# Introduction to Disaster Behavioral Health Webinar

## July 14, 2011

Moderator: Welcome! This is Marcela Aguilar from the Substance Abuse and Mental Health Services Administration's Disaster Technical Assistance Center (or SAMHSA DTAC). I will be your host for this webinar. This afternoon SAMHSA DTAC is pleased to present an introduction to disaster behavioral health. The webinar will feature Dr. Amy Mack, Project Director of SAMHSA DTAC; Dr. April Naturale of the Mental Health Association of New York City; and Dr. Curt Drennen of the Colorado Department of Public Health and Environment and Emergency Preparedness and Response Division and Mr. Anthony Barone of ICF International. I will now turn the webinar over to Dr. Amy Mack, SAMHSA DTAC Project Director. Dr. Mack is trained as a clinical psychologist and has been the SAMHSA DTAC Project Director since September 2009. She has worked in the public and private sectors, often addressing issues of violence and trauma. She has managed evaluation studies and program development projects to build the capacity of professionals in the fields of mental health and public health and emergency management. Please welcome Dr. Mack.

Dr. Mack: Thank you. I wanted to start off by thanking everyone. There are hundreds of people who are joining us today. I wanted to thank everyone. The fact that this is clearly such an important topic, these past several months we have seen an overwhelming number of disasters and I wanted to take a moment to commend everybody and thank everyone for their dedication to this field and for all of the work that they do, both in the line of duty and off. There is obviously a lot of passion and dedication for all of their hard work that truly comes through. For those of you that have perhaps suffered a loss I wanted to send our thoughts to you, especially in these most recent disasters. I wanted to make sure everyone was aware of the services that we have in terms of who we are. As you can see on your screen on the bottom right-hand corner there is a brochure, the Disaster Training and Technical Assistance brochure. I wanted to take a moment to let everyone know about our services that we offer. We were established sometime after the September 11th terrorist attacks back in 2001. The center was started in 2005 to provide free training and technical assistance to States, Territories, and Tribes so that they could be prepared for and able to respond to disaster behavioral health needs. When we refer to behavioral health, you will hear this term throughout the presentation, we are referring to both mental health and substance abuse issues that emerge. I wanted everyone to know that you can go to our website and you will see this later, it is http://www.samhsa.gov/dtac and you can download for free this publication, this brochure that gives you information about services we offer. I wanted to take a moment to highlight the different services when we talk about training and technical assistance. We have consultation and training. These are often focused on preparedness and response activities. We address needs for special populations such as children and youth, older adults, or other at-risk population. We also have dedicated training and technical assistance that are supported for free. In particular we do this with the Crisis Counseling Assistance and Training Program which is funded by FEMA and administered by SAMHSA. Lastly, we also are offering services about identifying promising practices and best practices, such as a separate webinar series you might be aware of that we are doing in which we have interviewed and collected information from States

about what are their promising practices in disaster behavioral health. We also have a website that contains free, downloadable resources and materials. In particular what I wanted to highlight for you today is our Disaster Behavioral Health Information Series, also known as DBHIS. There you will find fact sheets, different resources, booklets, and materials all downloadable for free that you can print out and distribute. They cover topics on disaster behavioral health preparedness and/or response, specific disasters. For so many of us right now we are dealing with floods, fires, the fallout after tornadoes, and other kinds of events that have taken place. You can find information specific to those disasters on this page as well as specific populations. Lastly, I wanted to make sure you were aware of electronic communications, the DTAC Bulletin, which is a monthly newsletter of resources and events and you can simply subscribe as you see the email address on the screen. That is something that comes monthly with various resources, usually pertinent to a particular topic or event that is taking place. We have The Dialogue, which is our quarterly journal and that is written by professionals from the field and we are also always looking for contributors. People can email us with ideas or suggestions. The last is our discussion board which is a way for disaster behavioral health professionals or non-behavioral health professionals who have questions can speak to one another by using our discussion board. The way to sign on is there on your screen. Lastly, this is our contact information if anyone is interested in contacting any of our TA staff or contacting me directly. We have our phone number, our email, and our website there available to you to call us anytime. If it is after hours we do have a phone answering machine that you can leave and message and we will be back in touch with you.

Moderator: Thank you Dr. Mack. The goal of today's webinar is to address mental health, substance abuse, and stress management needs of people who have been exposed to human-caused, natural, or technological disasters. We will begin with Dr. April Naturale who will provide an introduction to disaster behavioral health and its importance to disaster preparedness and response. We will then move on to Dr. Curt Drennen who will provide basic strategies for supporting the disaster behavioral needs of survivors. We will end with Mr. Anthony Barone who will discuss his experiences and lessons learned from applying disaster behavioral health concepts to disaster response. Following each presentation our guest speakers will respond to questions. The learned objectives of today's webinar are to provide a basic overview of core disaster behavioral health concepts, information on basic actions disaster response personnel can incorporate in their interactions with disaster survivors without the need for extensive training, and information on recognizing severe reactions to disasters and how to make a referral for a behavioral health assessment. I would now like to introduce Dr. April Naturale. Dr. Naturale is a traumatic stress specialist with a 25-year history as a mental health care administrator. She provides disaster and trauma response training and consultations throughout the U.S. and internationally. Please welcome Dr. Naturale.

Dr. Naturale: Thank you very much and to Dr. Mack for that introduction as well as starting and putting together this webinar. As she said, this is an important topic for all of us and why it matters to us is because of the Under-Secretary of Humanitarian Affairs at the UN told us in 2009 that the number of disasters requiring assistance on a large scale have doubled in the past decade. About 90 percent of those events are climate-related, large-scale disasters that really require mental health and health professionals and those in the community who are responding to disasters to have some understanding of the differences between disaster behavioral health and traditional mental health and substance abuse services. Disaster behavioral health itself is a set of supportive mental health actions as opposed to formal mental health treatment that address the survivor's emotional responses. While emotional responses themselves are pretty similar globally in all different cultures, the way that we cognitively perceive disasters can change our recovery pattern depending on whether it is a natural or human-caused event. Human-caused and

technological disasters tend to cause a little bit more difficulty in people making meaning of them which really can interrupt their recovery process. The actions provide a supportive presence. It is what the American Red Cross tells us is a compassionate presence or being present with. Again, as opposed to traditional mental health interventions, like psychodynamic psychotherapy, disaster behavioral health also provides information and referrals. A disaster or a traumatic event of some kind generally increases some type of anxiety and depressive-like symptoms in the general population. Information, education, and referrals as well as social supports can go a long way to decreasing those emotional responses. Information and education are very powerful tools to help us in responding to natural disasters and technological events. Our key concepts are that disaster behavioral health is strength based. Really what that means is that we are not going to pathologize, meaning we are not going to expect that all people are going to need mental health services. In fact, the opposite, about 90 percent of people will recover on their own without any mental health services or without any disaster behavioral health services. What we do know is that during that time that they experience the event and they move to recovery is that they often suffer some pretty serious symptoms in between there and we can help them move that recovery process along and also mitigate the development of any serious disorder. We have also learned that these services really need to be anonymous. We are not taking down names and we are not opening case records as we would in traditional mental health services. Also, we are not sitting in our office waiting for people to come to us. Outreach is the primary modality by which crisis counseling and disaster behavioral health services are delivered. That means that we might be standing out on a street corner where people are gathering in a church basement, at a school PTA meeting rather than in the traditional mental health offices. Then of course, our services have to be culturally competent. When we refer to culture we are not just talking about specific ethnicities and races, any culture, any group of people that considers themselves to be affiliated with each other. For example, we know that schools consider themselves to be a certain culture as well as some large-scale businesses, especially in rural towns where half the town may be employed by a particular business. They may have a way of being together and we refer to them as a culture. Different age groups may be considered a culture, again, of course including different races and ethnicities and immigrant groups which may be gathered and settled together in different areas of our communities. Again, our settings are nontraditional. We are out in the community where people are so that we can reach them with disaster behavioral health services that they might need, even though they don't know or look for disaster behavioral health services. Many of us in the field of health and mental health care think that because we do this good work and we are out there in the community that people will come to us, but basically there is still a lot of stigma about disaster behavioral health and other mental health services. We need to be out in the community where people are gathering. The key concepts of disaster behavioral health are that we really want to help strengthen the existing community support systems. We are not going to interfere with the natural process that people have as they come together and help each other after a traumatic event. We want to strengthen and enhance those natural supports. People will come together and help each other; we have all seen this whether you have experienced it yourself or watched it on television. People do outstanding things after a disaster. They come together and help each other, very often even before helping themselves and we want to foster that process. About 90 percent of the people after a disaster will recover fully on their own without us. We want to make sure that that process continues and that it is not inhibited, but rather enhanced in some way. The purpose of our services are to help survivors understand their situation. We know from the National Institutes of Health that one of the major concerns that the general population across the country has is that they would suffer with a mental illness of some kind. One of our primary goals is to provide information and education to help people understand that they may in fact be having response that are a very natural and common response to a trauma. This way they are not afraid that they are going crazy or that they are developing a serious mental health problem. What we want to do is decrease anxiety and help them get back to a sense of control over their lives, normalcy, routine. This will allow them the sense that they can in fact move towards recovery

and again have some control in their lives as they did before the disaster. Also, people often don't know how to express emotions or what to call them. We in the mental health and behavioral health professions have different terminology that they might not understand. We want to provide simple ideas and expressions that help them talk about what kind of emotions they are having. Then, how do they adjust to the disaster and to their losses. Much of this is how to help people to manage stress. A disaster is the type of trauma that can often increase stress responses in people. These are physical reactions often, palpations, panic attacks, fear, anxiety and we want to allow them to look at ways that they have helped themselves before to manage stress and introduce some new techniques that might help get them through this particular disaster. We know too that sometimes people's cognition is interrupted and they have difficulty making decisions or taking action. That is why we talk about developing coping strategies, things that they have used in the past that might help them to manage this time as well as planning on what actions that they need to take to move towards recovery. Helping them to make those decisions one step at a time, very simply in the planning process to move them towards the recovery process. A huge part of these services that we are providing is connecting people with community resources, again we want to foster the natural resiliency of communities to come together and help each other. Additionally, we want to foster social supports, having those within the affected area come together. Dr. Norris from the National Center for PTSD and of course, [inaudible] have taught us over much empirical research that social supports are the number one thing that can help people through a disaster. We want to foster those social supports and access in community resources as much as possible. The two types of disaster reactions are individual and collective. Someone may be experiencing stress because they were exposed to a loss of a family member and the grief that they are feeling because of that as well as maybe other incidents, losing or having their home damaged or having their whole community disappear. They may experience some of the more common responses like being tired, irritable, and maybe even for a little time hopelessness and difficulty with relationships. We will talk a little bit more about responses in a moment. When we see collective trauma it is often after a large-scale or -scope disaster, similar to what we are seeing right now in Joplin, Missouri as a result of a very large-scale tornado that damaged such a large part of the community that individuals who would normally go to that community are having difficulty because their supports are not there any longer. Those community responses can actually affect individual responses as well. There are four domains of disaster reactions. They include physical, which could be fatigue, headaches, or stomachaches. We especially see those things in cultures where it is unacceptable to express emotion. Others may have emotional responses like sadness, even crying, having difficulty going through their daily events because they are so stressed or overwhelmed, maybe even panic and anxiety. We have discussed that they also may have some cognitive difficulties. One of the most common of these is memory problems. Again, it can become severe and people may have difficulty with judgment and thinking process. We see many different types of behavioral responses from crying to shutting down to becoming hyperactive and so you may see people's reactions come from any of these four domains and often you will see that their reactions cross to two or three of those domains. We do need to talk about post-traumatic stress disorder because our job as disaster mental health responders is to monitor and survey those who may be in need of more services than just crisis counseling or our immediate responses. We want to try and identify people who may be at risk for suffering with posttraumatic stress disorder so that we can help to mitigate so that it doesn't get worse and to address it if we do see that it is developing. Again, I want to remind all of us that posttraumatic stress disorder is not the most common response. We only see that in about five percent to eight percent of the general population and about 10 percent of those after a disaster, unless you see a very large-scale incident like Katrina where there was an estimate of about 20 percent to 25 percent of the people at risk of developing PTSD. I do say "at risk of"; just because people are at risk doesn't mean that they are going to develop the disorder. A lot has to do with their social supports and connecting with resources and receiving attention as soon as they need it after a disaster. We do see PTSD in a percentage of the population and we want to be able to identify them as soon as we can,

make sure that if they have been exposed to death or injury that they are moving through that process without difficulty. If those who have seen dismemberment or gross or very difficult images they may be at more risk of developing PTSD. Those who see a problem or a threat to others may also actually experience some symptoms of PTSD. Remember that perception is as important and as actuality. It is what I call "I'm gonna die" fear. If somebody thinks that something is going to happen to them they may have a risk of developing PTSD and their reactions may include intense fear and horror, coupled with helplessness which is very significant. What we see in PTSD is nightmares and flashbacks, what we call the intrusive symptoms and severe avoidance, leaving the scenes of the incident, not associating with anyone associated with the incident previously, in a sense giving up their whole lives and going through a severe avoidance as well as a disassociation which may be—you have probably heard this before, people say, "It was like I was looking at movie. I wasn't even looking at myself." Or not being able to fear, to feel at all or feeling numb. Again, our reminder that most people don't develop PTSD, but are quite resilient. Those of you who work with children or who have children yourself you see this, one moment they may be very distressed and you give them a cup of hot chocolate. You put them in front of a nice cartoon and they may very quickly make the cognitive shift to feeling better again. All of us have the innate ability to recover ourselves. What we do in disaster behavioral health is to assist that process and make sure that people don't get stuck and that they can continue to move through the recovery process, adapting to those changes that may have occurred or losses that may have come as a result of the disaster. We all have this ability to change, behaviorally, cognitively and go on to function and adapt to some sense of normalcy in our lives even if that normalcy is different than what it was before. We also look to our FEMA, or Federal Government disaster assistance when there are large-scale disasters that overwhelm the local community and there are various types of assistance available, from infrastructure type of support, rebuilding roads and sidewalks to giving individual assistance with temporary housing, renting a house, or finding a new place in the form of loans or grants. People who are unemployed can receive unemployment assistance and you can see here in this slide that crisis counseling falls in the individual assistance category of FEMA disaster assistance. That is what Dr. Mack mentioned earlier, the Crisis Counseling Assistance and Training Program that is offered by SAMHSA and support by DTAC with all different types of resources and information for those to access who are working in the disaster behavioral health field. Thank you.

Moderator: Thank you Dr. Naturale. We have four questions for you. What have you learned from other trauma treatment experts on how to prevent PTSD?

Dr. Naturale: That is a really good question. There is not good empirical evidence about preventing PTSD, but we do know that, first if we can identify people who may be at risk and work with them we have a better chance of helping to mitigate the development of PTSD or avoid the PTSD from becoming chronic. There are some very good supporting evidence that tells us that early interventions such as crisis counseling can help people so that they don't develop more serious symptoms and actually some mind and body interventions and stress management can be very helpful in the early response to disasters so that people can avoid developing PTSD. These are often very simple types of techniques, as we said before, connecting with social supports, doing things like gentle stretching or yoga, breathing techniques like the relaxation response and breathing retraining. Again, connecting with others and resources that might help. There is some information about acupuncture also being helpful and music is also emerging as something that can help, music that is timed to the breath that can calm people and making sure also that they are not re-exposed to the materials around the disaster or the emotional responses that they have had before. In essence, keeping them away from the television and hearing other stories when they don't really want to

and being able to do calming techniques that help people to de-stress and not stay in a very hyperalert state where they may go into moving towards developing PTSD.

Moderator: Dr. Naturale, why don't more people get PTSD after a disaster?

Dr. Naturale: That is a good question and thank goodness more people don't. As we have talked about, it is quite a complex type of anxiety disorder, but most people really are quite resilient and do have the ability to move towards adapting to traumas. We have had to deal with trauma since the days of the saber-toothed tiger. We have learned as human beings to adapt and we have become quite good at it. We certainly see this in children. They are a little bit better than adults are usually because they are not so stuck in their ways like we are. Also, because we have learned to respond to disasters and provide the social support and the information and resources that people need we are able to keep and mitigate the further development of PTSD in the post-disaster population.

Moderator: What about group counseling techniques for communities following disasters?

Dr. Naturale: These are ideal techniques. Group counseling that provides the information around the normal responses to disasters as well as ways to cope and keep anxiety down and again, in addition coming together and people empowering each other, sharing information about how to cope and helping each other by being together and making sure that they all know that they are not isolated, they are not alone, and that help is out there is one of the best ways for communities to recover. One, we provide crisis counseling through the CCP programs. We see that there is a lot of individual work done in the beginning, but as the community moves towards recover they will naturally form some support groups themselves as well as those groups that might be fostered and empowered by crisis counselors. Towards the end of the recovery process you see that most of the work that is out there that is being done is in the form of group work.

Moderator: Does SAMHSA offer any CISM training?

Dr. Naturale: There are trainings in the Crisis Counseling Assistance and Training Program which is the FEMA- and SAMHSA-supported program. Those are available to all of the States once an area has been declared a disaster. DTAC has also offered these trainings or pieces of these trainings as they are doing today in the form of this webinar.

Moderator: Our last question. Many cultures have a fear of going to see a mental health professional. Besides the standard individual therapy setting are there alternatives that can be offered to assist those impacted by a disaster?

Dr. Naturale: Absolutely. As a matter of fact, we have learned more recently in some of the more recent research that outreach and crisis counseling can actually be more effective in mitigating the development of serious mental disorders than traditional therapy that is offered over multiple times. There is some research around that from 9/11, from Katrina, and from some of the work that has been done in Florida after the hurricanes. The Crisis Counseling Assistance and Training Program is an ideal model that talks about how to provide crisis counseling and supports in the outreach modality rather than traditional office space therapy as the best ways to support communities after a disaster.

Moderator: Thank you, Dr. Naturale. I would now like to introduce Dr. Curt Drennen. Dr. Drennen is with the Colorado Department of Public Health and Environment Emergency Preparedness and Response Division, managing the Disaster Behavioral Health Services section. Please welcome Dr. Drennen.

Dr. Drennen: Thank you. Good afternoon everybody. I want to put out a thank you to all of you for taking time out of your busy schedules to learn more about disaster behavioral health and all that is happening in this field. My part of this webinar I want to cover the following three objectives. First of all, provide you with some basic tips on how to interact with and support survivors and identify what they need the most; basically, what can you do. Second, provide you with basic tips on when to get other help. Finally, help you identify some of the characteristics of people who may need more help or special attention. When we are talking about disaster behavioral health often there is a very broad range of work that can be done. We are covering today the initial response period. Some of the fundamental here is disaster is a chaotic time for community and for individuals. This often leads to fear and stress. The processes of fear and stress actually decrease a person's ability to think and process and plan and problem solve. The purpose of disaster behavioral health in these early interventions that we will be talking about is to be able to improve adaptive functioning by helping people decrease their stress. I often try and provide the analogy of the tachometer on your car. When you rev your car up, up in the 7,000 or 8,000 or 9,000 ranges the car can function briefly at that level, but if you stay there for too long it quickly breaks down and does not provide you the transportation that you need. The basic same things happen with our bodies when we are overly stressed for an extended period of time our ability to process information, to problem solve, to focus, to plan, to communicate, even to follow directions tanks very quickly and it's difficult for people in that environment to engage in the activities that they really need to do. Disaster behavioral health, the basic interventions are designed to help bring down that individual's revved up system so that they can move forward and do what they have to do as an individual, as a family, or as a community to take care of themselves. What can you do? In the immediate aftermath of a disaster the first and most important thing is to connect with people. Like Dr. Naturale said, this is not therapy by any means. We are not waiting for people to come to an office seeking help. This is about an outreach approach to community and to individuals getting out and connecting with people. It is very simple, you get out there, you introduce yourself and you engage in general conversation, and you take your cues from them as to what their needs might be. One of the assumptions I didn't put in here is that disaster behavioral health happens as a part of a system. You are not out there on your own typically by yourself. You are part of a team, you are part of a larger structure that is reaching out to the community to provide these services. Following connection with someone, one of the most important things is to help people feel safe. Helping the system and addressing initial physical safety issues whether finding shelter, getting people out of the rain, getting people in a safe place away from fires or wind or even a terrorist threat if there is an active event happening. Getting people physically safe is the first step to reducing that extreme level of stress. The next step is limit exposure to other threats, whether they are personal threats from other people, threats from overexposure with the media as the media does its job to communicate and tell the story. Finally, helping people connect with their friends and family and making sure that they are safe. Third step is helping people calm down, getting folks grounded. The best way to do this is through conversation, but also think about how you like to be comforted. What are those things that you need when you are extremely stressed that help bring your feet back to the ground and get you comforted and ready to move forward? Basic steps for calming someone down, making sure they are oriented to the present situation and the environment around them, modeling with them and taking some regular breaths to slow themselves down. Finally, helping them kind of identify verbally what is in their environment. The next big thing is getting people connected. We know that people's individual social network is their greatest source of safety, greatest source of support. Helping the person identify who they need to get connected to, a parent, a child, a friend, a colleague, who do they care most about? Who are they worried about and what does that

person need from them? Finally, as you move forward, other things that are basics to this disaster behavioral health is getting people active, letting them have action in their life to feel like they are empowered to do what they need to do to move themselves forward. We really want to promote that sense of survivorship and not victimhood. Finally, speaking to the future that the community will get through this that an individual get through this. Will things return to what they were? Probably not. The individual and the community will have to form a new sense of normal moving forward. Talking about that recovery process and giving hope to that is critical. The things that we know are not workable are pretty simple. Reassuring people in the moment. One that you understand what they are going through or two, that everything will be okay. That tends to create a disconnection between the helper and the survivor. Don't try to fix the situation. Often helpers get into the field wanting to be of support and fix things for others. That is not a workable process in a disaster situation. Sometimes responders get really irritated with folks that are having an emotional response. Out of their own frustrations or fears or irritations they tell the person to calm down. That is not helpful. It can never really bring that person to a grounded situation. Finally, don't assume the pathology, like April talked about earlier. Don't assume the person is trying to get attention or is simply needy. Spend some time with them and find out what their true needs are. There are several core signals that you need to reach out for further help. Pull in a trauma specialist or a licensed mental health professional when you notice someone who is highly disoriented and confused and some basic connections and grounding techniques don't help them settle down and gain a sense of where they are. A frantic situation, panic person is often very difficult to get grounded. Pulling in extra support and help is often important. Someone who is extremely withdrawn or apathetic or shut down, they have pulled away from the groups that are in the immediate surroundings, that can be an important red flag. Someone who is angry, aggressive that can be a signal of being overwhelmed, but it can also be very difficult to pull someone out of that strong emotional response without some extra help. Finally, exceedingly worried. Someone who is exceedingly worried is stuck in the future. They are not staying present to the current situation, identifying what they need to do to move forward and so they may need some extra support and help. In all of this disaster behavioral health is structured to be all things to all people in some ways. At the same time we are also very cognizant of the high-risk populations within our communities. Children and youth, especially if they are separated from their families are important individuals that you need to get connected to quickly and help them get the support that they need. Parents and caregivers of children can easily be overwhelmed in the present situation following a disaster. Being a parent is often an overwhelming task all by itself and then you throw in the chaos of the disaster and that increased risk for overwhelm and overstress. Older adults simply because of limitations, physical limitations are a population that we want to be aware of. People with prior trauma or serious mental illness, not always, but often do have some significant inability to ground and get through high stressful situations. People with disabilities, not only functional and physical disabilities, but developmental disabilities often are in need of greater resources. People with a history of substance abuse, the stress of a disaster can push them back to using that old coping skill to move them forward. The last four points, individuals with low income often don't have the resources that middle- and upper-income folks have, therefore making it more difficult for them to replace the resources that they had after disaster. Public safety workers, your first responders, fire, police, emergency medical technicians, these folks are constantly putting themselves at risk, constantly overexposed to the traumas that follow a disaster. That overexposure puts them at a greater risk for downstream problems. The interventions for these folks often are the very same ones that we have already covered. You often need to take a little more time, slow down, connect with these individuals, find out what their needs are, what might be their extra risk and help get them connected to the resources that are hand.

Moderator: Thank you very much Dr. Drennen. We have three questions for you. First, when dealing with people who speak another language or are hard of hearing and no interpreters, including that person's relatives aren't available, how would one provide comfort and help minimize fear?

Dr. Drennen: This is a situation where preplanning really is so critical. You never know what the needs of individuals and groups and families after a disaster are going to be. Being able to access a wide variety of interpreters and being able to bring in that resource takes preplanning. If you haven't done that and if you don't have those resources, presence is your greatest friend. Being connected with people, being able to utilize simple communications techniques, having picture books, sign books that can help communicate across language barriers or other barriers is critical. Really connecting with those larger organizations within your community that can bring in those resources quickly is the most important.

Moderator: What about other specific populations such as those with developmental delays or autism or young children? How does one treat or address them in a disaster setting?

Dr. Drennen: Often some of the best things you can do are reach out to the caregivers and parents of these individuals. Having those caregivers being present and being a grounded source of support for children and for individuals with developmental disabilities often is their best cue to recognizing that they are safe and that they too are being cared for. Often reaching out to those caregivers is your first step. Second, again, I will repeat that presence. Being with them, slowing down, and getting at their level, connecting with them on a simple human level providing that comfort is what they need.

Moderator: What are some examples of things people can do that are taking action?

Dr. Drennen: Everything from sitting down and creating a plan, a playbook for yourself going forward after the disaster, creating priorities. If it is a shelter situation, maybe getting teenagers that don't feel like they have a whole lot to do to connect with and build an area for smaller children to feel safe and comfortable in to play or to help connect different age groups so that they can provide support and meet needs that the other individual or age group cannot meet in the present moment.

Moderator: Thank you again Dr. Drennen for your presentation. I now would like to introduce Mr. Anthony Barone. Mr. Barone is a senior associate with ICF International, assigned to the Fairfax County Health Department, Office of Emergency Preparedness as a public health preparedness planner. Please welcome Mr. Barone.

Mr. Barone: Good afternoon everybody. Thanks Curt and April for your information. It is absolutely wonderful. As a responder I want to be transparent in illustrating that I am not a disaster behavioral specialist. In other words, I actually represent fire, EMS, law enforcement industry as well as I am an active responder to emergencies and disasters throughout the United States on a Federal level as well as an EMS council member at a local jurisdiction. I am not a disaster behavioral specialist, but the goal for me being here today is to bring the concepts and the materials that April and Curt had discussed to a level where responders can use these in the field. To go over some things, disasters as we have seen and as a lot of you already know, impact individuals and populations. This can be the single survivor that you are working with in the field or the entire community. A lot of the consequences from disasters can be presented immediately or rapid or delayed. As a first responder you might not be seeing some of the consequences or risks immediately; they may present later on. In some patients or some survivors the

reactions or consequences can be very subtle or they can be very severe. Predominately first responders are trained to focus on lifesaving efforts. We do this at disasters when we are responding to emergencies and large-scale events with a limited amount of resources. We are trying to do the best and the most for the most amount of people. What we focus on as responders are sorting patients, typically by life-threatening injuries or illness. We look at green patients, or those who are able to ambulate and walk towards us and we categorize those patients for treatment and then we move on to yellow and red. Even expectant patients or black patients, we very seldom as responders in the heat of the moment focus on disaster behavioral support because of the nature of our training. First responders, we have to remember are not disaster behavioral specialists. We are not expected to be. One known fact is that disaster behavioral health is currently not fully integrated into our training and one of the consequences of that is that we are not necessarily fully aware of the psychological risks associated with disasters. A lot of things that Curt and April talked about today are not part of responder training yet they are critical in treatment of survivors and patients during disasters. In addition, disaster behavioral health practices are not a function of the day-to-day responses that emergency personnel see, whether you be in the ER as a nurse or a paramedic or an ER physician or an emergency manager. We deal with emergencies, large, small, and medium, all different sizes, but we don't always deal with disasters. A consequence of that is that responders are sometimes less likely to utilize the basic disaster behavioral skill set because it is not something we are familiar with on a day-to-day basis. Trying to bring DBH to the streets and to the disaster response in the field. What we can do as responders is focus not just on life-threatening events. We can also focus on psychological emergencies simultaneously. This is not to say that life-threatening events take second; they don't at all. We have to do the things that are absolutely emergent and critical—stopping blood, sorting patients, moving quickly, and doing everything we can. However, as responders we can apply the concepts that Curt talked about with safety connecting and calming to better assist and enable survivors to achieve a quicker recovery. An example, by ensuring scene safety we enable survivors to slow their tachometer, to being to calm. Doing mass patient transports, making certain that we keep families together and unified during these events will also help facilitate a more effective, efficient recovery for survivors. The biggest thing is making certain that we are controlled and measured with our response. By being professional, being controlled we enable survivors to have an example to look at and to mirror as well. Survivors do respond to disaster behavioral health treatment in the field by first responders. We don't have to be experts, but survivors will respond. Maintaining professionalism, compassion, empathy, these are all ways we can enable survivors to respond. From an emergency management or from an incident command perspective, maintaining command and control of your scene. Survivors see this. They can see a professional and a professional response unfolding. This allows them to calm by feeling more safe and by feeling assured that the responders there are going to take care of them. The quicker and the safe response that we have allows a normalcy to be achieved and for the survivors to move towards recovery. Just because we want to move fast during an emergency response we certainly do not want to compromise safety, safety for responders, and safety for the scene. Safety for the survivors is absolutely paramount and comes first always. Curt mentioned a little bit about preparedness and planning in pre-disaster preparation. This is absolutely critical for first responders to be able to apply disaster behavioral concepts in the field. We must integrate these concepts into our day-to-day practices and to trainings into exercises. We must focus on how these things can be used during training, during non-events so that we can apply these skills during disasters. If we don't focus on this now when the disaster has not occurred we will not be able to achieve this during the disaster. Curt also mentioned a little bit towards the end about being human. This is enormous. Responders, we are not disaster behavioral specialists, but we are human beings and we can encourage survivors. We can be very professional. A simple smile to someone can go a long way. Survivors do respond to empathy, compassion, and honesty. Just being human will allow them to also recover a lot more quickly. I have a few quick examples of a select couple of responses that go back quite a bit. Early on in my career I responded to a tornado in Blue

Ash, Ohio. It is a suburb of Cincinnati. During the response I was an emergency medical technician and doing a lot of recovery work. A tornado went through a community and leveled the entire neighborhood as well as the school that was right there. Our response was to help clean up some of the neighborhood and to help the survivors with the early recovery efforts. As a very young EMT I had absolutely zero training in DBH; however, the survivors responded tremendously to the communities outreach and the communities support. Us just being there and showing presence and being human allowed those survivors to be grounded and also to be calm. During Hurricane Charley, the same efforts in South Florida, the same concepts. As a responder, just being there and providing support was critical. What we saw with Katrina from the response and the recovery efforts were some challenges with disconnecting families and separating families. Working at one of the patient reception areas in South Florida we were receiving patients from C130s, critical care patients. The efforts to maintain unification was tremendous. We put forth a lot of efforts when patients came off and survivors came off of those planes to make certain that they were kept together and transported with one another or linked in some way, shape, or form and just keeping those families together. It was amazing to watch survivors walking off of the plane or having total loss of infrastructure, community, and belongings to watching them smiling, knowing that they are walking towards responders who are organized, have a solid command structure, and who are maintaining strong efforts to keep those families together. With those family networks and keeping them together allowed a lot of folks to really move forward with recovery. Separating survivors can be absolutely detrimental during disaster.

Moderator: Mr. Barone, we have two questions for you. First, how does one overcome the perceived stigma among some responders about coming forward and admitting they may have a specific issue stemming from exposure to a disaster?

Mr. Barone: Responders as well as survivors, we are all vulnerable to the effects of emergencies. Responders realize that we are sometimes the only thing between survivors and treatment. While we provide services to our survivors, also recognize our own limitations. We are not free from becoming or developing consequences of exposure to disasters. The stigma associated with coming forward has been knocked down tremendously. Responders that I worked with in the field across the country do talk very openly and they are—especially with a lot of these trainings that we are seeing, they are more open to discussing and saying “This is really bothering me.” The stigma is going away. That is something that I have seen in the field where in the past it was a challenge.

Moderator: How can an emergency manager best utilize the media to address fears and concerns by the public and to provide some psychological comfort?

Mr. Barone: Emergency managers working with the media is absolutely critical. By providing effective and efficient communication to the public, real time and being honest and being clear allow survivors to begin the recovery process. Providing information regarding where shelters can be, where they can obtain DBH assistance, where they can obtain food, FEMA assistance, wherever it might be the media is a tremendous asset that we must embrace and emergency management can use the media to get those messages out. Social media as well is one of the huge movements we have seen in the last several years. As we have seen with different applications, Facebook or LinkedIn or Twitter, getting that information out to folks quickly and having it be from one voice or one reputable organization is absolutely critical to moving towards the recovery process.

Moderator: Thank you so much Mr. Barone for your presentation. We have one question for all speakers. There has been a lot of movement towards the Psychological First Aid Field Manual developed by the National Center for Child Traumatic Stress. Can you take a moment to provide an overview for our participants?

Dr. Drennen: That is a tall task. Let's try, April and Anthony—I will start and you guys kick in wherever. Psychological First Aid developed by the National Center for Posttraumatic Stress Disorder and the National Child Traumatic Stress Network is quite amazing and flexible tool. It is split into eight core components, some of which I covered today in my part of the webinar. The first one is contact and engagement. That activity of getting out and connecting with survivors. The next one is providing safety and comfort, helping people calm down and have a sense of safety after an event. The third core component is stabilization, helping to get people grounded with a sense of what is going on and what needs to happen going forward. April, I am going to pass it to you.

Dr. Naturale: Thank you very much Curt. I want to reiterate what Curt said. Much of what is developed and delivered in Psychological First Aid, which is really aimed at the very early, the immediate days after a disaster is very much in line with the Crisis Counseling Assistance and Training Program. What you see is that people need to have support, that compassionate presence, make sure they are safe, and have comfort and their basic needs. We move to stabilizing them if they are very much in a panic or very emotionally overwrought. Then we start to do the same things that we would do in any type of support system—ask information what their needs are, are there family members that we can call for them. Do they have people that they want to connect with? What are their basic concerns? As Dr. Drennen said earlier, ask them where they are and what it is that that need. Do a little information gathering and then provide practical assistance. Can we help them make a phone call? Can we get them to a space to sit down, get a blanket, get some water, and talk about what their immediate needs are and how we can help to connect them with those immediate needs as well as the sixth component which is connection with social supports, whether that be a family member who can be with them or someone they can spend time with and not be alone. Social supports might be for some people an AA meeting, a sponsor and make sure that we have that conversation about providing the information about how very important it is to connect with others. In some situations you may have opportunity to address the seventh core action, which is coping. We can remind people that they may have done things in the past when they had a death in the family or another trauma. Maybe they are someone who likes to walk or stretch or exercise and they can get back to doing those things. Breathing retraining, yoga, meditation, listening to music, calming music. What can help them to cope as well as some of the more sophisticated techniques like CBT or other things that might help people to think differently and help control and regulate their emotions? The last core action is that linkage with collaborative services. Many people need assistance with either applying for help to FEMA or maybe for unemployment or other types of assistance and it is very appropriate especially in those early days to help people that may be overwhelmed and disorganized and need help connecting. We are not going to do case management where we are actually providing the specific services for them and filling out forms, but we are providing the emotional support to help them. PFA is very well supported by the FEMA staff who indicate that it is a very helpful and useful intervention to learn and the National Child Traumatic Stress Network does offer this training online as well and the booklet itself is available for download on the National Center for PTSD's website.

Moderator: Thank you Dr. Drennen and Dr. Naturale. We are going to wrap up today's webinar, but before concluding I want to let you know about an upcoming webinar that will focus on issues and best practices for mental health professionals and professionals in other fields who are responding to the needs

of culturally diverse communities in the aftermath of a disaster. The webinar will be presented on August 24th, 2011 at 2 p.m. eastern time. For registration information please visit the SAMHSA DTAC website at http://www.samhsa.gov/dtac. If you have followup questions for our guest speakers you can contact them via email. Their addresses are now on the screen. Thank you all for participating in the SAMHSA DTAC Introduction to Disaster Behavioral Health webinar.

[End of session.]