the Dialogue

2019 | VOLUME 15 | ISSUE 3–4

Helping People With Serious Mental Illness and
Substance Use Disorder During Disasters

IN THIS ISSUE

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In This Issue

Over the past few years, people across the United States have dealt with disasters of various sizes such as category 5 hurricanes, mass shootings, and wildfires. Most people touched by a disaster, whether directly or indirectly, are affected in some way. Many disaster survivors are able to move on and cope with the "new normal" of life after a disaster, while others may find their situation harder to handle. Preexisting conditions such as a history of mental illness or a substance use disorder may play a role in the ease of their recovery.

People living with serious mental illness (SMI) or substance use disorders (SUD) may experience challenges in day-to-day life that can prevent them from preparing prior to a disaster or increase their risk of post-disaster adjustment reactions. Like other disaster survivors, individuals with SMI and SUDs may also face being cut off by the disaster from their regular sources of treatment and medication, or their support network.

> In 2017, 11.2 million adults aged 18 or older had a serious mental illness and 18.7 million adults aged 18 or older had a SUD in the past year. It is estimated that 3.1 million adults aged 18 or older had a co-occurring SMI and SUD.
>
> Substance Abuse and Mental Health Services Administration, 2018

This double issue of *The Dialogue* focuses on assisting disaster survivors with SMI and/or SUDs after a disaster. Our first article, written by a psychiatrist with expertise in disaster mental health, focuses on why people with mental illnesses may need additional support to recover after a disaster and what we can do to increase their disaster preparedness and aid in their recovery after a disaster. The next article discusses legal challenges involved with licensing out-of-state mental and disaster behavioral health providers during disaster response and recovery. Our next article, written by an addictions researcher, describes what disaster behavioral health professionals can do to assist people with SUD after a

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disaster more effectively. A local provider in the U.S. Virgin Islands shares her team's experiences after the hurricane season of 2017 in the next article, and this is followed by a state planner from Missouri discussing how her state plans and prepares to work with people with SMI after disasters. We wrap up this double issue with an interview that focuses on an upcoming Substance Abuse and Mental Health Services Administration (SAMHSA)-supported disaster behavioral health training in Puerto Rico. The training focuses on the effect trauma has on the brain and how disaster behavioral health professionals can use this information to assist in the recovery of communities affected by disaster.

Has your program had success working with disaster survivors with SMI or SUD? Do you have suggestions or lessons learned from your experiences? We encourage you to contact us to share your recommendations. ■

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Contributors

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Beckie Gierer, M.S. is the Director for Continuity of Operations Planning with the Missouri Department of Mental Health (DMH) Office of Public and Legislative Affairs/ Office of Disaster Services. She has a master of science degree from the University of Central Missouri and has worked with the State of Missouri for 18 years. Ms. Gierer started her career with the Department of Public Safety and has worked for the Department of Social Services but has spent the majority of her years of service with the DMH (13 years). In addition to her role as the Director of Continuity, she serves as the grants manager for the Hospital Preparedness Program and Public Health Emergency Preparedness grants with the Office of Disaster Services and supervises Crisis Counseling Assistance and Training Program (CCP) grants after federally declared disasters. Ms. Gierer is also a contracted trainer with SAMHSA for the Federal Emergency Management Agency CCP and has trained crisis counselors in Missouri, North Carolina, and California.

Ms. Gierer has provided trainings for DMH consumers, staff and providers, voluntary organizations, hospitals, community businesses, and first responders at conferences and in agency settings. Her trainings have covered topics such as behavioral analysis, trauma, self-care/team care, personal preparedness, Mental Health First Aid, continuity of operations, Skills for Psychological Recovery, and the importance of accounting for the needs of individuals with mental and substance use disorders as part of emergency planning.

Ms. Gierer also serves on several committees in Missouri, including the Access and Functional Needs Committee, Governor's Partnership, Missouri Voluntary Organizations Active in Disaster, and the Missouri Coalition for Community Behavioral Healthcare disaster workgroup. She is a co-chair for the Children and Youth in Disasters Committee and a co-lead for the Pediatric Behavioral Health workgroup.

Linda Ligenza, LCSW is the Clinical Services Director for the National Council for Behavioral Health. She has extensive experience providing guidance and technical assistance to organizations integrating primary care and mental health and substance use, most recently through the SAMHSA-Health Resources and Services Administration Center for Integrated Health Solutions. Ms. Ligenza's expertise in trauma and trauma-informed care further assists the integration audience in improving practices, policies, procedures, and outcomes.

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Ms. Ligenza has a background in clinical, administrative, and public policy work based on her 30-year career. She worked first with the New York State Office of Mental Health and subsequently with the U.S. Department of Health and Human Services and SAMHSA in their Emergency Mental Health and Traumatic Stress Services Branch of the Center for Mental Health Services.

Lizette Llanos is the Academic Tutoring Supervisor and Outreach Coordinator for Island Therapy Solutions (ITS), a multi-dimensional practice that provides mental health services. Ms. Llanos oversees the tutoring program, manages a team of tutors, and delivers direct services to clients. She also educates the community on the wide range of services at ITS and participates in a number of community events to broaden awareness and help create a more inclusive community for everyone, regardless of ability.

Keila M. Medina, M.A. received her master of arts in counseling psychology from the University of the Virgin Islands (UVI) in May 2016. She began working with at-risk children and adolescents at the age of 15 through the Lighthouse with a Mission after-school program. As an undergraduate student at UVI, she spent 2 years working with at-risk young adults through a Women's Coalition program called Project Promise. Ms. Medina met Dr. Lindsy Wagner in January 2013 through her practicum program. After she successfully completed her undergraduate studies, she was hired full time at Island Therapy Solutions. She worked closely with Dr. Wagner as her Psychological Assistant, Master's Intern, and currently a Pre-licensure Intern. After the two category 5 hurricanes that hit the U.S. Virgin Islands, she was one of the team leads for the Crisis Counseling Assistance and Training Program. She is currently preparing for the Examination for Professional Practice in Psychology (EPPP); and upon successful completion, she will become an Associate Psychologist.

Imelda K. Moise, Ph.D., M.P.H. is an Assistant Professor of Geography at the University of Miami, Florida, where she also holds secondary appointments in the Departments of Public Health Sciences and International Studies. The goal of her research is to understand the effect of social determinants of health on health inequalities, particularly related to geographical targeting, the health of mothers and children, other vulnerable populations, and issues related to natural disasters. She is an expert on supporting neighborhood-scale interventions and linking research to practice or policy. Prior to joining the University of Miami, Dr. Moise was a Geographic Information System (GIS)/Global Health Monitoring and Evaluation Advisor in Washington, DC, where she supported U.S. Agency for International Development-funded health programs in low- and middle-income countries on various scopes of work. She has also worked with different international development agencies and nongovernmental organizations, and she spent 5 years as a research specialist in Illinois. She spent time coordinating federally funded research projects and program evaluation for state agency initiatives and ongoing programs aimed at improving health and well-being of low-income pregnant women, children, and their families; prevention of underage drinking; and at-risk alcohol use during pregnancy. She is currently finalizing a Robert Wood Johnson Foundation-funded research project titled "Examining age, race/ethnic, and gender differences in alcohol-related hospitalizations of young people and the impact of liquor-related ordinances." She also recently completed a fellowship with the American Evaluation Association focused on culturally responsive evaluation theory, and she recently coedited a book titled *Public Health, Disease and Development in Africa* (Geographies of Health Series, Routledge, 2018).
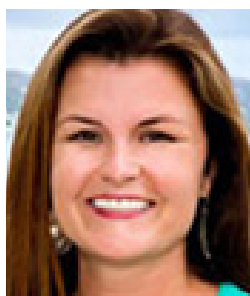
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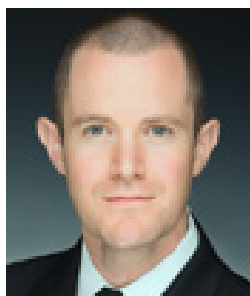
Joshua C. Morganstein, M.D. is Associate Professor and Assistant Chair in the Department of Psychiatry and Assistant Director of the Center for the Study of Traumatic Stress at the Uniformed Services University of the Health Sciences in Bethesda, Maryland. Dr. Morganstein is Chair of the American Psychiatric Association's Committee on the Psychiatric Dimensions of Disaster and a Captain in the Commissioned Corps of the U.S. Public Health Service. He leads disaster mental health education and consultation services at the Center for the Study of Traumatic Stress and provides disaster mental health subject matter expertise to federal and national organizations. Dr. Morganstein advised on the United Nations' 2015 Sendai Framework for Disaster Risk Reduction and coauthored the first curriculum recommendations for disaster behavioral health professionals. He served as a coauthor for the "Mental Health and Well-Being" chapter in a landmark interagency report, *The Impacts of Climate Change on Human Health in the United States,* and the American Psychiatric Association's position statement and resource document on climate change and mental health. Dr. Morganstein has authored a range of articles, chapters, and technical reports on the mental health impact of various disaster events including natural disasters, mass violence, terrorism, pandemics, and nuclear exposure. He is Assistant Editor for the second edition of the Cambridge *Textbook of Disaster Psychiatry.* In collaboration with the National Institute of Justice and University of California, Los Angeles, Dr. Morganstein is the site Principal Investigator for a study of community mass violence, focusing on the 2013 Washington Navy Yard workplace shooting.

Cheryl Sharp, M.S.W., ALWF holds the unique perspective of a person who has recovered from significant mental health challenges, and is a trauma survivor, a family member of a loved one who died as a result of mental health challenges, and a provider of substance use and mental health services. Ms. Sharp received her undergraduate degrees in psychology and women's studies followed by her master's degree in social work specializing in health and aging. Ms. Sharp has worked with adult trauma survivors for over 33 years training and speaking internationally on trauma-informed approaches and suicide prevention. She led the development of the National Council for Behavioral Health's curriculum to create trauma-informed approaches within over 700 organizations across the country. She received a SAMHSA Voice Award in 2015 for her work and personal stories educating the public about trauma, mental health and substance use, and suicide prevention, and the Lou Ann Townsend Courage Award for her contributions to people with psychiatric disabilities. Most recently, she received the On Our Own of Maryland 2018 Achievement Award for her contributions to the State of Maryland's Wellness Recovery Action Plan (WRAP) Outreach Project. Ms. Sharp believes in the limitless possibilities found within each of us to live our lives from a place of personal power. She has been a longtime supporter of the Copeland Center for Wellness and Recovery and serves on the Board of Directors. She enjoys living her life to the fullest as a mother and grandmother in eastern North Carolina. Ms. Sharp is an avid gardener, reader, sailor, traveler, and companion to her cat, Music.

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Lindsy Wagner, Psy.D., a licensed clinical psychologist, is the owner and Chief Executive Officer of Island Therapy Solutions. She is also the Founder and Board President of Coral Reef Academy, a school for children with autism and developmental disabilities. Her clinical specialties include conducting diagnostic evaluations, neuropsychological evaluations, and forensic neuropsychological evaluations, and providing consultation and training for children and families with a variety of presenting concerns including learning disabilities, neurological disorders, and emotional and behavioral concerns. Dr. Wagner also specializes in diagnosis and treatment of autism spectrum disorder. She conducts social skills groups with children with autism spectrum disorders as well as individual and family therapy. Dr. Wagner has taught at the University of the Virgin Islands. Prior to moving to St. Croix, Dr. Wagner was the Director of Training at the Watson Institute in Pennsylvania. Dr. Wagner completed her doctorate at the American School of Professional Psychology in Washington, DC. She completed 2 years of training at Children's National Medical Center in Washington, DC, in the Pediatric Neuropsychology Unit.

Hurricane Harvey disaster survivors Mellisa Velez (right) and David Walker (center right) meet with Jose Vidal (left), Disaster Survivor Crew Lead, at a Mobile Communications Operations Vehicle (MCOV) in Rockport, Texas, on the Gulf of Mexico near Corpus Christi. The Federal Emergency Management Agency (FEMA) deploys MCOVs to support the response work of Disaster Survivor Assistance teams in the field. Photo by Christopher Mardorf/FEMA.

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Caring for People With Mental Illness in Disasters

By **Joshua Morganstein, M.D.**

Introduction

There are about 11 million people in the United States living with a serious mental illness (SMI). Broadly, SMI is defined as the presence of a diagnosable mental illness and significant disability such that the person has difficulty with one or more life activities. Most people with SMI experience episodes of psychosis or severe depression.

In order to function well, persons with SMI often rely on healthcare and community support resources. They have increased risk for adverse outcomes following disasters (Norris et al., 2002). In the acute stages of a natural disaster, those living with SMI may function relatively well. Like the rest of the population, they often rise to the occasion to assist themselves and others in a time of great need. However, those with SMI are often less prepared for disasters and may have more extreme reactions when exposed to the stress or trauma of a large-scale community disaster. In addition, damaged infrastructure and diversion of community resources to lifesaving and sustaining activities often disrupt critical sources of support upon which people rely (such as jobs, supported housing, etc.), ultimately threatening the well-being of persons with SMI. Relevant public and private entities can mitigate adverse outcomes by engaging in disaster planning and response to address the needs of persons with SMI.

Vulnerability

Individuals with SMI are often less prepared for a disaster; they may be less likely to have needed supplies on hand or an established emergency plan (Eisenman et al., 2009). They may be more dependent on others to take necessary precautions prior to a disaster or assist them in the event of an evacuation. Persons with SMI may also lack stable housing, access to health care, and adequate social

In 2017, an estimated
11.2 million adults
in the United States had a SMI.
This number represented
4.5% of all U.S. adults.
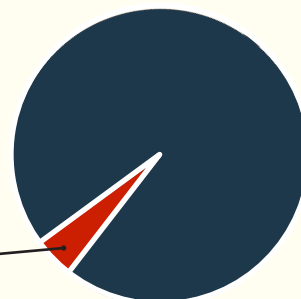
National Institute of Mental Health. (2019). Mental illness. Retrieved from
https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

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support, and they may therefore be missing critical elements of support in the immediate aftermath of a disaster.

Following a disaster, those with mental illness are more likely to develop stress-related symptoms or a relapse of prior symptoms (Norris et al., 2002). They may have difficulty tolerating psychological distress or a disruption in their social networks. Those with a prior diagnosis of posttraumatic stress disorder (PTSD) may be particularly vulnerable to an exacerbation of symptoms due to an association of elements of the current disaster and response, such as sirens or other loud noises, with their prior trauma (Neria et al., 2008).

Disrupted Support and Services

Many people living with SMI often rely on the care and support of family members, friends, or other caretakers. In the wake of a disaster, access to these caretakers may be disrupted. Family members may need to divert their time and energy to basic tasks of recovery, such as securing food, water, and safe housing, leaving less time and resources to care for their family member with mental illness.

Individuals with SMI may also rely on supported environments and mental health care, and these systems are often disrupted or overwhelmed following a disaster (Wang et al., 2007). Inpatient psychiatric units, hospitals, and outpatient clinics may close after a disaster. Individuals living in skilled facilities, group homes, or shelters may have been evacuated to an unfamiliar setting. Facilities may be understaffed and patients or residents required to relocate or evacuate. Pharmacies may be closed, or their supply chains interrupted, resulting in the inability to receive medications. Problems with transportation infrastructure may make it difficult to get to appointments. Increased demand for mental health services commonly observed following mass trauma may divert resources from those with SMI. Further, persons with SMI experiencing significant adverse effects frequently do not obtain mental health care, receive inadequate interventions, and prematurely drop out of care (Rodriguez & Kohn, 2008).

Services and Interventions

The provision of disaster resources varies based on size and scope of the event. Large-scale, complex events typically result in significant influx of resources, whereas smaller events may result in no new resources.

Though people with SMI may have exacerbations or relapse of symptoms, they also experience the expected range of responses to trauma exposure. Thorough evaluation for people with SMI helps to differentiate expected responses to disaster exposure from exacerbation or recurrence of symptoms of the underlying mental illness. When common disaster responses occur, providing reassurance and appropriate early interventions can prevent unnecessary stigmatization and demoralization. At the same time, mental health personnel should monitor people with SMI for exacerbation or relapse, as well as diminished functioning. This often delicate balance, when effectively managed, enhances self-efficacy, reduces stigma, and optimizes the effective and efficient use of resources.

The prevalence of SMI was higher among **women (5.7%)** than **men (3.3%)**.
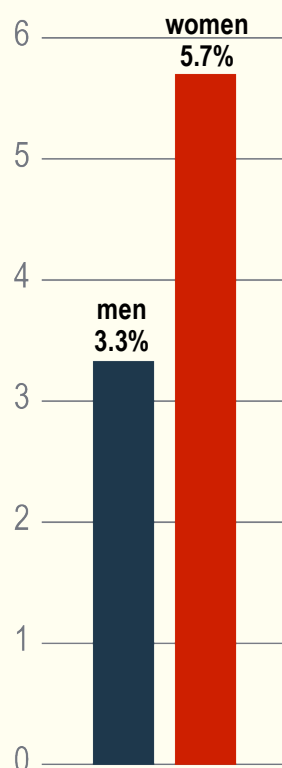
National Institute of Mental Health. (2019). Mental illness. Retrieved from **https://www.nimh.nih.gov/health/statistics/mental-illness.shtml**

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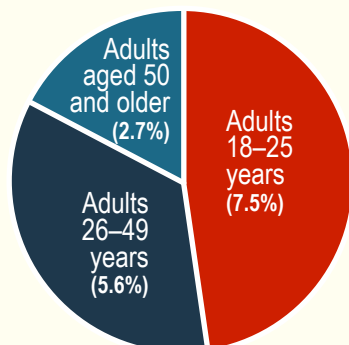
Young adults aged **18–25 years** had the highest prevalence of SMI **(7.5%)** compared to adults aged **26–49 years** **(5.6%)** and aged **50 and older** **(2.7%)**.

National Institute of Mental Health. (2019). Mental illness. Retrieved from **https://www. nimh.nih.gov/health/statistics/mental- illness.shtml**

Photo by Semmick Photo/Shutterstock.com.

Disaster mental health services designed for the general population, such as those based on concepts of Psychological First Aid, are equally beneficial for disaster survivors with SMI (Hobfoll et al., 2007). Procedures addressing safety, calming, social connection, personal and community efficacy, and a sense of hope and optimism are helpful during or immediately after a disaster. Care should be taken to avoid isolating or stigmatizing those with SMI. Encouraging those with SMI to be active partners in solving problems for themselves and their community fosters the critical elements of efficacy, hope, and social connectedness.

Given the frequent deterioration or exacerbation of mental health symptoms associated with insomnia, optimizing sleep is essential for persons with SMI and can serve to enhance the essential element of calming (McKibben et al., 2010). Behavioral interventions should be used to the extent possible and augmented with rational pharmacotherapy when needed. Pharmacies in the disaster region should include a broad range of psychiatric medications in order to allow those with SMI to stay on their prior regimens, anticipating refills as well as the need to replace medications lost or forgotten during evacuation.

The stress of the disaster and disruption in prior treatment may result in the deterioration of mental health status for some. Psychiatric hospitalization and normal supports may be necessary for stabilization. Although rates of hospitalizations do not typically increase significantly following disasters, disruption to existing facilities and staffing shortages often make it more difficult to obtain inpatient psychiatric services when needed. Ensuring personnel and resources are also available to assist with housing, employment, and reestablishment of prior psychiatric care can enhance recovery following a disaster.

Preparedness and Planning

When persons with SMI and those who care for them are prepared for disasters, distress is frequently reduced. In addition, limited
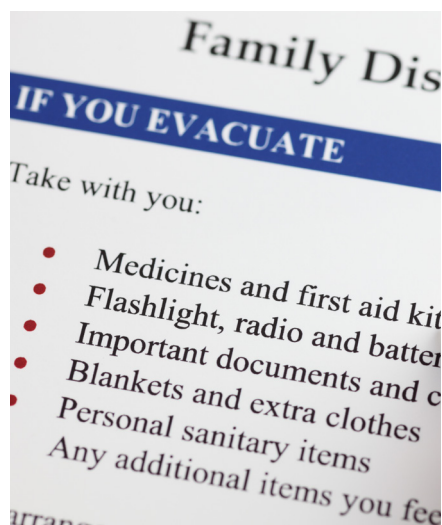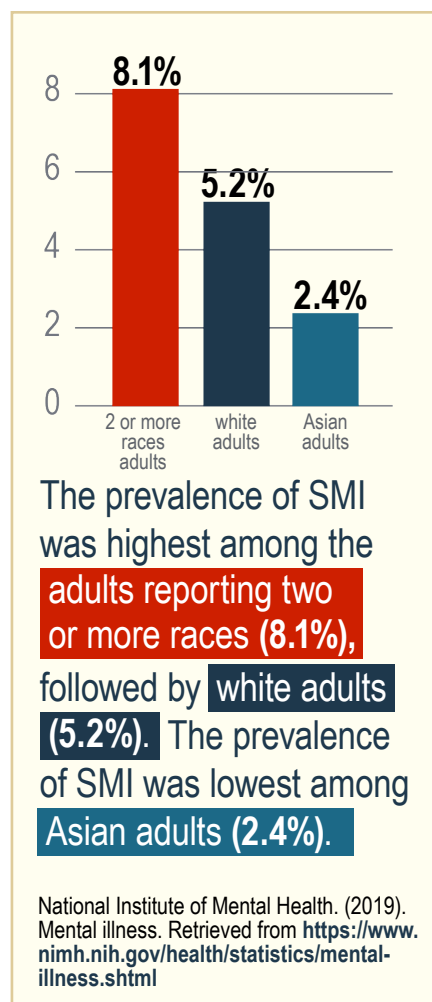
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cognitive resources can be focused on executing existing plans, rather than engaging in frantic efforts to figure out what actions to take during an acutely stressful period. An important initial step in planning involves identifying people with SMI within the community, including those living in residential facilities as well as people experiencing homelessness, whose rates of SMI are significantly greater than the general population (Folsom et al., 2005).

Caretakers and providers should work closely with those who have SMI to collaborate on development of disaster plans. A simple disaster plan can include emergency contact information, a list of medications and other items needed in the event of an emergency, and an adequate supply of critical medical and basic household items. In addition, helpful disaster planning practices include refilling medications before they are empty to avoid abrupt discontinuation following

The prevalence of SMI was highest among the adults reporting two or more races (8.1%), followed by white adults (5.2%). The prevalence of SMI was lowest among Asian adults (2.4%).

National Institute of Mental Health. (2019). Mental illness. Retrieved from **https://www.nimh.nih.gov/health/statistics/mental-illness.shtml**

an unexpected event. Identify emergency shelter and temporary housing options outside the local area able to accommodate persons with SMI in order to facilitate evacuation, rescue, or emergency evaluations at the time of a disaster.

Emergency personnel are increasingly called upon to assist individuals with acute exacerbation of mental illness in the community (Ford-Jones & Chaufan, 2017). First responders should be trained to identify and assist people with signs of active mental illness following a disaster. Symptoms of particular concern include psychosis

(hallucinations, delusions, paranoia, and disorganized thought processes); severe depression; suicidal or homicidal ideation or behavior; and substance misuse. Responders need training to assist persons with SMI in ways that assure successful communication and safety. Training should include an understanding of the common adverse psychological and behavioral responses to trauma, effective communication and interaction to avoid escalating adverse reactions, legal and ethical factors, and how to assist with medical and psychiatric referral when needed. For instance, simply asking if an individual has his or her usual medications and what they are for can begin a helping relationship.

Conclusion

Persons with SMI have special needs and vulnerabilities following natural disasters. In large part this is due to the disruption of relationships and resources upon which they often rely. At the same time, care must be taken to ensure that common reactions to disaster exposure are not treated as pathological. Disaster planning that addresses the unique needs of those with SMI allows for services and interventions that mitigate adverse effects by improving the preparedness of individuals with SMI and their support systems, ensuring those who provide routine and emergency care are adequately trained, and optimizing continuity of essential healthcare infrastructure and social services. ■

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Activating Legal Mechanisms in a Disaster May Help Meet the Temporary Needs of Individuals With Substance Use Issues

By **Maxim Gakh, J.D., M.P.H.**

Disasters pose many challenges and necessitate readiness both by governments and communities (U.S. Department of Homeland Security, Federal Emergency Management Agency [FEMA] 2011). Too often, disasters disproportionately affect the health and well-being of vulnerable populations (Bethel, Foreman, & Burke, 2011). This includes individuals with preexisting substance use issues, many of whom are particularly susceptible to the impacts of disasters (North & Pfefferbaum, 2013).

A disaster's immediate aftermath may exacerbate or resurface existing substance use issues at the same time that the existing systems and services needed to address such issues are strained (Palinkas, 2015; Hodge, Rutkow, & Corcoran, 2010). Disaster plans should thoroughly account for mental health and substance use needs (North & Pfefferbaum, 2013; Hodge, Rutkow, & Corcoran, 2010; Pfefferbaum et al., 2012). However, previous experience illustrates that responding to the

needs of individuals with substance use issues in a disaster's aftermath remains a challenge (Rutkow, Vernick, Mojtabai, Rodman, & Kaufmann, 2012). Immediately after Hurricane Sandy, for instance, individuals in medication-assisted treatment for opioid use disorder in New York City had difficulty obtaining medications (Pouget, Sandoval, Nikolopoulos, & Friedman, 2015). Similarly, some individuals staying in shelters after Hurricane Katrina required care for preexisting substance use conditions (North et al., 2015).

Photo by Igor Stevanovic/Shutterstock.com.

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One-tenth to **one-third** of people who survive trauma linked to an accident, illness, or disaster report problematic alcohol use, especially if they are troubled by persistent health problems or pain.

New York State, Office of Alcoholism and Substance Abuse Services. (2012). Substance use disorders and disasters. Retrieved from **https://www.oasas.ny.gov/AdMed/FYI/subused.cfm**

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Meeting the disaster-related needs of individuals with substance use issues requires legal preparedness (Hodge et al., 2010; Rutkow et al., 2012). Legal preparedness is paramount for disaster planning across a range of issues and is important for disaster readiness (Hodge & Anderson, 2008; Moulton, Gottfried, Goodman, Murphy, & Rawson, 2003). It involves the capacity, capability, and ability to use laws to reach preparedness goals (Moulton et al., 2003).

One important function of legal preparedness can be to boost the availability of licensed out-of-state providers in a disaster to meet the needs of individuals with substance use conditions and with other mental health and substance use needs (Hodge et al., 2010; Rutkow et al., 2012). This may be critical to disaster response because out-of-state providers can increase the capacity of a community to address disaster-related surges in mental health and substance use needs (Yun, Lurie, & Hyde, 2010). Legal preparedness operates in the context of provider licensure laws, which vary by state. State laws typically define educational and training requirements, scope of practice confines, reciprocity and endorsement, and other requirements for different types of providers (Page et al., 2017). However, a state government faced with a disaster may declare an emergency and provisionally alter certain existing legal requirements and structures (Hodge & Anderson, 2008).

Some states have adopted laws that aim to enable out-of-state providers to respond to disaster-related needs (Hodge et al., 2010; Hodge & Anderson, 2008; Rutkow, Vernick, Wissow, Kaufmann, & Hodge, 2011; Kels & Kels, 2013). For example, during a government-declared emergency, volunteer providers who hold a valid professional license in another state and who are preregistered may be permitted to practice temporarily (National Conference of Commissioners on Uniform State Laws [ULC], 2007) in 18 states and Washington, DC, all of which incorporated the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) into their laws (ULC, 2018). Similarly, during a declared emergency, the Emergency Management Assistance Compact (EMAC)—a multi-jurisdictional effort adopted by all U.S. states and many territories (EMAC, n.d.)—enables government-employed healthcare providers licensed in another state to practice temporarily in the state responding to the disaster (EMAC, 1996). And 17 states and Washington, DC, have also

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adopted a version of the Model State Emergency Health Powers Act (MSEHPA) provision that allows the state government responding to a declared disaster to waive in-state licensing requirements to enable response (Network for Public Health Law, 2012). Efforts like UEVHPA, EMAC, and MSEHPA facilitate disaster-related licensure portability and can help meet disaster-related needs, such as the needs of individuals with substance use issues (Kels & Kels, 2013; Rutkow et al., 2011).

In addition to multi-state efforts, some states permit disaster-related licensure portability through other statutes or through executive action (Kels & Kels, 2013; Hodge, Gable, & Cálves, 2005). For example, Idaho permits out-of-state psychiatrists to practice temporarily in the state during a disaster (Idaho Code Ann. § 54-1804). Recent gubernatorial action in North Carolina empowered licensed out-of-state providers, including psychologists, counselors, clinical social workers, and substance use counselors, to practice in North Carolina as part of the Hurricane Florence response (N.C. Exec. Order No. 64, 2018).

Permitting out-of-state professionals to practice temporarily in a disaster is necessary for a response strategy that relies on these professionals to help address the surge in need experienced by individuals with substance use issues. However, a response strategy that relies on out-of-state providers also requires

planning around other legal questions, such as the availability of liability protections and workers' compensation for out-of-state professionals aiding in a response (Hodge, Pepe, & Henning, 2007; Lopez, Kershner, & Penn, 2013).

Photo by Iakov Filimonov/Shutterstock.com.

Disaster recovery also involves challenges for addressing the needs of individuals with substance use issues. Disasters are linked to substance use and misuse, which may increase in a community recovering from a natural or human-caused disaster (Alexander & Ward, 2018; Kleinman & Biddinger, 2018; Gould, Teich, Pemberton, Pierannunzi, & Larson, 2015; Fan, Prescott, Zhao, Gotway, & Galea, 2015; Stoddard et al., 2011; Vlahov et al., 2002). A disaster may involve treating substance use issues that predate the disaster, intensify preexisting substance use problems, or present new venues or ways to connect individuals with treatment (North, Kawasaki, Spitznagel, & Hong, 2004; North & Pfefferbaum, 2013; North, 2007).

Despite these needs, disaster recovery can be slow and can lack the resources and infrastructure available during response (Chandra & Acosta, 2010). In addition, many legal tools and protections available for disaster response are limited to the disaster's direct aftermath (Hodge et al., 2010). The assets available to address the needs of

individuals with substance use issues may therefore be especially strained during disaster recovery (Chandra & Acosta, 2010).

At the same time, communities recovering from a disaster may be returning to pre-disaster shortages of service professionals for individuals with substance use disorders. Such professionals include psychiatrists, psychologists, social workers, counselors, nurse practitioners, and physician assistants who focus on substance use (Health Resources and Services Administration [HRSA], 2015). Every day this workforce is stretched in parts of the country, where supply fails to meet demand (HRSA, 2015; HRSA, 2018). Major investment is necessary to help close the current "national treatment gap"—that is, the discrepancy between those who need and those who actually receive substance use treatment—a problem that exists outside the preparedness landscape (Shepard et al., 2005). Such an investment is critical to prepare for and respond to a disaster, as well as to mitigate its consequences for individuals with substance use issues. ∎

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The Lingering Effect of Natural Disasters on Drug and Alcohol Use

By **Imelda K. Moise, Ph.D., M.P.H.**

The intensity, occurrence, and seriousness of recent storms, along with projections that these trends will continue or get worse, have made the study and management of natural disasters a new normal for public health. Storms have demonstrated their capacity not only to destroy property and take lives, but also to leave lasting psychiatric consequences on those in their path (Kessler, Galea, Jones, Parker, & Hurricane Katrina Community Advisory Group, 2006; Kessler, Galea, Gruber, Sampson, Ursano, & Wessely, 2008; Rhodes, Chan, Paxson, Rouse, Waters, & Fussell, 2010). Experts have long tried to quantify the damage caused by storms. Unlike destruction to infrastructure and property, some of the effects a storm has on the population in the affected areas are neither immediate nor obvious.

Exposure to a natural disaster is undeniably a stressful experience. Survivors of natural disasters have endured ordeals unfathomable to many, including loss of family, friends, homes, and community. It is understandable why there may be an increase in drug and alcohol use and misuse during and after disasters. Many of those affected by a disaster have experienced physical threats, and they may exhibit post-disaster behavior and readjustment

Following Hurricane Katrina, hospitalization rates for substance use disorders rose from **7.13 per 1,000** population in 2004 to **9.65 per 1,000** in 2008.

**HOSPITALIZATION RATES
FOR SUBSTANCE USE DISORDERS**
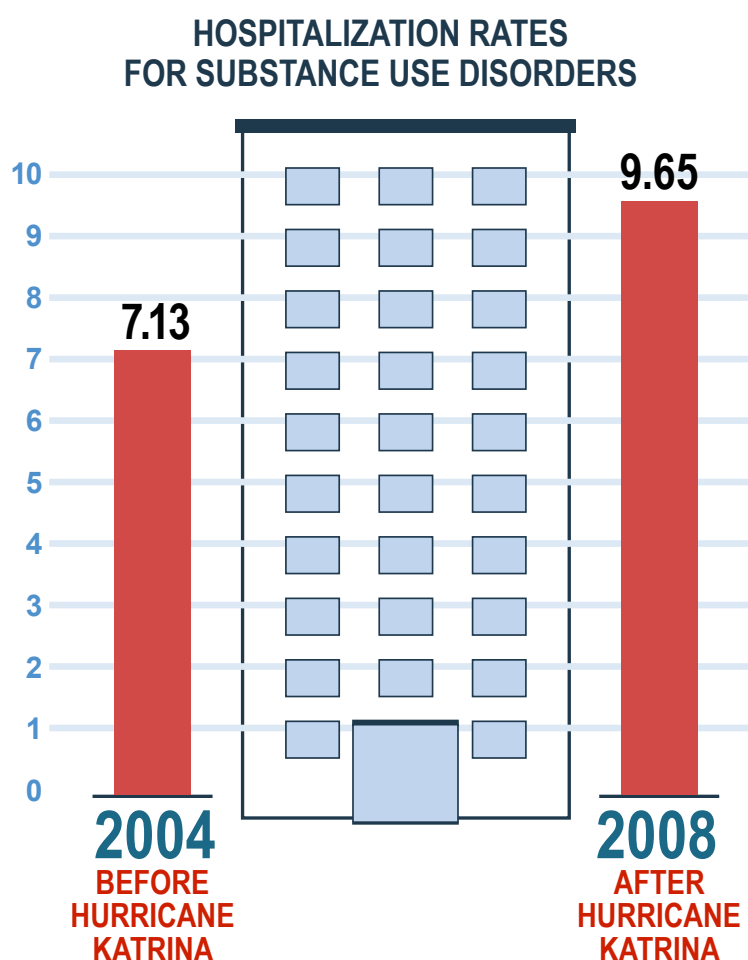
Moise, I. K., & Ruiz, O. M. (2016). Hospitalizations for substance abuse disorders before and after Hurricane Katrina: Spatial clustering and area-level predictors, New Orleans, 2004 and 2008. *Preventing Chronic Disease, 13*(E145). **https://doi.org/10.5888/pcd13.160107**

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problems as they process and address the trauma. In addition to addressing post-disaster behavior and readjustment problems, previous mental health issues may resurface during stressful or traumatic periods such as after a natural disaster.

For example, a study conducted with survivors of the Oklahoma City bombing (1995) found a prevalence of bombing-related PTSD of 41 percent, with over a quarter (26

percent) of study participants still experiencing active PSTD 7 years after the bombing (North, Pfefferbaum, Kawasaki, Lee, & Spitznagel, 2011). Participants with pre-disaster mental illness were more likely than those without to develop bombing-related PTSD (North et al., 1999). Similarly, a study of survivors of Hurricane Sandy (2012) found them more likely to suffer from disaster-related PTSD and depression, with even

higher rates of depression among those who experienced greater numbers of hurricane-related stressors (e.g., being injured or having a family member injured or killed during the disaster) (Gruebner, Lowe, Sampson, & Galea, 2015).

Regarding substance use and misuse in the wake of natural disasters, it is difficult to decipher the synergistic relationships and mediating factors that cause people to increase their use of drugs and/or alcohol. Previous research has shown that people tend to use drugs and alcohol to self-soothe in times of crisis or extreme stress (Cepeda, Valdez, Kaplan, & Hill, 2010; Flory, Hankin, Kloos, Cheely, & Turecki, 2009; Rohrbach, Grana, Vernberg, Sussman, & Sun, 2009). In our recent study, we reviewed hospital admissions records from New Orleans from 2004 and 2008 to see if there was a change in the rate of hospitalizations for substance misuse from before Hurricane Katrina (2005) to after the storm (Moise & Ruiz, 2016). We found that although the hurricane itself was a trauma for those who lived in the affected areas, the mental strain did not stop after the floodwaters receded. In some people, this strain manifested in hospitalization due to substance use disorders. Of note, the rate of hospitalizations had increased by almost one-third 3 years after the hurricane. People who had less money (people living in poverty), those who lived in close proximity to areas with levee breaches, and

MANAGING ALCOHOL, MEDICATION, AND DRUG USE AFTER A DISASTER

Pay attention to any change in your use of alcohol and/or drugs.

Consult with a healthcare professional about safe ways to reduce anxiety, depression, muscle tension, and sleep deprivation.

Use prescription and over-the-counter medication as indicated.

If you find that you have greater difficulty controlling alcohol or substance use since the disaster, seek support in doing so.

Eat well, exercise, and get enough sleep, and reach out to your family and others for support.

If you believe you have a problem with substance use, talk to your doctor or counselor about it.

New York State, Office of Mental Health. (n.d.). Alcohol, medication, and drug use after a disaster. Retrieved from **https://www.omh.ny.gov/omhweb/disaster_resources/pandemic_influenza/children/alcohol_medication_drug_use_after_disaster.html**

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Photo by Patryk Kosmider/Shutterstock.com.

Public health professionals and treatment programs continue to learn new things and are always looking to improve treatment and disaster behavioral health preparedness and response.

those who lived in areas where cleanup efforts were delayed were found to be at higher risk of hospitalization than their relatively less-affected counterparts.

So, the question becomes, what can you do to help? The link between substance use and misuse, mental illness, and disasters places public health professionals in a unique position to prepare, respond, and provide disaster behavioral health services to people with prior diagnoses and to those identified as high-risk (e.g., people living in poverty) during immediate relief and in future reconstruction efforts. Key components of immediate relief efforts may include a needs assessment; Psychological First Aid; monitoring and referral, including educating responders regarding disaster-related trauma; and psychiatric presentations on topics such as substance use and misuse. Strategies for promoting resilience and recovery during reconstruction efforts must be flexible and allow communities to develop strengths, acquire skills to cope, manage stress,

and recover from the disaster and its mental health- and substance use-related effects.

Public health professionals and treatment programs continue to learn new things and are always looking to improve treatment and disaster behavioral health preparedness and response. Therefore, in addition to providing survivors of natural disasters with disaster supplies, it may be necessary to increase access to counseling, treatment, and psychotherapy. We must understand that the need for humanitarian assistance during and after disasters goes beyond the provision of food, water, sanitation supplies, and medicine and must include mental health or social support services. As public health professionals, we must also be cognizant of the words we use when identifying and interacting with individuals affected by a substance use disorder and understand the role of stigma in these disorders. For the best terminology and language to use, and how to portray individuals with substance use disorders

accurately, see SAMHSA's series of webcasts *The Power of Language and Portrayals: What We Hear, What We See* at **https://www.samhsa.gov/power-language-portrayals**.

There is also great opportunity for collaboration and interdisciplinary work in prevention of substance use and misuse issues and conditions. In particular, geographers can contribute when trying to tease out connections between neighborhood contributions (place effects) on substance use and misuse and health disparities. For example, in the aftermath of natural disasters, geographers and local city governments can use geospatial techniques and analyses to pinpoint areas of greatest need. Then, working with disaster response personnel and volunteers, we can facilitate decision making around planning, design, and delivery of targeted mental health and substance use services and resource allocation in a timely manner, optimizing both outcomes and cost. While these techniques can be applied anywhere, for any public health outcome, they are especially relevant in post-disaster settings. ∎

Additional Resource

A Process Guide to Monitoring and Evaluation for Informed Decision Making provides an overview of geospatial analysis techniques and ways to apply geospatial analysis within the context of monitoring and evaluation, along with additional resources. (**https://www.measureevaluation.org/resources/publications/ms-14-98**).

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U.S. Virgin Islands Recovery

By **Lizette Llanos, Keila Medina, M.A.,** and **Lindsy Wagner, Psy.D.**

The U.S. Virgin Islands have experienced natural disasters in the past, but none compare to the hurricane season of 2017. On September 6, 2017, Hurricane Irma, a category 5 storm with top winds at 185 miles per hour, pummeled the U.S. territories, leaving significant damage to St. John and St. Thomas, and to a lesser degree, St. Croix. Two weeks later, on September 19, 2017, Hurricane Maria, also a category 5 storm with top speeds recorded at 165 miles per hour, passed south of St. Croix. The devastation of both went far beyond the loss of material possessions as residents continue to grapple with life after the storms.

Many damaged homes across the territory remain abandoned or covered with temporary blue tarps. The fragility of roadway, hospital, and government agency infrastructure compounds an already stressful situation. In the months post-hurricanes, many residents have not adopted the coping skills needed to maneuver stressors, including family dynamics, relocation logistics, the slow rebuilding process, and the lack of vital medical services.

Our office, Island Therapy Solutions (ITS), has seen a significant increase in clients in need of counseling services. Colleagues agree that the weight of the hurricanes, a slow rebuilding process, lack of adequate


St. Thomas, U. S. Virgin Islands – November 7, 2017: Top-heavy power pole leans precariously over road to St. John's ferry in Red Hook months after Hurricanes Irma and Maria hit. Photo by Dedicated Living/Shutterstock.com.

resources, and the annual hurricane season have caused undeniable trauma to people who are already under an incredible amount of pressure. Those who were on island during Hurricane Hugo, a category 4 storm that hit the territory in September of 1989, were re-traumatized. When we speak to these individuals, they indicate that there are major differences in post-hurricane recovery efforts.

One of the differences indicated is that in 1989, the federal agencies provided financial resources to families almost immediately after the storms. The FEMA process is now more lengthy and difficult; people have experienced delays in receiving needed funds, which has created high levels of stress. One issue that many families have run into is that the sole owner of their home was either off the island

A literature review estimated that **30–40% of direct disaster victims** developed **posttraumatic stress disorder** after the disaster.
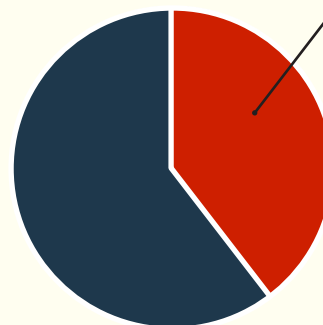
Goldmann, E., & Galea, S. (2014). Mental health consequences of disasters. *Annual Review of Public Health, 35,* 169–183. https://doi.org/10.1146/annurev-publhealth-032013-182435

or deceased when the hurricane occurred. Families were required to obtain death certificates or notarized letters from the owner to receive funding. With limited

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communication and government services, obtaining these documents was difficult.

Another difference was the overall recovery with two back-to-back category 5 hurricanes. After Hurricane Irma, the people of St. Croix donated thousands of items to the sister islands. The residents of St. Croix took supplies to St. John and St. Thomas for the entire 10 days following Hurricane Irma. This left the island of St. Croix unprepared for Hurricane Maria, as they were without many vital supplies including canned goods, gas, water, plywood, tarps, and generators. The people of St. Croix were short on supplies when Hurricane Maria became a threat, causing panic and chaos.

Many areas on the east end of the island had little damage and recovered quickly; however, many areas on the west end were devastated. Racial tension developed as it appeared the more affluent, Caucasian residents of the east end were served more quickly than local Black residents of the west end. A silent division that endured for decades resurfaced, so much so that Governor Mapp discussed it during one of his press conferences. He reminded the communities that all of the islands were affected by the hurricanes and that soon the entire territory would be in recovery mode. The governor provided hope to the people during his weekly conferences, and after the Crisis Counseling Assistance and Training

Hurricane Irma hit the U.S. Virgin Islands on September 6, 2017. Ten days later, on September 19th, Hurricane Maria made landfall at the U.S. Virgin Islands. Both hurricanes were category 5.

Irma   **Maria**
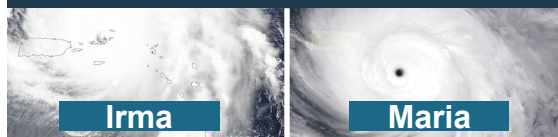
Photos by National Aeronautics and Space Administration, **https://worldview.earthdata.nasa.gov**.

Program (CCP) was granted in November 2017, the crisis counselors provided essential emotional support on all islands.

Through hope and emotional support, many communities and neighborhoods offered provisions for each other, including generators, food, or babysitting. Regardless of the emotional supports, many were financially stressed. Businesses closed or reopened slowly, resulting in involuntary layoffs. Several public-school buildings on the islands were condemned. The financial burdens, including lack of resources to repair homes or send school-aged children to private schools, became a major stressor. Due to these burdens, many families made life-changing decisions such as migrating and sending their children to live with family on the mainland, as well as sharing living quarters with other families comprising five generations.

These moves ultimately affected the mental health of individuals on the islands, some of whom have gotten counseling through the CCP. The crisis counselors of St. Croix facilitated individual crisis counseling to over 3,700 residents; provided public education and

group counseling to over 2,700 residents; and had brief educational and supportive contact with over 8,000 residents, many of whom were referred by other programs assisting with recovery such as the Women's Coalition, the Village, and ITS.

To date, ITS has provided free counseling services to 242 people through additional supplemental funding. The individuals had approximately 1,595 total visits from October 2018 through July 2019. Their diagnoses include PTSD, adjustment disorders, and anxiety disorders; we have seen an increase in cannabis use disorder and alcohol use disorder. The need for counseling is varied; individuals have had one to eight visits, depending on the severity of their situation or diagnosis. Our providers have facilitated therapy using a range of techniques and theories including cognitive behavioral therapy, dialectical behavior therapy, trauma-informed therapy, group therapy, and family therapy.

Today, almost 2 years after the storms, the changes the hurricanes wrought are still noticeable. Some are slowly recovering with hope, positivity, and preparedness, while others have moved on and made a new life elsewhere. ITS on St. Croix and Beautiful Dreamers on St. Thomas and St. John are working to help the people of the U.S. Virgin Islands be psychologically ready for another hurricane season. ■

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Missouri Planning Activities Around SMI and Disasters

By **Beckie Gierer, M.S.**

Missouri experiences natural disasters regularly. We received Presidential disaster declarations for back-to-back floods in 2016 and 2017 and for the EF5 tornado in Joplin in 2011. Since 2000, Missouri has received 31 major disaster declarations. Our breadth of experience ranges from the floods of 1993 to the death of Michael Brown in Ferguson to the duck boat tragedy in Branson. Following each event, we conduct after-action reviews to improve our response efforts and document lessons learned within our plans.

Missouri's Department of Mental Health (DMH) is the state mental health authority and annually serves more than 170,000 Missourians with mental illness,

Joplin, Missouri, 10 days after the 2011 EF5 tornado. Photo by Bob Webster/Creative Commons.

developmental disabilities, and substance use disorders. Within the DMH Director's Office is the Office of Disaster Services

(ODS), which is part of the Office of Public and Legislative Affairs and funded through the Hospital Preparedness Program and Public Health Emergency Preparedness grants. The Missouri DMH ODS collaborates with partners (state and nongovernmental agencies, faith-based organizations, federal agencies, and communities) on activities to support a coordinated mental health response for all Missourians in disaster situations. When disasters strike, ODS works with community mental health centers (CMHCs) to deploy staff to assist the individuals and communities affected by the event.
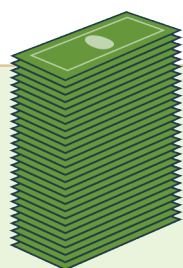
Serious mental illness costs America **$193.2 billion** in lost earnings per year.

In a national survey, **more than 18% of U.S. adults** reported that they had experienced a past-year anxiety disorder, such as **posttraumatic stress disorder, obsessive-compulsive disorder, or specific phobias.**

National Alliance on Mental Illness. (n.d.). Mental health by the numbers. Retrieved from **https://www.nami.org/learn-more/mental-health-by-the-numbers**

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The CMHCs serve Missourians with SMI daily in 36 catchment areas covering 114 counties and the City of St. Louis. Studies cited at websites of organizations such as SAMHSA and the Center for the Study of Traumatic Stress show that individuals living with SMI may be more vulnerable to disasters than individuals without SMI. People living with SMI may be less prepared than other people for disasters; can develop new or have a reoccurrence of symptoms after a disaster; and, like others, may experience a lapse in services following a disaster for various reasons. They often require an increase in services after a disaster.

ODS hears regularly from community partners regarding general mental health concerns and disaster mental health planning requests for their staff, the
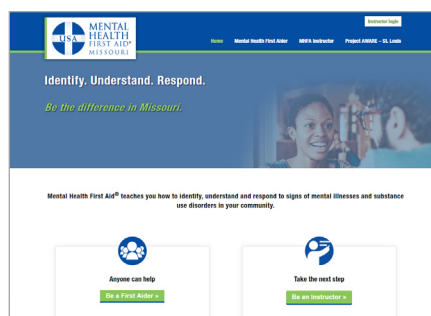
Missouri Institute of Mental Health, & Missouri Department of Mental Health (2018). Mental Health First Aid Missouri. Retrieved from **http://mhfamissouri.org**

individuals they serve, and their communities. Missouri is addressing these concerns through these planning activities:

- **Behavioral Health Strike Team (BHST)**—ODS in collaboration with the CMHCs is creating a statewide cadre whose members will train, participate in training exercises, and respond as requested. Our plan is to sustain and maintain the disaster

behavioral health expertise that so many of our agencies have from Crisis Counseling Assistance and Training Programs (CCPs) and community events, and grow that expertise in other agencies. BHSTs will deploy (1) for a mass-casualty or other crisis that affects the community but does not qualify for federal crisis counseling funding or (2) as backup to other regions of the state that may be overwhelmed responding to such an event. Status: In development.

- **Addressing SMI**—ODS sponsored two Mental Health First Aid (MHFA) Train the Trainers courses funded through existing grants. MHFA educates and empowers community members and agencies to support individuals with SMI. Hospitals, healthcare coalitions, social services, and mental health and substance use agency staff participated with the understanding they would train and be a local resource for individuals within their agencies and communities. Status: Ongoing.

- **Committees/Workgroups**—ODS participates in 21 committees and workgroups that place a focus on SMI and planning, preparedness, response, and recovery. For example, the Children and Youth in Disasters Committee promotes comprehensive interagency planning for the needs of children and youth in emergencies and disasters. There are six workgroups within this committee, and ODS co-chairs the Pediatric

Among adolescent survivors of **2011 tornadoes in Joplin, Missouri,** **2.8% experienced substance use disorders** in combination with posttraumatic stress disorder (PTSD) or depression. The prevalence of substance use disorders as a sole outcome was **less than 1%.**

Schiff, M., & Fang, L. (2016). Adolescents' exposure to disasters and substance use. *Current Psychiatry Reports, 18*(6), 1–6. **https://doi.org/10.1007/s11920-016-0693-2**

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Behavioral Health Workgroup. It focuses on substance use, SMI, human trafficking, and suicide prevention as it relates in the aftermath of a disaster or other traumatic event. Status: Ongoing.

- **Joint Emergency Preparedness Committee**—Ozark Center led the CCP after the Joplin tornado and chairs this committee. Members include Missouri DMH, the Missouri Coalition for Community Behavioral Healthcare, and several of Missouri's CMHCs. The committee's focus is to prepare CMHCs for any event so they can continue to provide treatment and support services to approximately 250,000 Missourians. This committee is engaged in building the BHST in Missouri. Status: Ongoing.

- **Education/Training**—In the last calendar year, ODS delivered education and training to our facilities, agencies, and offices and trained approximately 1,500 people in the state on continuity of operations, MHFA, Psychological First Aid, active threat, sheltering, the importance of including disaster behavioral health in emergency operations plans, self-care/team-care, responder care after a disaster, situational awareness, and hospital evacuation. In addition, ODS conducted 11 tabletop exercises with staff from DMH facilities and chief executive officers from CMHCs on earthquakes, blizzards, and ice storms. Tabletop exercises

Among adolescents who survived **Hurricane Rita, which hit the Gulf Coast in 2005,** of those who did not use or misuse drugs or alcohol 13 months before the hurricane, **15% had started smoking** after the hurricane, **25% had begun drinking,** and **8–9% had started smoking marijuana.**

Schiff, M., & Fang, L. (2016). Adolescents' exposure to disasters and substance use. *Current Psychiatry Reports, 18*(6), 1–6. **https://doi.org/10.1007/s11920-016-0693-2**
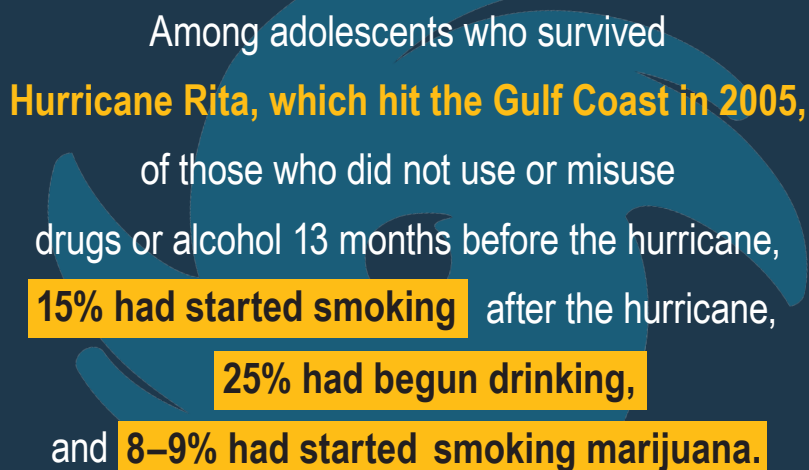
allow staff to review how their facility or agency would handle a disruption of services, a loss of a facility, staffing concerns, medication concerns, and communication challenges. Status: Ongoing.

- **Communication**—DMH has 7,000 employees system-wide, and many DMH facilities operate community-based homes or campus cottages located away from the main building. As a result, communication is a challenge. In 2018, ODS implemented a mass communication system for all DMH facilities and staff to communicate emergently via text, phone call (landline and cell), and email. Last fall, a facility went on a full lockdown due to an active threat. Fortunately, no one was

hurt, the lockdown was activated and lifted via the communication tool, and the system's value was established. Status: Ongoing.

Missouri DMH ODS facilitates disaster preparedness tools and training for all Missourians, with a focus on DMH staff; community partners; and individuals living with SMI, developmental disabilities, and substance use. The bottom line is that our mission to serve our clients, at all times, is at the forefront of everything we do! ■

You can find more information on the Missouri DMH website at **https://dmh.mo.gov/disaster**. Links to follow us on Facebook and Twitter are available at **https://dmh.mo.gov/about/socialmediadirectory.html**.

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INTERVIEW

Strength Through Connection: Disaster Behavioral Health Training in Puerto Rico

An interview with **Linda Ligenza, LCSW** *and* **Cheryl Sharp, M.S.W., ALWF**

Hurricane Maria hit Puerto Rico in September 2017, with winds reaching 155 miles per hour (Pasch, Penny, & Berg, 2019; U.S. Department of Commerce, National Oceanic and Atmospheric Administration, Storm Prediction Center, n.d.). Maria caused flooding on the island up to 9 feet above ground level, requiring rooftop rescue of hundreds of families. After the hurricane, no one on the island had electricity, 95 percent of cellular sites were nonfunctional, and only 2 percent of roads were usable (U.S. Department of Homeland Security, FEMA, 2017). Hurricane Maria was the third most expensive hurricane in U.S. history (Pasch, Penny, & Berg, 2019).

To help Puerto Rico and the U.S. Virgin Islands in the aftermath of the 2017 hurricanes, SAMHSA is supporting mental health and substance misuse consultation and training. *The Dialogue* recently spoke with trainers for Puerto Rico about how disasters and trauma affect survivors, the importance of connections, and how disaster survivors' strengths can help in disaster recovery.

Hurricane Maria hit Puerto Rico in September 2017. Photo by JEAN-FRANCOIS Manuel/Shutterstock.com.

What will your training cover?

Linda Ligenza: On the first day, we'll define trauma, its impact and prevalence, and how it affects the brain. We will cover various types of trauma, and how staff can recognize it. On the second day, we will focus on how responders can use a variety of approaches to promote healing and recovery. That's where we'll talk about building individual capacity to cope with adversity, using group methodologies and community resources.

Cheryl Sharp: We will be providing people with foundational knowledge of trauma and its impact and the information they need to tease out where people fall and what they need.

Whom will you be training?

Linda Ligenza: We will be training crisis counselors, including some mental health professionals and first responders. They've been in the field for more than a year.
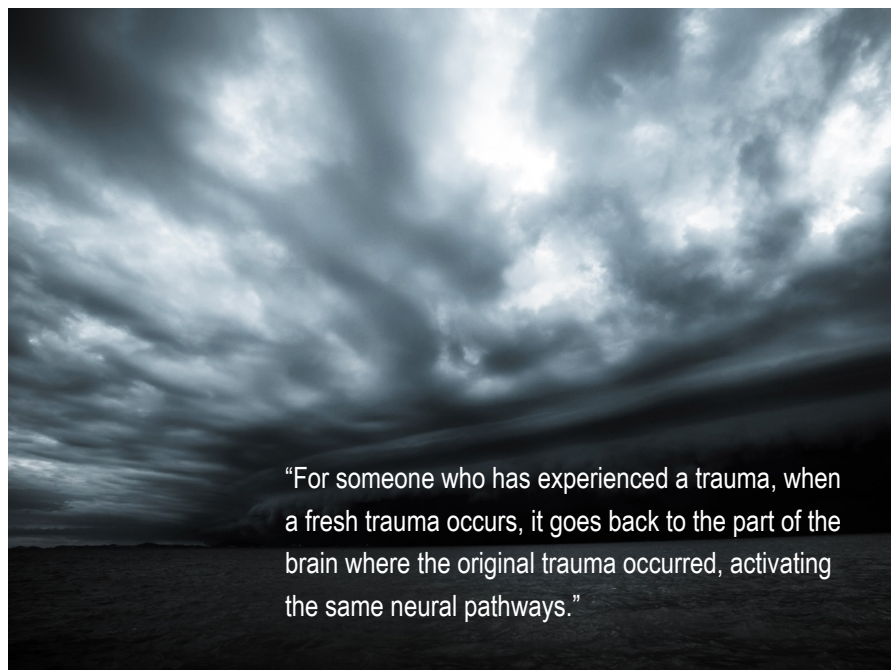
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"For someone who has experienced a trauma, when a fresh trauma occurs, it goes back to the part of the brain where the original trauma occurred, activating the same neural pathways."

Cloud cover presages Hurricane Florence. Photo by kckate16/Shutterstock.com.

How do disasters and trauma affect the brain and neurological systems?

Linda Ligenza: Trauma affects people in different ways. In people with preexisting trauma, the disaster may trigger old traumatic experiences and wounds and may cause more intense reactions. This population should be considered at higher risk for adverse reactions.

Are effects different for individuals with SMI?

Linda Ligenza: Individuals with SMI tend to react in two ways. For some, the disaster and its aftermath will exacerbate their symptoms, or, if their symptoms were under control, they may come back. On the other hand, some people with SMI are so used to dealing with stressors that they actually respond well to the disaster and function pretty well

after it. They often have supports through their mental health services and are more used to dealing with adversity.

Cheryl Sharp: I am a Hurricane Florence survivor. I am also a trauma survivor. I had a tremendous struggle throughout my young adulthood and eventually came to a place where I feel I have recovered and healed, but having gone through Florence and watching the devastation in my community, it does retrigger me. It's that sense of powerlessness. For someone who has experienced a trauma, when a fresh trauma occurs, it goes back to the part of the brain where the original trauma occurred, activating the same neural pathways. On the other hand, like others with trauma who have gone through recovery, I had a way to respond to what was going on during and after Florence.

How can staff recognize those impacts? Are there symptoms or signs that staff should look for?

Linda Ligenza: When staff talk with disaster survivors, they want to try to engage them in a conversation. Some survivors will want to share their experience while others may not. Staff should watch for signs indicating whether or not the person is able to perform their usual daily functions. For some people, if they had health problems before, those health problems may be exacerbated. Staff may see more anger and hostility, as well as difficulty managing emotions, especially in children. They may also be seeing symptoms such as feeling depressed. You have to distinguish between situational and clinical depression. If a person is not getting up in the morning, can't get the kids to school—that is more serious than someone feeling down but still being able to function. Interference with functional abilities is a huge sign.

Cheryl Sharp: It's that whole idea of having a conversation before jumping to judgment and labeling people. If you're looking for PTSD, it's important to be able to ask how the person is sleeping, functionality questions, how their mood is, and their level of fear. You can point out that your community has been through something that was really hard and ask people how they are coping. They may be coping in maladaptive ways, but the point is that we can only find out

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about a person's strengths through conversation.

All over our community, people have really risen up to be there for each other. This is common after disasters. People throw away their assumptions about people who are different, and they get back to the idea that we are all human beings.

It's also important to realize that you can't be in relationships with folks without having hard conversations. You need to be able to ask questions about many issues, including suicidality. Being able to ask hard questions is important, and making sure the person does not feel judged.

What can communities do to support their members and build capacity to recover from future disasters?

Linda Ligenza: After a disaster, there may be community stressors and triggers that prolong disaster reactions for some. As the community recovers physically, the people tend to recover and heal. Most communities will come together after a disaster and outside assistance is common. These supports contribute greatly to the community healing. There are memorial services and anniversary events. Faith-based and cultural organizations play a big role in helping the community heal and recover.

Cheryl Sharp: In my own community, I'm part of a disaster relief committee with several subcommittees. I sit on the

Photo by Mangostar/Shutterstock.com.

Emotional and Spiritual Impact Subcommittee. We work to figure out how we can provide resources that people can access, regardless of their financial situation. The group has brought together therapists willing to give a certain amount of time and number of sessions. Some of us will also do spiritual counseling. It's not clinical, but we're giving people access to someone to talk to and helping them use their spiritual beliefs as one of their strengths.

What are some considerations in working after disasters with individuals with preexisting SMI?

Linda Ligenza: In the states generally people with SMI are already connected to mental health services; the important task is getting them reconnected to services following a disaster. For many with SMI, they are most at risk of being unable to access their medications because of destruction to service centers. People in medication-assisted treatment for substance use disorders may be unable to access their medication as well. Also, people can get disconnected from their services because they couldn't get to service sites during and after the disaster, and so they may need support in getting reconnected.

What are ways to help disaster survivors toward better mental health, and to help them be better prepared for future challenges? Are there specific techniques staff can use?

Linda Ligenza: One of the most important strategies staff can use is to connect with individuals. Healing happens in relationships. After a disaster, people may become isolated. Staff can help disaster survivors connect with family members and friends and build those connections.

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Cheryl Sharp: If people are re-stimulated or triggered by an event, they aren't in the present. They are either back in the trauma, or they believe the current disaster has overtaken their life and they will never recover. You can teach mindfulness, both to children and adults. You can also teach people to go to a place of immediate gratitude versus being overwhelmed by what has happened. It is about allowing someone to be in extreme distress, while also allowing him or her options to come back to the present. Physical activity is also beneficial, and a way for community members to come together. It can be helpful to teach people breathing techniques to bring them back to center.

Linda Ligenza: Yoga is an important way of helping to reduce stress and build capacity to cope. Volunteering can be helpful. It's also important to do enjoyable things, even when there have been losses. People may feel that they don't have the right to do something enjoyable when so many people have died. Encouraging people to engage in recreational and fun activities, especially as a family, can be healing. Getting back to normal, routine activities is important as well.

Cheryl Sharp: Helping people focus on self-care is crucial. For us, for my family and what we went through, in those first days, there was not even a single thought of self-care. We were just thinking about the next thing that we needed

to do. Disaster survivors may also be dealing with guilt. I lost very little in Florence but was really overcome with watching what other people had lost. I had to step back and think about who I wanted to be

in the situation, and how I would take responsibility for my own well-being. A lot of people don't know how to do that, so it's a good opportunity for people to learn those skills. ■

Photo by fizkes/Shutterstock.com.

"Yoga is an important way of helping to reduce stress and build capacity to cope. Volunteering can be helpful. It's also important to do enjoyable things, even when there have been losses."

Photo by Andy Dean Photography/Shutterstock.com.

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RECOMMENDED RESOURCES

National Center for PTSD: The Effects of Disaster on People with Severe Mental Illness

This article from the National Center for PTSD reviews research on how individuals with SMI may react to a disaster. It covers the likelihood that people with SMI will develop PTSD, as well as how disasters and war may affect people with SMI. The article also describes ways mental health professionals can meet the needs of individuals with SMI.

Find the article at **https://bit.ly/2UAlPeV**.

Psychological First Aid: Alcohol and Drug Use after Disasters

This handout from the National Child Traumatic Stress Network discusses the potential for substance use and misuse after a disaster in an effort to relieve negative feelings and symptoms. It also explains the importance of choosing to stay in recovery for individuals that have had substance use issues in the past. Tips on how to maintain recovery include increasing attendance at support groups and talking to loved ones about providing extra support.

Download the handout at **https://bit.ly/2X2kb2f**.

Access the handout in Spanish at **https://bit.ly/2G5Vn2E**.

Access the handout in Chinese at **https://bit.ly/2USj3kj**.

Access the handout in Japanese at **https://bit.ly/2UsP8zP**.

Creating Safe Scenes Training Course

This course provides information to help first responders ensure safety for all involved in calls in which an individual is in crisis related to a mental illness or substance use disorder. The course covers signs and symptoms of specific mental and substance use disorders, risk assessment, and de-escalation techniques.

Find the training at **https://bit.ly/2v3c1L7**.

NAMI: Navigating a Mental Health Crisis

This guide from the National Alliance on Mental Illness (NAMI) describes mental illness and mental health crises and offers steps to take if a crisis occurs. An individual may experience a mental health crisis because of a variety of stressors, including trauma and exposure to violence. This guide provides techniques to help de-escalate a crisis, what a medical or law enforcement response may look like, and more.

Download the manual at **http://bit.ly/2J06ay8**.

Mental Health Response to Mass Violence and Terrorism: A Field Guide

This manual from the SAMHSA Store aids disaster response workers in assisting survivors after an act of terrorism or mass violence. It has a section on individuals with SMI and their potential need for additional support after a traumatic experience.

Read or download the manual at **https://bit.ly/2Z5jerW**.

https://www.samhsa.gov/dtac

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Recent Technical Assistance Requests

*In this section, read about responses 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: SAMHSA DTAC received a request from a Massachusetts resident concerned about the safety of his congregation and place of worship. He was looking for assistance with assessing the security of his congregation.

Response: SAMHSA DTAC directed him to the FEMA web page Resources to Protect Your House of Worship (**https://www.fema.gov/faith-resources**). This web page provides links to several webinars, trainings, and preparedness resources for testing an emergency plan. It also includes resources on trauma and resilience, and for learning about religious and cultural literacy and competency in disasters.

Request: SAMHSA DTAC received a request from a survivor of Hurricane Michael looking for support to help her recover. She wanted help with finding a professional to talk about her experiences during and after the disaster.

Response: SAMHSA DTAC provided her with information on several SAMHSA resources that can help provide disaster survivors with mental health and substance use support. The resources included the following:

- SAMHSA Disaster Distress Helpline—This 24/7, 365-day-a-year helpline provides crisis counseling and support to people experiencing emotional distress related to natural or human-caused disasters. Call 1–800–985–5990 or text TalkWithUs to 66746 to connect with a trained crisis counselor. For more information visit **https://www.samhsa.gov/find-help/disaster-distress-helpline**.

- SAMHSA's National Helpline—This helpline is a free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families facing mental and/or substance use disorders. It can be reached at 1–800–662–4357, and more information can be found at **https://www.samhsa.gov/find-help/national-helpline**.

- SAMHSA Behavioral Health Treatment Locator—This online tool can be used to find mental health and substance use disorder treatment services in a specific area. The locator can be found at **https://www.findtreatment.samhsa.gov**.

Request: SAMHSA DTAC received a call from a disaster behavioral health manager who was interested in training her staff so that they could be provide services for the state's existing CCP.

Response: SAMHSA DTAC thanked her for her interest in CCP trainings and explained the process that takes place when a state applies for and administers a CCP in response to a major disaster. SAMHSA DTAC shared her information with the state disaster behavioral health coordinator for her state, so she could be contacted to assist with future disasters. She was also provided information on several trainings that may be of interest to her and her team, including the following:

- FEMA Citizen Corps—The Citizen Corps program brings together local government, business, and community leaders to harness the power of every individual through education, training, and volunteering. Its network provides services to make communities safer, stronger, and better prepared to respond to the threats of terrorism, crime, public health issues, and disasters of all kinds. More information can be found at **https://www.ready.gov/citizen-corps**.

- Centers for Disease Control and Prevention (CDC) Preparedness and Emergency Response Learning Centers (PERLC)—CDC funds 14 centers across the United States to offer disaster response-related courses online free of charge. More information can be found at **https://www.cdc.gov/cpr/perlc.htm**. ■

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