolding disaster, and when, where, by whom, and to whom DMH services are delivered. In addition, comprehensive training must include instruction about navigational, engagement, screening and assessment, referral, and other intervention strategies that help the effort to respond to the needs of survivors of all ages (including emergency responders) who are seen either onsite or offsite at various points of time (ranging from hours to months after the event). In multicultural societies, ethnic diversity must be taken into account if mental health services are to be accepted and efficacious. Aggregate groups (e.g., families, communities, schools, and organizations) present unique system-level access, assessment, and intervention challenges that can be addressed in training. Pre-existing community conditions, resources, and history (e.g., political, economic, and cultural), pre-existing individual resources and history (e.g., mental health, medical, and economic), and the severity of the impact of the disaster on the community and helpers must also be taken into account to make post-disaster training relevant.

In the wake of disaster, there is always a sense of the race to understand complexity.

SUMMARY

Designing and implementing DMH training is shaped by several factors. This article describes guidelines related to seven specific factors, including the qualifications of trainers, and a belief in the inherent paradox involving DMH training related to simplicity and complexity. For greater detail and references, see: Young, B.H., Ruzek, J.I., Wong, M., Salzer, M., & Naturale, A. (2006). Disaster mental health training: Guidelines, considerations, and recommendations. In E.C. Ritchie, P.J. Watson, & M.J. Friedman (Eds.), *Interventions following mass violence and disasters*, (pp. 54-79). New York: Guilford Press.

This article was contributed by Bruce H. Young, LCSW, DMH educator and researcher, who provides DMH trainings for Federal, State, and nonprofit agencies both nationally and abroad. He works at the National Center for PTSD in Menlo Park, CA, and currently serves as expert-at-large for the California Disaster Mental Health Coalition.

Suicide and Other Trauma within Native American Communities

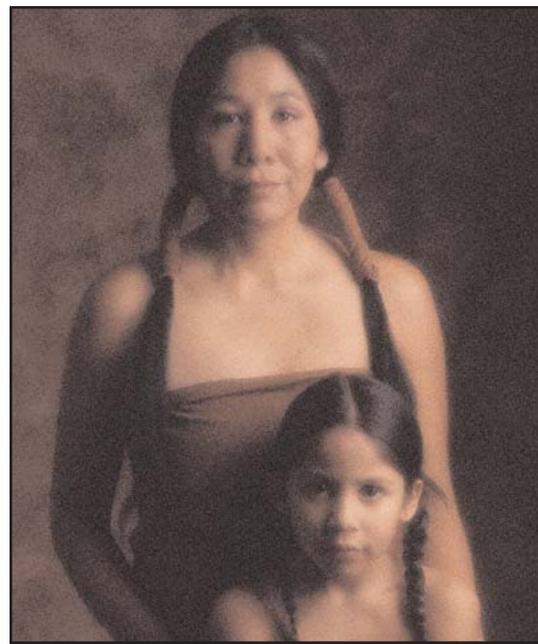
It is hard enough to imagine why one child would commit suicide, but when a younger sibling commits suicide on the anniversary of his brother's suicide, families are inconsolable. This is the sad tragedy repeated for many American Indian (AI) and Alaska Native (AN) families. AI/AN populations experience suicides at 7 times the rate of other racial groups, with the most at-risk population being ages 15–24 years. Typically, this is the time for planning one's life and preparing for a productive adulthood, not terminating all hope.

Parents and caregivers of AI/AN youth are often overwhelmed and do not understand the challenge when their children make the decision to end their lives. The personal turmoil of those youth is compounded by the environmental chaos that surrounds many AI/AN families and tribal communities.

Trauma has made many inroads within AI/AN families, tribes, and villages when one considers the historical markers that identify a tribal community today. The modern tribal community is identified by the physical boundaries that reduced tribes to confined locations and the emerging urban tribal communities created

with relocation programs. Alaskan villages are now permanent settlements when originally they were established as migration or hunting/fishing camps to take advantage of the multiple sources of food and subsistence.

A tribal community is also identified by the lengthy Federal and State regulations with parameters for who is Indian and who is not; and for what a tribe is and what it is not. These regulations create eligibility criteria for entitlements with limited funding often resulting in inadequate or ineffective services. A tribal community is further identified by the historical efforts of the Federal Government to address



the "Indian problem" by establishing programs to either eliminate or assimilate them: First by removing them from their historical homelands and introducing marriage, religion, and formal schooling; second by terminating treaties and undermining AI/AN traditional law and social order; and third by having tribes and villages assume the building of an economic infrastructure without funds or resources.

AI/AN populations have been described as being vulnerable and marginal due to the breakdown of cultural values and belief systems that historically were protective factors. Now the cultural values and belief systems have been almost decimated for many tribal communities. Tribes have not had the opportunity to build the infrastructure and resources to provide preventive care. They have been reduced to competing for Federal dollars in a shrinking funding pool with more families in need.

To compound the problem, there is unprecedented poverty among AI/AN children living in single-parent families. Analysis of the National Child Abuse and Neglect Data System data found higher rates of public assistance among AI/AN families compared to whites.

Poverty contributes to a number of less than desirable environmental conditions that create more stress and trauma. Chronic health problems plague AI/AN children who have 2.8 times the likelihood of developing diabetes than white children. The relationship between childhood obesity and diabetes has surfaced as one of the primary indicators of later health-related injuries and trauma.

It is very difficult for poor parents, and especially poor, single, Indian mothers, to provide the quality of care necessary to address the challenging health problems of AI/AN children. Poverty at this level can be debilitating. It affects the quantity and quality of food available to feed infants and children, leaving some malnourished. Malnutrition can lead to poor physical and brain development. As a result, AI/AN children are at risk for developmental delays due to the lack of adequate nutrition.

Another result of the social conditions in many tribal communities is a high incidence of violent crime. AI/AN women report more domestic violence than women from any other race. One study found AI/AN women were twice as likely to be abused (physically or sexually) by a partner as the average woman. The ability to maintain a healthy, productive life is seriously handicapped by stress and violence that is continuously experienced in the home. This

violence contributes to the major mental health problems seen in native youth and children, who often see suicide as a solution to end the violence.

Depression and substance abuse also occur at a high rate in tribal communities. The rates of depression among AI/AN children range from 10–30 percent, while the level of drug or substance abuse can be even higher. It is common for students enrolled in boarding schools to arrive directly from inpatient treatment facilities without benefit of followup care. In addition, children of substance abusing parents are at increased risk for injury due to car accidents, behavioral problems, and neglect, and are more likely to attempt/commit suicide and engage in personal substance abuse behaviors.

Suicide of AI/AN children and youth has been a continuous concern. In 1996, a survey of 13,000 AI/AN adolescents reported that 22 percent of females and 12 percent of males indicated having attempted suicide at some point. This is the highest rate of suicide in the 15–24 years age group for any U.S. population. This age group accounts for 64 percent of all AI/AN suicides. AI/AN males are 4 times more likely to commit suicide than other racial groups, and AI/AN females are 3 times more likely to attempt suicide than other racial groups.

AI/AN children are also victims of abuse and neglect more frequently than other children. In 2002, this is the only group to experience an increase in the rate of abuse or neglect of children under age 15. This is disconcerting when one realizes that AI/AN children make up only 1.2 percent of the U.S. child population. It is easy to understand why AI/AN children are vulnerable and lack resilience for other related traumas.

AI/AN children experience trauma in many ways. For example, AI/AN families lead the Nation in alcohol-related motor vehicle fatalities, in chronic liver disease and cirrhosis due to alcohol abuse, and in homicide. They also lead the Nation in deaths due to complications from diabetes such as infections and amputations.

The average rate of violent crimes that occur annually among AI/AN populations is more than 2.5 times the national rate for every other race or group in the United States. Tribes may be experiencing collective trauma and unresolved issues about survival and lack of power to make significant change. Collective trauma is common, and recent national events (Oklahoma City bombing, 9/11/2001 terrorist



attacks, Hurricane Katrina, floods, tornadoes, and wildfires) have demonstrated the effect of collective trauma on community members.

With this level of trauma, AI/AN children exposed to violence can have significant interference with their ability to develop normally. Traumatic stress can interrupt a native child's emotional development, disrupt normal brain development, and create the inability to respond appropriately in peer-to-peer or intimate relationships. Within the native community, relationships are critical. How one is recognized is based on relationships; to whom they are related, from what clan, band, or society their parents come, and with which home community they identify. Typically, one is not recognized by name but by their relationships or kinship ties to others in the community. In adulthood, these native children have difficulty forming positive relationships with others, and have confusing and explosive expectations about their roles as spouse and parent.

More AI/AN tribes are formally incorporating traditional native practices into the mental health delivery system (e.g., the use of the smudging ceremony can be described as a behavioral intervention). They are also focusing on strength-based principles such as connectivity to community and kinship ties, participation in community events, willingness

to commit to spiritual pledges, involvement in social or cultural circles (e.g., warrior society, dance troupe), and community readiness to address concerns of children and youth. Suicide and other traumas are being understood as interrelated and not isolated events. Tribes and native villages, families, and communities are making the commitment to better serve their children.

CIRCLES OF CARE INITIATIVE

The Circles of Care (CoC) initiative is a program that is funded by SAMHSA's Center for Mental Health Services (CMHS). This program supports AI/AN communities that are developing initial health service programs for children with serious emotional and behavioral disturbances. The story of the CoC initiative is one that demonstrates the power of thoughtful collaboration for addressing critical health policy issues. Under CoC, CMHS, the Indian Health Service, the National Institute of Mental Health, and the Office of Juvenile Justice and Delinquency Prevention in the U.S. Department of Justice, have provided critical funding and technical assistance to federally recognized tribes and urban AI/AN communities to plan, design, and assess the feasibility of a culturally respectful mental health system of care for their children and families. The initiative represents the collective vision of a large

Suicide and Suicide Prevention

For more information on suicide and suicide prevention, please visit the following Web sites:

- >> The National Suicide Prevention Lifeline is a 24-hour, toll-free suicide prevention service available to anyone in suicidal crisis. <http://www.suicidepreventionlifeline.org>.
- >> The Suicide Prevention Resource Center (SPRC) provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions, and policies, and to advance the National Strategy for Suicide Prevention (NSSP). <http://www.sprc.org>.
- >> NSSP represents the combined work of advocates, clinicians, researchers and survivors around the Nation. It lays out a framework for action to prevent suicide and guides development of an array of services and programs that must be developed. It is designed to be a catalyst for social change with the power to transform attitudes, policies, and services. <http://www.mentalhealth.samhsa.gov/suicideprevention>.

number of AI/AN tribal members, service providers, advocates, researchers, and Federal agency representatives who met as an advisory board regarding potential initiatives to address the unique mental health needs of AI/AN children, adolescents, and their families.

In line with priorities and objectives of the President's New Freedom Commission on Mental Health, the CoC initiative seeks to reduce mental health disparities and increase the cultural competence and effectiveness of systems of care for AI/AN children and families. The initiative bridges the gap from science to service by utilizing a community-based effort that identifies community needs, barriers to accessing services, service system gaps, local protocols for the inclusion of traditional healing, and potential community and outside resources available to address mental health needs.

INDIAN COUNTRY CHILD TRAUMA CENTER

The Indian Country Child Trauma Center (ICCTC) at the Center on Child Abuse and Neglect, University of Oklahoma Health Sciences Center, was established to develop and disseminate evidence-based treatment approaches that are culturally modified for native children who have experienced traumatic events. ICCTC has a nationwide focus that encourages partnerships among the more than

600 tribes, villages, and programs in the continental United States.

The ICCTC is a National Child Traumatic Stress Network Level II Center designed to develop interventions appropriate to AI country. The overall goal of the ICCTC is to develop, refine, disseminate, and evaluate trauma-relevant intervention models and protocols for use with AI children. Currently, there are no well-supported or rigorously evaluated protocols designed specifically for native children with trauma-related disorders and problems. There are no known treatment approaches that are evidence-based and specifically designed for AI/AN children who experience trauma.

ICCTC has identified a set of empirically supported intervention models, and has built on the foundation of native traditional teachings and practices to develop training manuals for the three evidence-based approaches: 1) parent child interaction therapy; 2) cognitive-behavioral treatment for children with sexual behavior problems; and 3) trauma-focused cognitive behavioral therapy. Recent research has focused on strength-based interventions for AI/AN communities. The benefit of the three evidence-based approaches selected by ICCTC is that they can incorporate the strength-based concepts such as relationship building, cultural identity, and other values. The life skills development

curriculum, which was developed specifically for ICCTC to build on the strength-based and life skills development of assertive and appropriate social interaction, is also being used.

ICCTC is using evidence-based models of treatment that are integrated with traditional native practices. Cultural appropriateness and competency are the foundation for the interventions. Addressing local or tribal beliefs or practices is critical because of the wide range of diversity among tribes. Modifications to the interventions explore the meaning of words and practices for treatment, recognizing that clinical treatment of trauma-related disorders may prove more sensitive.

Treatment of AI/AN children with mental health disorders is more than a shift in clinical approaches. Developing trauma-focused treatment for suicide and other tragedies involves focus on family trauma, family violence, community violence, and community readiness and healing. All therapeutic offerings should include a focus on family and community healing practices.

This article was contributed by Dolores Subia BigFoot, Ph.D., codirector of the Indian Country Child Trauma Center and assistant professor of pediatrics at the University of Oklahoma Health Sciences Center.

Basic Crisis Counseling Grant Program Course

The Basic Crisis Counseling Grant Program Course was held August 14–17, 2006, at the Emergency Management Institute (EMI) in Emmitsburg, MD. The course was designed to prepare State mental health authorities (SMHAs) to apply for Federal Emergency Management Agency (FEMA) Crisis Counseling Assistance and Training Program (CCP) grant funding and to administer a program following major disasters. Representatives from 27 States and three U.S. Territories attended the training conducted by SAMHSA, FEMA, and SAMHSA Disaster Technical Assistance Center (DTAC) staff.

Prior to the training, attendees completed an online pretraining. The pretraining provided an introduction to disasters and to CCP. This served to familiarize attendees with disaster mental health so that more advanced topics could be presented at the full training course. On the first day of the training, a Jeopardy-style quiz was used as a fun way to review the material covered in the pretraining.

Topics presented in the full training included disasters and a CCP, assessing the need for a CCP, the Immediate Services Program (ISP),

writing the ISP application, the Regular Services Program (RSP), evaluation, and closing down a CCP. It was decided early on that this training would be less didactic than trainings in the past. To achieve this goal, trainers facilitated numerous group activities and discussion sessions. A model disaster scenario featuring the fictional state of Minnark was used to allow attendees to work through the process of writing an ISP application for a developing disaster situation. Feedback from participants indicated that these activities were helpful and also encouraged networking between training attendees. On the last day of the training a final exam was administered. This exam not only provided information on how well the attendees learned the information presented, but also told trainers how well they completed their task of teaching the course. Final exam results were strong and the evaluations of the training completed by attendees were generally quite positive.



SAMHSA's Special Recognition Awards Ceremony

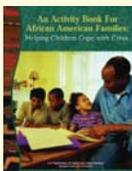
August 1, 2006, Charles G. Curie, SAMHSA's outgoing Administrator took time to recognize SAMHSA employees for their commitment and dedication to their work. In his remarks, he praised everyone at SAMHSA for their commitment to the health, well-being, and recovery of people who are working to overcome a mental illness and the dedication to preventing addiction and promoting mental health. Of special note was SAMHSA's response to the 2005 hurricanes and the outstanding work of agency personnel who served as part of SAMHSA's Emergency Response Center.

Mr. Curie also highlighted SAMHSA's accomplishments such as the President's Access to Recovery Initiative and the Strategic Prevention Framework. Mr. Curie asked all SAMHSA employees present at the ceremony to stand and be acknowledged for their contribution to the vision and mission of SAMHSA working to fulfill the promise of "A Life in the Community for Everyone."

A plaque commemorating the event and honoring the employees is on display at SAMHSA headquarters in Rockville, MD.

Recommended Reading

RESOURCES FOR CHILDREN AND FAMILIES

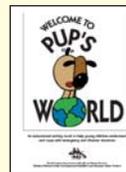


AN ACTIVITY BOOK FOR AFRICAN AMERICAN FAMILIES: HELPING CHILDREN COPE WITH CRISIS

This 90-page activity guide was developed by the National Black Child Development Institute and the National Institute of Child Health and Human Development, in collaboration with the Academy for Educational Development and other organizations serving the African-American community. The bulk of the guide is divided into sections with titles such as "Inspire Hope in Your Child," "Help Your Child Feel Safe," and "Share Your Faith with Your Child." Each section includes the following:

- >> A section heading listing one simple thing a parent can do to help his or her child.
- >> An explanation of the goals and purpose of the activities included in that section.
- >> An affirmation drawn from African and African-American quotations and proverbs.
- >> Several different activities focusing on a poem, an art project, a song or music, or a craft.
- >> A brief discussion of things to remember while doing the activities.
- >> A "Note to Parents" with facts or information that they can use during the activity.
- >> A "Did You Know?" section with additional information on a topic included in one of the activities.

Electronic copies of this resource may be downloaded at http://www.nichd.nih.gov/publications/pubs_details.cfm?from=&pubs_id=286. Hardcopies may be ordered at no cost by calling 1-800-370-2943 and asking for publication number 03-5362B.



WELCOME TO PUP'S WORLD!

This book and activity guide was created by the North Carolina Department of Health and Human Services, through a grant from SAMHSA. In the story, the character Pup experiences a tornado and learns about the people who are there to keep her safe. Welcome to Pup's World was written for children ages 6–9 years and contains activities to help them cope with the emotional aftermath of major disasters, as well as learn about emergency preparedness. The introduction has a section for parents and caregivers that details some common emotional reactions experienced by children after a disaster, and identifies specific actions adults can take to help them cope. This publication is also available in Spanish. English electronic copies may be downloaded at <http://www.dhhs.state.nc.us/mhddsas/disasterpreparedness/pupsworld-total.pdf>.

Spanish electronic copies may be downloaded at <http://www.dhhs.state.nc.us/mhddsas/disasterpreparedness/pupsworld-total-spanish.pdf>.



HOW ARE WE NOW? PROMOTING CONTINUED HEALING FOR OUR CHILDREN

This resource guide and activity book for parents, professionals, and paraprofessionals was developed as a collaborative effort by JPMorgan Chase, Bright Horizons Family Solutions, and Mercy Corps in response to the 9/11/2001 terrorist attacks. Some features include a lengthy section on children's reactions to traumatic anniversaries, kid-friendly activities designed to promote coping skills and cultural understanding, self-care suggestions for parents and caregivers, and recommendations for children's books dealing with various topics including feelings, respect, and multicultural issues. Electronic copies may be downloaded at <http://www.mercy corps.org/topics/children/1048>.

Upcoming Meetings

NATIONAL CONFERENCE ON DISASTER PLANNING FOR THE CARLESS SOCIETY

FEBRUARY 8–9, 2007
NEW ORLEANS

Hurricanes Katrina and Rita revealed how vulnerable carless residents are in emergency situations. Evacuation plans in most major cities across America fail to adequately take into account the needs of older adults, people with disabilities, and transit-dependent populations. This conference, sponsored by the University of New Orleans Transportation Center, the New Orleans Regional Planning Commission, and the Regional Transit Authority, will bring together government officials, professionals, and experts to discuss how to better prepare to help those who most need it. For more information, go to <http://www.carlessevacuation.org>.

28TH ANNUAL INTERNATIONAL DISASTER MANAGEMENT CONFERENCE

FEBRUARY 8–11, 2007
ORLANDO, FL

Presented by the Emergency Medicine Learning and Resource Center (EMLRC), this conference is designed to meet the educational needs of individuals and agencies involved with emergency preparedness, response, and disaster recovery. Highlights include lessons learned from recent disasters, disaster response strategies and tactics, medical and public health disaster management, and terrorism response strategies and tactics. For more information, go to <http://www.emlrc.org/disaster2007.htm>.

AMERICAN COUNSELING ASSOCIATION 2007 ANNUAL CONVENTION

MARCH 21–25, 2007
DETROIT

The American Counseling Association 2007 Annual Convention will include sessions on substance abuse, grief work, and volunteering for major national disasters. Preconvention learning institutes are scheduled for Wednesday and Thursday, March 21 and 22 and education

sessions will take place Friday through Sunday, March 23–25. The exposition hall will be open Friday and Saturday, March 23 and 24. For more information, go to <http://www.counseling.org/convention>.

DISASTER RECOVERY JOURNAL'S SPRING WORLD 2007

MARCH 25–28, 2007
ORLANDO, FL

This conference will focus on all aspects of disaster recovery, contingency planning, and business continuity. Attendees will gain knowledge and information through sessions, workshops, exercises, and networking opportunities. An exhibit hall will showcase the latest products and services in the industry. For more information, go to <http://www.drj.com/conferences/orl2007>.

16TH NATIONAL CONFERENCE ON CHILD ABUSE AND NEGLECT

APRIL 16–21, 2007

PORTLAND, OR

The American Psychological Association (APA) will cosponsor the Federal Office on Child Abuse and Neglect's 16th National Conference on Child Abuse and Neglect. This meeting is the only national conference devoted to issues of child abuse and neglect and brings together more than 2,000 practitioners, policy makers, community organizers, and researchers for a week of plenary, workshop, and skill-building sessions. More information will be posted closer to the conference date at <http://www.childwelfare.gov/calendar/cbconference/>.

SIXTH UCLA CONFERENCE ON PUBLIC HEALTH AND DISASTERS

MAY 6–9, 2007

TORRANCE, CA

The University of California, Los Angeles (UCLA) Center for Public Health and Disasters (CPHD) will host this multidisciplinary conference that brings together academicians, researchers, practitioners, and policy makers from public health, mental health, community disaster preparedness and response, social sciences, government, media, and nongovernmental organizations to address the public health consequences of natural and human-caused disasters. For more information, go to <http://www.cphd.ucla.edu>.

SAMHSA DTAC Launches Discussion Board

A new interactive communication tool is now available to disaster mental health coordinators, disaster substance abuse coordinators, Crisis Counseling Assistance and Training Program (CCP) directors and managers, and other disaster behavioral health professionals. SAMHSA DTAC designed the discussion board to generate discussion and facilitate knowledge transfer among those in the disaster behavioral health field. Two of the main forums are as follows:

- >> Active CCP programs.
- >> Disaster behavioral health preparedness and response.

A new forum on pandemic flu is the latest addition to the topics for discussion.

If you would like to join the discussion board, or you would like to suggest one of your colleagues for inclusion, please send an e-mail with a brief justification to dtac@esi-dc.com.

If you already belong to the discussion board, please visit it often to post your resources and questions. For technical issues or to suggest a new forum area for posting, please contact Leisel Bucheit, SAMHSA DTAC information systems manager, at 1-800-308-3515 or leiselb@esi-dc.com.

We hope that you find this new tool useful, and we look forward to your participation!

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.