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SAMHSA DTAC Dialogue Special Feature: Perspectives on Disaster Public Health and Disaster Behavioral Health Integration

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

the Dialogue

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- 7 Substance Abuse Services and Planning for Times of Disaster
- 9 The Role of Social Media in Disaster Planning
- 11 Recommended Resources
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Integration

Learn how different areas of the field relate to one another and how new methods of response are changing the way disaster behavioral health care providers engage with survivors.

Mental Health



Substance Abuse



Public Health



Disaster Preparedness, Response and Recovery

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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 homepage (<http://www.samhsa.gov>), enter your e-mail 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, e-mail DTAC@samhsa.hhs.gov, or visit the SAMHSA DTAC website at <http://www.samhsa.gov/dtac>.

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In This Issue

The field of disaster mental health is quite young; it has only recently become a recognized area of practice and research. Joined with the field of disaster substance abuse treatment, it today forms the broader area of disaster behavioral health, which in turn is part of the larger world of disaster management. While disaster behavioral health strives to be recognized as a distinct arm of disaster response and management, it is also integral to every aspect and needs to be integrated. In this issue, our guest authors provide perspective and insight regarding the need to integrate disaster behavioral health into the provision of public health services; how the uniqueness of substance abuse services can benefit from readiness activities; and how we as a field can deliver services using new technology, particularly social media, to provide rapid preparedness and response communications and support.

In addition, as SAMHSA continues to stay current with the disaster behavioral health field, we will be changing the name of this publication to better represent the field. We look forward to premiering the new name with the next issue.

Warmest Regards,

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Following Hurricane Sandy, FEMA Community Relations planners and Community Leaders discuss their disaster related needs at the Jewish Community Center in Coney Island. Photo: Andrea Booher/FEMA

SPECIAL FEATURE

Perspectives on Disaster Public Health and Disaster Behavioral Health Integration

Contributed by James M. Shultz, M.S., Ph.D.

Director, Center for Disaster and Extreme Event Preparedness (DEEP Center)

At the DEEP Center, we define a disaster as “an encounter between forces of harm and a human population in harm’s way, influenced by the ecological context, in which demands exceed the coping capacity of the disaster-affected community” (*Figure 1: Disaster Ecology Model Diagram*). Disasters affect populations, simultaneously creating public health and behavioral health challenges for the impacted communities.

When disaster strikes, physical consequences—damage, destruction,

disruption, displacement, death, debility, and disability—are most often overt and observable. Disaster public health needs are starkly evident. Conversely, psychological consequences tend to be less visible and, historically, overlooked.

This oversight is being redressed in the post-9/11 era. In the past decade, disaster behavioral health has been “unpacked” and showcased, separate from disaster public health, in order to ensure that the need for psychosocial support is recognized and prioritized.

This has propelled advances in disaster behavioral health science, programs, planning, and policy. However, disaster behavioral health is administratively and structurally separate from disaster public health.

The reality is that physical and psychological dimensions of disaster are not separate. Rather, they are intimately intertwined throughout all phases of the disaster cycle. The rising salience of disaster behavioral health is a good thing, but it is now time to unite and fully integrate disaster behavioral health and public health. Such integration is actively championed by SAMHSA and the Office of the Assistant Secretary for Preparedness and Response (ASPR).

Psychological Consequences of Disasters

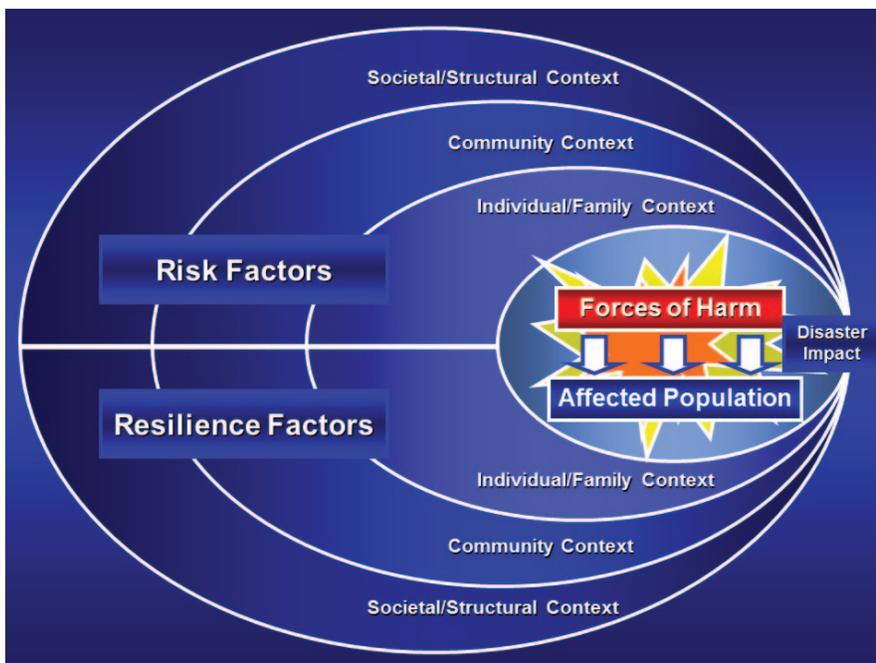
To gain perspective on the importance of integration of disaster public health and disaster behavioral health, let’s review the attributes of psychological consequences of disaster.

In a disaster, the psychological consequences (1) are widespread, (2) range across a spectrum of severity, (3) persist for a prolonged duration, and (4) reflect the unique and defining features of the specific disaster event.

These distinguishing *psychological*

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Figure 1: Disaster Ecology Model Diagram



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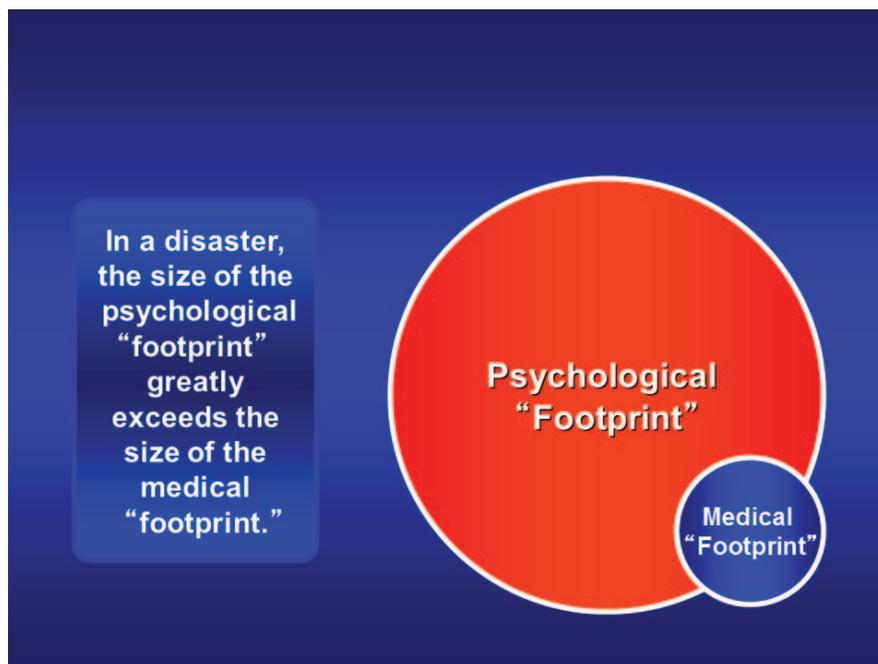
features relate directly to exposure to the *physical* forces of harm in a disaster.

We will illustrate each of these four points, drawing upon two well-known disaster case studies that occurred 11 years apart, the attacks of September 11, 2001, and Superstorm Sandy (October 28–31, 2012). Both 9/11 and Sandy forcefully impacted New York City, Washington, DC, and rural Pennsylvania (although Sandy’s immense geographic reach extended to portions of 24 states). Each event prompted a multistate, federal disaster declaration. Both events generated large-scale economic costs, affected transportation systems, and damaged infrastructure.

Superstorm Sandy was a conglomerate of familiar natural disaster elements (hurricane, storm surge, deluging rains, inland flooding, heavy snowfall with blizzard conditions) packaged into one gargantuan system. In contrast, 9/11 was a “one-off” act of terrorism never previously conceived nor replicated thereafter. Superstorm Sandy was a somewhat predictable natural disaster that was not brought about by human intent, notable primarily for enormousness of scale and variety of manifestations. 9/11 was unpredictable, unfamiliar, human-generated, and intentionally perpetrated.

Psychological consequences of disaster are widespread and pervasive (Figure 2: Psychological Footprint). In a disaster, more people are affected psychologically than are harmed physically. The “psychological footprint” is larger than the “medical footprint.”

Figure 2: Psychological Footprint



The importance of this point is that people who may need psychological support tend to be larger in number and geographically more dispersed than people sustaining physical injury, damage, or displacement. For the subset of persons who do sustain physical injury, many will experience powerful and enduring psychological overlays. For those disaster-exposed persons who escape physical injury, psychological casualties may be numerous but less likely to be identified or to seek mental health care.

9/11. September 11 provides the most potent and memorable example of the psychological footprint concept. While physical harm was geographically circumscribed within a square mile of downtown Manhattan, a wedge of the Pentagon, and a field in Pennsylvania, the psychological reverberations were experienced by Americans everywhere

throughout the country and around the world. Three thousand people were killed and 6,000 were injured, but hundreds of millions were affected psychologically. Both the American psyche, in terms of belief in safety within our borders; and American freedom of movement within the United States and abroad, were indelibly altered by this event (Morgan, Wisneski, & Skitka, 2011).

Sandy. *Sandy was a record-setting storm in terms of its geographic dimensions. The system’s cloud canopy ballooned to 1,000 miles in diameter, with tropical storm force winds extending 400 miles from the center of circulation. An estimated 60 million Americans experienced “weather” from Sandy, many of whom experienced considerable stress during the warning phase as the storm approached, and during the*

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impact phase, as Sandy traversed their respective locales. Eight million people lost electrical power, some for weeks. Millions were affected by damage to transportation infrastructure (subways, tunnels) and gasoline shortages. Several hundred thousand sustained severe damage to property, and tens of thousands lost their homes. These were distressing events for all, and potentially traumatizing for many. In contrast, in terms of physical harm, the “medical footprint” was limited to 113 deaths in the U.S. and several thousand injuries requiring medical care.

Psychological consequences of disaster range across a spectrum of severity (Figure 3: *Spectrum of Severity*).

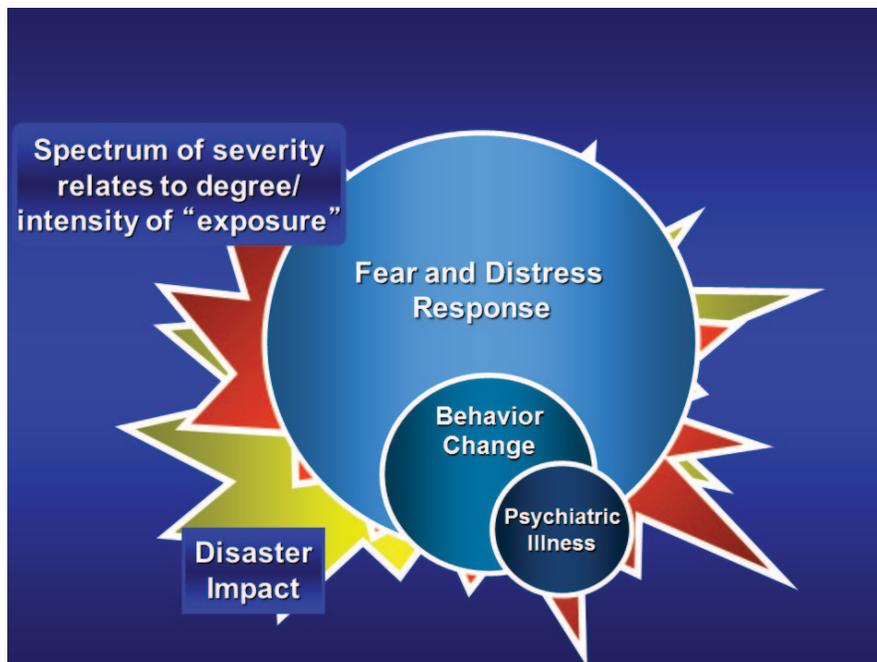
According to Robert Ursano, Director of the Center for the Study of Traumatic Stress at Uniformed Services University, and other thought leaders in the field,

almost everyone who is exposed to a disaster experiences expectable, transient fear and distress. This is a nearly universal reaction. Most individuals who are initially affected will rebound rapidly and regain full functioning without need for psychological intervention. However, related to the intensity of disaster exposure, a subset of disaster-exposed people will be affected to the point of exhibiting detrimental behavior changes (Butler, Panzer, & Goldfrank, 2003). As one example, unharmed but fearful citizens may converge en masse on area hospitals, clinics, or points of distribution. A smaller proportion of persons, especially those with the most intense exposures, are at risk of experiencing more pronounced psychological consequences, which may lead to posttraumatic stress disorder (PTSD), depression, generalized anxiety disorder, panic reactions, somatic

complaints, and/or increased substance use and misuse. Persons who have lost one or more loved ones may experience traumatic bereavement or complicated grief. Where disaster survivors fall on this continuum from transient distress to psychopathology relates directly to their intensity of exposure to the forces of harm.

The importance of this point is that it is possible to estimate the proportions of survivors exposed to varying levels of injurious or potentially traumatizing events and to provide active outreach to people in geographic areas or shelter environments who are most likely to need psychological support. Working upstream, it is possible, based on historic disaster experiences, to plan and prepare for the magnitude and extent of psychological needs for people exposed to common disasters across a spectrum of intensities of exposure (Schlenger et al., 2002; Schuster et al., 2001).

Figure 3: Spectrum of Severity



9/11. September 11 provided key research documentation for this point. In the immediate aftermath, the highest rates of distress symptoms were found for persons in lower Manhattan, close to Ground Zero. Elevated, but lower, rates were found for persons in the remainder of the New York City metro area. Nationwide telephone surveys indicated that many U.S. citizens displayed high rates of self-reported distress and even posttraumatic stress symptoms despite being distant from the scenes of impact. The areas of physical harm were localized based on the “surgical strikes” against high-value targets (World Trade Center; Pentagon), but the psychological effects spread concentrically around the

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impact zones, diminishing in intensity with greater distance. It is important to note that 6 months after the disaster all of these rates were reportedly significantly decreased.

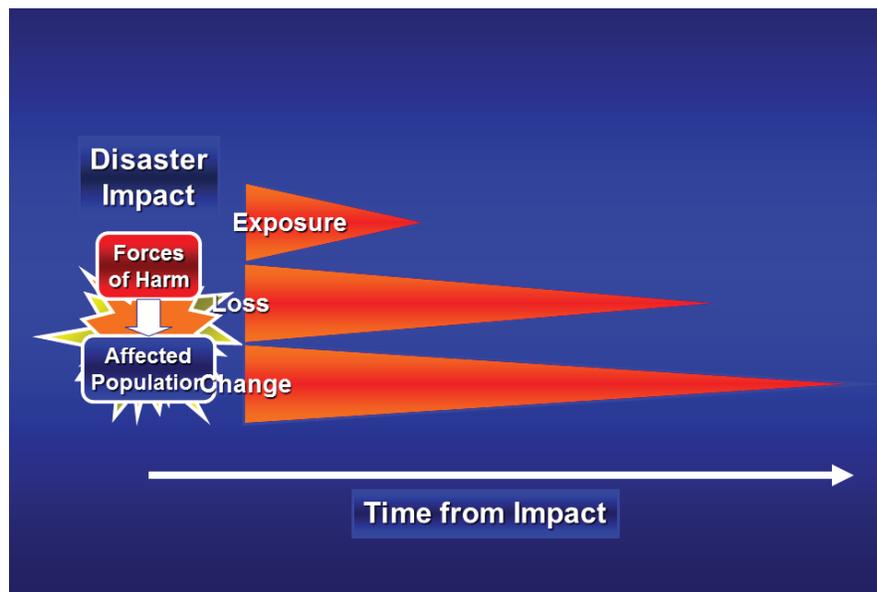
Sandy. In contrast to 9/11, the severe direct effects of Sandy extended over a broader geography. The areas of catastrophic destruction were concentrated in coastal New Jersey and New York City. Citizens in these areas sustained losses of homes and livelihoods, and they represent the subset of Sandy survivors most likely to experience serious psychological outcomes. Yet beneath this vast weather system, the majority of the 60 million touched by Sandy experienced the stressors of emphatic warnings and hurried preparations followed by a manageable encounter with inclement but unexceptional weather. Between these poles are the several million people who experienced distress associated with moderate property damage or the rigors of power outages compounded by harsh weather, transportation disruptions, and temporary school or work closures.

Psychological consequences of disaster persist for a prolonged duration (Figure 4: Range of Duration)

While the moment of disaster impact may be brief, the stress of disaster-provoked loss and change may continue for a protracted time period.

The importance of this point is that psychological stressors can persist long after the physical forces of harm have ceased. The realization of loss and change is likely to

Figure 4: Range of Duration



intensify with the myriad of hardships encountered in the aftermath of disaster. These ongoing experiences are psychologically stressful even when physical necessities are assured. Survivors who have lost loved ones are especially challenged as they attempt to cope with these interpersonal losses while simultaneously struggling with the transformed physical and social landscape following disaster. Prolonged grief may be part of the experience for some bereaved survivors.

9/11. September 11 will forever punctuate U.S. history. Eleven years later, psychological effects persist, including bereavement and memorialization of the 3,000 persons lost on that day. As painstaking construction of the One World Trade Center memorial nears completion, there are fundamental changes in the American way of life, including an altered sense of personal safety.

Sandy. Sandy is already history for most who were under the storm's wide cloud dome for a portion of the system's 2,000-mile path. However, in coastal New Jersey and portions of Staten Island and other hard-hit sections of New York City, recovery will be a long process. For these families, adversities in the aftermath will rival or exceed the stressors experienced on the day of impact. Sandy may have dissipated, but the ongoing hardships during recovery will be challenging to bear.

Psychological consequences of disaster relate to the defining features of the event (Figure 5: Type of Disaster)

Each disaster may be regarded as a unique event that presents a novel constellation of stressors. DEEP Center's current line of investigation examines how best to characterize the "trauma signature" of each disaster episode.

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The importance of this point is that **type** of disaster matters. Psychological consequences tend to occur at higher rates for disasters that are human generated, especially when there is intentional human causation.

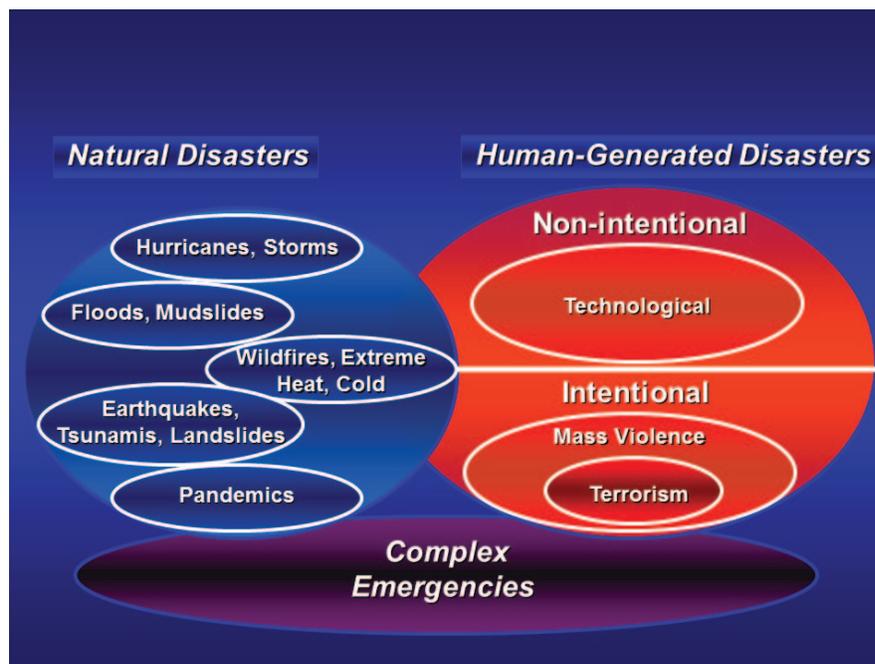
9/11. As an intentional human-generated act of terrorism, we have previously described 9/11 as “psychological by design.” The intention was to strike at national icons, inflict horrific physical harm and death, expose U.S. vulnerability to domestic attack, and leverage the actions of a small number to impact an entire nation. The human, economic, and psychological costs of 9/11 are simply staggering and the psychological impact extended to all Americans.

Sandy. *Sandy started as a relatively tame late-season hurricane that interacted with a winter storm system at mid-latitudes, exploded in size, and caused moderate damage along the northeastern U.S. coastline and focused devastation in several densely populated coastal areas. A defining feature of Sandy was the myriad of presentations of this single system.*

Disaster Public Health/ Disaster Behavioral Health Integration

From this exploration of the psychological dimensions of disaster, it is apparent that behavioral health consequences are public health consequences—and vice versa. These dimensions are inseparable and indivisible.

Figure 5: Type of Disaster



Disaster-related physical injury and death represent disaster behavioral health issues. Conversely, stress, distress, detrimental behavior changes, psychological impairment, and psychopathology can negatively affect the physical recovery process and the overall health outcomes for disaster-exposed and disaster-impacted populations.

Going forward, disaster prevention and preparedness, as well as response and recovery, are better and more economically addressed by planning and practice that blend rather than separate the disaster public health and behavioral health dimensions. ■

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Substance abuse treatment facilities and professionals must have a local plan that serves both the needs of clients and staff and fits into the overall community and state plans. Photo: K.C.Wilsey/FEMA

Substance Abuse Services and Planning for Times of Disaster

Contributed by **Dee S. Owens, M.P.A.**

Director, Alcohol-Drug Information Center, Indiana University

Disaster planning for substance abuse services is often neglected but highly necessary in today's world. Human-caused and natural disasters can strike at any time of the day or year, so questions must be asked: Is a substance abuse treatment facility ready? Is staff trained? Preparation and collaboration at the local and state levels are important for all staff, as is practice. Learning about the special needs of substance abuse clients, including staff in recovery, and the National Incident Management System (NIMS) will help any substance abuse treatment facility not only to play a critical role in a local disaster, but also to plan for

continuation of operations, should the workplace building itself be affected during crisis. It is important to begin now, and to put a plan into practice.

Substance abuse treatment facility leadership should start by finding out who the state disaster behavioral health coordinator is or where the county emergency management director is located; most states also have health department employees tasked to work in Emergency Support Function (ESF)-8. Each of these individuals is involved in planning and can plug a substance abuse treatment facility into a network and provide or help find training. He

or she will also be eager to recruit new volunteers to existing partnerships.

The state's department of homeland security holds the master plan and usually provides training (also available online at <http://www.fema.gov>) in NIMS and the Incident Command System (ICS), each of which is important to know as a responder in an actual emergency. As states and localities become more proficient in response and triage, they learn that access to the expertise of substance abuse providers and facilities as well as prevention professionals adds to the ESF-8 team.

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As importantly, substance abuse treatment facilities and professionals must have a local plan that serves both the needs of clients and staff and fits into the overall community and state plans. By being part of the overall strategy, substance abuse facilities can ensure that all people connected to them are better protected during a disaster and are accounted for if the facility is demolished. A continuity of operation plan is of the utmost importance and can answer critical questions, such as what to do if records are destroyed; how clients can get appropriate medication, such as methadone; how management can account for staff and whether there is a meeting place; and how statistics will be tracked to apply for grants? These details can be put in the plan.

Providing redundant systems of recordkeeping and communications as well as prearranging guest dosing at another facility, for example, can ensure as small a disruption as possible for clients and staff, who should have personal plans for their homes and families, if they are crucial to emergency operations. Agency directors should likewise be prepared, including ensuring a 3-day supply of food and water is available for clients and staff who might have to shelter in place.

Substance abuse clients (and people in early recovery, especially) are at high risk for relapse following a disaster, as learned in Oklahoma City and New York City following 9/11. We learned in these situations that even some staff in recovery relapsed after witnessing the horror of these terrorist events (Owens, 2004). Ensuring an Employee Assistance Program is available for all staff, monitoring their reaction, and encouraging self-care and reasonable work hours will go far to help mitigate the development of stress responses in staff.

Substance abuse prevention professionals are often frontline responders, especially when working in school settings. It is important to bring these and other substance abuse personnel to the table when making plans at any level of government, as their special skills and training always add to any conversation. Receptionists are the gateway to an agency and must be trained alongside counselors and prevention staff.

It is also important to join in exercises and tabletop events, in order to learn

if overarching plans work and to determine changes. Substance abuse prevention professionals should accept invitations to participate and understand that a facility's plan may need tweaking as well, based upon what is learned in the exercise. After-action reports are generated from feedback after an exercise and are helpful to continuity of operations plans as well.

A disaster affecting a facility or school is not only possible, it is somewhat likely, whether natural (flooding, tornado) or human-caused (as at Columbine or Sandy Hook). Preparation via planning and practice is smart business and ensures everyone knows what to do when problems arise. With a plan in place, substance abuse services can continue, staff can feel safe, and knowledgeable and engaged practitioners can enhance a community's response. Start a plan today! ■

Dee S. Owens has responded to and researched the Oklahoma City bombing, 9/11 in New York City, Hurricane Katrina in Mississippi, and the BP/Deepwater Horizon Oil Spill as a Special Expert at SAMHSA. Most recently, she led the mental health response to the Henryville, Indiana, tornado as part of the Indiana District 8 Disaster Team for the Indiana Division of Mental Health and Addictions All-Hazards Team.

Reference

Owens, D. S. (2004, August 13). *Substance Abuse Treatment Implications to Terrorism Events*. Retrieved from <http://www.samhsa.gov/csatsdisasterrecovery/lessons/10-SA%20Tx-Terrorism%20SSDP%208-13-04-disk.pdf>



Substance abuse clients are at high risk for relapse following a disaster, as learned in Oklahoma City and New York City following 9/11.



Social media offers disaster behavioral health care providers a cost-effective and creative way to easily reach advocates and consumers with messaging and services before, during, and after major events.

The Role of Social Media in Disaster Planning

Contributed by Christian Burgess

Director, Disaster Distress Helpline

Social media presents disaster behavioral health care providers with cost-effective and creative opportunities for building an online community of providers and consumers that can be easily reached with messaging and services before, during, and after major events. Following this paragraph are some lessons learned in utilizing social media for disaster outreach and engagement.

The Disaster Distress Helpline (DDH), a SAMHSA-sponsored program, is ready and available immediately when disasters strike. After a disaster we quickly mobilize social media platforms to connect with providers

and the general public for information and resource sharing, provide tips for healthy coping, and offer messages of support. The following list provides five best practices from the field that the DDH Outreach and Communications Team recommends for those working in disaster behavioral health who also seek to build a presence online:

1. It's not just about Facebook and Twitter.

Twitter (<http://twitter.com>) and *Facebook* (<http://www.facebook.com>) remain “musts” when building and maintaining an online presence. However, social media trends are constantly changing,

and so it's helpful to be aware of what else the web has to offer, which can also help you to reach more people or a particular demographic, or to use particular types of media. For example, *Pinterest* (<http://pinterest.com>) is popular among women, *LinkedIn* (<http://www.linkedin.com>) is targeted mostly to professionals, and *Tumblr* (<http://www.tumblr.com>) offers a creative way to use photo and video to communicate your message.

2. Avoid sensational messaging.

Before, during, and after disasters, social media is understandably crowded with a variety of sensational

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SOCIAL MEDIA *continued from page 9*

and graphic headlines and images. News outlets raise awareness but also need to stand out in their own crowded field; while emergency management agencies may need to use bold language to capture the attention of the public quickly, to get them to take messaging about evacuations and other preparedness measures seriously. However, disaster behavioral health care providers on social media can also provide an equally important service: ***promote calm***. Use strengths-based messaging and resources for coping to be the social media “calm in the storm.” For additional information about public communications in an emergency, see <http://store.samhsa.gov/product/Risk-Communication-Guidelines-for-Public-Officials/SMA02-3641>.

3. Use social media year-round, not just when disasters strike.

Social media use skyrockets leading up to, during, and immediately following major disasters. For example, ***Instagram*** saw 10 photo posts per second at the height of Hurricane Sandy’s impact (<http://instagram.com>). But when disasters strike, if you want users to look for your service in particular amid hundreds of other pages, feeds, and posts, it’s important to build your presence year-round with relevant and engaging information and resources. ***HootSuite*** (<http://hootsuite.com>) offers a platform for programming social media messaging in advance (up to 30 days, or even more than 30 days) if you have limited time or staffing, which can also be helpful in scheduling messaging during holidays and overnight.

4. Shorter is better.

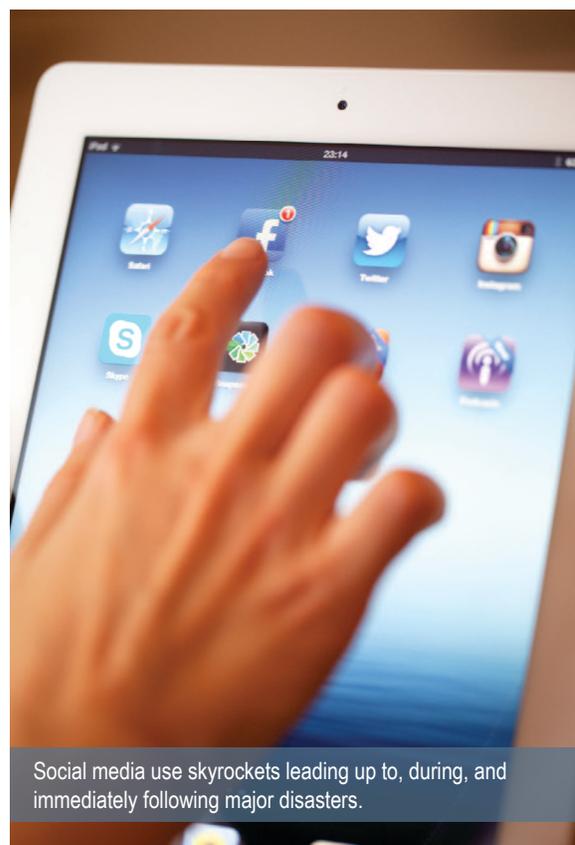
In social media, less is more. Your audience—no matter their age or background—will likely only have a few minutes to absorb not only your messaging, but also dozens of others! You can keep messages short but meaningful through variety and creativity, including the use of videos and viral photos. Also, you can save space when sharing web links by using a service such as ***bitly*** (<https://bitly.com>) that shortens web links and archives them for later use.

5. Have a plan for online crisis intervention.

Have a plan for crisis intervention in case a follower or subscriber indicates that he or she, or someone he or she cares about, is or may be a threat to him- or herself or to others. Also become familiar with the policies and practices of the social media sites themselves. For example, the American Foundation for Suicide Prevention has provided instructions for what to do if you encounter a threat of suicide on Facebook: <http://www.facebook.com/notes/american-foundation-for-suicide-prevention/how-to-report-suicidal-contentthreats-on-facebook/10150090259398144>.

Bonus Lessons Learned: Practice Self-Care

During disasters, maintaining an online presence via social media in order to connect with other providers and promote resources to the general public can take a toll on your psyche as with any constant exposure to media during crisis. Take breaks, practice healthy



Social media use skyrockets leading up to, during, and immediately following major disasters.

coping (e.g., engage your mind, body, or spirit away from the computer and reminders of the disaster), connect with colleagues for support, maintain normal routines to the extent possible, and reach out to DDH. **We’re here for you, too...online and off.** ■

You may contact Christian Burgess at cburgess@mhaofnyc.org.

FOR MORE INFORMATION

about the *Disaster Distress Helpline*, please visit its website at <http://disasterdistress.samhsa.gov>, its Facebook page (<http://www.facebook.com/distresshelpline>), or its Twitter feed (<http://twitter.com/distressline>).

RECOMMENDED RESOURCES

SAMHSA DTAC Resources on Children and Disasters

SAMHSA DTAC is proud to announce several recently developed resources to address the needs of our most vulnerable populations: children and youth. Environmental factors, such as a disruption in social support networks and school systems, influence children's recovery following a disaster, and their developmental stage also plays a large part in how they cope with disasters. Every community is concerned about how disasters affect their children and youth and seeks ways to address these concerns. Below are several disaster behavioral health resources for children and youth.

NEW PODCAST! Helping Children and Youth Cope in the Aftermath of Disasters: Tips for Parents and Other Caregivers, Teachers, Administrators, and School Staff

This newly released podcast was designed to inform parents and other caregivers, teachers and other school staff, and behavioral health professionals about what kinds of responses to expect in their children and youth in the aftermath of disasters, such as a school shooting, and to help determine when a child or youth exposed to a disaster may need mental health services. Guest speakers include Robin Gurwitsch, Ph.D. and Russell Jones, Ph.D. This podcast can be found at <http://www.samhsa.gov/dtac/podcasts/children-trauma/index.asp>.

Tips for Talking With and Helping Children and Youth Cope After a Disaster or Traumatic Event: A Guide for Parents, Caregivers, and Teachers

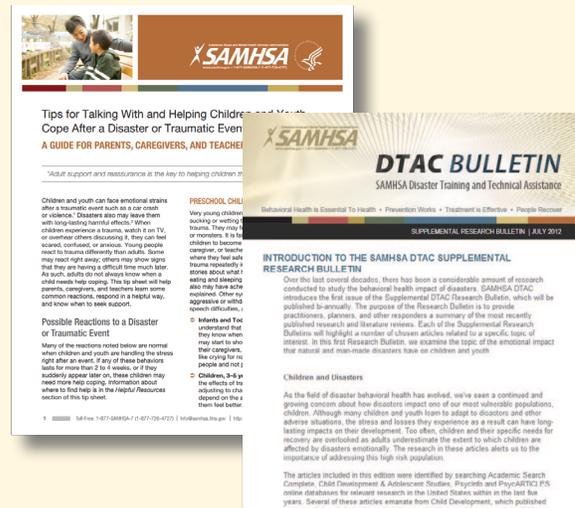
This tip sheet helps parents, caregivers, and teachers to recognize and address common reactions in children of different age groups (preschool and early childhood to adolescence) who have been affected by disasters or traumatic events. It describes stress reactions that are commonly seen in young trauma survivors and offers tips on how to respond in a helpful way and when to seek support and identifies resources. This tip sheet can be found at <http://store.samhsa.gov/shin/content/KEN01-0093R/KEN01-0093R.pdf>.

SAMHSA DTAC Supplemental Research Bulletin: Children and Disasters

SAMHSA DTAC's first *Supplemental Research Bulletin* examines the emotional impact that natural and human-caused disasters have on children and youth, one of the populations most at risk for negative mental health outcomes after a disaster. Developed in July 2012, this bulletin examines five recently published research and literature review articles and provides a discussion of the risk factors linked to children's responses to disaster, protective factors, and resilience. It concludes with suggestions about policy and practice. To view the *Supplemental Research Bulletin*, please visit http://www.samhsa.gov/dtac/bulletin/SAMHSA_DTAC_Supplemental_Research_Bulletin.htm. ■

AVAILABLE ONLINE

SAMHSA DTAC Resources on Children and Disasters



Upcoming Events

CONFERENCES

Australian and New Zealand Disaster and Emergency Management Conference

May 29–30, 2013; Brisbane, Australia

This conference is jointly sponsored by the Australian Institute of Emergency Services, the Australian & New Zealand Mental Health Organization Inc., and the Association for Sustainability in Business Inc. The conference will cover topics in natural and human-caused hazards and disaster prevention, preparedness, response, and recovery. It will include discussion of human and social issues that arise during and after disasters.

<http://anzdmc.com.au>

Eighth European Society for Traumatic Stress Studies Conference

June 6–9, 2013; Bologna, Italy

The theme for this conference is “Trauma and its Clinical Pathways: PTSD and Beyond.” The purpose of this conference is to bring together researchers and clinicians to discuss topics including trauma prevention and recovery in emergency services and disasters, innovative practice and therapy models in different cultural contexts, traumatic stress, assessment of children and youth, trauma across the lifespan, the psychopharmacology of posttraumatic stress disorder (PTSD), and posttraumatic growth.

<http://www.estss-2013conference.eu>

The College on Problems of Drug Dependence 75th Annual Meeting

June 15–20, 2013; San Diego, California

According to the website, the goal of this meeting is “to present and disseminate information about ongoing research in the biomedical, behavioral, and social sciences.”

<http://www.cpdd.vcu.edu>

Global Health and Well-Being: The Social Work Response

June 17–19, 2013; New York, New York

This conference is co-sponsored by the National Association of Deans and Directors and the New York Association of Deans of Schools of Social Work. The purpose of the conference is to define the social work response to address pressing health and psychosocial problems globally. One of the conference themes is “Trauma, Crises, and Response,” including natural disaster, war, and violence. The conference will include keynote addresses,

roundtable discussions, panels, and breakout workshops.

<http://www.nyu.edu/socialwork/continuing.education/socialwork.response.html>

The World Conference on Disaster Management

June 23–26, 2013; Toronto, Ontario, Canada

The World Conference on Disaster Management will bring together disaster management professionals from over 35 countries to provide “a global perspective on current issues and concerns in the industry.” Conference track topics include resilience, crisis communications, emergency management, and business continuity management.

<http://www.wcdm.org>

21st World Congress for Social Psychiatry

June 29–July 3, 2013; Lisbon, Portugal

Sponsored by the World Association for Social Psychiatry, the topic of this conference is “The bio-psycho-social model: The future of psychiatry.” The main topics include natural and human-caused disasters, such as the Fukushima Daiichi nuclear disaster, and mental health; ways to create alliances to respond to mental health challenges; and comorbid mental and physical illnesses.

<http://www.wasp2013.com>

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

July 9–11, 2013; A Coruña, Spain

This conference is organized by the Wessex Institute of Technology (WIT) and co-sponsored by WIT Transactions on the Built Environment and the International Journal of Safety and Security Engineering. The purpose of this conference is, according to its website, to provide a forum for partners in disaster management and leading academics to exchange information “on current global health risks, and how best to prepare for, respond to and recover from disasters in order to reduce human health impacts.” The conference will bring together leading academics and disaster management professionals to exchange information about best practices for prevention in disaster management and public health related to both natural and human-caused disasters.

<http://www.wessex.ac.uk/13-conferences/disaster-management-2013.html>

American Psychological Association Convention

July 31–August 4, 2013; Honolulu, Hawaii

The American Psychological Association Convention will offer half- and full-day workshops on psychological practice, education,

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CONFERENCES *continued from page 12*

science, and research in areas including ethics, assessment, trauma, geriatrics, and technology in psychology.

<http://www.apa.org/convention>

WEBINARS

Building Awareness of Disaster Behavioral Health

The goal of this SAMHSA DTAC webinar series is to educate participants about the mental health, substance abuse, and stress management needs of people who have been exposed to human-caused, natural, or technological disasters. The webinars help build awareness about preparedness and response efforts in this area. The content of both webinars can be utilized by non-mental health professionals who are involved in emergency management/disaster response and interested in learning more about mental health and substance abuse issues. Both of these webinars featured nationally known mental health and substance abuse experts, as well as representatives from the fields of public health and emergency management.

<http://www.samhsa.gov/dtac/webinars/webinars.asp#table2>

Cultural Awareness: Children and Youth in Disasters

The goal of this 60-minute podcast is to assist disaster behavioral health responders in providing culturally aware and appropriate disaster behavioral health services for children, youth, and families affected by natural and human-caused disasters. The podcast aims to accomplish the following:

- Define cultural awareness.
- Demonstrate the importance of cultural awareness in disaster services, particularly with children and youth.
- Identify common reactions of children to disaster and trauma.
- Present helpful approaches to working with children impacted by a disaster.

Featured speakers include April Naturale, Ph.D. of SAMHSA DTAC and Russell T. Jones, Ph.D. of Virginia Tech University. Dr. Naturale is a traumatic stress specialist with a 25-year history in health/mental health administration. Dr. Jones is a professor of psychology at Virginia Tech University and a clinical psychologist who specializes in trauma psychology in the areas of natural and technological disasters as well as interpersonal violence.

SAMHSA DTAC encourages participation by behavioral health, public health, and other professionals involved in emergency management/disaster response activities who are interested in learning more about working with children and youth following a disaster or need a refresher about the disaster response issues specific to this population.

<http://www.samhsa.gov/dtac/podcasts/cultural-awareness/register.asp>

Deployment Supports for Disaster Behavioral Health Responders

The goal of this 30-minute podcast is to prepare disaster behavioral health (DBH) responders and their family members for deployment by reviewing pre- and post-deployment guidelines and ways to prepare oneself and one's family members for the stress of deployment and reintegration into regular work and family life. This podcast aims to accomplish the following:

- Increase awareness of the unique issues DBH responders face, especially with numerous or long-term assignments.
- Provide pre-deployment guidelines to assist DBH responders and their family members as they prepare for deployment.
- Assist the DBH responder and family members by providing post-deployment guidelines and practices that enable reintegration with family members and routine employment.

The featured speaker is April Naturale, Ph.D. of SAMHSA DTAC. Dr. Naturale is a traumatic stress specialist with a 25-year history in health/mental health administration. She directed New York's disaster mental health response following the terrorist attacks of 9/11 and spent several years in the Gulf Coast area after large-scale hurricanes devastated the region.

SAMHSA DTAC encourages participation by behavioral health, public health, and other professionals involved in emergency management/disaster response.

<http://www.samhsa.gov/dtac/podcasts/deployment/register.asp>

Integrating All-Hazards Preparedness with Public Health

According to its online description, this webcast by the National Association of County & City Health Officials (NACCHO) "feature[s] four NACCHO demonstration sites that integrate all-hazards preparedness into traditional public health activities."

<http://webcasts.naccho.org/session-archived.php?id=684>

Planning for Pandemic Influenza: Issues and Best Practices

According to its online description, this webcast by NACCHO features discussions of "local challenges relating to vaccine distribution, isolation and quarantine, risk communication, hospital and personnel surge capacity, and community engagement."

<http://webcasts.naccho.org/session-archived.php?id=505>

Promising Practices in Disaster Behavioral Health Planning

This SAMHSA DTAC webinar series consists of nine webinars addressing promising practices in integrated mental health and substance abuse disaster behavioral health planning. These free webinars are meant to assist state and territory disaster behavioral health coordinators, disaster mental health coordinators, and disaster substance abuse coordinators, as well as emergency management/

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WEBINARS *continued from page 13*

behavioral health coordinators for tribes, with the development and implementation of their disaster behavioral health plans.

<http://www.samhsa.gov/dtac/webinars/webinars.asp#promising-practices>

Psychological First Aid: The Role of Medical Reserve Corps Volunteers in Disaster Response

This NACCHO webcast provides an overview of the disaster mental health field and the role and evolution of Psychological First Aid (PFA).

<http://webcasts.naccho.org/session-archived.php?id=823>

Self-Care for Disaster Behavioral Health Responders Podcast

The goal of this 60-minute podcast is to provide information, best practices, and tools that enable disaster behavioral health responders and supervisors to identify and effectively manage stress and secondary traumatic stress through workplace structures and self-care practices. The podcast will do all of the following:

- Define the stressors unique to disaster behavioral health responders, including secondary traumatic stress.
- Present best practices in self-care for disaster behavioral health responders.
- Provide tools that can be used to promote self-care.
- Identify supports that can be provided by supervisors and management to assist disaster behavioral health responders.

Featured speakers include April Naturale, Ph.D. of SAMHSA DTAC and Jeannette David, Georgia Disaster Mental Health Services Coordinator.

SAMHSA DTAC encourages participation by behavioral health, public health, and other professionals involved in emergency management/disaster response who are interested in learning more about self-care best practices.

<http://www.samhsa.gov/dtac/podcasts/selfcareDBHResponders/register.asp>

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

This webcast by the Maternal and Child Health Bureau within the Health Resources and Services Administration features resources and tools for pediatric disaster planning, lessons learned from the H1N1 pandemic, and perspectives from national stakeholders and partners in planning.

<http://learning.mchb.hrsa.gov/archivedWebcastDetail.asp?id=222>

TRAININGS

Early Responders Distance Learning Center

The Early Responders Distance Learning Center of Saint Joseph's University created and administers accredited courses for the emergency response community on preparing for and responding to terrorist incidents. The courses offer a specialized focus on psychological perspectives and issues.

<http://erdic.sju.edu>

Federal Emergency Management Agency (FEMA) Online Courses

FEMA offers free independent study courses that can be completed for continuing education units. Courses cover topics such as emergency preparedness, developing and managing volunteers, and the Incident Command System.

<http://training.fema.gov/IS>

The National Child Traumatic Stress Network (NCTSN) Psychological First Aid Online Course

The NCTSN Learning Center is an online training center geared toward professionals and families seeking to learn more about child traumatic stress. Many resources specifically focus on disaster-related trauma and grief. The NCTSN Learning Center also features Psychological First Aid (PFA) Online, a 6-hour course in which the student plays the role of a provider working in a scene after a disaster. According to the online course description, "this professionally narrated course is for individuals who are new to disaster response and want to learn the core goals of PFA, as well as for seasoned practitioners who want a review. It features innovative activities, video demonstrations, and mentor tips from the nation's trauma experts and survivors. PFA Online also offers a Learning Community where participants can share experiences of using PFA in the field, receive guidance during times of disaster, and obtain additional resources and training."

<http://learn.nctsn.org>

University of North Carolina (UNC) Center for Public Health Preparedness Training Web Site

According to this site, it "offers free short Internet-based trainings developed by the UNC Center for Public Health Preparedness (CPHP) on public health preparedness topics such as disease surveillance, basic epidemiology, bioterrorism, and new/emerging disease agents."

<http://cphp.sph.unc.edu/training/index.php>

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 homepage (<http://www.samhsa.gov>), enter your e-mail 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 e-mail address in the "SAMHSA DTAC Bulletin" section of our website at <http://www.samhsa.gov/dtac/resources.asp>.

The SAMHSA DTAC Discussion Board is an online discussion forum for disaster behavioral health stakeholders. Become a member of this community by visiting <http://dtac-discussion.samhsa.gov/register.aspx> and completing the brief registration process. Within 2 business days, you will receive your login and password via e-mail, along with further instructions on how to access the site.

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> to access these materials.

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