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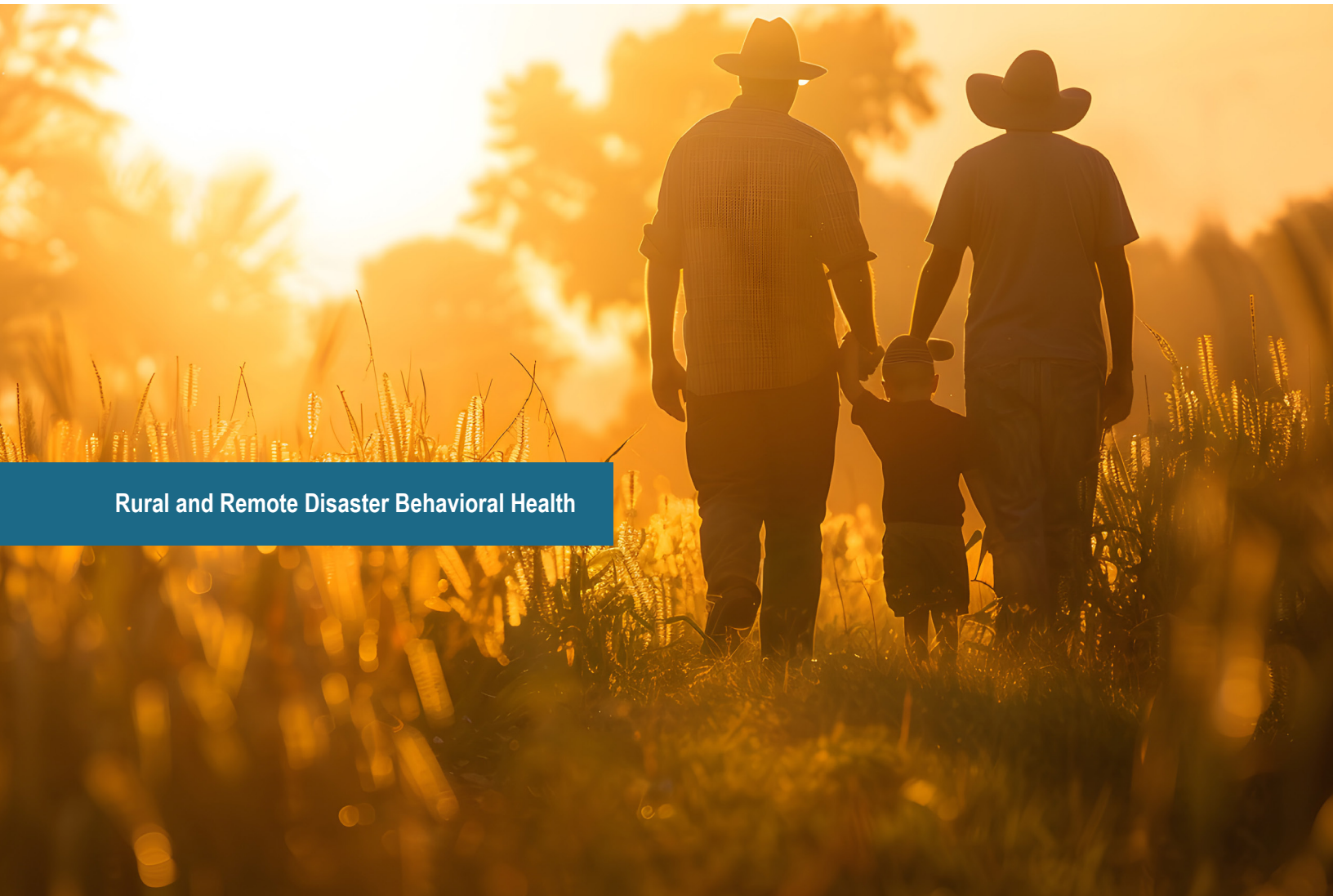

Rural and Remote Disaster Behavioral Health

SAMHSA
Substance Abuse and Mental Health Services Administration

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The Dialogue is a quarterly technical assistance journal on disaster behavioral health which is produced by the Substance Abuse and Mental Health Services Administration (SAMHSA) Disaster Technical Assistance Center (DTAC). Through the pages of *The Dialogue*, disaster behavioral health professionals share information and resources while examining the disaster behavioral health preparedness and response issues that are important to the field. *The Dialogue* also provides a comprehensive look at the disaster training and technical assistance services SAMHSA DTAC provides to prepare states, territories, tribes, and local entities so they can deliver an effective disaster behavioral health response.

SAMHSA DTAC provides disaster technical assistance, training, consultation, resources, information exchange, and knowledge brokering to help disaster behavioral health professionals plan for and respond effectively to mental health and substance misuse needs following a disaster.

To learn more or receive *The Dialogue*, please call 1–800–308–3515, email **dtac@samhsa.hhs.gov**, or visit the SAMHSA DTAC website at **https://www.samhsa.gov/dtac**.

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In This Issue

Rural communities, characterized by their geographical isolation and unique sociocultural fabric, are found in every state in our nation. These communities face particular challenges during emergencies. While all communities and disasters are unique, rural communities affected by disaster often have a common set of experiences.

When dealing with a range of hazards—like floods, wildfires, tornadoes, droughts, and industrial accidents—rural populations often face complications that extend beyond physical damage. Disasters have a significant and unique impact on behavioral health in these areas. This issue of *The Dialogue* explores several critical aspects of rural disaster behavioral health (DBH), providing insights into how rural residents cope with and recover from disasters. The articles examine the disparities in access to mental health services, the role of community resilience, and the effectiveness of outreach and intervention strategies tailored to rural settings.

By highlighting personal experiences, evidence-based practices, and innovative approaches, this issue seeks to inform DBH policymakers, practitioners, and researchers about effective approaches for addressing DBH needs in rural communities.

In our first article, experts from the Bioecological Center for Rural Children's Health (BeRCH) identify unique behavioral health challenges facing seasonal and migrant farmworkers, as well as solutions for supporting their behavioral health. Next, author Marisa Fife, a registered nurse and integral part of the Substance Abuse and Mental Health Services Administration (SAMHSA) Disaster Technical Assistance Center (DTAC) writing team, shares her personal account of surviving Hurricane Ida as a rural resident in 2021 and spotlights her lessons learned and best practices in rural communities. In the next article, Lynn Moskowitz and Steve Moskowitz of the State of New York discuss their perspectives on supporting rural and remote communities through their state's recent Crisis Counseling Assistance and Training Program grants in an interview with SAMHSA DTAC staff. After that article, Beckie Gierer, Director of the Missouri Department of Mental Health Office of Disaster Services, explores the nuances of rural DBH and offers specific guidance on planning, preparedness, and response. In another interview with SAMHSA DTAC, Jennifer Dunn, Deputy Assistant Commissioner for Operations South with the Georgia Department of Behavioral Health and Developmental Disabilities, discusses her DBH work focusing on agricultural and farming communities, including successful strategies and tactics for community outreach and engagement.

If you have experience with rural DBH, other community members can learn from your efforts. Please contact us to share your stories and lessons learned.

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Contributors

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Jennifer Dunn, LMFT, is currently serving as the Deputy Assistant Commissioner for the Georgia Department of Behavioral Health and Developmental Disabilities. She previously worked as the University of Georgia's Rural Health Agent for the Southwest District of the University of Georgia (UGA) Extension. She earned both her bachelor's and master's degrees in child and family development from the University of Georgia in 1996 and 2001, respectively. Dunn is a licensed marriage and family therapist, a recipient of the Intensive Cognitive Behavior Therapy for Schizophrenia Certification at the Aaron T. Beck Institute for Cognitive Behavior Therapy in Philadelphia, and a trainer for Mental Health First Aid and QPR (Question, Persuade, and Refer) to assist with suicide prevention. Before beginning her position with UGA Extension, Dunn worked for the Department of Behavioral Health and Developmental Disabilities for 16 years, where she served as the Regional Services Administrator for the 24 counties located in the southwestern portion of the state. In her current role, Dunn is helping advance the vision and mission of the Department of Behavioral Health and Developmental Disabilities in the southern part of the state with a focus on rural communities. She also is an Advisory Board member for the Georgia Department of Community Health's State Office of Rural Health and their Georgia Farmworker Healthcare Program.

Marisa Fife, RN, B.S.N., is a Science/Medical Writer supporting SAMHSA DTAC. She earned her B.S. in pre-veterinary & animal science from the University of Massachusetts and her B.S.N. from Johns Hopkins University School of Nursing. After working over 15 years in animal and human health care, she has developed a unique interdisciplinary perspective. Her career as an oncology nurse allowed her to interact with diverse communities across the United States, often impacted by local and national disasters, giving her an understanding of the complex nature of health care. During the COVID-19 pandemic, while working as a nurse on an oncology and bone marrow transplant unit, she saw firsthand how global health emergencies could impact healthcare systems, providers, families, and patients. After transitioning to medical writing 3 years ago, she now uses her clinical and medical writing knowledge to advocate for global, community, personal, and multi-species health. Fife contributes content to

SAMHSA DTAC resources that support behavioral health as part of community disaster recovery efforts and resilience in a world of increasing environmental change.

Beckie Gierer, M.S., has worked with the Missouri Department of Mental Health (DMH) for 18 years and the State of Missouri for 23. She is the Director for the DMH Office of Disaster Services, as well as a contracted trainer with SAMHSA for the Federal Emergency Management Agency (FEMA) Crisis Counseling Assistance and Training Program (CCP). In this role she has trained crisis counselors in states and territories across the country in response to disasters and public health emergencies. Gierer provides trainings for DMH consumers, staff, and providers; voluntary organizations; hospitals; businesses; and first responders on behavioral analysis, trauma-informed care, self-care/team care, personal preparedness, Mental Health First Aid, Psychological First Aid, continuity of operations, Skills for Psychological Recovery, disaster fatigue, and the importance of behavioral health in emergency planning. She is also part of a cadre of FEMA trainers for continuity of operations and one of three in FEMA Region VII. Gierer was part of the team that created and stood up the first-ever Behavioral Health Strike Team for the State of Missouri. She has deployed and/or worked on responses to crisis events including flooding, tornadoes, a wildfire, pandemic, school shooting, train derailment, and the Branson duck boat accident. She has contributed to resources such as the Missouri Well-being Playbook for health care and an online course called Trauma-Informed Care for Helping Professionals. An advocate for mental health and suicide prevention, Gierer has both professional and personal experience with mental health crisis and recovery and shares those experiences through her work. She has a master of science from the University of Central Missouri.

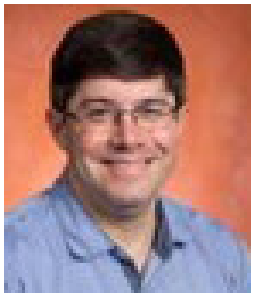
Joe Grzywacz, Ph.D., is the Associate Dean of Research in the College of Health and Human Sciences at San José State University, a proud Hispanic-serving institution, and former Florida State University faculty. Grzywacz has worked with Latino farmworker communities in 5 states over 25 years to undertake and publish research on their topics of concern. He has published over 275 peer-reviewed papers, enabled by 20+ years of continuous federal support from agencies like the National Institutes of Health, Centers for Disease Control and Prevention, and the U.S. Environmental Protection Agency. Many of those papers focus on pesticide exposure, strategies to disseminate health information that honors cultural beliefs while achieving behavioral change, migration-related stressors, and the myriad health threats farmworkers and their families confront and work through with honor and dignity.

Lynn Moskowitz, B.S., earned her degree in communication at Ohio University and has worked in some form of communications for many years, from her time as a newspaper reporter and photographer to her work in public relations and media design for numerous nonprofits. Following a volunteer effort supporting a FEMA CCP in 2008, Moskowitz became a regular member of paid CCP staff for each of the subsequent major disaster response activities administered by the New York State Office of Mental Health.

Steve Moskowitz, M.S.W., B.A., recently retired from serving as the Director of the Bureau of Emergency Preparedness and Response for the New York State Office of Mental Health (OMH). Prior to his 16 years with OMH, Moskowitz's career arc included stints in clinical services to youth and families, not-for-profit agency administration, family mediation, and most recently as an adjunct instructor at the State University of New York College at New Paltz teaching disaster psychology.

In his time with OMH Moskowitz participated in numerous major disaster responses and initiated and/or directed five FEMA CCPs including responses to Superstorm Sandy and the COVID-19 epidemic. Efforts at OMH also included creating training curricula used in New York State for preparing both responders and the public on the psychological impact of trauma and disaster and cooperative efforts at bridging gaps between the public and mental health sectors in the application of mental health support following critical events.

Javier I. Rosado, Ph.D., is an Associate Professor at the Florida State University College of Medicine's Isabel Collier Read Medical Campus in Immokalee, Florida. He also serves as a psychologist at a Federally Qualified Health Center primarily treating Latino migrant farm-working families. Rosado is the Director for the Florida State University Center for Child Stress & Health—an affiliate partner in SAMHSA's National Child Traumatic Stress Network—and is the Co-Principal Investigator of the Bioecological Center for Rural Children's Health.



Gregg Stanwood, Ph.D., is Professor at the Florida State University College of Medicine, and he also serves as the Co-Principal Investigator of the Bioecological Center for Rural Children's Health. He is a developmental neuropharmacologist and behavioral neuroscientist. His lab studies investigate the developmental origins of brain disorders through careful assessments of brain developmental trajectories following genetic and environmental perturbations. His research particularly focuses on the long-lasting neuro(mal)adaptations that can be induced by environmental stressors. His work integrates multidisciplinary studies of brain architecture, cell signaling, and behavioral pharmacology.

Supporting Seasonal and Migrant Farmworkers: Mental Health and Substance Use Risk in the Face of Extreme Heat and Wildfires

By the **Bioecological Center for Rural Children's Health (BeRCH) at Florida State University,** including **Javier I. Rosado, Ph.D.,** Florida State University College of Medicine's Isabel Collier Read Medical Campus, **Gregg Stanwood, Ph.D.,** Florida State University College of Medicine, and **Joe Grzywacz, Ph.D.,** San José State University

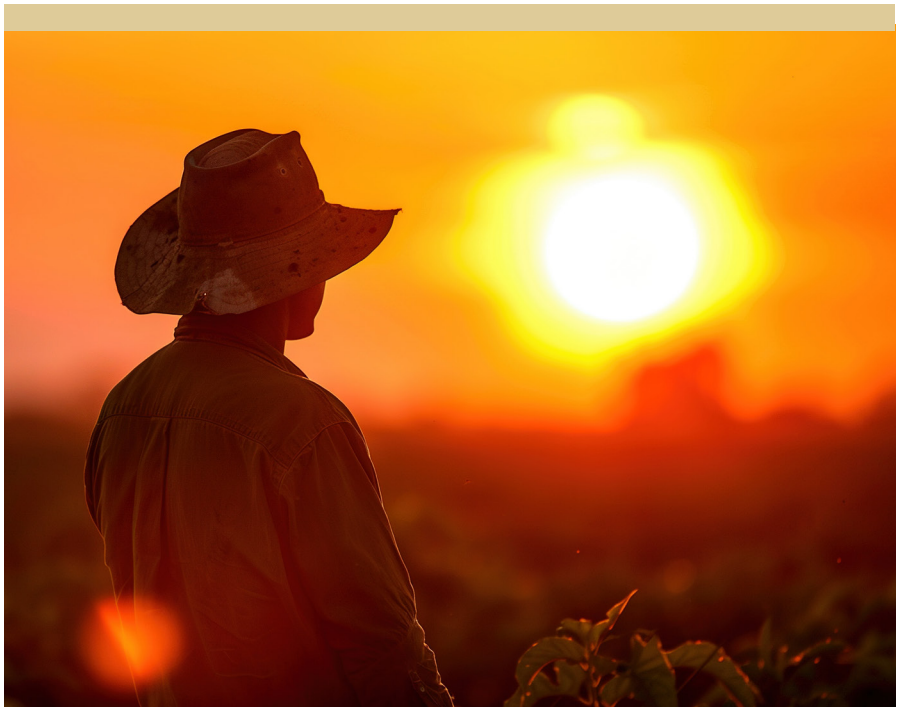
Introduction

As a psychologist serving migrant and seasonal farm-working families, my clinical days start early, accommodating families who schedule appointments around their work. During one of my recent sessions, a client we will call Miguel sat before me with his hands weathered from years of toil and shared something to the effect of "I find myself at the mercy of the skies." He continued expressing in Spanish, "el sol quema más que antes" to convey "the sun scorches more fiercely than before." The weight of his worries was evident in his furrowed brow. "It's as if the seasons themselves are confused. The unpredictability . . . it haunts me." When I offered hope, he asked, "How can I plant seeds of hope when the climate may betray me?" Miguel's fear of extreme heat extends beyond his livelihood to the crops he cultivates with pride—a sentiment shared by many farmworkers.

Who Are Seasonal and Migrant Farmworkers?

Seasonal and migrant farmworkers are a diverse and essential workforce in the U.S. agricultural industry. They are hired workers, distinct from farm owners and their families, responsible for planting, cultivating, and harvesting crops, with some also involved in animal production. The National Center for Farmworker Health estimates there are 2.9 million agricultural workers in the United States, with

15 percent identified as migrants, meaning they relocate within states and regions to follow crop cycles. Most farmworkers (85 percent) are classified as settled or seasonal, indicating they stay in one location. Most of these workers are Hispanic/Latino (70 percent) and foreign-born (70 percent), with males comprising the majority, though about one-third are female.



Understanding the Risk of Heat-related Illness and Wildfires Among Seasonal and Migrant Farmworkers

A report from the U.S. Centers for Disease Control and Prevention (2008) indicated that migrant and seasonal farmworkers are 20 times more likely to die on the job from a heat-related illness than U.S. civilian workers. Although the physiological "causes" of elevated heat-related fatality and illness are unknown, the proximal causes are identifiable—prolonged exposure to high temperatures (and humidity, especially in tropical areas like Florida) and demanding tasks in open fields with limited access to water and shaded rest areas. A piece-rate payment system likely often exacerbates the risk. Piece-rate is where workers are paid to complete a particular task by every "unit" created or harvested (like how much fruit is picked daily), encouraging workers to push beyond their physical limits without breaks for rest or hydration.

Wildfires pose an elevated and existential threat to farmworkers. When a wildfire ignites, farmworkers' opportunity to earn wages for food and shelter immediately ends because few are eligible for or covered by unemployment insurance. Further, wildfires destroy large swaths of land, destroying agricultural production for an entire region, often forcing farmworkers to seek agricultural work in another unaffected region. As one team reported in response to a series of wildfires in California, the farmworker population is often "invisible": They infrequently receive emergency preparedness and evacuation information, and they are often an afterthought when disaster aid arrives (Méndez, Flores-Haro, & Zucker, 2020). Similar reports have been documented in hurricanes and other regions affected by climate-related natural disasters (Pagán-Santana, Liebman, & Seda, 2023).

Mental Health Implications of Heat-related Illness, Wildfires, and Other Climate-related Natural Disasters

Heat and humidity are linked with poor mental health. A summary of scientific studies reported in 2021 that for every 1-degree Celsius increase in temperature, there is a 2.2 percent increase in mental health-related death and a 0.9 percent increase in mental health symptoms and disorders (Liu et al., 2021). The summarized studies were undertaken in the general population, with ongoing access to centralized air conditioning in their homes, offices, and cars. Now consider farmworkers with limited cooling opportunities while

working in open fields, often using congregant transportation to fields in un-air conditioned buses, and residing in housing that frequently lacks air conditioning with a corresponding high heat index within the dwelling (Quandt et al., 2013).

Eco-anxiety

Behavioral health experts are observing an increase in climate-related anxiety and stress, termed eco-anxiety, among the general population (SAMHSA Disaster Technical Assistance Center, 2024). This includes a range of emotional responses, from anxiety to depressive states. For farmworkers, eco-anxiety is compounded by their connection to their work and harvest. Climate disasters like wildfires cause ecological grief, affecting not only their livelihood but also their identity. The loss of crops can lead to significant stress, anxiety, and depression, and substance use as a coping mechanism.

Exacerbation of Preexisting Behavioral Health Conditions

Preexisting mental illnesses heighten the risk of adverse mental health outcomes from climate- or weather-related disasters. Farmworkers face mental health disparities due to hazardous work conditions, poverty, inadequate housing, and lack of support. Constant relocation can cause depression and stress, while social and cultural isolation contributes to psychiatric distress, depression, and anxiety. Up to 45 percent of migrant farmworkers report moderate depression, and 18 percent experience significant anxiety levels (Hasan et al., 2021). Depressive symptoms also increase with higher amounts of perceived discrimination and economic insecurity in Latina farmworker women (Roblyer et al., 2016).

Substance Use Disorders

Migrant and seasonal farmworkers may be at a higher risk for alcohol misuse due to factors such as the physical and emotional stress of their work; however, it's important to note that 26 percent of workers completely abstain from alcohol (Grzywacz, Quandt, Isom, & Arcury, 2007). Frequent heavy drinking is more common among single farmworkers and those who do not follow the crop (Grzywacz, Quandt, Isom, & Arcury, 2007). The risks associated with alcohol use among this demographic are multifaceted, including isolation when separated from family and support networks and cultural norms regarding alcohol as a social or stress-relief tool. Psychological distress arising from climate-enhanced disasters can further increase this substance-use vulnerability.

Synergies in Exposure

Understanding the impact of environmental hazards like extreme heat and wildfires requires recognizing that these stressors do not occur in isolation. Seasonal and migrant agricultural workers face a combination of stressors, including weather hazards, poverty,

and adverse life events, which collectively pose significant health risks. We define the cumulative impact of these exposures as "synergies," which are super-additive relationships where the combined effect of multiple factors exceeds the sum of their individual effects. The synergy between environmental threats and other stressors likely contributes to heightened mental and overall health risks. Our recently funded Bioecological Center for Rural Children's Health (BeRCH) at Florida State University aims to identify and mitigate the interactive cumulative health consequences of these stressors on farm working families, examining factors like chemical stressors (e.g., pesticides) and non-chemical stressors (e.g., childhood adversity and trauma, heat exposure, social determinants of health) to improve health outcomes, environmental justice, and equity.

To support the mental health of migrant and seasonal farmworkers, consider the following strategies:

- Adopt a biopsychosocial approach to care, recognizing the intricate relationship between biological, psychological, social, and environmental factors in health and well-being.
- Promote integrated care models that incorporate behavioral health services into primary care and emergency medicine settings. These models are particularly effective for farmworkers, who often face barriers to healthcare access. Due to myriad barriers, farmworkers often delay seeking medical care until their health concerns become chronic and are most likely to seek care from either primary care or emergency departments. Furthermore, they are far more likely to seek medical care over behavioral health care. Introducing behavioral health services during medical appointments is often an effective strategy for engaging farmworkers in care.
- Provide culturally and linguistically appropriate training and care, catering to the preferences of farmworkers, many of whom may speak Spanish and come from cultures where mental health issues are stigmatized.
- Utilize culturally and linguistically appropriate educational materials from organizations like the Migrant Clinicians Network who provide heat-related illness resources for farmworkers.
- Following a disaster-related event, assess and treat posttraumatic symptoms by aiding patients in deriving meaning from adversity. Unlike traditional posttraumatic stress disorder models emphasizing negative symptoms, some Hispanic/Latino groups prefer treatments centered on personal meaning-making from trauma.
- From the onset of treatment, identify needs and connect families with needed social services and supports.
- Prepare for care transition by offering treatment summaries and assisting in locating local service providers for patients who are relocating. ■

Rural Disaster Behavioral Health: A Guide for Outreach Workers and Crisis Counselors

By **Marisa Fife, RN, B.S.N.**

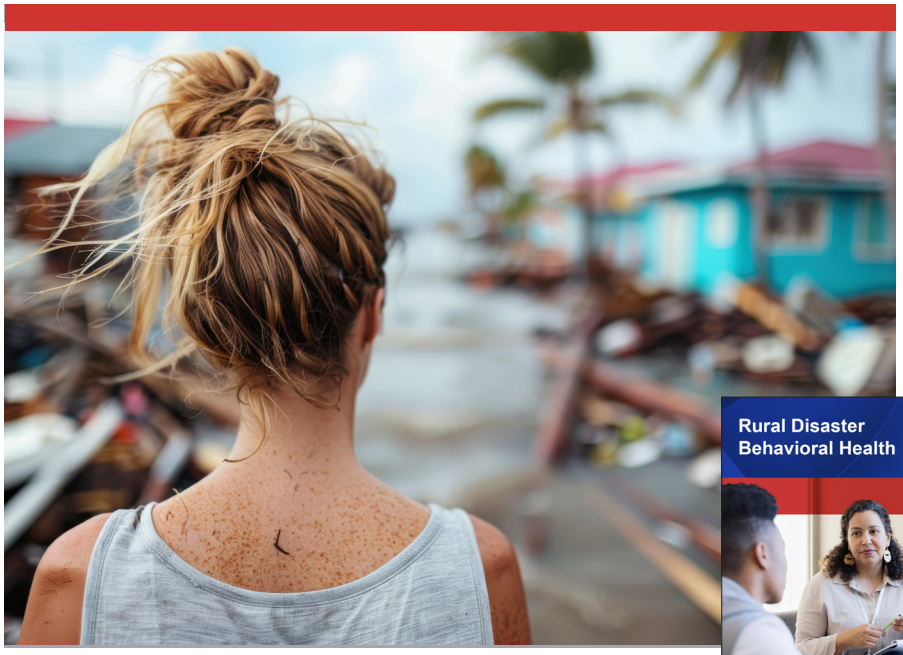
An integral member of the SAMHSA Disaster Technical Assistance Center (DTAC) writing team, Fife is also a disaster survivor who lives in a rural area and has responded to disasters, including Hurricane Katrina and COVID-19. In this article, she shares her personal experience, lessons learned, and recommendations for disaster behavioral health (DBH) planners and responders.

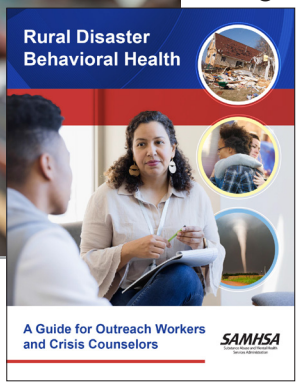
Rural Disasters: A Survivor's Viewpoint

In August of 2021, Hurricane Ida, a deadly and immensely destructive Category 4 Atlantic storm, made landfall on the Louisiana coast near to where I live. I had been preparing for days, but food and supplies were scarce in the small rural grocery stores nearby, and I didn't have the income at that time to purchase a generator. The power went out. The wind roared not like a lion, not even like a train, but like a deep, rumbling bellow so elemental it was as if the earth itself were speaking. And perhaps it was.

During the wind, rain, and flying tree branches, I did what I wasn't supposed to do. I went outside to check on my livestock. I remember running across my flooded yard with my poncho whipping around me and the rain slapping my face, the trees around me writhing in Ida's fury. Like many people with livestock or crops, my concern was not for myself, but for the living things in my care. How would we evacuate if things flooded? What safe harbor could we go to? How would I find food for the many living creatures depending on me? Why hadn't I made a plan for this sooner?

The animals made it safely through the storm, but we lost power for 2 weeks. We were fortunate, as many people in my area did not have electricity for months after Ida. We relied on battery-powered lighting and sunlight. I remember showering after the hurricane under the rainspout of my house during a thunderstorm because we had well water, and our pump didn't work without electricity. We ate canned food I had saved up, cooked on our propane grill, and drank the precious few jugs of water I had found and hoarded before the storm. To cope with the heat and humidity in the weeks following Ida (it was 90 degrees F and above), I lay on the floor with the dog to try and cool down, and I taped sheets over the windows to block out light to keep the house as cool as possible. When the air conditioner finally came back on with the power, the relief my animals and I felt was immense. And we knew how lucky we were, because so many of my neighbors had it much, much worse.





My National Oceanic and Atmospheric Administration (NOAA) radio was my only way of getting outside news for those 2 weeks, as we did not yet have internet in my area and phone lines were down. We could text occasionally, but often had no mobile service. I was horrified to hear that a local man had been attacked by an alligator as he tried to evacuate his flooded home during the hurricane. I heard stories on the radio of people running out of water, food, and medications. Nearby, a woman's farm flooded, and she made a call for help to get her animals out before they drowned. In the days after Ida, the sun shone hot and furious on all who survived, my animals and me, and the people who had lost their homes and loved ones.

The mental health impacts in my community and surrounding areas ran deep. Many of my neighbors still had psychological scars, haunted by memories of similar storms like Camille and Katrina, which had brought the region to its knees in years prior.

This could have gone better, I thought, as people murmured about past hurricanes like Katrina. Hadn't we learned anything at all from those prior disasters? Couldn't so much of the loss of life and property have been prevented? These were challenging questions in my community at the time, and for years after, as people here are still recovering from Ida. Small towns still have closed buildings and tarps on the roofs of homes. There was a lack of construction supplies and skilled construction workers in the time that followed. There were not enough workers with chainsaws to go around and clear streets of downed trees and lines. People didn't know where to go or who to call to ask for help. As of 2024, recovery efforts in the Gulf Coast region impacted by Ida are still ongoing. And I now have a generator, an evacuation plan, a much larger store of human and animal food, a supply of extra medications, extra fuel, a chainsaw, and gallons of clean drinking water.

How can we make disaster planning and response in rural areas better? Below are a few evidence-based ideas and helpful resources, including SAMHSA's *Rural Disaster Behavioral Health: A Guide for Outreach Workers and Crisis Counselors*, the source of some of the information in this article.

If there is anything you get from this article, please let it be this: what you do as a DBH professional truly and profoundly matters.

A Snapshot of Rural Populations in the United States

Rural and urban areas have similar rates of mental illness, though suicide rates are significantly higher in rural areas (Mohatt et al., 2021). People in rural areas also may be more likely to lack access to technology, skilled behavioral healthcare workers, or full healthcare services, meaning rural residents may not be able to get mental health treatment as easily or frequently as urban residents

(Mohatt et al., 2021; Sampaio, Gonçalves, & Sequeira, 2022).

How To Help Rural Communities and Individuals

Planning and preparation for disasters is difficult for reasons including uncertain timing, the challenge of political agreement around disaster preparation and response, and the context of the disaster (Shmueli, Ozawa, & Kaufman, 2021). Rural communities may face challenges in emergency preparedness, including fewer resources and less funding than needed; the lower geographical concentration of the population in many areas, making it harder to reach survivors; and limited or uneven service coverage areas for internet and mobile devices (Rural Health Information Hub, 2022c).

From planning and preparedness to response and recovery, steps can be taken to help rural communities address their unique challenges and leverage their key strengths.

Promoting Mental Health Literacy in Rural Communities

Mental health literacy is knowledge, beliefs, or attitudes about mental health issues and conditions that help with prevention, management, or recognition of specific disorders or psychological distress (Sampaio et al., 2022). For community

While the United States Census Bureau defines an urban area specifically as a densely populated and well-developed area that has a population of over 5,000 people or includes 2,000 or more housing units, the Census only defines a rural area as any area that is not considered an urban area, making it a broad and varied category (United States Census Bureau, 2023).

As of 2020, 46 million people in the United States, 14% of the total population, lived in rural areas (U.S. Department of Agriculture Economic Research Service, 2021).

The average income in the United States is $64,143 per capita, as compared to rural per capita income of $49,895 (Rural Health Information Hub, 2024d).

The average poverty rate for the United States is 12.8% while the poverty rate for people living in rural areas in the United States is 15.4%, based on 2021 data from the Census Bureau (Rural Health Information Hub, 2024d).

Unemployment rates are similar across rural areas and the rest of the country. The rural population's unemployment rate is 3.7%, while the urban population's rate is 3.6% (Rural Health Information Hub, 2024d).

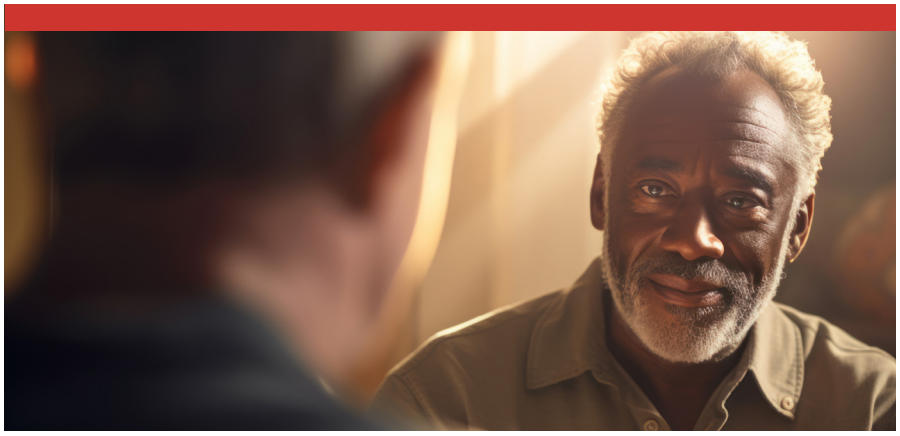
members, this translates to awareness of what mental health is and how to access mental health services, as well as further mental health education and understanding as they progress in their treatment journeys. People are less likely to access mental health care when health literacy issues are present (Mack, Whetsell, & Graves, 2022). People in rural areas also may be concerned with lack of privacy and lack of culturally competent health care (Mack, Whetsell, & Graves, 2022).

Fortunately, there are several strategies to help rural communities, including using education to reduce stigma, offering telehealth options, and working with local partners and community leaders.

Working With Rural Communities and Their Existing Networks

It is important to determine which officials and community leaders should participate in partnerships; develop planning documents; and define outcomes expected for success before, during, and after disasters (Haskins, Barney, & Paudel, 2019). Rural communities are generally as diverse as those in urban areas, and disaster response should be tailored to the specific needs of the community (Sampaio et al., 2022). Rural populations affected by disaster may include tribal communities, people with access and functional needs (e.g., older adults, people with disabilities, people with limited English language proficiency), children, pregnant people, and people without housing (Rural Health Information Hub, 2022b).

Planning should include provisions for the deep impact loss of agricultural economy can have in rural areas; unique needs of seasonal and migrant workers who may speak a language other than English; and livestock needs, as many farmers and caretakers of livestock refuse to leave their animals even when asked to evacuate (Sampaio et al., 2022). Common emotional, physical, behavioral, and cognitive reactions to disaster are reviewed in the SAMHSA *Rural Disaster Behavioral Health* guide. Additionally, signs of urgent need for referral (e.g., severe distress,



a person's desire to hurt or kill themselves or someone else) are highlighted. Resources like the SAMHSA Disaster Distress Helpline and the 988 Suicide & Crisis Lifeline are also mentioned.

Promoting Shared Decision-making in Rural Communities

Shared decision-making is a best practice model of patient-centered health care with the goal of helping patients have objective, informed, meaningful, and collaborative discussions with their care team about their health care (SAMHSA Bringing Recovery Supports to Scale Technical Assistance Center Strategy [BRSS TACS], 2023). Shared decision-making helps patients participate actively in their health care (Agency for Healthcare Research and Quality, 2013). Scientific evidence indicates that patients are open to more information about their health care and would like more autonomy in decisions affecting their health. Fostering the provider-patient relationship leads to better health outcomes, lower anxiety, better compliance with treatment plans, and faster recuperation (SAMHSA BRSS TACS, 2023). Lastly, there are also ethical considerations—patients have the right to be informed about their health care and to be an active participant in decisions about their health (U.S. Preventive Services Task Force et al., 2022).

Finding Rural Partnership Opportunities

Community partners are crucial to the success of emergency preparedness and response programs (Rural Health Information Hub, 2022a). When possible, rural communities should meet with partners to define activities, assess the extent of a disaster, formalize partnerships, and draft preparedness plans. Existing systems in rural communities—such as faith communities, rural hospitals, medical schools, law enforcement, fire service, humanitarian organizations, community health workers, libraries, and pharmacy professionals—could all benefit from emergency response and disaster training to help them further assist rural communities.

Assisting People in Acute Distress in Rural Areas

After experiencing a disaster, many people have anxiety and concerns surrounding their health, recovery efforts, well-being, and safety (Administration for Strategic Preparedness and Response [ASPR], n.d.; Texas Health and Human Services, n.d.). Children, women, and older adults with functional and access needs may be the most vulnerable and suffer increased psychological distress after disasters (Makwana, 2019). Behavioral health professionals located in rural areas experiencing a disaster are often the first to respond by delivering acute and chronic stress management guidance, counseling, and other behavioral health services to survivors in shelters, schools, and temporary housing, and in the agricultural sector (ASPR, n.d.). Although stress reactions, trauma, anxiety, emotional instability, and other psychological effects are frequently experienced by survivors of disaster, many people recover with minimal or no assistance, or with effective behavioral health interventions (Texas Health and Human Services, n.d.).

What can be done to help people with ongoing disaster-related behavioral health issues? Resources that may be helpful to rural disaster-affected communities include Mental Health America's Finding Help: When to Get It and Where to Go, the SAMHSA Disaster Distress Helpline, and the 988 Suicide & Crisis Lifeline. ■

Building Relationships, Fostering Trust: Lessons Learned Serving Rural and Remote Communities

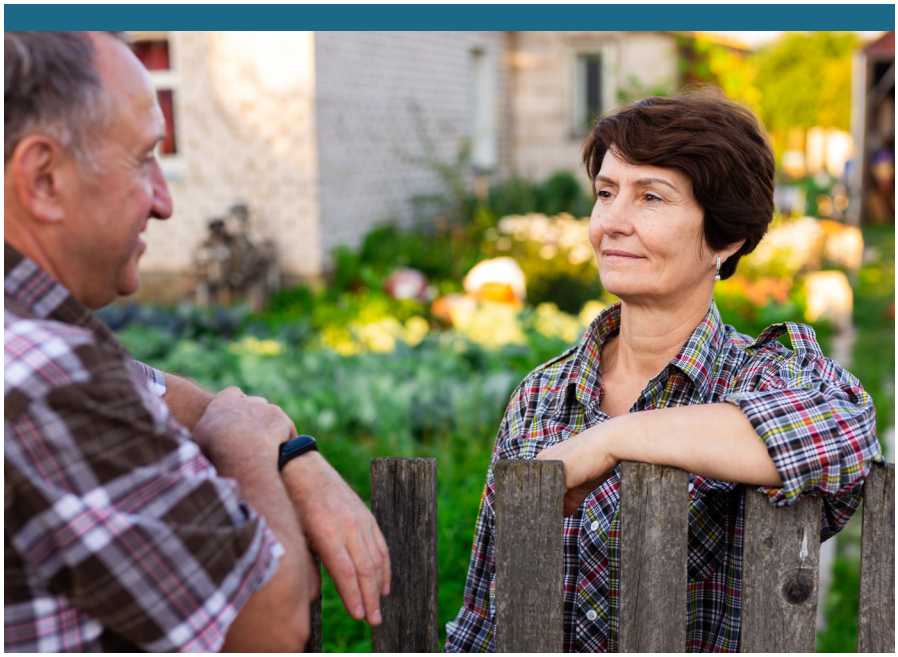
By **Lynn Moskowitz,** B.S., New York State Office of Mental Health, **Steve Moskowitz,** M.S.W., B.A., New York State Office of Mental Health, and **Sofia Cabrera,** B.A., SAMHSA Disaster Technical Assistance Center

While based on common principles, disaster behavioral health (DBH) services for a state, territory, or tribe reflect the jurisdiction's unique blend of communities and their evolving needs. *The Dialogue* recently met with Lynn Moskowitz, previous Crisis Counseling Assistance and Training Program (CCP) Media Director, and Steve Moskowitz, previous CCP Program Director, to capture their perspectives on supporting rural and remote communities through New York's recent CCPs. Based on their DBH outreach and engagement experiences, they identify potential challenges, lessons learned, and strategies for ensuring rural communities receive the DBH services they need.

What are some of the unique challenges you have encountered providing DBH services through your CCP to rural and remote communities?

The challenges in providing services to rural and remote areas begin at the outset, as information on immediate response and recovery efforts is often seen as a local concern. As a result, this information is not readily shared with organizations and agencies perceived as from "outside" the community. There's also an element of confidence in the local capacity to address the less-tangible aspects of recovery, such as mental health, while facing the more obvious physical and structural needs resulting from the event.

Once the commitment is made to provide CCP services, the most significant challenge to successfully implementing those services is often a lack of familiarity with the key structures and working partners in those communities. As a first step, it is important to identify key partners, whose cooperation and support will be necessary to achieve successful outreach and engagement. Engagement should happen at multiple levels and with various community organizations, including local emergency management and response organizations (e.g., the Red Cross), local government leaders, school systems, faith-based organizations, food banks, and chambers of commerce. The goal is to demonstrate the CCP's respect for the community and interest in learning about and serving the needs of its diverse constituencies.



How does your approach to service delivery differ in urban versus rural settings?

The most obvious difference is that in rural and remote communities engagement occurs more on a person-to-person or small group basis, while efforts in urban settings, like New York City, focus on working with existing organizations and groups. Thus, rural and remote services will likely include more direct contact with those who need immediate assistance. In smaller, more insular communities, face-to-face familiarity and relationships are a key aspect of overcoming the twin stigmas attached to being an outsider as well as someone providing mental health support.

In our CCPs, strategies across several areas of the program had to be considered—some logistical, like travel, availability of cell services, and even the safety of crisis counselors when working far away from their home bases. To a large degree, these strategies only differ from considerations in more urban environments in the particulars of the challenges and the methods employed to address them. In urban settings, educational and "how to reach us" media is often distributed on a mass scale (e.g., social media, citywide signage on buses, transit shelters). Rural settings rely more heavily on paper messaging disseminated via community outlets, such as schools, churches, and community centers.

How do you build trust and address disparities with individuals and communities in rural and remote areas following a disaster or emergency?

Overcoming the stigma of being from "outside" of the community is right up there with dealing with the caution toward mental health often encountered in those areas. Sometimes the stigma and caution are associated with confusion about and a lack of trust in mental health services. In other cases, it may be tied to specific belief systems of groups found in these communities, such as the ultra-Orthodox Jews in the hill towns of Ulster County or the Amish farms in Central New York.

The most valuable tool for crisis counselors in overcoming disparities is building authentic relationships with the local populations and ensuring that CCP assistance is provided in a manner that respects the community. This may include tailoring the language and imagery used in conversations, presentations, and public messaging to reflect the value systems of those they're working with.

We have overcome these challenges by having staff wear easy-to-identify, project-branded clothing to raise awareness of CCP services and dedicated teams, with a focus on building confidence and trust. We also employed media outreach tactics with visuals reflecting the urban, rural, and remote populations being served.

How did your CCP use telehealth or other technologies to reach rural populations?

The use of telehealth and technology—including webcasts, social media, and a sophisticated

website—was instrumental in helping us advance our Project Hope CCP COVID-19 response. There was a greater acceptance of information technologies since our last CCP and the need for virtual communication due to the pandemic. To meet the wide-ranging need for services across the 56 counties of New York, Project Hope-COVID was a hybrid CCP. It facilitated local, provider-based crisis counseling in counties with the highest rates of COVID-19 and virtual services in counties that were less severely impacted. Most of the individuals served received telehealth or virtual communication. While 14 counties hosted traditional CCP crisis counselor programs, the rest of the state was reached virtually.

For the purpose of this article, we are defining telehealth as all of the virtual communication we created for Project Hope, including a 7-day-a-week Emotional Support Helpline, a sophisticated website, robust social media, and the psycho-educational and training web portal housed at the New York State Psychiatric Institute (NYSPI).

NY Project Hope created a mental health education component in both the Immediate Services Program (ISP) and Regular Services Program (RSP) plans.[1] We were able to utilize the education and training expertise of the NYSPI Center for Practice Innovation to develop and maintain a web portal that enabled New Yorkers to access Project Hope resource information, educational materials, self-assistance modules, and links to crisis counselors. Our Zoom presentations played a significant role in providing key messaging for organizations, school staff, and other community organizations, and building their awareness, confidence, and trust to promote the program among their existing community connections.

We hired staff with previous CCP and media experience to build a communications team with expertise in web design and management, social media, and community education. They also created a community outreach state mental health authority (SMHA) staff position to help identify needs by reaching out to specific groups and tailoring Project Hope presentations accordingly.

Strengths of Rural Areas

Residing in rural areas has its challenges, but rural communities also have many strengths. For example, health promotion programs can thrive when implemented in a rural area due to a strong sense of community and relationships, shared interest in improving health, and willingness to overcome challenges as a collective effort (Rural Health Information Hub, 2024b).

These strengths are apparent in many scenarios, especially when recovering from disasters. Resiliency among rural communities is typically strong and connected to shared history.

What would you recommend to someone managing a DBH program pursuing telehealth or other technologically facilitated services to reach rural and remote communities?

First and foremost would be to acknowledge that creating telehealth and/or web-based activity is a marriage of the content which the

[1]The ISP and RSP are grants that are part of the CCP. Both provide supplemental support to state, territory, and tribal grantees. The ISP supports grantees in providing services in the immediate aftermath of disaster. The RSP generally supports grantees in providing services toward the end of the immediate aftermath and through the first year after the start of a disaster. Learn more at the SAMHSA DTAC website.

Federal Emergency Management Agency (FEMA) and SAMHSA are skilled at providing to a CCP and the very different set of skills and knowledge necessary to convey that psycho-educational information to the communities they wish to reach.

Important considerations include knowledge and familiarity with key concepts of communication, such as how to create a truly effective message, and ways to leverage available technologies to deliver information to the target population(s). Effective messaging balances the content one seeks to convey with an appropriate tone and feel for the target audience. Continuity is a concern, given the episodic nature of disasters. The valuable lessons and skills acquired in one CCP may not survive staffing transitions and leadership changes to be applied to the next event. While support from SAMHSA and FEMA project officers and SAMHSA DTAC is critical to establish a CCP, the SMHA must be aware of the unique CCP implementation challenges in rural and remote communities and factor these into the structure and scope of their grant applications. ■

Challenges in Rural Areas for Behavioral Health

While the prevalence of behavioral health issues is similar in rural and urban populations, there are significant differences and distinct challenges experienced by the two populations (Morales, Barksdale, and Beckel-Mitchener, 2020).

- **People living in urban areas are more likely to obtain help from a mental health service provider more frequently than those who live in rural areas (**Morales, Barksdale, and Beckel-Mitchener, 2020).
- **Mental health service providers in urban areas are more likely to have specialized training** (Morales, Barksdale, and Beckel-Mitchener, 2020).
- **Approximately 60% of the rural population lives in areas that have a shortage of behavioral healthcare providers** (Morales, Barksdale, and Beckel-Mitchener, 2020).
- **There is a lack of access to care in rural areas due to geographic distance** (U.S. Department of Agriculture & National Association of County Behavioral Health and Developmental Disability Directors, 2023).
- **"More than 90% of all psychologists and psychiatrists and over 80% of MSWs work exclusively in metropolitan areas"** (U.S. Department of Agriculture & National Association of County Behavioral Health and Developmental Disability Directors, 2023).
- **Rural counties often experience slower or unavailable internet and technology, limiting access to telehealth care delivery and healthcare information** (U.S. Department of Agriculture & National Association of County Behavioral Health and Developmental Disability Directors, 2023).

Responding in Rural Communities

By **Beckie Gierer,** Missouri Department of Mental Health, Office of Disaster Services

Missouri is one of the majority of states with many rural communities, and these communities are no stranger to natural disasters. From severe storms, flooding, and tornadoes to droughts, Missouri has experienced many disasters over the years. Most recently, the state has had a long-lasting drought that has impacted the farming communities across Missouri and other states.

A drought response looks and feels different than responses to other disasters. The drought doesn't usually rise to the level needed for a crisis counseling program, so there aren't individuals dedicated to responding to disaster behavioral health (DBH) needs. There always seem to be some challenges related to funding, staffing, transportation, and even access in rural communities. We want to help and we want to get resources and information out to as many people as we can in the impacted areas, but how do we do it?

In Missouri, the Department of Mental Health (DMH) has an Office of Disaster Services (ODS) that helps coordinate and respond to DBH needs in collaboration with the behavioral health agencies that support the impacted communities across the state. Our process, like many states, is supported by the fact that all disasters start and end locally. The most recent drought in the state, which initially was declared for 60 counties, has impacted the farming community with agriculture loss, livestock feed, cattle sales, and water supply issues, just to name a few. Because this isn't the first disaster many of these communities have faced, they also have other layers we need to consider when working to support them. In addressing the various disasters impacting Missouri's rural communities, we have had to get creative with how to reach people. We have learned some hard lessons but have had many successes. The following are some things to consider, lessons learned, and best practices we have found when providing DBH services during a drought:

Have a website of resources and information at the ready. When disasters happen, one of the first things we do is start pushing resources that are available through different channels. The State of Missouri works to share resources from all the different state and nongovernmental agencies across several media avenues. A website is one of the ways we do this. You can find examples of drought resources on the Missouri DMH ODS website. It is also important to think about how you will maintain that website

in non-disaster times. We add new resources and adjust links that are no longer active so that the website is ready for the next disaster. We also add "banners" to our main DMH website so people can easily click the banner to find the resources needed during disasters.

Coordinate social media. Each state agency in Missouri has social media channels that are used to share messaging. Nongovernmental agencies also have social media where they share good resources. It's important to work with all partners to cross-share messaging on social media channels, helping to reach more people and different audiences. The messaging shared should be focused on that specific disaster.

Use radio. In 2021–2022, DMH worked with *Brownfield Ag News* to get the word out to the farming and rural communities about mental health. Brownfield produced a radio podcast series called *Managing Mental Health*, and DMH was able to partner for several episodes on disasters and mental health. The great thing about these episodes is that we can continue to push them out on social media, as resources on our website, and through email as we have other events—like the most recent drought.

Use advertising. We found that when we partnered with an advertising agency to reach impacted areas, our reach and sharing of information jumped considerably. We have since incorporated

advertising into all of our disaster response initiatives. The advertising agency helped us:

- Push out 988-specific messaging with graphics that reflected rural areas and farming communities.
- Create targeted ad placement on Snapchat, Facebook, X, TikTok, Google, and YouTube. They created a social media toolkit for multiple agencies to use while responding to a specific disaster.
- Mail information on coping skills, helplines, and other resources to every mailing address in the impacted areas.
- Develop online training for responders.

Build networks. The networks you build in "blue sky" times are going to be the same people you work with when disasters happen. Make sure to attend the local meetings of community organizations active in disasters and your local/state emergency management agency. Consult with your Emergency Support Function partners, and even branch "outside the box" to those you don't normally work with to build those relationships ahead of time. In the past, we have partnered with various local and state agricultural agencies to share messaging and resources and deliver presentations and trainings at their local events and meetings. These activities allowed us to reach more impacted individuals and community members—oftentimes demystifying mental health in the process.

Host and attend meetings. I know we are all "meeting'd out," but it is often through these meetings that you will meet new partners, hear what services are being offered, identify opportunities for collaboration, and learn information you may not already know.

Partner with your local behavioral health agencies. Because every disaster starts and ends locally, we want to work with the agencies and staff that are in the communities already doing the work. Talk to them about what they are seeing and hearing; types of phone calls they may be receiving; and how the disaster is impacting their work, staff, and community members. During the drought

response, the agencies leading the effort shared what they were hearing and seeing with us, which allowed us to share that information with the local behavioral health agencies. There were reports of people feeling despair, depression, anger, and more. The behavioral health agencies were able to start checking in on different individuals and groups in their communities to determine how best to help.

Meet people where they are. Finding impacted individuals in rural areas can be challenging, but we can meet people where they are in the community. That may mean visiting the local feed stores and suppliers, stopping by "coffee time" at McDonald's, or hanging and leaving information in various locations. This may also involve talking with local city halls and post offices, regional or local emergency managers, or even just finding out where the local "hangouts" for the impacted community members would be and then spending time there.

Attend and participate in events at schools and churches, as well as club activities. Identify upcoming local events where you can have a presence through tabling, presenting, and/or sharing resources. Work with schools/clubs like 4-H and Future Farmers of America; attend state and local fairs; and speak at town halls, church fish fries, or picnics.

Lastly, I would suggest creating a plan. The plan should always be in draft form because outreach tactics likely will change based on what the community needs, the best ways to reach people (e.g., virtual versus in person), and the disaster situation and impact. We know in planning there are assumptions you can make, and this is no different. We can assume that not everyone looks at the same social media, reads the newspaper, or even watches the news anymore. We should also assume that people and communities are resilient. Disasters aren't going away and we need to consider the impacts that may come. Thinking outside the box, working together, getting creative, and demystifying mental health to address stigma are all ways we can help more individuals and communities cultivate preparedness and resilience before a disaster strikes. ■

Key Challenges in Rural Behavioral Health: The Four As

The four As to rural behavioral health are accessibility, availability, affordability, and acceptability (Rural Health Information Hub, 2024a).

Accessibility: In rural communities, people have less access to public transportation, so they rely more on personal vehicles. Behavioral health care can be inaccessible if access to transportation is limited (Rural Health Information Hub, 2024a).

Availability: A lack of behavioral healthcare services can lead to long waitlists and wait times for people seeking services, which may cause them to not seek services. Another challenge to availability is not having services at all. For example, research has shown almost 70% of rural counties do not have a sufficient number of psychiatrists (Rural Health Information Hub, 2024a).

Affordability: Reimbursement rates for healthcare providers from insurance companies in rural areas are lower than those in urban areas. Rural residents are also less likely to have insurance at all (Rural Health Information Hub, 2024a).

Acceptability: Mental health stigma is prominent across the United States. However, in rural counties, where community members are more likely to know each other, there is more fear of judgment due to the stigma surrounding mental health care as compared to people living in larger metropolitan areas where the community is not as close (Rural Health Information Hub, 2024a).

Agricultural Behavioral Health: Meeting Farming Communities Where They Are

By **Jennifer Dunn,** LMFT, Georgia Department of Behavioral Health and Developmental Disabilities, and **Sofia Cabrera, B.A.,** SAMHSA DTAC

Rural Americans, especially farmers, face unique behavioral health challenges before, during, and after disasters. Providing them with supportive resources and services is crucial. Innovative outreach approaches are needed to address stigma and limited access to behavioral health services in remote areas. *The Dialogue* spoke with Jennifer Dunn, Deputy Assistant Commissioner for Field Operations South at the Georgia Department of Behavioral Health and Developmental Disabilities. She shared her experiences creating engaging materials and welcoming spaces for farming communities to express their needs and obtain behavioral health services.

What is your current role, and how did you begin providing services to rural communities?

The Commissioner of the Department of Behavioral Health asked me and another gentleman to be his Deputy Assistant Commissioners, one for the North and one for the South. Before this role, I worked in Southwest Georgia for 16 years. I also worked with the University of Georgia as a result of Hurricane Michael, which hit on October 10, 2018.

When we've had a disaster or hurricane in Georgia it's been mostly in the coastal area. Who would've thought it would hit South Georgia the way it did? The hurricane wiped out generations of crops. Some of our counties lost 100 percent of their timber. A lot of people didn't have crop insurance. Every county in Georgia has agriculture and natural resource agents who work directly with farmers and producers. I was hearing from them. I was getting calls from banks who had farmers going in to talk about receiving loans. I was even getting calls from preachers.

We were invited to a rural stress summit in Atlanta 2 months after Hurricane Michael. About 38 states met to discuss disasters and their impact on rural populations. Midwestern states tended to be ahead of where we were because a lot of them had a person or group of people assigned to address the mental health and stress of their rural communities, either funded through the U.S. Department of Agriculture or through their extension programming. Our department came together to determine how we could reach our farmers and asked ourselves,

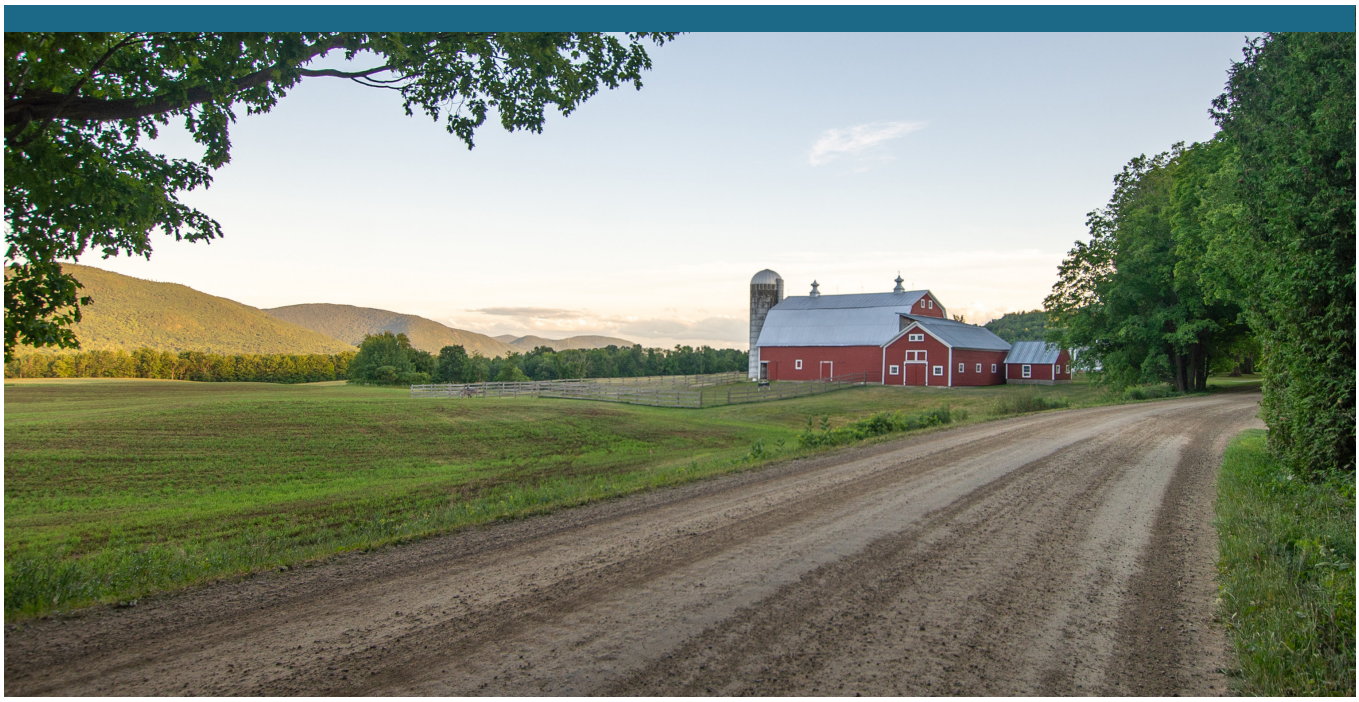
"Where do farmers go?" Every year, farmers attend production meetings. If they grow cotton, they go to a cotton production meeting. If they grow peanuts, they go to a peanut meeting. These meetings always happen January through March, right before planting begins. I started going to these meetings.

What do your sessions at these meetings look like?

At the meetings, we brought in local health departments and provided blood pressure checks before our session. This would get some conversation going and lead us into our first discussion about stress. I'd start by going through some of the things inside our folders, including tips to reduce blood pressure, eat well, and get better sleep. I'd ask how many of them are stressed and the entire room raises their hand. I'd ask, "What stresses you all out?" Every time, they'll say something to do with money. Input prices, commodity prices, interest rates, inflation, labor costs—you name it. We try to make it fun because it's a heavy topic. Someone in the room may yell out something that loosens up the crowd, like "my wife's Amazon habits," and we'll joke around about it.

But then we'll talk about their ongoing stressors, which are almost always outside of their control. They can't control the weather, or how much they're going to yield from their crop. I'll talk to them about good stress versus bad stress, and then we'll talk about how they relieve their stress. I always get two answers: drinking and praying. They may mention fishing or hunting, and I explain to them that, believe it or not, those are forms of meditation. Farmers who were in the service may bring up Navy Seals box breathing—if it's macho enough for the Navy Seals, it's good enough for them!

The state with the largest proportion of residents living in rural areas is Vermont at 64.9% (U.S. Census Bureau, 2022). **States with the next largest rural populations are Texas, North Carolina, Pennsylvania, and Ohio.**



I also ask them, "Who do you go to for help?" Their answers are often spouses, family members, other farmers, or faith leaders. We then talk about how they can be someone else's support. I give them an example: I once received a call from a farmer who was overwhelmed. He shared that he had bank loans he was struggling to pay off and deer were destroying his crop. He was having trouble sleeping and marital problems. His family life and overall quality of life were suffering. I ask the farmers how they could support this fellow farmer. I remind them that they are holding a folder from us that has resources they can share with him. If they don't want to keep the folder or information for themselves, maybe they can keep it for someone else.

How do your approach and the materials you offer differ from those you may use to connect with a more urban community?

We knew we needed to tailor how we talk about our work. If I show up to a group with 50 farmers and say, "I'm here to talk about mental health and emergency preparedness," they're probably not going to be very receptive. Don't force them into death by PowerPoint. An agriculture agent I worked with last year did her dissertation on how farmers and folks in rural communities want to be communicated with via face-to-face communication. They want to be talked to. They may want a website later and some nuggets of information on a flyer. I sometimes present one PowerPoint slide with my name and contact information, but that's it. I only talk for 10 to 15 minutes. Connecting with the farmers is what is most important.

We put together Rural Georgia: Growing Stronger folders with emergency preparedness and health-related information inside. We developed this flyer with the slogan "You're the most important asset on your farm" after I spoke with a farmer who said that he can fix everything on his farm—tractor, irrigation pump, you name it—but not himself. We have QR codes on the flyer that link to 988, local county extension agents, the Georgia Farm and Ranch Assistance Network, and more. In the first meeting we attended, we made our folders available on a table in the back of the room and nobody grabbed one. We learned to put the folder on their placemat, which is also where their pesticide credit application is located. To spray pesticides, they need this paperwork. If our folder is found with that item, they're more likely to flip through

If I help just one person at each meeting I go to, it's worth it. And that one person may not even be in the room. I sometimes tell my participants, "You're now part of my army. Go out and talk to people about this."

As of 2022, 7.7 million rural residents (23% of the rural population) reported they had a mental illness and 5.7% of this population had thoughts of suicide (Rural Health Information Hub, 2024c).

it. I tell them that if they don't want the right side of the folder that has all the mental health resources, they should take it for the left side with emergency preparedness resources.

What challenges might others face in connecting with and providing services to farmers?

Agriculture is the number one business in Georgia, but only 2 percent of our state contributes to agriculture. The average age of a farmer in Georgia is 59. There are not a lot of people doing this work. Emergency preparedness is such a fascinating way to get to talk to people about mental health and stress. When we have grants and opportunities to meet with people we may otherwise not often connect with, it gives us the chance to reach people that may have needed those connections prior to the disaster.

There are obvious challenges, like stigma. In those smaller settings where I'm talking to a farmer one on one after a meeting, I'll often ask, "How willing would you be to go to our local mental health provider?" A lot of times they aren't very willing. If they drive the red Dodge 250 and that truck is parked in front of the local mental health clinic, everyone driving by is going to be like, "Hey, why's Tommy at the mental health clinic?" They often live in these

small communities where it feels like everybody knows your business, and they worry about that. We try to combat this issue by making services available in alternative locations like public libraries, doctor's offices, and community centers.

Telehealth and technology can sometimes be an issue. There are some people who will strongly refuse even scanning a QR code. It can be a generational challenge. Sometimes it's simply a broadband challenge. Even if I wanted to, where I live, I don't have access to the internet.

Rates of use of some substances are higher in rural areas:

Youth alcohol use is more prevalent among the rural population (29.8%), as compared to urban (28.3%) (SAMHSA, 2021).

In rural areas, 26.7% of people smoked cigarettes in the past year, while 20% of people in small metro areas and 15.8% in large metro areas smoked cigarettes in the past year (SAMHSA, 2021).

The past-year smokeless tobacco use rate in rural areas is 7.1%, compared to 4.1% in small metro areas and 2.2% in large metro areas (SAMHSA, 2021).

What strategies or tips do you have for other states and service providers hoping to connect with their farming communities?

First, know that humor is a great way to relieve stress and facilitate the meeting. They like to have a little mental break from all the other information they are receiving. Throughout the meeting, they are getting bombarded with materials from the plant pathologist or entomologist. This is often the first part of the meeting in which they can interact more.

I often give out my phone number during these meetings. People may not want to call 988 or an 800 number, but they may feel more comfortable talking to someone they've seen and interacted with before. I always get at least one call from a participant after the meeting. I also make it a point to hang around after the meeting and chat with attendees. If someone didn't want to share their story or thoughts during the meeting, they may come up to me after.

My husband and I have a timber farm. My dad was a farmer. He's one of those farmers that had a full-time job on top of being a farmer, and he's retired now. I often call him my guinea pig for these meetings. I test out approaches on him and hear his perspective on topics. Sometimes he'll come to the meetings, and I'll call him out. Other times, farmers will ask me who he is and they'll know him. But regardless, even if I'm in a county farther away where farmers don't know my dad, they feel a little more connected to me. They feel that I get it. If someone on your team has a personal connection to the farming community, you can share that.

Lastly, find a ringer—a couple of farmers who can support your approach. I try to find one or two people before the meeting and give them some information on questions I'm going to ask to see if they'll kick our discussions off. I recently went to a meeting where an older gentleman told me that, after finding out that his blood pressure was high with us last year, he lost about 30 pounds. I asked him to share that with the crowd, and he did. Sometimes if you can get one or two people in the crowd talking, you will get more interaction. Every county is different, so have them tell you why they're different. Give them a seat at the table. We have this saying in the mental health field: "Nothing about us without us." When we work with a patient, we don't give them a treatment plan without consulting with them first. We shouldn't do the same with a community. ■

RECOMMENDED RESOURCES

Rural Disaster Behavioral Health: A Guide for Outreach Workers and Crisis Counselors

This guide from the Substance Abuse and Mental Health Services Administration (SAMHSA) was developed for workers and volunteers supporting rural populations after a disaster. It reviews risk factors these populations may experience, such as a lack of access to the internet, inaccessibility of resources, and more. The guide also discusses the strengths of a rural population and common disaster reactions.

Find the guide in the SAMHSA Store at https://store.samhsa.gov/product/rural-disaster-behavioral-health-guide-outreach-workers-and-crisis-counselors/pep23-01-01.

Challenges and Solutions for Disaster Behavioral Health in Rural and Remote Communities

This *Supplemental Research Bulletin* from SAMHSA covers challenges and possible solutions for providing behavioral health care in rural areas. Responders understanding the community they are helping, as well as the community's strengths and struggles, is critical in a successful response. Important questions to ask when developing a disaster plan are included.

Find the issue at https://www.samhsa.gov/sites/default/files/dtac-challenges-solutions-dbh-rural-remote-communities.pdf.

Rural Emergency Preparedness and Response Toolkit

This toolkit from the Rural Health Information Hub can help your organization in planning, response, and recovery efforts involving rural communities. Featuring six modules and a series of case studies, the evidence-based toolkit details important issues to consider in emergency planning, the types of disasters most likely to affect rural communities, and additional resources.

Find the toolkit at https://www.ruralhealthinfo.org/toolkits/emergency-preparedness.

All-Hazards Preparedness for Rural Communities

This guide, developed for rural agricultural communities, outlines preparedness and recovery strategies for disasters. It is divided into four sections: general preparedness measures, natural disasters hazards, biological emergencies, and human-caused or technological threats. A variety of checklists are also included to help families develop their emergency plan.

The guide can be found at https://www.prep4agthreats.org/Assets/Factsheets/All-Hazards-Preparedness-for-Rural-Communities-Book-Cover.pdf. The guide is also available in Spanish.

Disaster Preparedness for Older Adults in Rural Areas

The Federal Emergency Management Agency has a web page with information on how older adults living in rural communities can better prepare for a disaster. It covers how to learn the hazards in your area, how to make an effective plan and what questions to consider, and what to include in your disaster preparedness kit. Additional resources are included that can help you get emergency alerts and, if you receive benefits, learn how to receive them electronically.

Find the web page at https://www.fema.gov/blog/disaster-preparedness-older-adults-rural-areas. It is also available in Spanish.

Recent Technical Assistance Requests

Following are responses that SAMHSA Disaster Technical Assistance Center (DTAC) staff have provided to recent technical assistance requests. Send your questions and comments to dtac@samhsa.hhs.gov.

Request: A representative from Colorado's Department of Public Health and Environment reached out to SAMHSA DTAC seeking best practices to foster trust between the state's LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, and other gender identity and sexual orientation minority populations) communities and the state authority. The individual further inquired SAMHSA DTAC about trainings that cover matters beyond introductory information on the LGBTQIA+ community.

Response: To aid in the state's effort to bridge the gap between the community and state entity, SAMHSA DTAC provided the individual with topical resources that may be useful in the state's endeavors. Below is a sample of the resources provided:

- **LGBTQIA+ Communities and Disaster**—This edition of *The Dialogue* highlights the importance of disaster behavioral health personnel deepening their understanding of LGBTQIA+ communities to provide improved services during disaster events. The issue details LGBTQIA+ populations' experiences of challenges and disparities in and after disasters, offering insights on effective ways to address LGBTQIA+ needs and promote well-being.

  https://www.samhsa.gov/sites/default/files/dtac-dialogue-vol-18-issue-4.pdf

- **LGBTQIA+ Populations**—This section of the SAMHSA Disaster Behavioral Health Information Series (DBHIS) resource collection includes materials focused on the LGBTQIA+ community. It provides links to external behavioral health organizations, as well as resources designed to enhance understanding and support of these communities in the disaster behavioral health field.

  https://www.samhsa.gov/resource-search/dbhis?rc%5B0%5D=populations%3A20166

- **APA LGBT Resources for Practitioners**—Developed by the American Psychological Association (APA), this web page provides behavioral health practitioners with a comprehensive hub of resources and publications related to lesbian, gay, bisexual, and transgender (LGBT) populations. The web page covers support for LGBT children, youth, and family, as well as research on LGBT health issues.

  https://www.apa.org/pi/lgbt/resources/practitioner

- **National LGBTQIA+ Health Education Center Learning Resources**—This web page offers resources on various aspects of mental health for the LGBTQIA+ community. The resources are categorized by type and cover a range of topics within the broader theme of behavioral health for healthcare professionals and individuals seeking information on LGBTQIA+ mental health.

  https://www.lgbtqiahealtheducation.org/resources/in/behavioral-health

Request: An individual contacted SAMHSA DTAC in search of articles detailing trends in the disaster behavioral health community after the 1-year anniversary of a disaster. While recognizing available resources, such as resources provided by the Crisis Counseling Assistance and Training Program and the Model for Adaptive Response to Complex Cyclical Disasters, the individual specifically sought more detailed information on activities occurring 1 year post-disaster.

Response: In response to the individual's inquiry, SAMHSA DTAC compiled and provided a list of research articles on the long-term impacts of disaster. The following references are a sample of the research provided:

- Danese, A., Smith, P., Chitsabesan, P., & Dubicka, B. (2020). Child and adolescent mental health amidst emergencies and disasters. *The British Journal of Psychiatry, 216*(3), 159–162. https://doi.org/10.1192/bjp.2019.244
- Galea, S. (2007). The long-term health consequences of disasters and mass traumas. *CMAJ, 176*(9), 1293–1294.
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- Hull, A. M., Alexander, D. A., & Klein, S. (2002). Survivors of the Piper Alpha oil platform disaster: Long-term follow-up study. *The British Journal of Psychiatry, 181*(5), 433–438.
- Ingram, L. A., Tinago, C. B., Cai, B., Sanders, L. W., Bevington, T., Wilson, S., . . . Svendsen, E. (2018). Examining long-term mental health in a rural community post-disaster: A mixed methods approach. *Journal of Health Care for the Poor and Underserved, 29*(1), 284–302. https://doi.org/10.1353/hpu.2018.0020
- McFarlane, A. C., & Van Hooff, M. (2009). Impact of childhood exposure to a natural disaster on adult mental health: 20-year longitudinal follow-up study. *The British Journal of Psychiatry, 195*(2), 142–148.
- Neria, Y., Nandi, A., & Galea, S. (2008). Post-traumatic stress disorder following disasters: A systematic review. *Psychological Medicine, 38,* 467–480. https://doi.org/10.1017/S0033291707001353

Request: A pediatric specialist from the Colorado Office of Emergency Preparedness and Response contacted SAMHSA DTAC to obtain grants specific to disasters and pediatrics, as well as additional resources related to disasters' effects on children and youth.

Response: While clarifying to the pediatric specialist that SAMHSA DTAC does not allocate disaster funds directly, SAMHSA DTAC supplied the individual with a list of external resources that may be able to provide desired grants to the state authority, including the American Red Cross and the Federal Emergency Management Agency (FEMA). Additionally, SAMHSA DTAC provided the state representative with a collection

Are you looking for disaster behavioral health resources?

Check out the new and updated SAMHSA DTAC Disaster Behavioral Health Information Series (DBHIS) installments.

https://www.samhsa.gov/resource-search/dbhis

of resources tailored to children and youth in disaster situations. A few examples of the resources included are outlined below:

- **Children and Adolescents**—Two sections of the SAMHSA DBHIS resource collection focus on the common responses and needs children and adolescents may have during and after disasters. These sections include resources that highlight the unique needs of children and adolescents during and after disasters, as well as how adults who work with children, and parents and other caregivers, can offer support to children and adolescents in coping. Following are SAMHSA DBHIS sections related to children and adolescents:
- Resources intended for children and youth: https://www.samhsa.gov/resource-search/dbhis?rc%5B0%5D=audience%3A20195
- Resources about children and youth and disasters: https://www.samhsa.gov/resource-search/dbhis?rc%5B0%5D=populations%3A20155
- **Children and Disasters**—Part of the Survivors of Disasters Resource Portal (https://www.samhsa.gov/dtac/disaster-survivors) at the SAMHSA DTAC website, this web page describes how children and teenagers may experience disasters differently from adults, offers tips for disaster planning for families, identifies common reactions to disasters in children and teenagers, and provides suggestions for adults for helping children and teenagers cope after disaster. Links to related resources are also provided.

  https://www.samhsa.gov/dtac/disaster-survivors/children-and-disaster
- **Understanding Child Trauma**—This web page from SAMHSA presents statistics on child trauma, which may be experienced as part of a natural or human-caused disaster, and lists signs of traumatic stress in children and youth. It also offers tips for parents and other caregivers for helping children and youth cope with trauma. Links are also provided to downloadable infographics in English and Spanish provided by the SAMHSA National Child Traumatic Stress Initiative.

  https://www.samhsa.gov/child-trauma/understanding-child-trauma
- **Caring for Children in a Disaster**—This part of the Centers for Disease Control and Prevention (CDC) website provides information for parents and families, schools, health professionals, and emergency managers about how to help children and youth cope with disasters and other emergencies. The web page features information about how disasters affect children differently from adults, tools and resources, and information specific to children with special healthcare needs.

  https://www.cdc.gov/childrenindisasters/index.html

  The page is available in Spanish at https://www.cdc.gov/childrenindisasters/es/index.html.

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Help Improve SAMHSA's Disaster Services and Products

As a subscriber to this newsletter, you are invited to participate in a short, web-based survey to provide the SAMHSA Disaster Technical Assistance Center (DTAC) with feedback about your experiences with our products and services. The survey should take no more than 15 minutes. Complete the survey by going to the survey web page, or copy and paste the URL https://iqsolutions.qualtrics.com/jfe/form/SV_bjYCSJDUQAGi1h3 into your web browser.

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Groups

New Online Forum for the Disaster Behavioral Health Field

The SAMHSA Disaster Technical Assistance Center (DTAC) has set up a new online community for the disaster behavioral health (DBH) field: the SAMHSA DTAC DBH Google Group. The group provides a forum for disaster behavioral health professionals to share information and resources and discuss issues in the field. All who work or volunteer in disaster behavioral health are welcome. The only requirement is a Google account, which can be set up free of charge. Visit the group today to check out high-quality disaster behavioral health resources, training opportunities, and more.

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ACCESS ADDITIONAL SAMHSA DTAC RESOURCES
The *SAMHSA DTAC Bulletin* is a monthly e-communication used to share updates in the field, post upcoming activities, and highlight new resources. Contact SAMHSA DTAC to be added to the *SAMHSA DTAC Bulletin* subscription list.

The SAMHSA Disaster Behavioral Health Information Series contains resource collections and toolkits pertinent to disaster behavioral health. Installments focus on specific populations, specific types of disasters, and other topics related to all-hazards disaster behavioral health preparedness and response. Visit the SAMHSA DTAC website at https://www.samhsa.gov/resource-search/dbhis to access these materials.

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