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The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER BEHAVIORAL HEALTH

ASK THE FIELD

The Dialogue: Social networking sites, such as Facebook and MySpace, are popular ways of creating online communities. How have such sites been used to increase the effectiveness of outreach and support efforts in crisis counseling, especially in rural and hard-to-reach communities?

Contributor is listed at the end of this article:
In July 2007, Kansas was hit by severe storms, tornadoes, and flooding. These events created many unique target populations including the difficult-to-reach adolescent population. Factors that made outreach more difficult were inherent adolescent resistance to assistance and lack of community gatherings targeted at the adolescent population. Kansas Assisting Recovery Efforts (Project KARE-2) attempted to reach high school students by attending parent-teacher conferences, setting up presentations with the schools, attending community events where adolescents might be present, and stopping by local eating establishments during the evening hours when adolescents might be hanging out or working. These attempts were minimally successful, but Project KARE-2 continued to explore alternative outreach strategies to ensure that this population of survivors did not go unassisted.

One specific strategy included the creation of MySpace and Facebook pages on the Internet. MySpace and Facebook are networking Web sites that allow people, groups, and organizations to establish and maintain contact. These two Internet sites are particularly popular among adolescents and young adults. Project KARE-2 was hopeful that the utilization of these sites would allow for increased outreach to the adolescent population. At the very least, these Web pages could promote KARE-2 and provide educational information to this population. With this goal in mind, Project KARE-2 created a Facebook page.

The Facebook page came equipped with basic features. It contained pictures and information about Project KARE-2. The pictures reflected not only the devastation these communities suffered, but also the reconstruction that Project KARE-2 continues to see. The information included KARE-2 services,

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educational links, upcoming outreach activities, and a link to the official Web site.

MySpace and Facebook profiles are a cost-free way of effectively reaching the adolescent populations in rural communities. Unlike other Web sites, there are no setup or maintenance fees that would affect the project's budget. The Facebook account was especially valuable in providing educational information and allowing users to express feelings and concerns about their experiences with the flooding. It also allowed adolescents to express themselves in a way that was acceptable to this age group.

Approximately 30 people joined the Project KARE-2 group on Facebook. However, the page was open to public viewing so anyone could access the information. Some recommendations for future Crisis Counseling Assistance and Training Programs (CCPs) include starting the site as soon as possible after the disaster to reach as many people as possible, and expanding the reach of the program by joining other disaster-related pages or groups that are generated through social networking. Including the Facebook profile and Web site address on educational materials is also a good idea, especially when materials are targeted to schools and youth groups.

This submission was contributed by Carolyn Denney, Team Leader, Project KARE-2 CCP.

Redefining the Target

The Mercy Model: A Leadership Approach to Public Mental Health Systems and Population-Based Programs

Following major disasters, the existing public health infrastructure is often fragmented or completely destroyed, as was evident following the Indian Ocean Tsunami of 2004 and Hurricane Katrina in 2005. In an effort to address this fragmentation, and based on previous experience working with the United Nations Children's Fund, the U.S. Agency for International Development, Louisiana Department of Education, and Texas A&M Health Science Center developed and implemented what is known as the Mercy Model. The Mercy Model is a method or set of precepts describing the facilitation, organization, and leadership of systems following a disaster. At its most basic level, the Mercy Model represents a public health leadership approach. This paradigm is characterized by a collaborative style, attitude, and set of knowledge that guides efforts to create international and domestic teams that facilitate biopsychosocial recovery programs.

Relief personnel face operational environments that vary in nature, severity, and complexity. The basic Mercy Model approach has shown its effectiveness by supporting relief leadership and maximizing available resources in a post-disaster environment. For example, it was used to provide psycho-educational services for more than 200,000 school children in Banda Aceh, Indonesia, and 150,000 students in the Louisiana Unified School District. The Mercy Model helps mobilize systems far larger than the coordinating team to create large-scale, system-level, and population-based recovery programs. By using this model, relief personnel learned to effectively broaden their view of potential targets from beyond that of the individual disaster victim to the systems and populations affected by the disaster.

The Mercy Model promotes methods and strategies to work in a disaster response environment where responders neither completely control nor have the resources to affect unilateral systems rehabilitation. Instead, the strategy in such cases is to increase response impact through effectively collaborating with other agencies, nongovernmental organizations (NGOs), international organizations, and nations. By targeting systems and population effects, the Mercy Model shifts the familiar "individual as patient" paradigm to a "system as patient" paradigm.

Photo courtesy of FEMA Photo Library

Systemic interventions include the following:

- Rapidly assessing systems to identify needs, strengths, resources, potential to increase capacity, and sustainability of any increased capacity
- Continuously conducting target analysis and strategic target development to ensure optimal matching of limited resources to the highest-value targets
- Addressing public health and system-level interventions
- Providing essential health system leadership
- Seeking and promoting collaborative, coordinated responses instead of unilateral action

In Indonesia, the Mercy Model was used to help coordinate relief agencies and the Indonesian government's disaster relief effort to provide

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specific infrastructure and program support for children's services. Through this effort, an array of population-based services was created during the post-tsunami relief environment that was eventually delivered to all 200,000 school-aged children in Aceh Province. Equally important, the approach taught local agencies methods to independently develop and deliver their own programs without outside support.

The Mercy Model is composed of 10 precepts that guide leaders toward successful systemic change that provides the necessary foundation for evidence-based interventions to be maximized. The 10 precepts are as follows:

1. Define the role as supportive. System-level disaster responders are interested only in enhancing capacity. Begin with experiencing the world through the eyes of those who have been affected by the disaster.
2. Motivate and encourage staff to maximize their dedication and discipline. Integrate and foster relationships with key staff while deferring to the wisdom and direction of the host nation. Obtain official invitation from the host nation to function as peers on the same team to identify goals.
3. Develop a working knowledge of the organizational structure of the host nation. Learn its political, organizational, and cultural history.
4. Study and assimilate, to the extent possible, the organizational culture recognizing system strengths and weaknesses, and identifying key personnel and organizations.
5. Observe the management style of the existing organization, and evaluate the impact of its efforts on the overall goal.
6. Frame the relationships of the various agencies as integral to a successful effort.
7. Guide all partners into a long term view of future capacity in terms of their current assets. Develop a vision that is community focused and wellness-based.
8. Refocus from long-term vision into immediate needs. Guide all partners to accept that immediate solutions must be designed to contribute to the long-term vision and larger system.
9. Guide leaders to practice coordination, cooperation, and communication essential to reaching their common goal, and encourage coordinated efforts.
10. Promise only what can be delivered.

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In the post-Katrina recovery efforts, the Mercy Model was used to help the Louisiana Department of Education regain its operational footing and create a statewide system of behavioral health interventions for students and families affected by the hurricane. In Indonesia, the process from initial conception to implementation was completed in just 9 days. In Louisiana, it took 12 days. There were seven personnel assigned to population-based operations in Indonesia and four assigned to the Louisiana Department of Education.

Most recently, the Mercy Model was used to assist the Afghanistan Ministry of Public Health in developing its national mental health strategy. Developing it required working with the Ministry and more than 30 donor nations, international organizations, and NGOs to craft a vision for national services, as well as the means and methods to achieve it. The Afghan-U.S. team worked collectively to successfully articulate and begin developing services for the country.

The Mercy Model has been applied nationally and internationally in times of disaster and humanitarian crisis. In the summer of 2007, the U.S. Public Health Service, Office of Force Readiness and Deployment (OFRD) conducted a field training exercise that included the Mercy Model as one of its training presentations. Subsequently, OFRD has used the model as part of its training for health diplomacy missions in South America and Asia. Currently, an application of the Mercy Model is being explored to support the prevention of violence, particularly in a community disproportionately affected by suicide. Continued use of the Mercy Model in future disasters and crises will allow for increased cooperation and response capacity among relief personnel and national governments.

This article was contributed by LCDR Jeff Coady, Psy.D., Deputy Team Leader for the U. S. Public Health Service Disaster Mental Health Team II; CAPT Kevin McGuinness, Ph.D., Team Leader for the U.S. Public Health Service Disaster Mental Health Team IV; and CAPT Jon Perez, Ph.D., National Behavioral Health Consultant for the Indian Health Service, as well as Team Leader for the U.S. Public Health Service Disaster Mental Health Team II.

Photo courtesy of FEMA Photo Library

Disaster Planning and Opioid Treatment Programs

Among the many types of healthcare delivery organizations affected by disasters are substance abuse treatment programs. In 2007, more than 13,000 facilities provided drug abuse treatment to more than 1 million patients on any given day. There are three primary types of drug abuse treatment: residential/inpatient, outpatient drug-free, and outpatient medication-assisted treatment. Disaster planning is important for all three modalities, although each is likely to give rise to particular disaster-related issues.

Of the three main treatment modalities, medication-assisted treatment, in particular methadone maintenance treatment, is especially vulnerable to disaster-related service disruptions. Methadone is the most widely used but not the only type of medication used to treat opiate addiction. Two other medications used are buprenorphine and 1-alpha-acetylmethadol (LAAM).

Methadone maintenance involves the use of methadone medication, typically in conjunction with counseling and other services, to treat people who are addicted to heroin and other opiates. In 2007, there were more than 1,000 opioid treatment programs (OTPs) providing methadone treatment in the United States. The States with the largest number of OTPs are New York (162), California (154), Texas (74), and Illinois (60), all of which also are among the top 10 in terms of the total number of declared disasters by State.

Two factors make disaster planning for OTPs especially problematic. First, as a result of the historical circumstances from which it has evolved, methadone maintenance treatment is subject to strict Federal and State regulations that do not generally apply to other forms of substance abuse treatment. Medication is generally dispensed to patients through a closed, clinic-based system, and limitations are placed on the amount of medication that patients are eligible to take away from the clinic. Second, lack of patient access to medication results in the rapid onset of aversive withdrawal symptoms and may lead to drug use relapse and associated high-risk behaviors. A further complicating factor is that notwithstanding the substantial scientific evidence regarding the effectiveness of methadone treatment OTPs are regarded with stigma in some communities, which may inhibit their inclusion in community-wide disaster planning efforts.

Photo courtesy of FEMA Photo Library

The issue of disaster planning for methadone treatment programs is not a topic that has been well studied. The issue first became a subject of research after the terrorist attacks of September 11, 2001, because of the large number of methadone treatment programs in New York City, several of which were in close proximity to the World Trade Center. Hurricane Katrina, which resulted in the closure of seven clinics serving more than 1,000 patients in New Orleans alone, stimulated further attention.

To further understand the types of disaster-related problems OTPs face, and the status of disaster planning within the methadone treatment system, the University of California, Los Angeles (UCLA) Integrated Substance Abuse Programs is conducting a study of the methadone programs in the five gulf coast States: Alabama, Florida,

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Louisiana, Mississippi, and Texas. The primary focus of the study is on the direct and indirect effects of hurricanes, but the project is also interested in other types of disasters. The study is being conducted by Deborah Podus, Ph.D.; Jane Maxwell, Ph.D.; and M. Douglas Anglin, and is funded by grants from the National Institute on Drug Abuse and the Robert Wood Johnson Foundation's Substance Abuse Policy Research Program.

The first component of the UCLA OTP disaster study involved a self-administered survey of OTPs in the region to obtain information on organizational characteristics, disaster-related program impacts, disaster planning, sources of information on disaster planning, and other topics. Subsequent stages of the project, which are ongoing, involve more indepth interviews with a subset of treatment programs and interviews with State and Federal regulators. Of the 141 OTPs identified from lists maintained by Federal and State regulators, 64 percent (90 of 141) of the programs contacted responded to the survey. Participating programs were located in 45 counties/parishes across the five-State area.

Preliminary analysis of survey data indicates that OTPs are highly vulnerable to the direct and indirect effects of seasonal hurricanes. Of those that responded to the survey, 39.3 percent reported having structural or infrastructural (e.g., electrical, Internet, telephone) problems due to at least one of the eight major hurricanes that struck the gulf coast during the 2004 and 2005 hurricane seasons (i.e., Charley, Frances, Ivan, Jeanne, Dennis, Katrina, Rita, and Wilma). An even greater percentage, 65.2 percent, reported one or more service delivery problems due to the eight storms. Approximately 25 percent of the programs indicated that officials in their county/parish have urged a voluntary or mandatory evacuation due to a hurricane in the last 5 years.

However, major hurricanes were not the only types of disaster-related problems that programs faced. When all types of disasters and emergencies are considered, 73 percent of the OTPs reported at least one disaster-related infrastructural problem and 76.4 percent reported one service delivery problem. Apart from hurricanes, other reported causes of significant treatment disruptions included other weather-related events (e.g., ice storms, rain, snow) and technological problems such as power outages.

Disasters have significantly impacted OTPs in a variety of ways. Survey respondents were asked to indicate whether they had experienced any of 8 structural/infrastructural problems and 10 service delivery problems as a result of hurricanes or other disasters. The four most frequent structural/infrastructural problems were power outages (62.9 percent), disrupted Internet access (55.1 percent), disrupted landline or mobile phone service (53.9 percent), and transportation problems making travel to the clinic difficult (52.8 percent). The four most frequently reported service delivery problems were problems verifying dosage information for displaced guest patients (59.6 percent), an influx of displaced guest patients (53.9 percent), the need to maintain extended clinic hours (44.9 percent), and a shortage of treatment staff (28.1 percent).

With respect to efforts to mitigate disaster-related impacts, all participating OTPs reported that

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they had a disaster plan, and most reported that they participate in exercises or mock runs of their plan. However, when it comes to interacting with other agencies in the community for purposes of disaster response, the data suggest that clinics are not well integrated. For example, only 16.9 percent of OTPs reported that they have partnered with another agency for purposes of an exercise, and less than 30 percent of OTPs report knowing "a good deal" about how local government and community agencies, such as mental health, law enforcement, emergency management, or the American Red Cross, would handle circumstances related to a natural disaster in their areas. In addition, when asked if they thought it likely that their OTP would receive the help it needed from city and/or county or parish agencies in the event of a disaster, only 39.3 percent reported that they thought it likely, 24.7 percent reported that they thought it unlikely, 4.5 percent expressly stated they did not know, and 31.5 percent left the open-ended question blank suggesting that they also were uncertain. Further complicating the integration of OTPs into local disaster planning efforts is the fact that in many OTPs the most common way staff update their knowledge about disaster planning is through informal conversation.

These preliminary findings so far indicate that methadone treatment programs in the gulf coast States are extremely vulnerable to the direct and indirect effects of hurricanes and other disasters. To the extent that many of the problems resulting from hurricanes also result from other types of severe weather events, these findings are probably also applicable to OTPs in other geographical areas. The survey indicates that in this high-risk region of the country, OTPs have taken some measures to mitigate the impact of disasters on their ability to deliver essential services, but many clinics do not appear to be able to draw on local resources to help support them in such an event. While greater initiative on the part of OTPs to update their knowledge of disaster planning is needed, increased effort and support by disaster planners to take into account the particular needs of this population and to assist programs in improving OTP planning and preparedness would also assist the ability of the treatment system to be more responsive to patient needs.

This article was contributed by Deborah Podus, Ph.D., Associate Research Sociologist, University of California, Los Angeles, Integrated Substance Abuse Programs.

Psychological First Aid Utilization by Health Systems

The National Child Traumatic Stress Network (NCTSN) Trauma Treatment Development Center of North Shore/Long Island Jewish (LIJ) Health System has developed an application guide and accompanying toolkit to facilitate the utilization of psychological first aid (PFA) by health systems during disaster preparedness exercises and following mass-casualty events.

After disasters and other mass-casualty events, hospitals and health systems (which include more than one hospital/facility) provide immediate and anticipated emergency medical care including necessary prophylactic medication. Health system disaster response systems require cooperation within and between departments of local, regional, State, and Federal agencies involved in disaster relief. Post-disaster health system services focus primarily on provision of urgent physical health care for survivors. Post-disaster planning and implementation of health system behavioral/mental health response services for survivors and employees and their families have not been developed to the same extent as the physical health services.

Health systems have regular disaster response preparedness exercises. However, these exercises often do not include provision of a systematic acute behavioral health intervention for support of survivors or for hospital personnel. This is an important unmet need. This will require that behavioral health disaster response teams are developed and trained in PFA within hospital settings, and that they are deployed during disaster preparedness exercises.

During planning for post-disaster PFA provision by health systems, understanding is needed of health systems' roles within wider disaster response communities as designated by the federally mandated National Incident Management System (NIMS). Health system utilization of PFA post-disaster behavioral/mental health intervention response teams also will require that they have been integrated within health system Hospital Incident Command Structure (HICS). These PFA provider teams may include staff members of emergency medicine, psychiatry, psychology, pediatrics, geriatrics, social work, nursing, chaplaincy, and other departments. There are no national standardized protocols for the development and deployment of health system post-disaster behavioral/mental health intervention teams. Health system disaster response team leaders will need to assign specific roles and responsibilities to PFA provider team members that may include designating them as mental health unit leaders (officers), mental health site leaders (officers), PFA providers, and runners (sometimes referred to as support staff).

The goals of health system PFA implementation by behavioral health teams include the following:

- Reduction of initial distress following traumatic events to survivors and their families, hospital personnel, first responders, and other disaster relief workers and their families
- Fostering of adaptive functioning and coping of survivors and their families, hospital personnel, first responders, and other disaster relief workers and their families
- Facilitation of continuity in disaster-response efforts by linking survivors to other community recovery support systems and referring them to needed health system physical and behavioral/mental health services
- Improvement of the ability of nonbehavioral/mental health disaster responders to attend to the urgent healthcare and other needs of survivors

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Sites for PFA provision within a health system: behavioral/mental health disaster response PFA providers are most likely to be deployed to the following health system service sites following disasters:

- Family reception centers
- Medication points of dispensing (PODs)
- Decontamination centers
- Special-needs shelters for people (care cannot be provided in standard shelters)
- Inpatient units (e.g., psychiatric, extended geriatric care, pediatric)
- Outpatient units (e.g., psychiatric, extended geriatric care, pediatric)
- Post-mortem identification/morgue sites
- Field hospitals and medical triage areas
- Staging areas or respite centers for disaster relief workers
- Emergency operations centers
- Emergency departments

HEALTH SYSTEM DISASTER PREPAREDNESS EXERCISES

All health systems conduct frequent disaster preparedness exercises. PFA may be utilized during the following preparedness exercises and scenarios:

- Tabletop exercises that allow health systems to practice their responses in a simulated situation with participants reviewing and discussing their post-disaster roles and responsibilities
- Functional exercises that realistically simulate disasters without moving people or equipment to real sites (e.g., Greater New York Hospital Association, http://www.gnyha.org/eprc/general/drills_exercises)
- Full-scale/field exercises that test the mobilization of all or as many as possible of the response components, take place in real time, employ real equipment, and test several emergency functions (e.g., Greater New York Hospital Association, http://www.gnyha.org/eprc/general/drills_exercises)

The most common scenarios played out during health system exercises in which PFA may be utilized are the following:

- Patient influx (surge capacity) exercises to assess ability to handle a rapid influx of patients
- Special needs shelters, often set up in collaboration with local health departments, to assess the ability to serve groups such as frail older adults who require ongoing medical care, people with severe mental illnesses, people with disabilities, and mothers with infants who require care that cannot be provided in standard shelters
- Evacuation/relocation exercises to assess the safe evacuation and relocation of patients
- POD exercises to assess the ability to quickly and effectively distribute medication to large numbers of community members and/or healthcare facility staff members
- Decontamination (DECON) exercises to assess the ability to reduce and/or remove the threat of injury due to contaminant exposure by healthcare facility staff and/or community members
- Family reception center exercises to assess the ability to address the needs of patients' family members
- Pandemic influenza exercises to assess the ability to exercise required altered or crisis standards of care (http://www.ahrq.gov/research/altstand/ altstandsum.htm)

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PILOT PFA EXERCISE

The North Shore/LIJ Health System's NCTSN Trauma Treatment Development Center provided PFA, as a pilot effort, during a North Shore University Hospital Manhasset POD exercise of the provision of prophylaxis to hospital employees and their families following a release of a biological agent during a terrorist attack. This prophylaxis would be required after an actual disaster before employees could begin their disaster-response activities. In addition to the health system POD team, eight center employees participated in the exercise: five PFA providers, two evaluators (who observed some PFA interactions), and one mental health team leader. Eight volunteer actors performed brief vignettes developed by the NCTSN Center that described hypothetical employees with negative psychological responses to the disaster and/or POD experience. All health system POD team members were informed how to call upon PFA providers for assistance, if necessary.

Photo courtesy of FEMA Photo Library

Following each utilization of PFA, providers and recipients (and observers) completed evaluations of the effectiveness of the PFA core actions provided. Although the numbers of participants in various data analyses were small, the data indicated that, on average, seven of the eight core actions were provided during each PFA session, and the average effectiveness rating for a core action was 3.89 (3=moderately effective and 4=mostly effective). Anecdotal evidence suggested that health system employees participating in the exercise as disaster responders viewed the presence and actions of the PFA providers overwhelmingly favorably and as the POD exercise continued, their requests for PFA provision increased.

CHALLENGES IN IMPLEMENTING PFA IN HEALTH SYSTEMS

The majority of PFA providers within a health system will be behavioral health professionals. However, emergency operations management of health systems after a disaster is usually led by nonbehavioral/mental health professionals, and PFA providers will need to function within those teams. Therefore, interdepartmental collaboration, which includes behavioral/mental health departments, and administrative understanding of the disaster response roles and expertise of different departments, are essential to health system PFA provision. Since health system disaster preparedness exercises often take place during weekends, behavioral health PFA providers willing and authorized to work on weekends will be needed. Health systems also will need support for the training, implementation, and evaluation of PFA disaster response utilization. An additional challenge is that funding resources for health system disaster response planning and implementation have not traditionally focused on increasing behavioral health response capacity.

For more information on the PFA Health System Application Guide and the accompanying Toolkit, contact Tammy Blancher, Ph.D., at tblancher@nshs.edu or 516-562-3262.

This article was contributed by Sandra Kaplan, M.D.; Tammy Blancher, Ph.D.; Suzanne Sunday, Ph.D.; and Ayme Turnbull, Psy.D., Adolescent Trauma Treatment Development Center, North Shore/LIJ Health System.

Special Feature

Psychology Beyond Borders

In 2004, an international assembly convened 90 experts working in fields related to terrorism, disaster response, and psychological trauma. These experts deliberated for 3 days to collectively develop recommendations for how to address the global problem of psychological trauma. One of these recommendations was a call for the formation of an organization that carried on the work started at this assembly, by supporting research, service, and policymaking based on the best available evidence about how to mitigate the impact of traumatic events. To meet this need, Psychology Beyond Borders (PBB) was founded in 2006 as an organization committed to evidence-informed psychosocial practice focusing on research, service, education, and policy in areas impacted by disaster, terrorism, and armed conflict.

PBB works to accomplish this mission through a variety of paths. PBB projects have included direct in-country activities such as a current project working with parents and children in Bantul, Indonesia, who were affected by the earthquake in that region in 2006, and the work on secondary traumatic stress with M.S.W. students working in post-Hurricane Katrina Louisiana. Work also includes partnerships with organizations and professionals working in the areas of child soldiers, aging and psychosocial trauma, and international psychosocial response. These are all aimed at developing programs that will help to inform best-practice responses to psychological trauma. The goal is to marry research and service to provide empirically grounded recommendations for trauma response and policy development. Through the annual Mission Awards program, small grants are offered to projects that support the mission.

PBB is committed to evidence-based work in psychosocial trauma and to actively promoting the best-practice response to psychological distress. For more information, go to http://www.psychologybeyondborders.org or a podcast available on iTunes under the name "Beyond Fear: Managing the Psychology of Terror."

This article was contributed by Conor Seyle, Ph.D., Research Officer, PBB.

Recommended Reading

TRACKING HUMAN FACTORS IN THE FINANCIAL CRISIS: LESSONS FOR PANDEMIC PLANNING

This white paper contends that there are significant similarities between the current global financial crisis and a pandemic disease outbreak. These similarities are particularly pronounced in the area of human factors, specifically in the psychosocial response to adverse events that involves elements of uncontrollability, unfairness, and loss. The sudden and dramatic onset of the economic crisis resulted in many organizations suspending their pandemic preparedness efforts to focus on the dire threat at hand. As the economic situation transitions from a "sudden crisis" to a "smoldering crisis," business continuity planners and others charged with an organization's pandemic influenza preparedness may benefit from identifying, understanding, and

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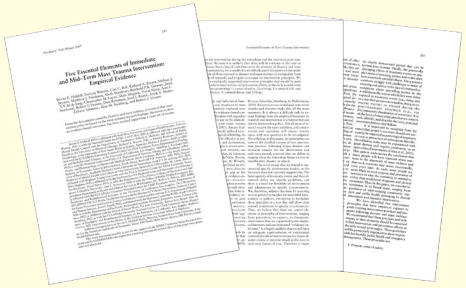
benchmarking these dynamics to inform policies, plans, and preparedness efforts for a pandemic.

Effective pandemic planning must be predicated on accurate assumptions about the individual and collective response to the threat. The global economic crisis, viewed as "pandemic-light," offers a unique opportunity to practice and prepare for the actual event. It may turn out to be the best test of pandemic preparedness possible, if approached in a thoughtful and structured manner.

For access to this white paper, visit Extreme Behavioral Risk Management at http://www.xbrm.com.

FIVE ESSENTIAL ELEMENTS OF IMMEDIATE AND MID-TERM MASS TRAUMA INTERVENTION: EMPIRICAL EVIDENCE



This article was the result of a worldwide panel of experts convened to address the study and treatment of those exposed to disaster and mass violence. Given the current lack of evidence-based recommendations, the goal of the panel was to extrapolate from related fields of research and gain consensus on effective intervention principles. The panel's work resulted in the identification of five empirically supported intervention principles targeted at the early to mid-term stages of response. While there are effective clinical interventions for survivors who develop posttraumatic stress disorder (PTSD), and for whom such treatment is accessible and acceptable, what remains needed are more broad-scale interventions that inform primary and secondary prevention, PFA, family and community support, and community support functioning. These five principles are seen as central core elements of intervention and will help in the process of setting policy and designing intervention strategy. They apply to all levels of intervention, from those focusing on the individual to those that are broadly community based.

The five principles identified by the panel promote the following:

- A sense of safety: Promoting a sense of safety both in reality and in perception has been demonstrated to reduce negative post-trauma reactions including biological responses. Interventions should bring people to a safe place as much as possible in addition to making it clear that the environment is safe.
- Calming: While some anxiety is a normal and healthy response to mass trauma, increased arousal that interferes with life tasks is both impairing and a potential precipitant of future disorders. Interventions should help people resolve concerns and provide education on anxiety management.
- A sense of self and community efficacy: Believing that one's actions are likely to lead to positive outcomes is important in trauma recovery. Survivors should be included in decisionmaking and planning as much as possible to empower them in their own recovery.
- Connectedness: Social support not only provides opportunities for problem solving, acceptance, and emotional understanding, but also is a central component of combating stress and trauma. Survivors should be connected with family and loved ones as soon as possible after a disaster. Interventions should facilitate opportunities for supportive transactions.
- Hope: Those who remain optimistic are likely to have more favorable outcomes after experiencing mass trauma. Interventions that help survivors rebuild communities and establish growth opportunities help foster hope in survivors.

For access to this article, go to http://www.psych.org/Resources/DisasterPsychiatry/ResourcesfromOtherOrganizationsAgencies/ScientificLiterature/FiveEssentialElementsofImmediate.aspx.

Conference Highlights

STATE SYSTEMS DEVELOPMENT PROGRAM CONFERENCE

AUGUST 20–22, 2008, WASHINGTON, DC

The theme of this conference, sponsored by the SAMHSA Center for Substance Abuse Treatment, was Partnering to Support Recovery-Oriented Systems of Care, and emphasized the importance of collaborating to sharpen the focus and results of systems of care. Many State Disaster Substance Abuse Coordinators participated in the Disaster Coordinators' Preconference Meeting, as well as the Essence of Disaster Preparedness session. The preconference session provided an overview of implications of the National Response Framework and the Pandemic All-Hazards Preparedness Act for Single State Authority (SSA) disaster substance abuse planning. The SAMHSA Disaster Technical Assisstance Center (DTAC) helped facilitate discussion groups in which participants evaluated existing SSA all-hazards plans and identified steps needed to initiate planning changes at home. The Essence of Disaster Preparedness session addressed special issues affecting methadone dosing, lessons learned from recent disaster responses, and recent Federal requirements. SAMHSA DTAC provided an overview of pandemic influenza planning challenges at this session.

NORTHEAST STATES DISASTER PLANNING WORKSHOP—BEYOND THE CRISIS COUNSELING PROGRAM: STRATEGIES FOR RESPONDING TO UNPRECEDENTED EVENTS

OCTOBER 20–21, 2008, ATLANTIC CITY, NJ

This workshop provided an opportunity for States in the northeast to share best practices in behavioral health response to disasters and increase communication and standardization among States. The forum focused on integrating disaster behavioral health services into all aspects of preparedness, planning, response, and long-term recovery. Representatives from Washington DC, New Jersey, New York, Pennsylvania, Massachusetts, New Hampshire, Vermont, Rhode Island, and Maine all presented on promising practices in disaster behavioral health being developed in their respective States. Additional topics presented include models of intervention, developing a credential program, the use of therapy dogs, and addressing issues of substance abuse.

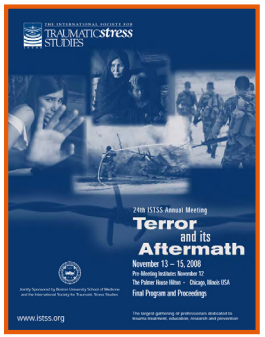
AMERICAN PUBLIC HEALTH ASSOCIATION 136TH ANNUAL MEETING AND EXPO

OCTOBER 25–29, 2008, SAN DIEGO

The theme of this meeting was Public Health Without Borders and included more than 200 oral and poster sessions related to public health aspects of disaster preparedness and response. Disaster-related sessions explored multiple topics including the psychological consequences of slow-motion technological disasters, the emergency preparedness status of gulf coast community mental health centers, and a town hall breakfast on pandemic influenza and community resilience. SAMHSA DTAC provided a presentation on State pandemic influenza behavioral health planning trends and the use of technologies to deliver psychosocial support.

INTERNATIONAL SOCIETY FOR TRAUMATIC STRESS STUDIES 24TH ANNUAL CONFERENCE

NOVEMBER 13–15, 2008, CHICAGO



The theme of this conference was Terror and its Aftermath, and sessions included the effects of terror on the military, on refugees, and on children. Many of the presentations at the conference were directly related to disaster behavioral health. Multiple presentations addressed behavioral health following Hurricane Katrina. Specific presentations addressed disaster behavioral health as it relates to the special populations of older adults and children. Additionally, representatives from SAMHSA, the National Center for PTSD, and other organizations spoke about the CCP.

Upcoming Meetings

19TH WORLD CONFERENCE ON DISASTER MANAGEMENT

JUNE 21–24, 2009
TORONTO, CANADA

This conference will provide the opportunity to gain valuable education, training, and best practices to mitigate, prepare for, respond to, and recover from emergencies and disaster. Individuals will learn how to develop strong resiliency tactics that will sustain business operations and communities during critical times such as natural, technological, or human-caused events. For more information, go to http://www.wcdm.org.

2009 NATIONAL COMMUNITY PREPAREDNESS CONFERENCE

AUGUST 9–12, 2009
ARLINGTON, VA

This conference is open to all who are interested in making their communities safer, stronger, and better prepared for all types of hazards. It will bring together approximately 600 State and local elected officials, emergency management, fire and police services, public health and emergency medical services, NGOs, private business and industry, advocacy groups, and members of the public. For more information, go to http://www.iaem.com/NCCP2009.htm.

INNOVATIONS IN DISASTER PSYCHOLOGY 2009: VULNERABLE POPULATIONS

SEPTEMBER 3–5, 2009
VERMILLION, SD

This conference is intended for national and international disaster behavioral health, health, and mental health professionals. The overall objective is for the participants to learn more about how to optimally serve vulnerable populations in preparation for and response to disasters. For more information, go to http://www.usd.edu/dmhi/conference.cfm.

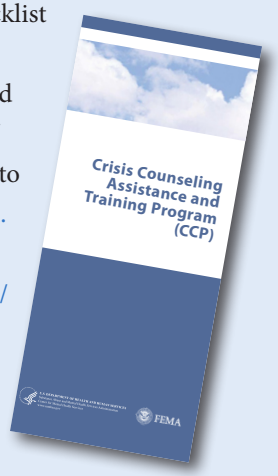
DISASTER MANAGEMENT 2009—FIRST INTERNATIONAL CONFERENCE ON DISASTER MANAGEMENT AND HUMAN HEALTH: REDUCING RISK, IMPROVING OUTCOMES

SEPTEMBER 23–25, 2009
NEW FOREST, UNITED KINGDOM

This conference focuses on current global health risks, and how best to prepare for, respond to, and recover from disasters to reduce the impact on human health. It will help participants understand the nature of global risks, learn risk management strategies to prepare for disruptive events, and identify the best prevention methods in disaster management and public health. It will provide a forum for the exchange of information between leading academics and partners in disaster management. For more information, go to http://www.wessex.ac.uk/09-conferences/disaster-management-2009.html.

CCP BROCHURE AND STATE CCP CHECKLIST

The CCP Brochure and the State CCP Checklist are now available online. To download electronic copies of these resources, go to http://mentalhealth.samhsa.gov/cmhs/EmergencyServices/progguide.asp.



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 SAMHSA DTAC at dtac@samhsa.hhs.gov.