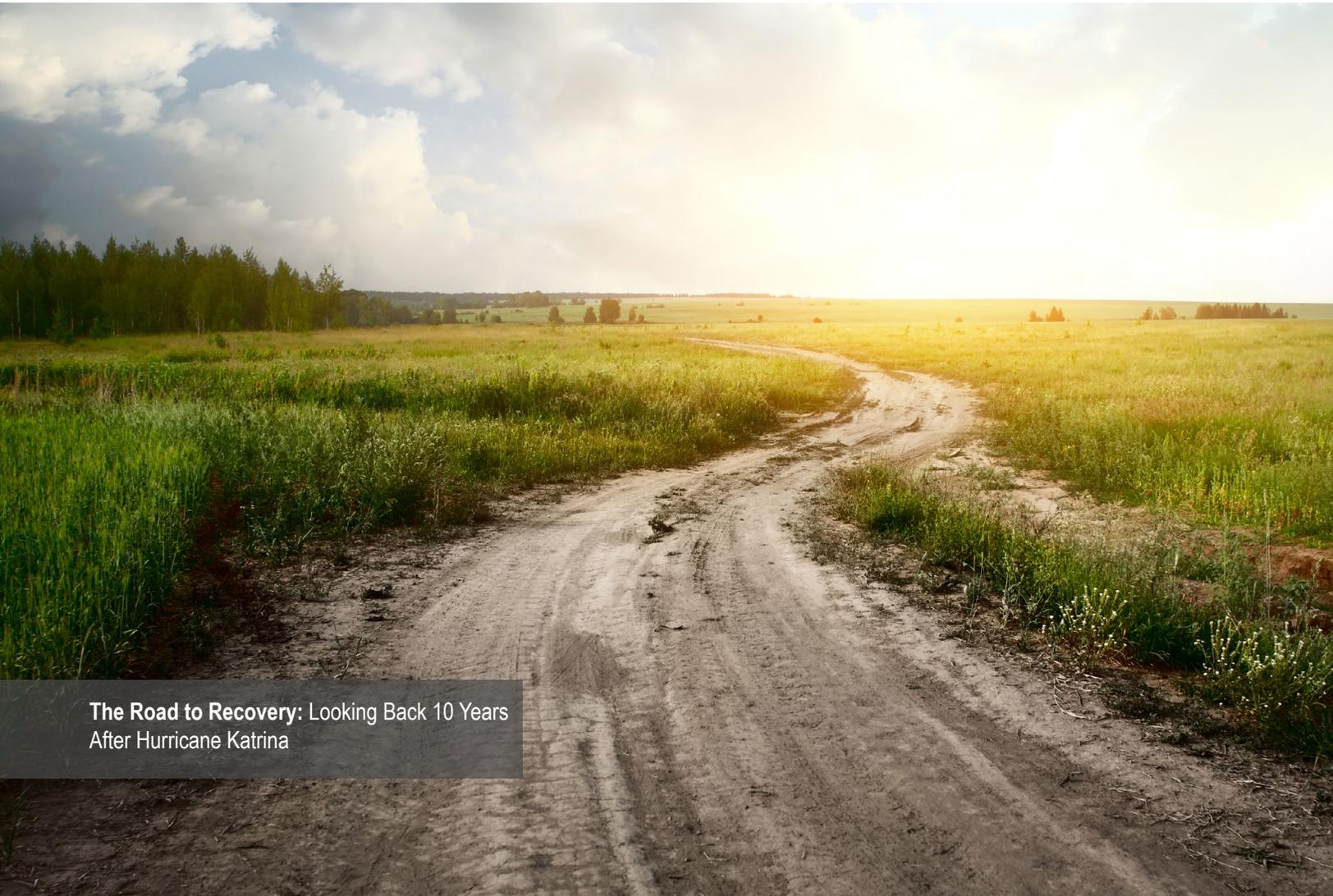
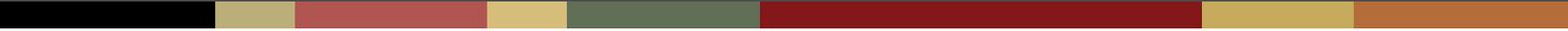


A Quarterly Technical Assistance Journal on Disaster Behavioral Health
Produced by the SAMHSA Disaster Technical Assistance Center

the Dialogue

2015 | VOLUME 11 | ISSUES 3-4



The Road to Recovery: Looking Back 10 Years
After Hurricane Katrina

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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 behavioral health (mental health and substance abuse) response to disasters. To receive *The Dialogue*, please go to SAMHSA's home page (<http://www.samhsa.gov>), enter your email address in the "Mailing List" box on the right, and mark the checkbox for "SAMHSA's Disaster Technical Assistance newsletter, *The Dialogue*," which is listed in the Newsletters section.

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 abuse needs following a disaster.

To learn more, please call 1-800-308-3515, email DTAC@samhsa.hhs.gov, or visit the SAMHSA DTAC website at <http://www.samhsa.gov/dtac>.

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In This Issue



The 2005 hurricane season broke many weather records in the United States, including the most named storms (28), most hurricanes (15), second-highest number of hurricanes to strike the United States (6—Cindy, Dennis, Katrina, Ophelia, Rita, and Wilma), the most major (category 3 or higher) hurricanes (4—Dennis, Katrina, Rita, and Wilma), costliest (Katrina), and most intense (Wilma) (Blake, Landsea, & Gibney, 2011; Farris, 2007; National Oceanic and Atmospheric Administration, National Climatic Data Center, 2012).

More than 1,800 people lost their lives. Over 1 million people were displaced with nearly 600,000 evacuated from the effects of Hurricane Katrina. Millions more survivors were left to find a new normal. It's the 10-year anniversary of that devastating season, and this edition of *The Dialogue* focuses on the recovery of the Gulf Coast and those associated with the response.

Two articles share lessons learned from the SAMHSA response perspective. A special feature Q&A with the State Disaster Behavioral Health Coordinators of Alabama, Louisiana, Mississippi, and Texas describes

how their disaster behavioral health response operations have changed as a result of Hurricane Katrina. Other articles focus on the unique challenges of supporting special populations—children, first responders, and Native Americans—following Hurricane Katrina.

This special edition is in memory of all those who lost their lives and is in honor of all those who survived. We wish to thank everyone who worked tirelessly to support the survivors on their road to recovery—a new normal.

We hope you find the articles in this edition helpful and we encourage your feedback—what is your “new normal”?

Warmest regards,

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Katrina

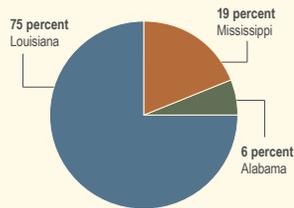
The Aftermath and The Recovery

The Aftermath

1.504 Million

Estimated number of individuals aged 16 years and older that evacuated from their homes, even temporarily, because of Hurricane Katrina

Number of Evacuees by State



Source: Green, J. A., & Polivka, A. E. (2008, March 1). Hurricane Katrina evacuees: Who they are, where they are, and how they are being. *Monthly Labor Review*, 32-51. Retrieved from <http://www.bls.gov/pub/mi/2008/03ar03a.pdf>



70%

of all occupied units were damaged

Katrina displaced more than **1,000,000** people in the Gulf Coast region.



Up to **600,000** households were still displaced a month later.



At their peak, hurricane evacuee shelters housed **273,000** people.

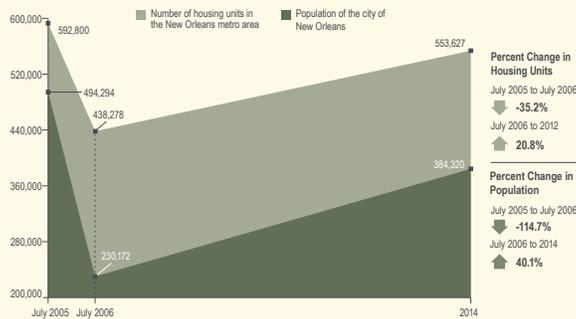


At least **114,000** households were relocated to FEMA trailers.

Source: The Data Center

The Recovery

Change in the Number of Housing Units in the New Orleans Metro Area Compared to the Change in Population of the City of New Orleans, 2005-2014



Source: Population Estimates and Intercensal Population Estimates

In 2014, New Orleans returned to the list of the nation's 50 most populous cities, ranking 50th at 384,320.

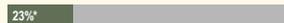
Percent of evacuees who returned to their pre-Katrina residences or county, October 2005-October 2006



Percent of evacuees who did not return to their pre-Katrina residences and did not even return to the county in which they were living, October 2005-October 2006



Percent of Louisiana natives affected by the storm that no longer live in the State

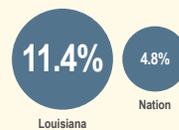


*8% of Louisiana's population in 2005

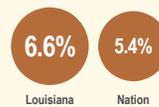
Source: Green, J. A., & Polivka, A. E. (2008, March 1). Hurricane Katrina evacuees: Who they are, where they are, and how they are being. *Monthly Labor Review*, 32-51. Retrieved from <http://www.bls.gov/pub/mi/2008/03ar03a.pdf>

Unemployment Rate: Louisiana Versus the Nation

September 2005



April 2015



Source: U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics; U.S. Bureau of Labor Statistics, April, 2015

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SPECIAL FEATURE

Gulf Coast Disaster Behavioral Health Coordinators Look Back

Perspectives From Alabama, Louisiana, Mississippi, and Texas

In this special Q&A, Chance Freeman from Texas, Kris Jones from Mississippi, Acquanetta Knight from Alabama, and Cassandra Wilson from Louisiana share their insights from responding to Hurricane Katrina and talk about how disaster preparedness and response have changed in the ensuing 10 years.

The Dialogue: How has your approach to disaster behavioral health planning and response improved or evolved since Hurricane Katrina?

Acquanetta Knight (AK), Alabama:

There has been an increased focus among partners and stakeholders on incorporating cultural competence into planning, especially as it relates to sheltering during disaster. Since Katrina, disaster behavioral health training has also been designed to expand the response workforce. At least annually, training on the effects of trauma during disaster, posttraumatic stress disorder related to disaster, and Psychological First Aid (PFA) has been provided statewide. Plans include the development of a Critical Incident Stress Management tabletop exercise.

Cassandra Wilson (CW), Louisiana:

We also have expanded training and exercises, including routine tabletop exercises conducted with

the state psychiatric hospitals and state university psychiatry units in several areas of the state to practice evacuation and shelter-in-place protocols for each agency. Also, suicide prevention, substance use screening and referral, and domestic violence training were incorporated into the Louisiana Spirit Crisis Counseling Assistance and Training Program (CCP). Additionally, all state employees are now required to complete Emergency Support Function (ESF)-8 training.

To build response capacity, we developed a Behavioral Health Cadre to offer support to individuals who need crisis, grief, and loss assistance after traumatic events that is beyond the capability of local response systems. Also, we established protocols to employ needed CCP staff at the state level (short term), as contracts are no longer feasible, and Louisiana has now implemented an Employee

Emergency Database to facilitate call-back of staff for emergency assignments.

We expanded planning and readiness activities after Hurricane Katrina in a statewide effort to integrate behavioral health into overall public health response. We revised data collection systems for substance use services to determine if clients served were affected by or displaced as a result of a disaster. We established protocols for emergency access to psychiatric services in disasters, as well as protocols for use in medical special needs shelters (MSNSs) and for public/quasi-private hospitals with psychiatric units to shelter at the state's psychiatric hospitals in the central and northeast parts of the state. We developed contingency contracts for transportation of psychiatric clients to sheltering sites, and we pre-identified psychiatric surge beds for evacuated shelterees or evacuees.

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We also enhanced backup systems for critical data and improved emergency communications systems for critical staff. We initiated annual reviews and updates with state psychiatric hospitals for prestaging of supplies and staffing, and we created written evacuation agreements with providers for use of the state's psychiatric facilities as an evacuation/shelter site. Additionally, we now include in our response plans the deployment of members of the behavioral health first responder team and local governing entities in affected regions to assist with evacuation and sheltering.

Also, local government entities have taken ownership of the primary behavioral health responder

role at the community level with support from the state as needed. Coordination of the behavioral health resource is also being pushed out to the locals to promote a seamless response system and to strengthen partnerships with other ESF agencies.

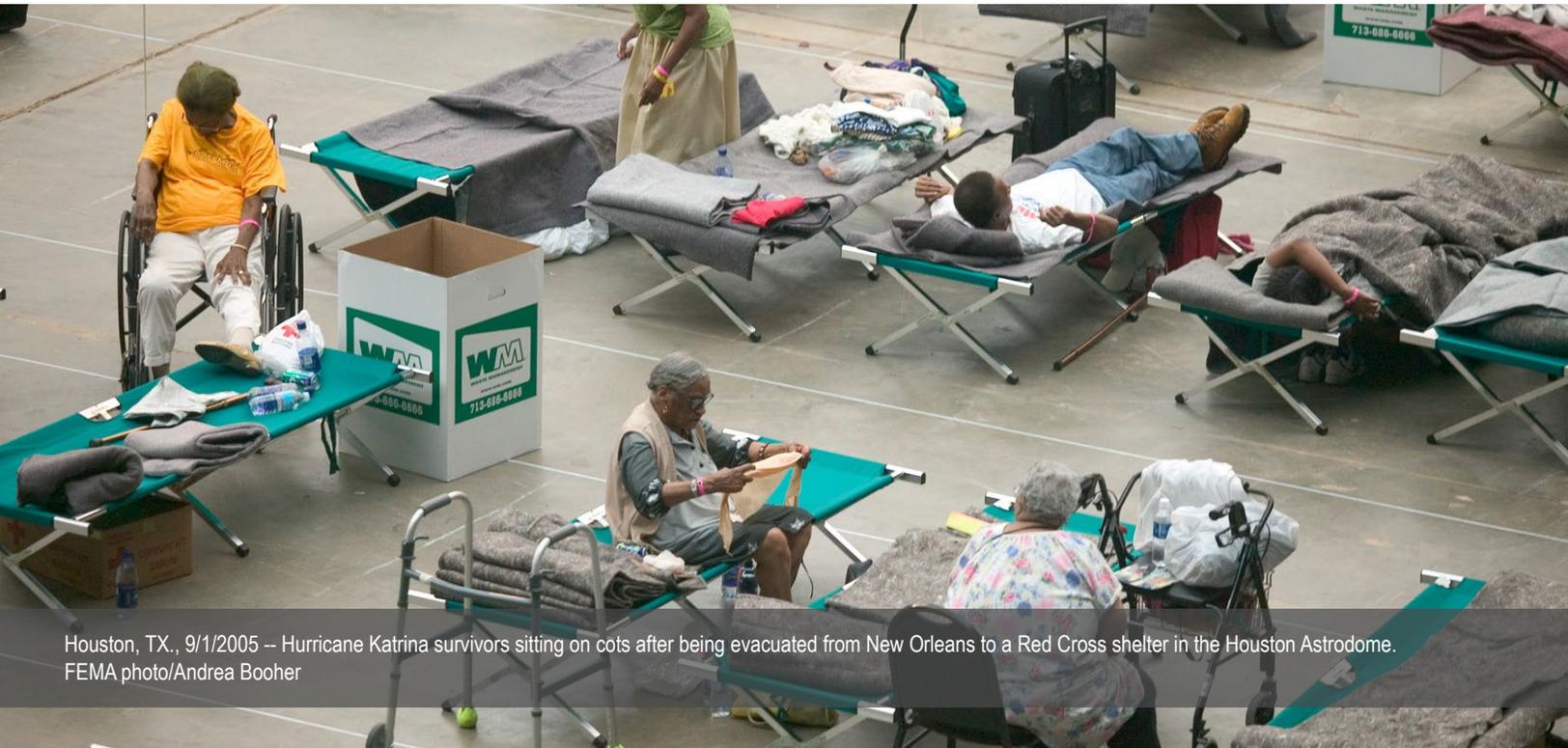
Since Katrina, the state has also focused on improving how services are delivered. In the Louisiana Spirit CCP, trained first responders and stress managers were deployed statewide to support other responders post-event. We have made this component of Louisiana Spirit a permanent part of our CCPs. We also developed and implemented tools for local government entities to support timelier implementation of the

CCP. Additionally, we made evacuation preparation plans more comprehensive, with specific details of supplies, equipment, and personnel that need to be in place prior to the arrival of evacuees. HVAC-capable generators are now on site at psychiatric facilities, nursing homes, and hospitals through Federal Emergency Management Agency Hazard Mitigation grants.

Kris Jones (KJ), Mississippi:

Mississippi had the opportunity to change and improve our disaster behavioral health planning and response. Prior to Katrina, a formal system did not exist. Post-Katrina, the Department of Mental Health (DMH) recognized the importance of solidifying disaster planning and

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Houston, TX., 9/1/2005 -- Hurricane Katrina survivors sitting on cots after being evacuated from New Orleans to a Red Cross shelter in the Houston Astrodome. FEMA photo/Andrea Booher

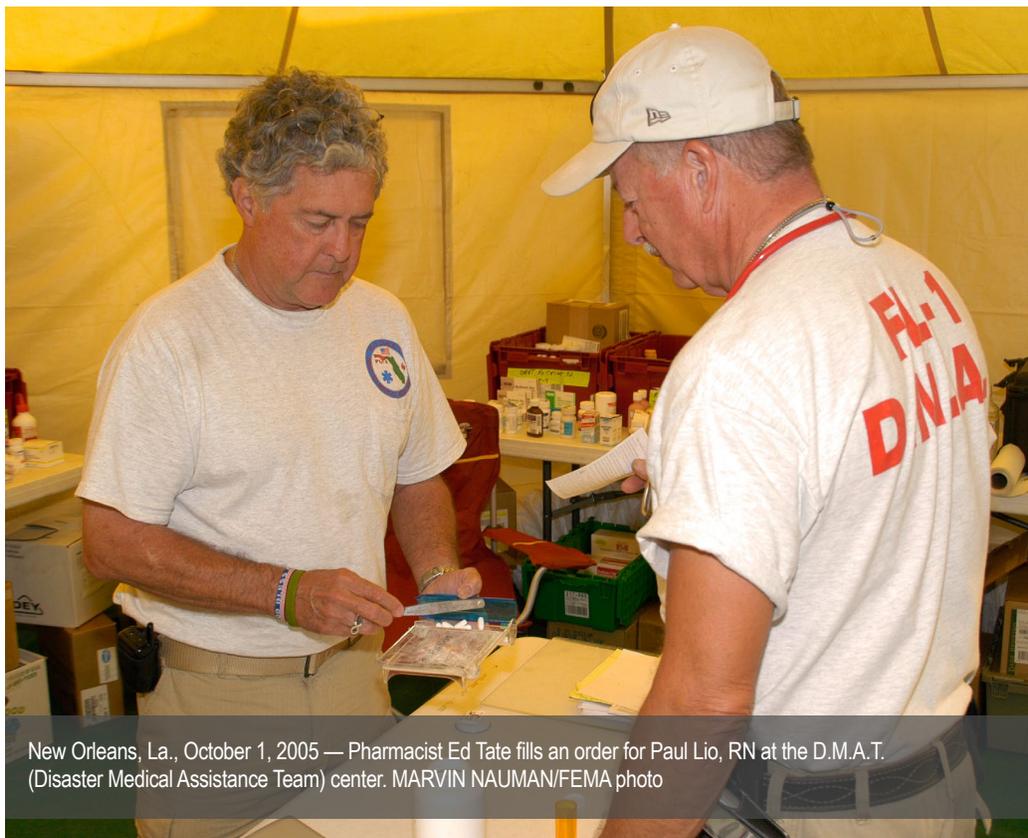
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response activities as part of the agency's mission. DMH created the Division of Disaster Preparedness and Response to manage not only disaster preparedness and response activities but also continuity of operations activities for the public mental health system. Subsequently, that division has increased its level of responsibility and oversight and is now the Office of Incident Management. The office remains responsible for disaster preparedness and response activities, as well as the agency's incident management reporting system for agencies certified by DMH.

Chance Freeman (CF), Texas:

Texas is fortunate to have a robust network of volunteers and 39 mental health authorities willing to respond to any disaster. However, since Katrina, Texas has focused on developing tools to assist disaster behavioral health responders in tracking encounter data and response/recovery expenses. This toolkit is accompanied by a training that explains the role of crisis counselors, how disaster response differs from the clinical setting, and how to track encounters as well as how to track and report response expenses. The toolkit is updated regularly based on lessons learned from previous response activities and as advancements in data gathering are made.

Understanding Texas' vastness and diverse cultures, the state is developing and rostering regional



New Orleans, La., October 1, 2005 — Pharmacist Ed Tate fills an order for Paul Lio, RN at the D.M.A.T. (Disaster Medical Assistance Team) center. MARVIN NAUMAN/FEMA photo

disaster behavioral health response teams. These teams will be trained according to qualifications established by the state's Disaster Behavioral Health Consortium and will include individuals with specialized training in Incident Command, PFA, spiritual care, victims assistance, and Critical Incident Stress Management. The state also recognized the need to develop local/regional Disaster Behavioral Health Consortia. These groups will serve as advisory groups to local and regional public health planners, emergency managers, and incident command. Lastly, the state is still in the process of incorporating providers of substance use treatment services into the overall emergency management landscape.

TD: In your opinion, what is the most important lesson(s) learned from the behavioral health response to Hurricane Katrina?

AK: To me, the most important lesson learned during Katrina was the importance of making sure first responders had information regarding behavioral health resources, particularly information specific to substance use disorder treatment. During Katrina, states and regions were able to effectively plan and develop emergency treatment protocols for evacuees who presented without prescriptions. These emergency policies, coupled with the dissemination of treatment and response information, proved to be critical strategies.

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CW: One key lesson for Louisiana was that behavioral health agencies should be prepared with training and resources to respond to requests for crisis support from other partner agencies. Also, as Acquanetta mentioned earlier, cultural competence and appropriateness are crucial. In Louisiana, we learned that community staffing post-event should reflect the makeup of the area to help broker into communities that need services. We learned the importance of identifying specific cultures and ensuring that services and staff can meet their needs.

Some of our other lessons learned are as follows:

- It is critical to educate staff to ensure coordination of crisis

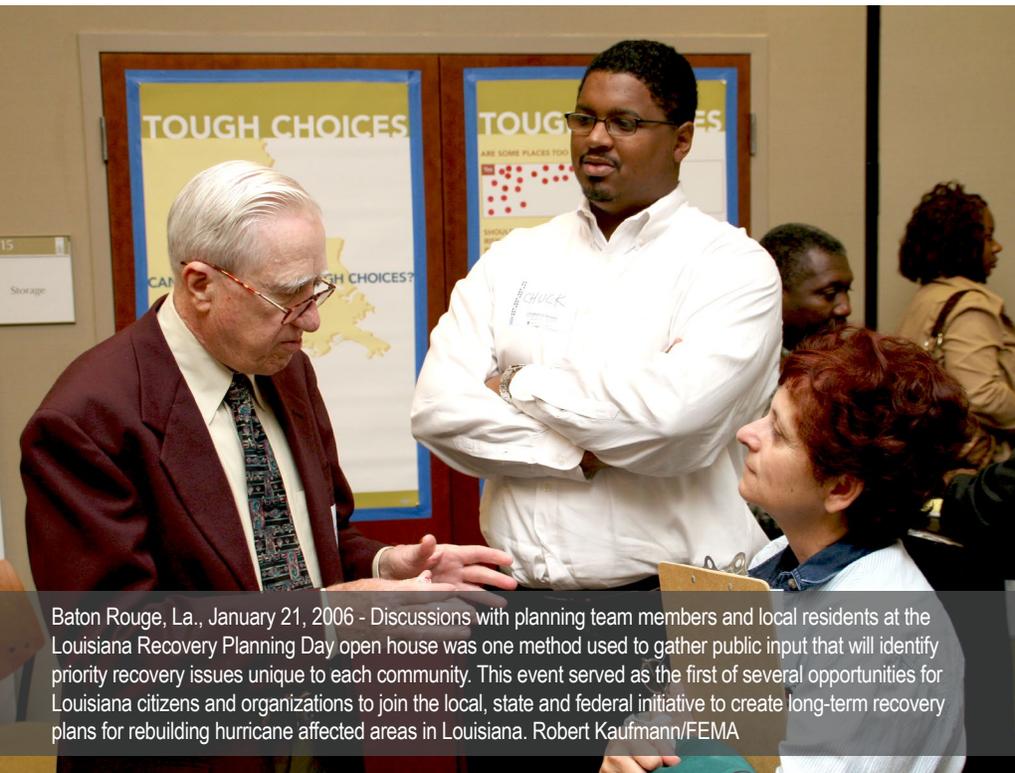
support and PFA to survivors evacuated to MSNSs and critical transportation needs shelters across the state.

- The specialized crisis counseling services developed during Katrina should be utilized to help survivors develop the skills needed to recover psychologically.
- Continuing partnerships are essential in each affected area (public, private, faith-based, advocacy organizations, etc.), either directly or indirectly.

KJ: Two of the most important lessons learned from Katrina were the importance of establishing relationships with emergency management partners at state and

local levels prior to an event and the need to engage individuals who are most knowledgeable about the operations of state systems during an event. During the response to Katrina, DMH learned that the height of an event is not the time to learn the incident management structure, its moving parts, and its key players. Although the CCP is a valuable resource to behavioral health agencies during and after an event, DMH quickly learned that engaging individuals who are most knowledgeable about the operations of state systems led to more positive outcomes for communities, rather than hiring “unseasoned” staff with little systems experience. Through our experience with Katrina and subsequent disasters, we have found that people affected by the event most often need assistance with getting basic needs met. When people were successful in getting those needs met, we found that the longer-term mental health effects of the event were lessened.

CF: Substance use-related services are important components of emergency planning, response, and recovery. During Katrina, we underestimated the number of individuals who needed opioid treatment services. However, communities stepped up and did what was needed to ensure individuals received the medications, treatment, and wrap-around services that they needed. This is a true testament of how



Baton Rouge, La., January 21, 2006 - Discussions with planning team members and local residents at the Louisiana Recovery Planning Day open house was one method used to gather public input that will identify priority recovery issues unique to each community. This event served as the first of several opportunities for Louisiana citizens and organizations to join the local, state and federal initiative to create long-term recovery plans for rebuilding hurricane affected areas in Louisiana. Robert Kaufmann/FEMA

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dedicated Texas is when it comes to caring for those in need.

TD: Knowing what you know now about disaster behavioral health planning and response, how would you have done things differently in Hurricane Katrina?

AK: The only thing that comes to mind is alerting the disaster response workforce to the magnitude of the disaster, which was unprecedented and somewhat unforeseen. While anyone watching news accounts could understand the severity of the hurricane's initial impact, the sheer number of people presenting with overwhelming needs was in some ways difficult to prepare for and predict. However, Alabama, and the surrounding Gulf states, did a heroic job in responding to these needs, addressing behavioral health concerns, and welcoming evacuees on short notice.

CW: There are several things we would have done differently, based on what we learned from Katrina. Some I have touched on already. Others include better integration of behavioral health services into overall state planning and response efforts. We also would have more thoroughly planned for and tracked behavioral health clients to be evacuated—ensuring clinics/providers include readiness planning with clients and their families, and that clients have access to emergency behavioral health services. We would have

ensured availability of onsite behavioral health support at locations such as parish pickup sites and assembled trained behavioral health mobile crisis teams. We also would have developed and implemented organized systems and structures at the state level to track all evacuees and quickly link them to identified resources while in shelters and upon discharge. Finally, we would have established a protocol for mental health clinics patients' medication planning during an emergency or disaster.

KJ: Knowing what we know now, DMH approaches disaster behavioral health much differently: technical assistance related to disaster preparedness and planning for DMH-certified provider agencies has been integrated into DMH's routine practice; and workforce development in the areas of PFA, mental health first aid, and suicide prevention is ongoing. A critical component of local disaster response has become the use of mobile crisis response teams (made up of clinicians, case managers, and peers) funded through state appropriation, but operated by local community mental health centers. The primary role of these teams is to respond to behavioral health crises in their communities; however, the teams respond to and coordinate with state and local emergency management agencies during an event. This enables DMH to put into practice the philosophy that events are best handled locally.

CF: Understanding the size and scope of the event, Texas would have requested additional assistance through Texas-based membership organizations such as the National Association of Social Workers—Texas Chapter and the Texas Psychological Association. The state would have also looked to the Texas Voluntary Organizations Active in Disaster (VOAD) for volunteers and engaged substance use providers much sooner.

TD: What were some of the most significant behavioral health impacts among survivors/evacuees and how were those different or similar to those among residents already living in the community (who could also be considered survivors)?

AK: The most significant differences were cultural. Alabamians, for the most part, sought shelter in neighboring communities during Katrina's onset and returned to their communities as soon as possible. Conversely, individuals and families from the New Orleans area traveled several hundred miles to take shelter. In many cases, these shelters were developed in rural areas of Alabama. In some instances, transport occurred so rapidly that evacuees didn't know their shelter destinations. These individuals experienced uncertainties about their futures and, in some cases, longed for reconnection with their loved ones. They also missed traditional Louisiana customs and foods that provided a daily

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sense of comfort, routine, and security. Rural Alabamians made every attempt to welcome and accommodate evacuees. Preparing communities and providing just-in-time or PFA training may have empowered more rural areas of Alabama to better understand the customs and culture of evacuees.

CW: There was a lack of PFA training among all responders to better prepare them to handle survivors/evacuees experiencing emotional distress. Another issue was cultural insensitivity or ignorance of responders, which increased the psychological impact on survivors. And many evacuees in the workforce underestimated the psychological impact of losing an

entire community and the lengthy recovery process.

Also, the capacity to rebound was just not there for many who found themselves homeless and living on the streets, in abandoned structures, or under bridges with little hope of recovery. Residents felt they could not survive outside of their community and had limited to no access to behavioral health services.

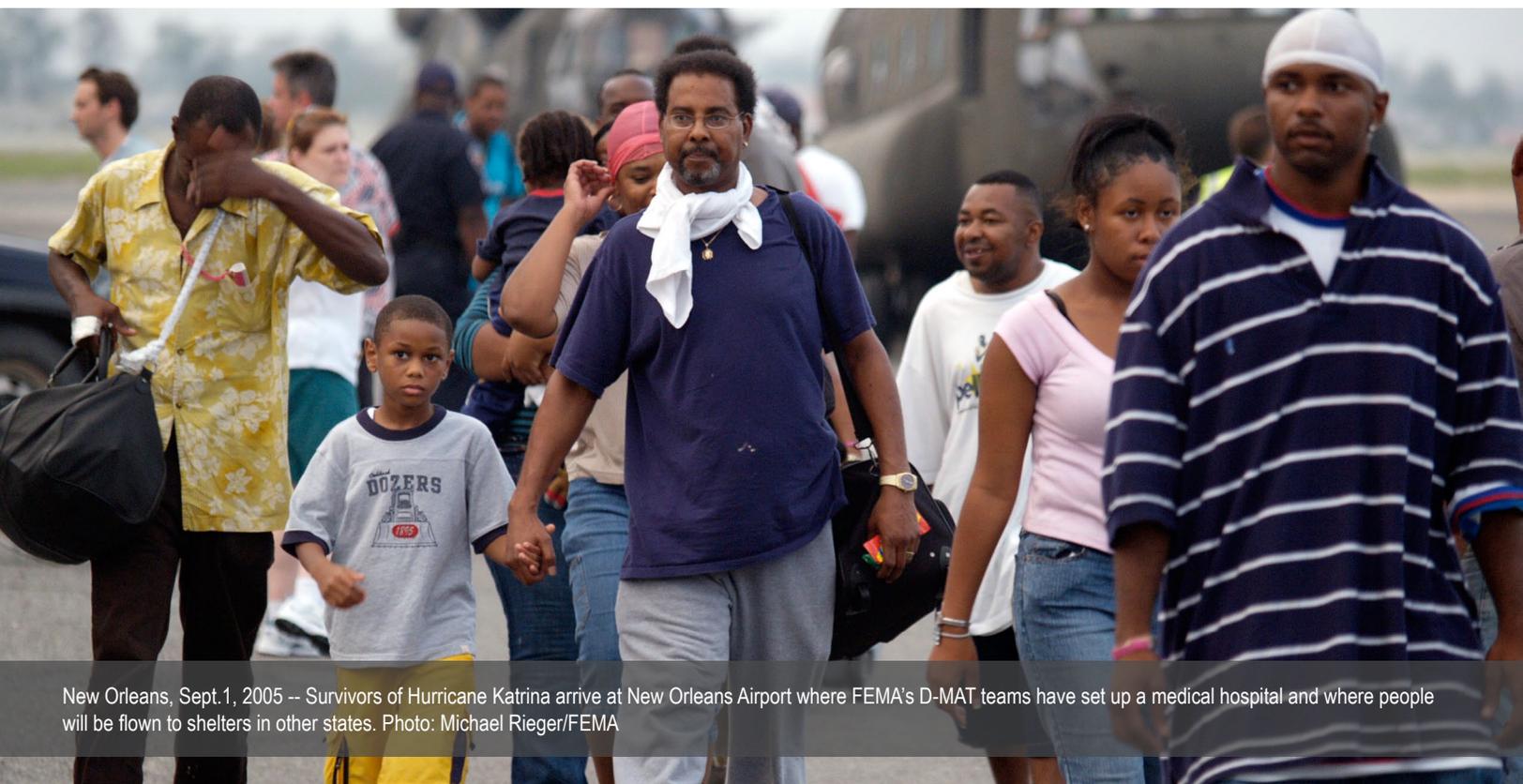
TD: In general, how many evacuees went home versus stayed in their new location?

CW: This number is not definitive. According to the U.S. Census Bureau, the population estimates for New Orleans suggest a 21 percent decrease (difference between the

2000 and 2014 censuses). However, this population decline could be the result of multiple changes in the area and not specifically related to Hurricane Katrina.

Another source estimates that as many as 30,000 evacuees have permanently relocated to Baton Rouge and the surrounding area. Because there was not a formal tracking system in place post-Katrina, repatriation of evacuees from various shelters (in state and out of state) focused on returning survivors using state and federal transportation assets. The LA Swift bus line between New Orleans and Baton Rouge, which was started after Hurricane Katrina to help people return to their homes and

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New Orleans, Sept. 1, 2005 -- Survivors of Hurricane Katrina arrive at New Orleans Airport where FEMA's D-MAT teams have set up a medical hospital and where people will be flown to shelters in other states. Photo: Michael Rieger/FEMA

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jobs in New Orleans, transported over 12,000 commuters monthly from Baton Rouge to New Orleans from 2006 until 2013 to help displaced residents rebuild their homes and livelihoods (Samuels, 2013).

TD: How many evacuees did your state take in following Hurricane Katrina?

AK: It's reported that 14,500 evacuees took shelter in Alabama following Katrina. In addition to shelters established by VOADs, Alabama used its statewide community college and parks systems to provide shelter and temporary housing.

TD: What were the challenges to providing services to evacuees?

AK: Overall, the challenges were few. It's amazing how seamlessly the response effort worked. In large part, this is because partnerships are maintained in Alabama when disasters and disaster recovery are not in progress. These preexisting relationships stood the most powerful test of time to date in the state.

CW: Our greatest challenges were not knowing where people were, and a completely shut down transit system. Most in the New Orleans area were evacuated to various other cities and states immediately after the storm. With limited or no infrastructure left, it was increasingly difficult to locate survivors in need of services. This was especially true of the

school systems. Also, relocation of residents resulted in a significant loss of staff.

CF: The greatest challenges we experienced regarding evacuees included:

- Locating appropriate service delivery sites, especially for methadone maintenance medications
- Accommodating the large number of individuals in need of behavioral health providers
- Obtaining medical records
- Tracking clients separate from Texas residents
- Being affected by Hurricane Rita 1 month after Katrina

TD: How did the communities who received evacuees respond to them?

CW: Overall, communities seemed to welcome evacuees, with the exception of those areas less receptive to the culture or perceived culture of the evacuees. Many states made provisions for a number of evacuees with housing and jobs. Other evacuees were met with fear and with less-than-desirable accommodations for this diverse population.

AK: News stories during the time reported how welcomed evacuees felt in Alabama. One story indicated that the reputation of some of Alabama's shelters resulted in evacuees specifically seeking those

resources based upon word of mouth or previous experience. Colleges, the faith-based community, and citizens provided support to adults and children who were being sheltered. The governor established a state office to manage the extensive supply of donations and to develop a list of volunteers willing to provide additional services.

CF: Texas communities welcomed evacuees. Many benefited from the rich culture that the evacuees brought with them. The evacuees who stayed enriched their communities through music, art, and food. ■

Contributed by:

- **Chance Freeman**, former Texas Disaster Behavioral Health Coordinator, Texas Department of State Health Services
- **Acquanetta Knight**, Director of Planning and Resource Development at the Alabama Department of Mental Health
- **Kris Jones**, Director, Bureau of Quality Management, Operations & Standards, Mississippi Department of Mental Health
- **Cassandra Wilson**, Director, Emergency Preparedness Operations, Louisiana Department of Health and Hospitals, Office of Behavioral Health

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Part of the Fabric of Recovering Communities: The Katrina Assistance Project

Contributed by Anne Mathews-Younes, Ed.D., D.Min., Director, Division of Prevention, Traumatic Stress, and Special Programs, SAMHSA Center for Mental Health Services

It's hard to believe that it has been 10 years since Hurricane Katrina hit the Gulf Coast. The memory of the disaster is still fresh for many people. In Katrina's aftermath, the need for mental health (MH) and substance abuse (SA) services was unprecedented and at times seemed overwhelming. In addition to the enormous numbers of affected individuals, the storm's destruction left many state and local MH and SA agencies unable to serve their communities. Practitioners were dislocated, facilities damaged, patient records destroyed, and distribution channels for pharmaceutical supplies disrupted. Most seriously, many hospitals were closed, so emergency psychiatric services were hard to find.

SAMHSA determined that as many as 500,000 people needed behavioral health assistance after Katrina's landfall and so moved swiftly to create the Katrina Assistance Project (KAP). KAP was funded by the Federal Emergency Management Agency through SAMHSA (at approximately \$12 million) to support the MH and SA needs of people affected by Hurricane Katrina. Over 600 licensed, well-trained, and resilient MH and SA clinicians from across

the country deployed to fill the gap between the services offered through the Crisis Counseling Assistance and Training Program (CCP) grant and the services needed to restore essential local MH and SA service delivery systems.

Enter the "Orange Shirts"

In all, 130,000 people received services. Two weeks after Katrina's landfall, KAP "orange shirters" spread out over the disaster-affected area, offering care wherever they found people in need. They helped individuals displaced by the storm and supported the efforts of first responders. By maintaining a visible presence where people gathered and reaching out to people in need, KAP professionals entered the mainstream of life in the newly created communities of "dislocated" and often distressed people.

The clinicians often had to modify their traditional approaches and improvise in the fragmented post-disaster environment. Sometimes they had to see an agency's regular clients, find and engage new ones, and provide professional support to local agency staff. Their orange shirts could be seen in shelters, tent cities, trailer parks, and on the

cruise ships where first responders and their families lived. In all these settings, KAP professionals brought hope to people and helped foster a new sense of community.

KAP evolved into an innovative, field-based model for providing clinical MH and SA services, an approach that many equated with the mobile medical and surgical teams used by the military.

Katrina brought the need for professional MH and SA care into public view and demonstrated the importance of these services in the recovery process.

KAP personnel took treatment out of traditional clinical settings and became part of the fabric of these recovering communities.

The SAMHSA KAP initiative was essential to rebuilding communities in the Gulf Coast region. While it did not involve bricks and mortar, it contributed strength of a different kind. KAP offered hope where it had been washed away, and empowered people to rebuild lives shattered by Katrina's destruction. ■

All Hands: SAMHSA's Response to Hurricane Katrina

Contributed by Brenda Mannix, Project Director, SAMHSA Disaster Technical Assistance Center, and former SAMHSA Incident Commander During Hurricane Katrina

Hurricane Katrina struck on August 29, 2005. Even 10 years later, I am flooded by a jumble of memories and emotions, and it is so difficult to focus on just a few short operational lessons learned.

When Katrina hit, SAMHSA—for the first time—activated an emergency response center for a disaster. Previously, SAMHSA participated in very limited roles during national drills and exercises, so few employees had any experience with incident command or disaster response activities. The majority of disaster response work was carried out by the SAMHSA Emergency

Coordinator, who at that time was Daniel Dodgen, Ph.D., and staff of the Emergency Mental Health and Traumatic Stress Services Branch (EMHTSSB) within the Center for Mental Health Services, led by Mr. Seth Hassett, M.S.W. EMHTSSB houses both the FEMA/SAMHSA-funded Crisis Counseling Program and the National Child Traumatic Stress initiative; both programs provided intensive services and supports to the states, communities, and individuals affected by the disaster. Mr. Hassett also served as SAMHSA's first Incident Commander for Hurricane Katrina, until he transferred command to me.

What I remember most always comes back to people—the people who were affected, our colleagues in local and state agencies, many of whom themselves were disaster survivors and yet became responders, and my colleagues at SAMHSA and from around the federal government who volunteered to support SAMHSA's efforts. In total, more than half of SAMHSA's employees worked in the emergency response center or were deployed to Gulf Coast states to assist in response operations. The other half of the Agency's staff picked up the work of their deployed colleagues and carried

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Photo: Steve Zumwalt/FEMA

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on regular business. There was no “I” in that team, and I continue to be proud of being a part of that response.

Hurricane Katrina was a unique response for SAMHSA. In most disasters SAMHSA provides technical assistance, training resources, and coordination and consultation regarding mental health and substance use treatment needs. Katrina destroyed so much infrastructure in the Gulf Coast and so many people were evacuated and unable to return that a typical mental health response could not be launched. For the first time in its history, FEMA awarded a mission assignment to SAMHSA to provide mental health and substance use services. SAMHSA staff, clinicians from other agencies—such as the Health Resources and Services Administration, the National Institute of Mental Health, and the Centers for Disease Control and Prevention—and clinicians from around the country were deployed to provide support to survivors, help relieve clinicians who also needed to attend to their own recovery, and stand up treatment facilities. With so many deployed people, we quickly had to develop policies to ensure everyone’s health and safety—managing tours of duty, managing each state’s licensing requirements and temporary reciprocity requirements, providing time for rest, transitioning back to work, providing an opportunity to share

on-the-ground assessments, and handling sickness, injuries, and other emergencies—which included for instance, Hurricane Rita.

A New Framework

Following Hurricane Katrina, the U.S. Department of Homeland Security and FEMA led an effort to update and revise the National Disaster Recovery Plan, which became the National Response Framework. The National Response Framework describes how the federal government responds to all

types of disasters and emergencies. It is built on scalable, flexible, and adaptable concepts identified in the National Incident Management System (NIMS) to align key roles and responsibilities across the nation. This updated framework places a strong emphasis on planning and partnership building. SAMHSA required all staff to become trained on NIMS and encourages all states, communities, and facilities to develop disaster response plans, update them regularly, and train staff on

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Photo: Marvin Nauman/FEMA

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Incident Command. Through the SAMHSA-funded Disaster Technical Assistance Center, states and communities can access disaster planning and response tools, including tip sheets, program guides, and webcasts discussing best practices in planning for disaster behavioral health needs and responding to special populations.

All of these advancements are for naught if you don't have relationships with people and organizations. SAMHSA's Hurricane Katrina response efforts succeeded in part because of the partnerships and relationships it had with other agencies, organizations, and states. Knowing whom to contact is 90 percent of the battle.

SAMHSA staff either knew the right people to connect with for resources or knew people who knew the right people. It's all about relationships. Many of the people I worked with during the Hurricane Katrina response have moved on to other roles and positions, but they are still people I count on as expert resources and great colleagues.

Dr. Daniel Dodgen is now the Director for the Division of At-Risk Individuals, Behavioral Health and Community Resilience within the HHS office of the Assistant Secretary for Preparedness and Response. Ms. Terri Spear replaced Dr. Dodgen as SAMHSA's Emergency Coordinator. Mr. Hasset is now the director of

the Division of State Assistance within the HHS Administration for Children and Families. Captain Maryann Robinson, Ph.D., is the current Branch Chief of EMHTSSB. As for me, I am just finishing my first year as Project Director for SAMHSA's Disaster Technical Assistance Center. I am pleased to be in a role where I can continue to help connect people to each other in preparation for responding to disasters. I look forward to continuing this dialogue, so please reach out and let us know what you think of this edition and what other information would be helpful to you in your disaster preparedness and response activities. ■



SAMHSA's response efforts succeeded in part because of the partnerships and relationships it had with other agencies, organizations, and states. Knowing who to contact is 90 percent of the battle. SAMHSA staff either knew the right people to connect with for resources or knew people who knew the right people. It's all about relationships.



New Orleans, La., June 12, 2013 – FEMA Louisiana Recovery Office Deputy Director of Programs Andre Cadogan joins city of New Orleans Mayor Mitch Landrieu, Recovery School District Superintendent Patrick Dobard and other federal, state and local government officials at the Fisk Howard school groundbreaking ceremony. Photo: Lynette Fontenot/FEMA

Turning Rebuilding Into Reengineering: New Orleans School Systems After Katrina

Contributed by CAPT Jon Perez, Ph.D., SAMHSA Regional Administrator for Health and Human Services Region IX

Hurricane Katrina caused enormous damage in Louisiana and Mississippi, destroying homes and businesses, communities, and entire public service systems. One of those systems severely damaged was the public school system across much of southern Louisiana and Mississippi, and particularly the Orleans Parish public school system, which includes New

Orleans. After the hurricane, New Orleans schools were destroyed and the entire school system was decimated.

This is a brief story about how sometimes just a little help can bring big results.

As part of SAMHSA's massive recovery effort for Katrina, there was also a little known, but

important area of support that involved helping the Louisiana Department of Education (DoE) recover from the enormity of the damage caused to the public education system in southern Louisiana. I led a small team of four U.S. Public Health Service officers that integrated into the DoE recovery team during the critical period immediately following the

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hurricane when DoE created the models it would eventually use to create the new public school models for Orleans Parish and New Orleans. Ten years after the destruction, those resulting public school models are being lauded for their innovation.

The job facing DoE was overwhelming as Katrina destroyed virtually all the existing New Orleans and Orleans Parish school districts:

All 65,000 public school students were forced to evacuate the city. Administrators, teachers, and support staff were similarly displaced. The storm also took an enormous physical toll on the public schools' long-neglected facilities. According to a facilities assessment done in 2008, more than two-thirds of the district's 300 plus buildings were considered to be in "poor" or "very poor" condition due to storm damage and long-neglected maintenance.

(Cowan Institute for Public Education Initiatives at Tulane University, 2010, p. 4).

This destruction affected an already troubled school system that perennially ranked as among the lowest performing school systems in the country. And those charged with addressing these problems were all personally affected by the hurricane, as well.

"Overwhelmed" was the word most often used by the DoE team to describe the situation and themselves, as the more they

learned about the destruction, the more they wondered how, if ever, they could repair it all. That was where the SAMHSA team came in...the group was composed of behavioral health professionals, a couple with decades of emergency and disaster response experience working with entire recovery systems. And while our team hadn't seen this kind of devastation before in the United States, we had seen it in other places, and we knew that helping the team heal would help the larger system heal as well.

The SAMHSA team became part of the DoE team and functioned as liaisons between the ongoing federal response and state personnel, as additional staff for DoE, and perhaps most importantly as counsel for the DoE team leadership. We were people from the outside who came not to tell

DoE what to do, but be members of their team, and work side-by-side with them to more fully assess damage, begin short-term recovery operations, and chart longer term healing for the school systems and their students.

From New Orleans to Baton Rouge, the team assessed, consulted, engaged constituents, and developed immediate action plans to get educational programs, if not all the schools, operating again. This alone was an extraordinary effort involving the range of educational personnel and resources in the state, and the remaining students themselves. But it was during these activities, and during ongoing deliberations among everyone affected, that the possibilities for real successes became evident.

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Baton Rouge, La., January 17, 2006 - This class is being conducted in a new modular building used as a temporary classroom at Audubon Elementary School. Robert Kaufmann/FEMA

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As more information became available, and more constituents—from elected officials to students and families—were consulted, the idea of just repairing a previously problem-plagued system became untenable. But for the DoE team, what were the realistic alternatives? How do you repair and rebuild on such a scale?

It was here the integrated team, and its members with perspectives outside DoE, provided a critical change in thinking about the overall response paradigm. Specifically, we ceased approaching the recovery effort as system “rebuilding,” and began working on system “reengineering.” Inherent in this was the idea that in great crisis, opportunity for great change was also present. What it did for the team itself was shift the stance from victim of disaster to leaders



in innovation. “What if...” became the mantra, and renewed energy to promote large scale change became evident.

The changes seen now in the New Orleans school systems, again described by the Cowen Institute at Tulane University, which has been involved with the effort from the beginning, are remarkable:

The 2013-14 school year marks the eighth full school year since the dramatic transformation of the public school system in New

What If...?



Orleans. Although structures and policies continue to evolve, the overarching reform mechanisms that were catalyzed by Hurricane Katrina and its subsequent flooding in 2005 continue to define the public education model. School autonomy, parental choice, and high-stakes accountability remain hallmarks of the system.

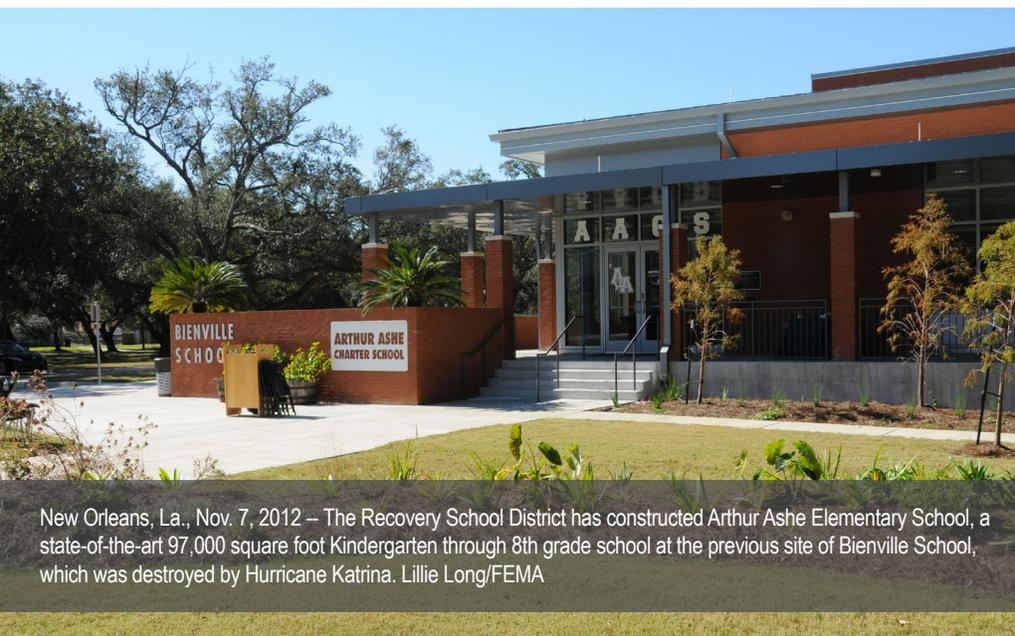
(Sims & Vaughan, 2014, p. 2).

A small team helping another small team can sometimes promote the achievement of significant things. And it is a testament to the efforts of Louisiana, its people, its government, its schools and administrators, and even a small team of personnel sent by SAMHSA to help in a time of overwhelming need. ■

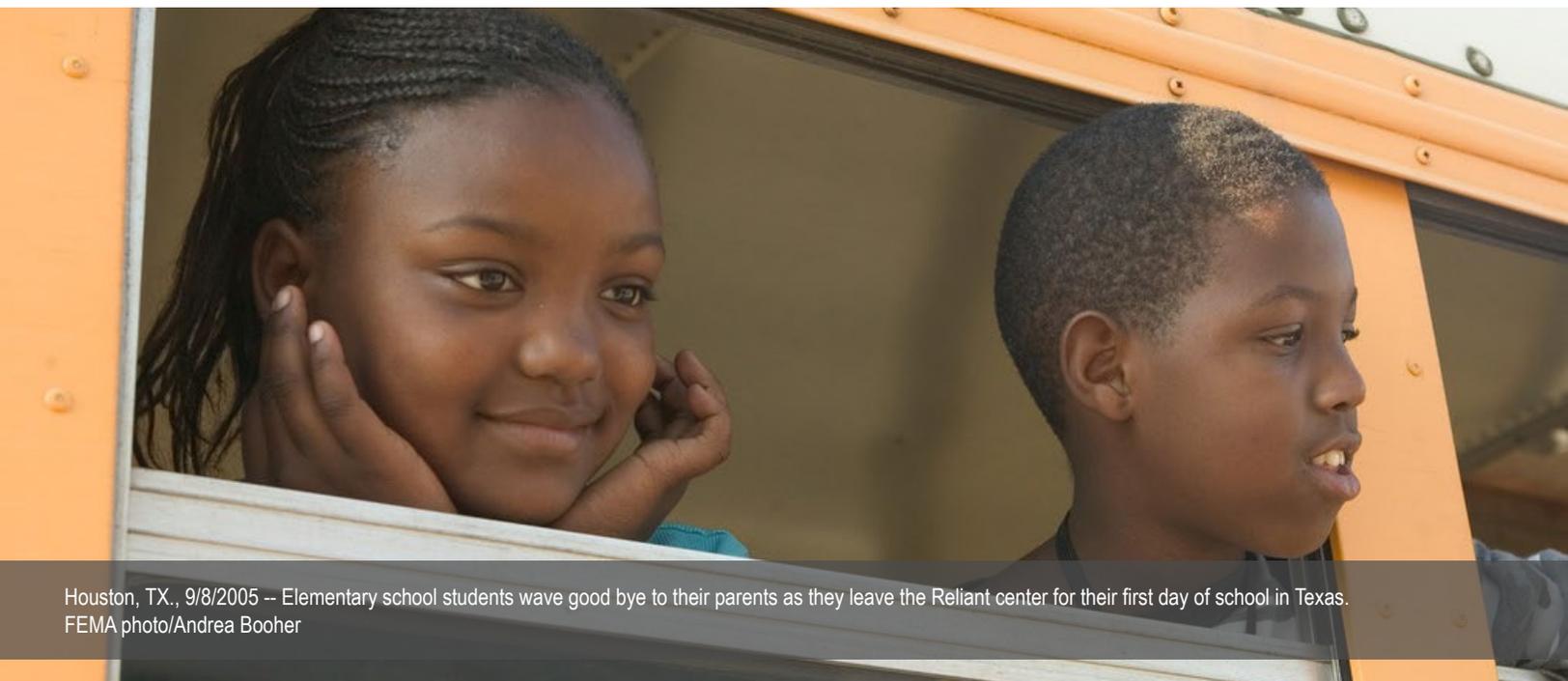
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New Orleans, La., Nov. 7, 2012 – The Recovery School District has constructed Arthur Ashe Elementary School, a state-of-the-art 97,000 square foot Kindergarten through 8th grade school at the previous site of Bienville School, which was destroyed by Hurricane Katrina. Lillie Long/FEMA



Houston, TX., 9/8/2005 -- Elementary school students wave good bye to their parents as they leave the Reliant center for their first day of school in Texas. FEMA photo/Andrea Booher

Hurricane Katrina: Recovery and Resilience Among Children

Contributed by Joy D. Osofsky, Ph.D., and Paul J. Ramsay Chair, Department of Psychiatry and Pediatrics, Louisiana State University Health Sciences Center

As is well known and very much on our minds at the time of the 10th anniversary of Hurricane Katrina and the breach of the levees, Katrina caused a disaster of proportions not previously known in the United States. At that time, and for many years that followed, there was increased need for behavioral health support, consultation, intervention, and treatment services. This was a result not only of the destruction and horrors witnessed by many, but also the long-term displacement and instability in families with children attending multiple schools, family

economic difficulties, stress that, at times, resulted in domestic violence and substance use, and a change in the life, routines, and familiarity that children always knew.

Important questions can be asked about the longer term effects of the trauma. Does having such experiences early in life foretell unhappy and unstable development? Or can such adversity result in greater strength, ability to cope, and resilience? Depending on the circumstances and experiences, both are true. Since 2005, as a result of multiple

grants,¹ the Departments of Psychiatry and Pediatrics at Louisiana State University Health Sciences Center have been following—and providing school-based intervention and treatment services to—children affected by Hurricane Katrina. In collaboration with schools, we have also been carrying out screenings once a year since Hurricane Katrina,

¹ Through the Louisiana Rural Trauma Services Center in the National Child Traumatic Stress Network funded by SAMHSA, Louisiana Spirit Crisis Response Program through the Office of Behavioral Health of Louisiana, and then the Mental and Behavioral Health Capacity Project funded as part of the medical settlement following the Deepwater Horizon Oil Spill

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and as of 2015 have data on over 54,000 children and adolescents. These screenings help us track the course of behavioral health symptoms, work with schools and communities, and guide the provision of services.

Based on empirical data and anecdotal reports, our team has observed both significant, ongoing behavioral health problems, many of which are also related to family dysfunction, as well as much resilience in the children. Most children demonstrate resilience, even if persistent behavioral health symptoms exist. There are so many stories describing long-term displacement and loss of parental employment. For example, one teenager 3 years after Katrina stated, *“I will never have the same life that I had before Katrina and I may never be successful or rich; however, I know that after this experience I will be able to face and overcome future adversities.”* Students in one of our strength-based programs reached out to returning younger children to decrease risk-taking behaviors when usual activities were not available, and they volunteered with the school to help plant new trees to preserve the wetlands.

Right after Hurricane Katrina, almost 50 percent of students met the cut-off for behavioral health referral, and the percentages remained relatively high for the next 4 years. Since 2010, reductions progressively occurred

with some transient increases at the time of new disasters. By 2014, approximately 25 percent of the students met the cut-off for referral.

Percentage of Students Meeting the Cut-off for Behavioral Health Referral

2005 **approx. 50%**

2014 **approx. 25%**

There has been a further slight decline in the past year. According to the recovery timeline of the Centers for Disease Control and Prevention (2012), for most children, the greatest improvement in symptoms occurs in the first 3 years following a disaster and then symptoms stabilize to expectable national levels. After Hurricane Katrina, due to the severe nature of the disaster, not only has stabilization of symptoms in this disaster-prone region of the country taken longer, but it also remains higher than national expectations.

Important lessons have been learned and changes made in this region of the country even as we now are in the middle of another hurricane season.

- First, the state is better prepared, with preparedness being embedded in all systems so that by June of each year, most institutions, individuals, schools, communities, and children and

families have a plan—a much more robust plan than was in place at the time of Katrina.

- Second, it is recognized that some behavioral and emotional reactions to trauma may be “normal” or represent a new “normal” with widespread disaster and continuing anxiety.
- Third, knowledge has pointed to the importance of recognizing and addressing, in culturally sensitive ways, behavioral health needs of children and families after a major disaster.
- Fourth, special behavioral health needs of communities, for example, those of first responders (including teachers), and their families need to be recognized and addressed. Self-care for those who are responding and supporting others needs to be implemented.

Finally, and perhaps most important, we have learned that most children will be resilient—especially with support from adults. Therefore, in responding to disasters, it is crucial to be sensitive to both the needs of children and those of caregivers and community/education providers so that they can be knowledgeable and emotionally available to support the children. We have learned that for recovery and resilience, schools and communities play key roles. ■

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The "Spirit of Louisiana" is a fire truck given to New York City after 9/11. Following Hurricane Katrina, the city sent it to New Orleans with a full regiment of firefighters. Photo courtesy of Danny Adams

Katrina's First Responders

An Interview with Danny Adams, Assistant Fire Chief, Ret./Disaster Behavioral Health First Responder Lead, Baton Rouge, Louisiana

Danny Adams served the Baton Rouge area as a firefighter for 30 years, retiring in 2008. As Assistant Fire Chief, he supervised the Critical Incident Stress Management Team for the Baton Rouge Fire Department. He continues to serve on the Behavioral Health Board of the International Association of Fire Fighters in Washington, DC.

Mr. Adams currently works with the Office of Behavioral Health (OBH)/Disaster Preparedness. He is part of the state behavioral health emergency response for all disasters, providing support

to the bus triage process during evacuations and stress management for employees and volunteers working with disaster response. He leads the Behavioral Health First Responder Team for OBH. He served as First Responder Coordinator for the OBH/Louisiana Spirit Program starting in 2006 after Hurricanes Katrina and Rita, and as Quality Assurance/First Responder Liaison for the Deepwater Horizon Oil Spill. Training provided by OBH included safeTALK and Applied Suicide Intervention Skills Training (ASIST) for Hurricane Isaac for

which he served as one of the primary trainers. He also provided coordinative assistance to stress managers and teams through the OBH First Responder staff.

What was your role in the immediate Hurricane Katrina response?

At the time Hurricane Katrina hit, I was nearing the end of my career as Assistant Fire Chief in Baton Rouge. As Assistant Fire Chief, part of my responsibility was running the Critical Incident Stress Management (CISM) Team for the department and the Baton Rouge area. Once we realized

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the full devastation caused by the hurricane, my chief asked me to help other firefighters cope with the stress surrounding the rescue and recovery process. The OBH Crisis Counseling Program (CCP) grant to be implemented in the New Orleans service area was interested in recruiting a first responder to coordinate and assist crisis counselors with reaching out to the first responder community. With my background—coming from a family of law enforcement personnel—and job experience, I felt I was a good match for the job and agreed to come on board part-time, working for the OBH *Louisiana Spirit* CCP.

Why do you think you were successful in your role?

When I started my outreach work with Louisiana Spirit, I realized using only behavioral health professionals to reach this group would not work. By pairing a first responder with a behavioral health professional, you add a level of credibility that opened up doors for the crisis counselors and help while reducing the stigma of mental health. When we ran into resistance, as a part of the OBH Louisiana Spirit team, I was able to reach out to the community first responder leadership as a peer, resulting in a request from this community to “please come help my people.”

The Louisiana Spirit program also received assistance from other

jurisdictions. New York City sent the “Spirit of Louisiana” (a fire truck given to the city by Louisiana after 9/11) with a full regiment of firefighters to serve as backup so our people could go to see their families. Catholic Charities and Louisiana State University, Health Science Center for Psychiatry, also provided much-needed assistance. Several first responders continue to see behavioral health professionals in their communities for more intense counseling.

Did you find differences among the first responder groups?

We found firefighters to be more resilient due to the nature of the environment they work in. Typically, they work in groups or pairs and usually talk about what has happened when they return from a call. Law enforcement officers may not have a partner, making it more difficult to cope with tragic events. OBH Louisiana Spirit partnered with a retired officer, Dave Benelli from the New Orleans Police Department, who later became a CCP First Responder Team Lead for the Louisiana Spirit Orleans Service Area to help the program gain access to the officers when we met with resistance.

How did you best help the first responder community?

I found that taking care of the wives and families of the first responders in the field was the best way to help relieve their stress.



Many of the people our program worked with were nearing the end of their careers and did not want to jeopardize their positions by leaving their posts. Letting them know that OBH Louisiana Spirit had people on site with their families helping them allowed the first responders to continue on with their work. Two unfortunate situations occurred where law enforcement officers took their own lives. During these tragic events, our program assisted the department and family through peer support.

Through the OBH Louisiana Spirit program, we also produced short videos using people and scenes from the community to increase our credibility. These videos helped show first responders that their reactions to the disaster were

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normal. This group is not used to asking for help. We tried to reinforce the idea that “we are not superheroes; we are just human beings.”

Reaching out to the nontraditional first responders, those individuals that due to the extraordinary circumstances found themselves in the role of a first responder, was a little more challenging. One of the groups that Louisiana Spirit worked with was the Department of Wildlife and Fisheries. We (the CCP first responder team) would meet them on the docks and talk to them before they would go out. Sometimes just talking to someone about what’s going on helps. In our outreach, we made sure we reached out to a special population we referred to as the “citizen groups.” These groups were made up of community members who would regularly get together to engage in rescue activities. Both of these groups proved to be very resilient. By helping others they were also helping themselves through the recovery process.

How is the population of first responders dealing with the long-term effects of Katrina?

Responders were in rescue mode for nearly 5 years after Hurricane Katrina. Many were still living and working out of trailers while their families were staying out of state in apartments or hotels. Responders would use their holiday and vacation time to visit their families.

As a community responder, I know a lot of responders who had family in Houston, Texas, that they visited during their time off.

Even 10 years later, you may still hear that people are dealing with the aftermath of Hurricane Katrina in the field. Some are still dealing with issues from the loss of their home or income. Many responders had second jobs that were lost during that period and had trouble getting back their second source of income. Disasters after Katrina that continued to re-traumatize responders, such as the Deepwater Horizon Oil Spill in 2010, affected the income and livelihood of many responders operating camps and fishing boats in the shrimping industry. Also Hurricane Isaac in 2012 caused major flooding in different areas of Louisiana that didn’t normally get flooded. The responders were constantly handling the unexpected in their jobs and daily lives.

However, overall, responders are resilient. I’m seeing responder groups across the state come together now little by little. We are not there yet, but as a responder, I see a lot of good things being brought to the table and revamping of protocols to prepare responders for future disasters. Also, our work continues at OBH to bridge the gap to offer support to responders during these times. I also heard about a lot of domestic violence, alcohol, and substance use after

Hurricane Katrina, and I have seen leadership in this population (first responders) work tirelessly to get support to address these issues while supporting their staff.

The goal of OBH Louisiana Spirit was to make sure responders understood that Hurricane Katrina was a major disaster that caused compounding distress for everyone and that it is okay to ask for help. When working with this population, you need to show them that you can recover. An outcome was that community first responder departments were getting better and more prepared to recognize signs of behavioral health issues in this population and how to connect them for further support.

As a peer, I recently taught a class at the New Orleans Fire Department and the new chief was very supportive of the team-based efforts the department had been doing to support each other. He said that we have to stay prepared for the next disaster. I agree with that attitude because this population needs to prepare and not react post-disaster. OBH promotes more community trainings and tips for coping with disasters. I strongly believe that when you have the right coping skills instilled in your people, chances for bad disaster reactions are reduced. ■



Charenton, LA October 18, 2005 - Tricia Mora, Vice Chairman of the Chitimacha Tribe, and USCG Vice Admiral Thad Allen toured the mobile homes which FEMA provided for tribe members from several areas of Louisiana who were displaced by the hurricanes. Photo by Greg Henshall / FEMA

Native American Communities Affected by Hurricanes Katrina and Rita

Contributed by **Beth Boyd**, *University of South Dakota*

While most Americans remember that hundreds of thousands of African Americans were affected by Hurricanes Katrina and Rita in the late summer of 2005, few people know that thousands of Native Americans were also affected by the storms. Six federally recognized tribes and several smaller unrecognized tribes along the Gulf Coast experienced the destructive effects of wind, rain, and flooding. The Mississippi Band of Choctaw reportedly experienced

the most extensive damage, but the following tribes also were affected:

- Poarch Bank Creek Indian Tribe in Alabama
- Coushatta Indian Tribe
- Jena Band of Choctaw
- United Houma Nation
- Pointe-au-Chien Tribe
- Isle de Jean Charles Indian Band of Biloxi-Chitimacha
- Grand Caillou-Dulac Band

- Biloxi-Chitimacha Confederation of Muskogee
- Tunica-Biloxi Tribe in Louisiana
- Chitimacha Tribe in Mississippi

Tribal leaders estimate that 5,000 to 6,000 Native Americans lost their homes and everything they owned due to Hurricanes Katrina and Rita. Many of those displaced lived in areas around New Orleans prior to the storm and returned to their tribal communities in need of shelter, food, water, clothing,

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and other resources. Some tribal communities along the Gulf Coast were affected by both storms and were then further stressed by providing shelter and resources to returning tribal members.

Difficulties Obtaining Assistance

The media rarely covered these groups' experiences. Because media coverage plays a major role in the ability to obtain assistance, they were largely overlooked by governmental and nongovernmental relief organizations. FEMA provided disaster relief services to affected areas generally and the Bureau of Indian Affairs provided public safety and emergency services for federally recognized tribes.

For tribal groups that have not been officially "recognized" by the federal government, the process of obtaining assistance can be even more complex. "Federal recognition" is a legal term that establishes a tribe's status as a sovereign nation unto itself with the right to self-govern, define their own membership, and engage in a "nation-to-nation" relationship with the United States. Federal recognition also entitles tribes to certain federal benefits, services, and protections because of treaties and trust relationships made between the two governments.

Much of the post-hurricane disaster assistance received by



Purvis, MS., October 3, 2005 -- Over 1,000 trailers are getting ready for distribution at the FEMA Trailer Staging Area in Purvis, Mississippi. Nicolas Britto/FEMA

tribal groups without federal recognition came from other tribes and Native American organizations across the country. The National Congress of American Indians set up a relief fund to assist the tribes in Alabama, Louisiana, and Mississippi. Tribal communities across the country sent medical personnel, relief workers, financial assistance, clothing, food, water, and mattresses.

The Essential Role of Cultural Competence

This disaster taught disaster response organizations that services need to be culturally responsive in order to be truly helpful. For many rural and minority communities,

services that were centrally located within the mainstream community simply did not reach or serve the diverse needs of all. This is especially true for providing psychological support and serving the behavioral health needs of those affected by the disasters. Culture has a great influence on how a disaster is perceived, experienced, and processed, as well as how healing occurs. For many Native Americans affected by the storms, the need for culturally competent support and healing was best met by turning to their tribes or other Native communities.

Language also plays a role in determining whether tribes or tribal communities receive needed

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resources in a timely manner following a disaster. There are approximately 180 tribal languages still spoken in North America, and many of those languages do not have a word for “disaster.” The concept of disaster is especially difficult when the situation involves a natural event. Events such as storms, floods, and earthquakes are understood to be part of the natural world and not conceptualized as something unusual or a “disaster.” In some situations, this may contribute to delays in tribes asking

for and receiving disaster assistance. Although this was not the most significant issue following the hurricanes of 2005, it often plays a role in the aftermath of natural disasters in tribal communities.

The effect of Hurricanes Katrina and Rita has been long-lasting for many and has led to erosion of coastal lands, needs for elevated lands and housing, and threats to fishing and shrimping livelihoods. ■

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KATRINA RESEARCH HIGHLIGHT: SUPPLEMENTAL RESEARCH BULLETIN

In this issue of the SAMHSA DTAC Supplemental Research Bulletin, we review five articles about the intermediate and long-term negative mental health and substance misuse trends in survivors of Hurricane Katrina to seek an understanding of the lasting impact of large-scale disasters.

The analysis looks at the positive effects of using coping skills and highlights the need to plan better in an effort to mitigate distress and attend to survivors who are displaced or evacuated from their communities and ultimately separated from their social supports as a result of a disaster.

Read the analysis: http://archive.samhsa.gov/dtac/bulletin/SupplementalResearchBulletin_Issue3.tml.htm

RECOMMENDED RESOURCES

TIP 59: Improving Cultural Competence

This guidance defines and describes cultural competence and explains its importance in behavioral health (mental health and substance use disorder) treatment and services. It covers core areas of cultural competence for counselors and others who provide behavioral health services, ways for individual practitioners and organizations to be more culturally aware and competent, and information about counseling people of specific cultures (e.g., African American, Hispanic and Latino, white American).

Read and download the guidance at <http://1.usa.gov/1yTZCrN>

Applying Cultural Awareness to Disaster Behavioral Health Webinar

This webinar covers key principles of cultural awareness and how people of different cultures interact around the time of a disaster. It also provides suggestions for more culturally aware disaster preparedness, response, and recovery.

View the webinar at <http://bit.ly/1d1Ozmh>

Understanding Historical Trauma When Responding to an Event in Indian Country: Tips for Disaster Responders

This tip sheet helps disaster response workers better understand historical trauma in the Native American culture and how it may affect disaster preparedness and response efforts, and offers strategies for providing disaster response assistance with cultural sensitivity.

Download the tip sheet at <http://1.usa.gov/1Hsf7tD>



Webinars



Trainings



E-Learning



Conferences



UPCOMING EVENTS

American Public Health Association (APHA) Annual Meeting; October 31 – November 4, 2015; Chicago, Illinois

The annual meeting of the APHA attracts more than 12,000 attendees from around the world. This year's meeting will feature scientific and general sessions on topics including disaster epidemiology, protecting disaster response workers, health care perspectives on disaster preparedness and response, and research-supported ways to reduce the impact of natural disaster and war on survivors.

<http://apha.org/events-and-meetings/annual>

National Pediatric Disaster Coalition Conference; November 2 – 4, 2015; Scottsdale, Arizona

The National Pediatric Disaster Coalition Conference is designed to serve as a forum for exchange of lessons learned and best practices, foster networking and relationship development for better pediatric preparedness, expedite work to address children's needs related to disasters, and provide opportunities for coalitions and alliances. Sessions will cover topics such as preparedness for children with access and functional needs, community resilience, work toward a national concept of operations for children's and family mental health after a disaster, and reunification of families after disasters.

<https://www.npdconference.org>

International Society for Traumatic Stress Studies 31st Annual Meeting; November 5 – 7, 2015; New Orleans, Louisiana

This year's meeting will feature symposia, workshops, and presentations on a variety of traumatic stress-related topics, including aspects of the biology, physiology, and treatment of posttraumatic stress disorder; implementation of evidence-informed post-disaster interventions; post-disaster grief; and long-term outcomes after disasters. Meeting planners suggest that mental health care providers (psychiatrists, psychologists, social workers, counselors), nurses, researchers, marriage and family therapists, administrators, victim advocates, journalists, and clergy may benefit from this meeting.

<https://www.istss.org/am15/home.aspx>

International Association of Emergency Managers 63rd Annual Conference; November 13 – 18, 2015; Clark County, Nevada

This event may interest emergency managers, homeland security officials, first responder coordinators, business continuity planners, and others. It provides educational sessions, hands-on training, and opportunities for collaboration and networking. Sessions at this year's conference will cover topics such as applying research to practice in disaster management, post-disaster financial recovery, and animals in disasters.

<http://www.iaem.com/page.cfm?p=events/annual-conference>

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UPCOMING EVENTS

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Association of Healthcare Emergency Preparedness Professionals 1st Annual Conference; November 17-18, 2015; Omaha, Nebraska

This conference will focus on disaster preparedness for health care facilities. It will provide a forum for networking and information exchange. People who may benefit from attending include disaster preparedness staff who work in inpatient acute care facilities, outpatient clinical services, in residential and long-term care facilities, preparedness coalitions, and public health agencies.

<https://ahepp.site-ym.com/?page=AnnualConference>

ADDITIONAL WEBINARS AND TRAININGS

NEW! Behavioral Health Response to Ebola

This webinar for providers relates lessons learned while supporting a quarantined individual who was homeless in Dallas, Texas, during the 2014 Ebola outbreak.

<https://youtu.be/MFLBFeb2dok>

Poster Winners – Elderly in Disasters: An Integrated Review

In this webinar, presenters affiliated with the Daniel K. Inouye Graduate School of Nursing at the Uniformed Services University of the Health Sciences, discuss the content of their poster, which won an outstanding poster award at the National Center for Disaster Medicine and Public Health's Annual Learning in Disaster Health Workshop.

<http://ncdmph.adobeconnect.com/r72x5v80yxb/>

Disaster Mental Health: Introduction

This free, 30-minute online course is designed to prepare licensed or certified professionals (psychiatrists, psychologists, clinical social workers, marriage and family therapists, psychiatric nurses, professional counselors, school counselors, or school psychologists) to provide disaster mental health services through the American Red Cross. The course explains how disaster mental health figures into the full array of services that Red Cross chapters and disaster relief operations provide. It also identifies the psychological effects of disasters, differences between what people do as Red Cross disaster mental health workers and as mental health professionals, and next steps for people who would like to become Red Cross disaster mental health volunteers.

<http://www.redcross.org/take-a-class/disaster-training>

Disaster Planning and Disaster Response Trainings From the North Carolina Institute for Public Health

These online trainings cover a range of topics in disaster preparedness and response, and disaster behavioral health. Trainings and training modules that may be of interest include:

- Assisting Persons With Disabilities During an Emergency
- Disaster Behavioral Health
- Emergency Preparedness and the Need To Include Persons With Disabilities: Basic Issues for Organizations To Consider
- Equipment and Resources To Assist Persons With Disabilities During an Emergency
- Introduction to Mental Health Preparedness
- Mental Health Interventions in Disasters
- Preparing for a Hurricane
- Responder Health and Safety
- Self-Care for Disaster Responders
- Working With Community Partners

https://nciph.sph.unc.edu/tws/training_list/?mode=view_kw_detail&keyword_id=2088

https://nciph.sph.unc.edu/tws/training_list/?mode=view_kw_detail&keyword_id=2089

ADDITIONAL WEBINARS AND TRAININGS

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Mental Health Preparedness From the John Hopkins Center For Public Health and Preparedness

These free online trainings were developed to enhance public health system competency, capacity and public health workers' willingness to effectively respond to emergencies. Trainings focused on mental health preparedness include:

- Disaster Mental Health Intervention
- Disaster Mental Health Planning
- Introduction to Mental Health and Disaster Preparedness
- Mental Health Consequences of Disaster
- Psychology and Crisis Response
- Roots of Terrorism
- Self-Care

<http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-public-health-preparedness/training/online/mental-health-trainings.html>

Building Workforce Resilience Through the Practice of Psychological First Aid—A Course for Supervisors and Leaders

This 90-minute course from the National Association of County and City Health Officials provides training in Psychological First Aid (PFA), including an overview of PFA, how leaders in emergency management and other fields can use PFA, and exercises to help leaders learn how to use PFA in real-world situations.

https://live.blueskybroadcast.com/bsb/client/CL_DEFAULT.asp?Client=354947&PCAT=7365&CAT=9403

University of Minnesota School of Public Health's Online Courses

These free online courses address many topics in disaster preparedness and response and disaster behavioral health. Available courses include the following:

- Crisis Intervention During Disaster (Public Health Emergency Training Series)
- Dirty Bomb! After the Blast
- Disaster 101: An Immersive Emergency Preparedness and Crisis Leadership Workshop
- Global Outbreak: A Public Health ICS Simulation
- Introduction to Business Continuity Planning for Disasters and Emergencies
- Isolation and Quarantine (Public Health Emergency Training Series)
- NIMS (National Incident Management System) and ICS (Incident Command System): A Primer for Volunteers
- Personal and Family Emergency Preparedness
- Planning for and Engaging Special Populations in Emergency Preparedness
- Preparing Employees for a Disaster in the Workplace
- Road to Resilience: Building Community Resilience to Disasters
- Road to Resilience: Protecting Animals in Disaster
- Special Populations (Public Health Emergency Preparedness Series)

<http://sph.umn.edu/ce/online>

Behavioral Health is Essential To Health Prevention Works Treatment is Effective People Recover

SUBSCRIBE

The Dialogue is a publication for professionals in the disaster behavioral health field to share information, resources, trends, solutions to problems, and accomplishments. To receive *The Dialogue*, please go to SAMHSA's home page (<http://www.samhsa.gov>), enter your email address in the "Mailing List" box on the right, and select the box for "SAMHSA's Disaster Technical Assistance newsletter, *The Dialogue*."

SHARE INFORMATION

Readers are invited to contribute to *The Dialogue*. To author an article for an upcoming issue, please contact SAMHSA DTAC at DTAC@samhsa.hhs.gov.

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. To subscribe, please enter your email address in the "SAMHSA DTAC Bulletin" section of the home page of our website at <http://www.samhsa.gov/dtac>.

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 <http://www.samhsa.gov/dtac/dbhis-collections> to access these materials.

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