



The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER BEHAVIORAL HEALTH

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SAMHSA DTAC Director's Corner

Although the holidays are behind us, for many disaster survivors the holiday season may be the very catalyst that resurfaces emotions thought to be resolved. Images of the Deepwater Horizon Oil Spill no longer make the front pages of newspapers, but those of us in the disaster behavioral health field know that many in the Gulf Coast States are still trying to recover from the impact of this technological disaster. Additionally, States in the Northeast, as well as Iowa and Tennessee, continue to address the behavioral health needs of many affected by massive flooding. In this issue, your

peers remind us how important it is to be aware of our own personal biases and how these biases could affect our work; share strategies and approaches for dealing with escalating anger in disaster survivors; provide us with information about how text messaging has been a successful method to reach survivors, especially teenage survivors, who wouldn't otherwise reach out for help due to stigma; and describe a free training resource for health and behavioral health providers—especially those from rural areas—who are interested in working with military families. And, as always, the

SAMHSA Disaster Technical Assistance Center (DTAC) is available to any U.S. State, Territory, or individual in need of information, assistance, or training related to all-hazards disaster behavioral health preparedness and response. Please feel free to contact us toll-free at 1-800-308-3515 or email us at DTAC@samhsa.hhs.gov.

Warmest Regards,

Amy R. Mack, Psy.D.
SAMHSA DTAC Project Director

Understanding, Accepting, and Managing Anger in Disasters

Contributed by Gladys Padro, M.S.W., LSW¹ and Steven Crimando, M.A.²

Disasters may evoke a broad spectrum of reactions in survivors, as well as responders. The cause and phase of the disaster, whether natural or human caused, may influence the intensity of emotions. Across the spectrum of reactions, anger is often one of the most understandable but most difficult to manage. Anger can be productive if channeled in the right way, but it can also become a significant obstacle to recovery, eroding physical and mental health, as well as family and community cohesion. In some instances, it can even represent a danger to mental health responders who want to assist survivors. It is important that responders and caregivers understand anger in the post-disaster environment and use effective anger management strategies.

Understanding Anger

Disasters of human intent that cause loss of innocent lives, such as terrorist attacks, may generate the most anger, while natural disasters are often considered beyond human control. However, some survivors may become intensely angry once they recognize human factors involved in a natural disaster (e.g., they may feel that the

government neglected to mitigate the disaster through upgrades to the physical infrastructure or provided insufficient post-disaster resources). As a result, some survivors may project anger toward counselors, if they perceive the counselors to be

representatives of government agencies. Of course, the intensity of anger can be highly variable, the targets of anger can shift or remain fixed, and targets are not mutually exclusive.

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FEMA Community Relations workers Stacie Eldridge and Vince Lewas visit Eleanor Maddens, whose home was damaged by Hurricane Charley in 2004. Photo courtesy of Andrea Booher/FEMA.

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Anger can be projected toward several targets at once, and assisting survivors with anger can be tricky because it is a dynamic and ever-changing reaction. As such, we cannot suggest a universal approach to coping with anger.

Some survivors feel entitled to their anger and are not quick to let it go, and some degree of anger must be allowed. Counselors should introduce anger management techniques slowly while emphasizing that anger management is actually a way of shifting control back to survivors, not just a ploy to quiet them.

Accepting Anger

Anger can be motivating in some instances and actually a powerful force in overcoming certain obstacles. But anger can be unpleasant and there is a natural tendency to see anger as a negative emotion that should be squelched. Before suggesting that anger is counterproductive in disaster recovery, responders should consider the following:

- > Is the anger justified?
- > Is the anger purposeful?
- > Can the anger be channeled in a constructive manner?
- > Does something about the target or intensity of the anger represent a danger?

Allowing ventilation, affirming the anger, and demonstrating that it can be tolerated and understood are effective first steps to de-escalating

anger. But these steps must be taken safely and constructively if possible.

Survivor anger, which increases or escalates over time, is common in long-term recovery projects during the “disillusionment” phase, when frustration runs high. In such instances, verbal de-escalation and relaxation techniques are useful. Anticipate escalating anger in recovery projects that survivors may perceive as delayed, “too little, too late,” or complicated by setbacks.



Managing Anger

Anger can be contagious, and even counselors can become angry, especially if they have been impacted by the disaster. This is not uncommon and should be both acknowledged in training and reinforced in team supervision. Survivors benefit most from counselors who can remain neutral and avoid being pulled into the “blame game,”

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Suggestions for Managing the Anger of Others

- > React and respond in a calm but firm manner.
- > Encourage the person to sit down.
- > Use calming “entrainment” techniques. Start by speaking louder than normal; then gradually lower your voice. Speaking calmly will promote calm.
- > Help define anger verbally: “I understand that you are upset” or “It sounds like you’re really angry about this.”
- > Rehearse ahead of time what you would say or do in situations with angry individuals.
- > If the situation appears dangerous, leave and call 911 if necessary.

Suggestions for Managing Your Own Anger

- > Express anger in a way that is not confrontational.
- > Take a break from the issue or person making you angry.
- > Put energy into creating solutions for the problem.
- > Use humor and relaxation techniques, such as breathing exercises or visualizing a calm scene.
- > Exercise (physically).
- > Talk to a spiritual healer.
- > For a long-standing issue, consider anger management counseling or classes.

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yet sustain their compassion and commitment in the face of anger. Counselors who become consumed with anger are not helpful to survivors.

During the impact phase or later with populations that are hard to reach, counselors are often meeting survivors for the first time—and during one of the worst times of the survivors' lives. Without much of a baseline knowledge of an individual, it can be difficult to assess when a survivor may cross that fine line between losing emotional control and losing physical control to the point of becoming a danger. Anger may also be an issue as people assess their losses during the disillusionment phase of disaster, especially if resources are not fully realized as expected. The following are three simple safety tips:

1. Never sacrifice safety for rapport: As a disaster responder whose primary skill set is talking and listening, you know that building trust and creating an empathic connection is critical, but these should not be to one's own detriment. You can rebuild rapport quicker than you will heal from a physical or psychological injury if a survivor becomes violent.
2. Getting out or away too soon is always better than too late: Trust your instinct and intuition. If the situation or behavior feels threatening or dangerous, it probably is.

3. Don't run from danger; run toward safety: Always have a plan B or exit strategy for any situation. In a home, know at least two ways out of the structure; in the community, identify safe places to go (e.g., lighted area, safe people) if the going gets rough.

In conclusion, counselors should be mindful to stay within the scope of their assigned program roles. After many years of work in the field of disaster response, one constant is true: the issues people have prior to the disaster are likely the

same ones they have in the aftermath, especially those related to character and personality. Assisting a survivor in managing his or her anger is one way to help survivors cope with their response to the disaster, but if the survivor had long-standing issues with anger management prior to the disaster, these will likely continue and may even be exacerbated by the event. In some cases, these issues limit the effect of our assistance, so you may need to reconsider your definition of success. Full resolution is not always the goal. ■



A Red Cross volunteer comforts a Nashville, TN resident who relocated temporarily to an American Red Cross shelter in the aftermath of the flooding in 2010. Photo courtesy of Daniel Cima/American Red Cross.

Case Study: Opening the Lines of Communication through Text Messaging

Contributed by Scott Sumrall¹



It's no secret that the top choices of communication among young adults are text messaging and email.

So it makes sense that tapping these channels is the latest method of reaching young adults with behavioral health needs.

In 2005, Anonymous Communication (AnComm), a company “dedicated to empowering students,” launched *Talk About It*, a program to provide schools with the ability to hear from their students via the same methods students already use to communicate with one another—text and email. The immediate result was the disclosure of extremely personal problems and, often, troubled cries for help. Year in and year out, behavioral health issues have topped the list of topics students discuss via *Talk About It*, namely depression, stress, cutting/self-injury, family problems, and bullying.

“As long as we ignore these channels of communication as valid means of treating those in need, we further ensure that there will always be those suffering in silence,” said Carter Myers, President of AnComm.

That's why the Mississippi Department of Mental Health (MSDMH) has partnered with AnComm's *Talk About It* program to add text and email channels to its statewide Helpline services. Individuals now have the option of sending a text or email to a member of the Helpline staff, and trained staff members are available to provide help with mental health issues and suicide intervention around the clock, including after a disaster.

Overcoming the “Code of Silence”

Like the schools where this program began, many communities do an excellent job of providing accessible mental health treatment options in the form of facilities, programs, and professionals to ensure no person in need falls through the cracks. Unfortunately, simply providing these resources does not guarantee that those who need them

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¹ Director, Division of Disaster Preparedness and Response, Mississippi Department of Mental Health

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most will use them. Due to the pervasive “code of silence,” such resources can often be ignored, never accessed by those who can benefit most from the experiences, advice, and counseling of ready professionals. Because of the stigma associated with behavioral health, many young adults are afraid or embarrassed to seek help. *Talk About It* offers young adults a more comfortable and easy way to initiate contact with the Helpline while remaining anonymous.

Individuals who access the *Talk About It* program can discuss a variety of topics, including depression, bullying, suicide, stress, grief, death of a loved one, relationships, self-esteem, physical/emotional/verbal abuse, cutting/self-injury, drugs, alcohol, and peer pressure.

“Our goal is to continue to shatter the silence surrounding mental health and create a new avenue of communication that will reach out to young adults.”

We must recognize the dramatic impact that technological devices have had on communication. The simple act of asking for help can be a nearly impossible task for those who prefer to communicate, often intimately, through scores of text messages in a single day. If we are to ensure that everyone

has a voice, then we must make use of these new technological channels to connect those in need with valuable resources. “We believe young adults will gravitate toward this program because it is less intimidating than calling a Helpline and speaking directly with a staff member,” said Shannon Rushton, MSDMH Director of Constituency Services. “The program will allow our Helpline staff to provide a service to the many teenagers in Mississippi who need to discuss mental health issues but may be ashamed to talk to someone. Our goal is to continue to shatter the silence surrounding mental health and create a new avenue of communication that will reach out to young adults.”

Using this technology and allowing individuals to begin counseling interactions in a less invasive manner, MSDMH and AnComm create a “teachable moment” in that first response that leads to greater voice-to-voice and face-to-face interactions as trust builds through the ensuing dialogue.

Measuring the Impact

In the first 10 months of MSDMH’s *Talk About It* program (January–October 2010), 172 individual users have accessed the site, with 1,948 logins and 374 messages between staff and individuals seeking assistance or information. The program is in the beginning stages of use for disaster notification, but like all programs at MSDMH, it is available to those affected by a disaster. As



in everyday life, all lines of communication are important when individuals have been affected by a traumatic event, and *Talk About It* provides another method of communication.

Individuals can access the MSDMH *Talk About It* program by visiting <http://www.dmh.ms.gov> and clicking the *Talk About It* button on the home page. After creating an account, individuals can anonymously email a Helpline staff member or reach Helpline via text messaging. Assistance is available 24 hours a day, 7 days a week.

MSDMH sees the *Talk About It* program as a vital piece in fulfilling its mission to support a better tomorrow by making a difference in the lives of Mississippians with mental illness, substance abuse problems, and intellectual/developmental disabilities one person at a time. ■

Special Feature

The Impact of Personal Bias for Providers and Clients

Contributed by Mary Migliaro, M.Ed.¹

Each of us is endowed with personal bias instilled in us by our families and through our life experiences. How we recognize and deal with that bias can affect our work with clients and influence the success or failure of client relationships.

One definition of bias, according to Webster's Dictionary, is "an inclination or preference, esp. one that interferes with impartial judgment: prejudice." Prejudice is defined as "an adverse opinion or judgment formed beforehand" or a "preconceived idea or preference." Let us combine these definitions and consider bias to be a type of prejudice—a preference that is based on a preconceived idea and that affects one's ability to be impartial.

Bias, however, is not always negative. Positive bias, for example, is often observed in parents' beliefs about their children. Most parents believe their child is the cutest, brightest, etc. A negative bias, on the other hand, may manifest itself in actions that, though not violent, can still be quite harmful. As an example, studies have shown that negative

bias toward elderly people is common and that even those considered elderly have negative bias against other elderly people. Another example of negative bias is a person's negative perception of a particular race, which may be due to the person's upbringing and exposure to different racial populations. While some biases may not affect your day-to-day work, others can greatly affect your professional relationships and success as a provider.

Professionally, you may have a personal bias or preference for working with a certain population. Some treatment providers enjoy working with teenagers, while others prefer working with adults. This does not necessarily mean that you *cannot* work with other populations, but you have your preferences. Playing to your personal preferences will certainly enhance the professional relationships you have with your clients, but you may not always be able to work with your preferred group. Recognizing bias can help you be more successful in working across the population. We must also keep in mind that every client we work with brings his or her own personal bias to

the relationship. Some clients seeking treatment for mental health issues may be biased against the mental health practitioner. In their experiences, they may have been told that mental health treatment is "just for crazy people." This naturally brings a negative tone to the relationship before you can even deliver services. Bias, in fact, goes both ways. How we work with the bias in the relationship will color that relationship and determine the success or failure of the treatment.

Often, it is the presence of stereotypes that enhances certain biases. Think about how stereotypes may affect your relationships and work by filling in the blanks below:

1. Women with blonde hair are _____

2. Unsupervised teenagers are usually _____

3. Obese people are _____

¹ Chief Executive Officer, Mission Possible Consulting

4. Homeless men are

5. Asians are

These stereotypes, which lump everyone with similar traits into one group, can lead to bias or even prejudice toward an entire group of individuals. We certainly have seen this happen since September 11, 2001. It is unreasonable to classify all persons of a particular gender, race, religion, etc. as the same, and such stereotypes are particularly likely and risky when we lack a great deal of experience with a population. Assessing our stereotypes and how we act on our personal bias is important. Acting on bias, even subtly, can present issues when working with clients in the behavioral health field.

Sometimes, a provider's personal bias is intensified when he or she is undergoing a great deal of stress or is approaching professional "burnout." Intense bias is often observed in providers' attitudes toward "repeat clients" or those clients with closed cases who have returned to treatment for whatever reason. Providers may be disappointed when a client relapses after what had been successful treatment. The more times the client returns, the more frustrated the provider becomes with the client's "inability to follow the program."

How can negative bias manifest itself in your work?

Here is an example:

You are aware of your personal bias toward women in domestic violence situations, and your client is a battered wife. After several meetings with her, the two of you have developed a plan for her to gain independence from the batterer. She agrees to follow the plan but aborts her efforts to leave the batterer midway through the plan. At her next visit, you greet her as warmly as possible; however, your body language and tone of voice are exhibiting disappointment and a lack of empathy for her decision. This translates to your client as disapproval and reinforces her feelings of inadequacy. This compounds the feelings of inadequacy and low self-esteem fed by her relationship with her batterer, so the next time you attempt to prepare a plan for an improved outcome, she is more likely to be resistant. She may even terminate her relationship with you altogether.

This negative bias toward particular clients is often observed in providers working with victims of domestic violence and families interfacing with child protective services. Some child protection workers

even think a child that disrupts his or her foster placement is "just being difficult." These reactions demonstrate that some providers fail to realize the emotional impact of removing a child from his or her family. Many people are also biased against battered women because they often return to the batterer time and time again. Those with this bias may lack the empathy required to understand or tolerate a woman's return to such a dangerous situation.

As a caring human services provider, you are motivated to create an atmosphere that enhances the best possible outcome for your client. Both addressing your personal bias and identifying the personal bias of your client will set the stage for success. Identifying our own personal bias or biases requires each of us to examine how we feel about a variety of issues, including race, gender, physical characteristics, religious preferences, sexual orientation, socioeconomic status, etc.

Steps for Managing Your Personal Bias

1. Recognize and acknowledge your personal bias or biases.
2. Maintain the characteristics of human services professionals: empathy, internal locus of control, positive regard for others, good listening skills, skill in offering affirmative responses, and ability to avoid

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emotive language such as “poor thing” or “handicapped.”

3. Identify things you might have in common with a particular client: Is he or she a parent? Does he or she like animals? Try to focus on your human connection.
4. Talk with a colleague you trust to see if a new perspective might help you to understand and work with your client in a more individualized, bias-free way. If you discover that you’re really struggling with a particular bias or biases, consider seeking your own therapy.
5. If you still feel you cannot work with a particular client, consider how you might

transfer the person to another provider, making sure the client is unaware of the true reason for the transfer. He or she can simply be told your schedule is closed to new clients or something similar. If you live in a rural community where no other providers are available, then consider tapping into external resources for referral, such as the National Suicide Prevention Lifeline at 800-273-TALK or by utilizing a State or local referral program like 2-1-1 that can connect the client with providers with whom you may not have a professional relationship.

We are all human, and we all have personal biases, both positive and negative. If you think you have

no bias, consider this: Inside the entrance at the Museum of Tolerance in California, you will find two doors. The first door is marked, “If you are not prejudiced, enter here.” The other is marked, “If you are prejudiced, enter here.” When you attempt to open the first door, a sign says, “Wrong! Think again!” The second door is the only entry to the museum.

The key to dealing with our personal bias is recognizing and acknowledging it. We are humans with biases just as our clients are humans who bring their personal biases to a relationship. Being honest with ourselves about these biases will ensure that we provide the best services for our clients in a humane and compassionate way that leads to successful outcomes. ■

RECOMMENDED RESOURCE

Meeting the Needs of National Guard and Reserve Families

Online training equips community providers to serve the military and veteran population

Contributed by Mimi McFaul, Psy.D.¹ and Nicola Winkel, M.P.A.²

In many ways, a military family is like any other family—they have the same strengths, challenges, stressors, and joys. But a military family is also

very different from a civilian family—they have unique experiences relating to service, deployment, and reintegration that require additional

knowledge, skills, and abilities on the part of the providers who assist them. With the conflicts in Iraq and Afghanistan, there is an ever-increasing

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need for community providers who are equipped to serve and support these military families:

1. Over 530,000 service members from the National Guard and Reserves have deployed since September 11, 2001.
2. These are “Citizen Soldiers” and Service Members, who live in almost every community throughout the country. Only 44 counties in the United States have not deployed a member of the National Guard or Reserves.
3. Demographics from the U.S. Department of Veterans Affairs (VA) indicate that although all Iraq and Afghanistan veterans are offered 5 years of free health care at the VA, as many as half of the returning service members do not enroll in the VA system. Additionally, many service members in the National Guard and Reserves live geographically separated from military installations or VA facilities.

Given the likelihood of these service members and their families accessing care in the community, it has become increasingly important for providers in both urban and rural areas to gain familiarity with military culture; to stay up-to-date on the latest key issues, such as combat and operational stress, posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), substance abuse, and suicide;

and to be aware of the key resources available to assist these individuals and families.

The Citizen Soldier Support Program (CSSP) focuses specifically on building bridges between local community resources and military families. CSSP, in partnership with organizations such as the Western Interstate Commission for Higher Education (WICHE), addresses the need for increasing the number of trained community providers, especially in rural areas.

Through a combination of on-the-ground trainings in states across the country and an online training library accessible from anywhere, CSSP provides access to high-quality training content geared toward health and behavioral health providers and other community partners. The training library currently includes the following components of Treating the Invisible Wounds of War:

1. Posttraumatic Stress Disorder (3.0 contact hours)
2. Traumatic Brain Injury (4.0 contact hours)
3. Issues of Women Returning from Combat (2.0 contact hours)

There is no cost for providers to go through these online trainings, which can be accessed at <http://www.aheconnect.com/citizensoldier/>.

After completing the modules, providers are invited to join the provider database at <http://www.WarWithin.org>.

For communities that have an interest in conducting onsite provider training focused on working with the military and veteran population, technical assistance for planning is available from WICHE. Contact Mimi McFaul, Associate Director of the WICHE Mental Health Program at 303-541-0288 or mmcfaul@wiche.edu for more information. ■



Upcoming Meetings

17th Annual “Earthquakes: Mean Business” Seminar

February 4, 2011; St. Louis, MO

This seminar will showcase information on earthquake hazards and earthquake risk in the central United States. Preparedness topics include earthquake risk and mitigation, emergency management, business continuity, and citizen preparedness.

<http://gatewayccc.us/Earthquakes%C2%A0%20Mean%20Business%E2%80%9DSeminar.htm>

Public Health Preparedness Summit 2011

February 22–25, 2011; Atlanta, GA

The purpose of this summit is to strengthen and enhance the capabilities of public health professionals and other participants to plan and prepare for, respond to, and recover from disasters and other public health emergencies.

<http://www.phprep.org/2011/?CFID=27545957&CFTOKEN=27034006&jsessionid=f030100314c52b4456101f1346f5b48754f4>

Disaster Management Conference 2011

March 9–11, 2011; Winnipeg, Manitoba, Canada

The purpose of this conference is to provide a forum for emergency preparedness planners, health professionals, first responders, elected officials, educators, and policymakers to share experiences, showcase technologies, and provide information and solutions on emergency management.

<http://www.gov.mb.ca/emo/general/conference/index.html>

Disaster Recovery Journal’s Spring World 2011

March 27–30, 2011; Orlando, FL

This conference will cover crisis communication, crisis management, case studies, risk management, risk assessment, and work area recovery.

<http://www.drj.com/springworld/conference/overview.html>

Lessons from Adversity: Strengthening Preparedness with Reflections from 9/11

April 7–8, 2011; New Paltz, NY

Mental health professionals, emergency managers, and others nationwide will be planning for the 10-year anniversary of the September 11, 2001 terrorist attacks. To help prepare for both commemorative events and future disasters, this conference and training will focus on a careful review of lessons learned over the past decade.

<http://www.newpaltz.edu/idmh/conferences.html>

2011 National Hurricane Conference

April 18–22, 2011; Atlanta, GA

The purpose of this conference is to improve hurricane preparedness, response, recovery, and mitigation to save lives and property in the United States and the tropical islands of the Caribbean and Pacific. The conference is a national forum in which Federal, State, and local officials can exchange ideas and recommend new policies to improve emergency management.

<http://www.hurricanemeeting.com/>

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Upcoming Meetings

Partners in Emergency Preparedness 2011 Conference

April 26–27, 2011; Tacoma, WA

This conference is a forum for discussing partnerships between businesses, schools, governments, nonprofits, emergency management professionals, and volunteer organizations.

<http://capps.wsu.edu/emergencyprep>

2nd International Conference on Disaster Management and Human Health: Reducing Risk, Improving Outcomes

May 11–13, 2011; Orlando, FL

This conference will cover topics in emergency preparedness, risk mitigation, global risks and health, and pandemic and biological threats.

<http://www.wessex.ac.uk/11-conferences/disastermanagement-2011.html>

International Oil Spill Conference

May 23–26, 2011; Portland, OR

This conference will provide a forum in which professionals from the international community, the private sector, government, and nongovernmental organizations can highlight and discuss innovations and best practices across the spectrum of oil spill prevention, preparedness, response, and restoration.

<http://www.iosc.org/>

National Voluntary Organizations Active in Disaster (VOAD) 19th Annual Conference

May 24–26, 2011; Kansas City, MO

This conference will provide a forum in which emergency management individuals from Federal, State, and local VOADs can discuss collaborative disaster planning, disaster case management, pastoral care, and community resilience.

<http://www.nvoad.org/avc/>

The International Emergency Management Society 18th Annual Conference 2011

June 7–10, 2011; Bucharest, Romania

The purpose of this conference is to improve preparedness and mitigation, to prevent disasters, and to ensure that the response and recovery regarding the psychological aspects of emergencies are consistent with the best available techniques.

<http://www.tiems.org/index.php/tiems-2011>

The World Conference on Disaster Management

June 19–22, 2011; Toronto, Canada

The purpose of this conference is to provide information on emergency management, business resiliency, risk management, pandemic planning, natural disasters, emergency response, and emergency health.

<http://www.wcdm.org/>

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Upcoming Meetings

National Association for Rural Mental Health (NARMH) 37th Annual Conference

June 22–25, 2011; Dubuque, IA

The NARMH conference will bring together two organizations that serve the behavioral health needs of rural people to discuss effective programs and practices, explore new dimensions and directions, and dialogue about rural behavioral health and agriculture policy. The purpose of this conference is to promote accessible behavioral health services for at-risk populations affected by rural crisis in agricultural communities.

<http://www.narmh.org/conferences/2011/default.aspx>

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

Webinars and Trainings

Integrating All-Hazards Preparedness with Public Health

This webinar by the National Association of County and City Health Officials (NACCHO) features four demonstration sites that integrate all-hazards preparedness into traditional public health activities. This webinar has been archived at <http://webcasts.naccho.org/session-archived.php?id=684>

Planning for Pandemic Influenza: Issues and Best Practices

This webinar by NACCHO features discussions on local challenges relating to vaccine distribution, isolation and quarantine, risk communication, hospital and personnel surge capacity, and community engagement. This webinar has been archived at <http://webcasts.naccho.org/session-archived.php?id=505>

Psychological First Aid: The Role of MRC Volunteers in Disaster Response

This webinar by NACCHO provides an overview of the disaster mental health field and the role and evolution of psychological first aid. This webinar has been archived at <http://webcasts.naccho.org/session-archived.php?id=823>

State of All Hazards Preparedness for Children: Partnerships & Models for Merging Emergency Department & Disaster Preparedness Efforts Nationwide

This webcast by the Maternal and Child Health Bureau, within the Health Resources and Services Administration, features resources and tools for pediatric disaster planning, lessons learned from the H1N1 pandemic, and perspectives from national stakeholders and partners in planning. This webinar has been archived at <http://www.mchcom.com/liveWebcastDetail.asp?leid=414>

ABOUT SAMHSA DTAC Established by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Disaster Technical Assistance Center (DTAC) supports SAMHSA's efforts to prepare States, Territories, and local communities to deliver an effective mental health and substance abuse (behavioral health) response to disaster. SAMHSA DTAC provides disaster behavioral health preparedness and response consultation; develops resource collections addressing disaster behavioral health planning, special populations, and emergent topics; and supports collaborations between Federal entities, States, local communities, and nongovernmental organizations. To learn more about SAMHSA DTAC, please call 1-800-308-3515, email DTAC@samhsa.hhs.gov, or visit us on the web: <http://www.samhsa.gov/dtac/>