WINTER 2005

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

# The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER MENTAL HEALTH AND SUBSTANCE ABUSE

## CALL FOR INFORMATION

"The Dialogue" is an arena for professionals in the disaster behavioral health field to share information, resources, trends, solutions to problems, and accomplishments. Readers are invited to contribute profiles of successful programs, book reviews, highlights of State and regional trainings, and other news items. If you are interested in submitting information, please contact Kerry Crawford at dtac@esi-dc.com.

## JOIN "THE DIALOGUE" DISCUSSION BOARD

Do you have a question you would like to share with fellow disaster behavioral health coordinators? Are you frustrated with thwarted efforts of collaboration with other agencies or organizations? Have you found a resource you think others might find useful in planning?

Send your questions and responses to "The Dialogue" Discussion Board, and we will include your comments and queries in the next issue (Spring 2005).

Our first discussion topic is:

**How could your department benefit from a disaster behavioral health online training? What topic do you think is of the highest priority and the greatest use to your State/Territory?**

Please send your comments to dtac@esi-dc.com. Help us make this an effective method of communication for the field.

# *Substance Abuse Emergency Preparedness: Reshaping the Plan in New York*

New York State's Office of Mental Health (OMH) has a key role in providing human and facility resources during an emergency under the Human Services Section within the State Emergency Management Office (SEMO) Comprehensive Emergency Management Plan (see the October 2004 issue of "The Dialogue" for articles about OMH emergency preparedness and response www.mentalhealth.samhsa.gov.dtac.dialogue/October2004.asp#four). A lesson learned from 9/11 was that the role of the substance abuse agency in a coordinated, state-level disaster preparedness plan needed to be further examined and clarified. (In this article, substance abuse applies to alcohol and all other drugs.) Three years later, the State's understanding and support of the responsibilities of the Office of Alcoholism and Substance Abuse Services (OASAS) in a large-scale disaster is well defined. The role can be categorized into three general components: interagency collaboration, intra-agency emergency preparedness infrastructure, and addiction-specific issues.

Interagency Collaboration—Interagency collaboration is critical to enable the resources of the substance abuse system to be utilized in a disaster situation and to facilitate the utilization of resources located within other agencies when they are needed by the substance abuse system. For example, in New York the substance abuse system resources include 13 State-operated addiction treatment centers (ATCs), with a capacity of more than 600 beds, and more than 1,300 licensed treatment providers. OASAS also has an extensive prevention system of more than 1,700 prevention and intervention programs located in schools and communities throughout the State. Many of these providers responded immediately to the 9/11 attacks by caring for children and their families. In order to mobilize these resources in a large-scale emergency, OASAS partners with OMH and SEMO to avoid duplication of effort, ensure proper allocation of resources, and provide a coordinated response using the Incident Command System. Partnerships with other State agencies are necessary, in part, so that their resources can be utilized by the substance abuse system. For example, planning for a large-scale biological event includes collaboration with the Department of Health on how to train staff to manage outbreaks in facilities and how to facilitate case tracking of infected people who may be in the treatment system. Interagency collaboration is necessary so that each agency can support, and be supported by, sister agencies during emergency situations.

Intra-Agency Emergency Preparedness Infrastructure—Emergency planning must consider that State resources (human, structural, and financial) may be affected by the emergency or disaster, and the agency must be prepared to address both internal and external large-scale emergencies. Therefore, developing an emergency preparedness infrastructure requires the development of workforce and business continuity plans and a management infrastructure that uses the Incident Command System (ICS). To prepare for the Republican National Convention last year, OASAS initiated extensive employee training sessions in the New York City office that included safe building evacuation protocols, shelter-in-place procedures and alternate worksite planning. In addition, ICS training was provided by OMH and all key staff at OASAS were trained. Subsequently an agency Department Operations Center using the ICS was implemented and tested. While business continuity and employee training are ongoing initiatives of the agency, educating OASAS staff on the ICS was a new undertaking.

*continued*

Addiction-Specific Issues—The substance abuse system is uniquely responsible for ensuring that patients receiving methadone therapy can continue to access medication during all types of emergencies. OASAS, in collaboration with the methadone treatment providers, has developed such a plan. The experience of 9/11 also highlighted the role of the substance abuse system in three other ways: school-based counseling for children and their families; preventing/decreasing the use of alcohol or other substances by the general public and first responders who may use substances to cope with the aftermath of an emergency; and preventing relapse for individuals in recovery who may be particularly vulnerable during a disaster.

While substantial best-practice research and literature has focused on crisis counseling from a mental health perspective, further research is needed to develop best practices that address substance abuse counseling in post-disaster situations and how to decrease the relapse potential for those in recovery who are caught in a disaster. The extensive body of knowledge in prevention and intervention for substance abuse, which includes building resiliency, may be particularly useful in developing behavioral health crisis counseling best practices for schools, the general public, and first responders. Specifically, by combining the expertise of mental health and substance abuse crisis counseling theories and strategies, a true behavioral health crisis counseling model could evolve.

Reshaping the substance abuse system's emergency preparedness plan in New York required integrating the agency into the existing State Comprehensive Emergency Management Plan, building an intra-agency infrastructure to enable the agency to respond using currently-accepted protocols (e.g., the ICS), and identifying the unique contribution of the substance abuse system to emergency preparedness. There are many challenges that lie ahead in each of these areas and more work remains to be completed. Integration of substance abuse prevention and treatment expertise in the planning, response, and recovery phases of emergency management is an important component of comprehensive emergency planning.

*This article was contributed by Patricia Perry, Ph.D., R.N., emergency planner, New York State Office of Alcoholism and Substance Abuse Services.*

# *Mental Health Disaster Preparedness as a Public/Private Partnership*

Prior to September 11, 2001, responsibility for attending to the mental health needs of U.S. citizens affected by a disaster fell almost exclusively to local and State agencies. These efforts were supported by funds from a variety of Federal agencies. But the overwhelming need that resulted from the 9/11 terrorist attacks resulted in a broad-based response that crossed into the private sector. This model, which includes an active role for the private sector, can be put to use as preparations are made for future crises and disasters. Involving businesses in the process of planning and preparing for disasters is beneficial both for the public agencies responsible for developing statewide plans and for the businesses. Whether a disaster is manmade or natural, it is certainly in the best interest of an employer to return operations to normal as soon as possible with the least amount of disruption to employees. Likewise, services that are provided by the private sector can help reduce the demand on public resources during times of great need.

An increasing number of companies are recognizing the organizational benefits of disaster and crisis planning, particularly as it relates to taking care of their employees. However, many are still uncertain about the bottom-line impact and the true return on investment that results from good disaster planning. To successfully motivate potential business partners as collaborators in addressing disaster-related mental health issues, we need to approach the task both conceptually and pragmatically.

## PUBLIC HEALTH AS A CONCEPTUAL MODEL

Public health offers the best model for a mental health approach to disaster preparedness and relief. If an approach based on these time-honored principles is adopted, a more collaborative, diverse, community and resiliency-based model will be achieved—a model that is complemented by traditional mental health/counseling services, not driven by them. A public health approach places an increased emphasis on prevention, and capitalizes on the unique aspects of the community it is intended to serve by incorporating its inherent strengths and weaknesses into the planning and delivery process. Companies, like cities and towns, are communities with unique characteristics that need to be considered in determining how and to what extent an understanding of their characteristics will contribute to addressing mental health needs in a disaster.

This conceptual model is important for several reasons. Any stand-alone effort to address a crisis or disaster will be much less effective than one that is part of a multifaceted, integrated program. Clinically, there is a strong mind-body connection at play in the mental health effects of disasters, crises, and other highly stressful or traumatic events. People who have their basic physical, safety, and humanitarian needs met are in a much better position to remain psychologically stable. Disaster mental health providers know this fact better than anyone and therefore we need to be certain the model and language reflect attention to the broader "human impact" issues resulting from crisis or disaster.

One immediate advantage of moving from a mental health model of silos to a broader human impact model is that the longstanding societal fears and prejudices about mental health can be largely avoided. As planners and providers this allows us to have a direct positive effect on mental health via avenues that were

*continued*

previously overlooked, underutilized, or poorly integrated. This paradigm shift is particularly important in helping to bring the private sector to the disaster planning table. Business leaders often avoid such "touchy-feely" subjects as mental health and psychology, or believe that they have fulfilled their duties by having an Employee Assistance Program (EAP) available for their staff.

Bringing in grief counselors is often the primary and sometimes sole intervention provided by employers following a serious disaster or crisis. Alternatively, by operating from a human impact model, employers can offer a much wider variety of support and services for their employees in such circumstances—services that have a direct influence on return to productivity and overall organizational functioning. Perhaps most importantly, these services and supports will safeguard against negative business impacts such as productivity declines, higher health insurance and workers' compensation costs, and eroded profit margins. In addition, the desired services can be predetermined, planned, and budgeted as part of the company's overall business plan.

## BEYOND BUSINESS CONTINUITY: THE HUMAN IMPACT PLAN

To develop such a model, it is necessary to provide a concise framework with concrete procedures that companies can use to meet the needs of their stakeholders. It's important to note that many businesses already take some steps in preparing for disaster. Disaster recovery plans and emergency response plans are becoming increasingly common in this age of Sarbanes-Oxley and the increased threat of terrorism. However, their scope is limited: disaster recovery plans often focus on getting the computers and phones working again, and emergency response plans typically outline evacuation and rescue procedures.

For companies to be truly crisis-ready they need to invest the same level of planning for the human impact aspects of disaster. The development of a human impact plan is a cost-effective strategy for ensuring that employees are healthy, willing, and able to return to work following a crisis or disaster. For those companies who consider their employees their greatest asset, a Human Impact Plan (HIP) can mean the difference between financial success and costly losses.

An HIP is not unlike other disaster preparedness plans. It involves articulating procedural and infrastructure components including roles and responsibilities, activation and deactivation thresholds, concept of operations, training, and plan maintenance. The real substance of an HIP, however, comes in the form of its attention to key focus areas overlooked in other planning models. These areas define exactly how and what the organization will do from a prevention, response, and recovery perspective to address the range of human impact needs that arise in relation to a disaster and crisis. Many of the activities found in an HIP might already exist within a company, but they are typically scattered across departments with procedures, roles, and responsibilities poorly defined.

The development of an HIP structures, organizes, and centralizes these policies and procedures; and coordinates them with all other internal or external crisis preparedness plans. This type of planning is often championed within a company by the director of human resources. As part of the planning process, the planning team will consult with State and local officials to assure good coordination, maximize resources, and avoid unnecessary redundancies. When applied to disaster mental health planning in the public sector, the human impact model will include much of the same

*continued*

infrastructure but the detailed component activities will be slightly different.

The five primary focus areas are humanitarian assistance, psychological services, family preparedness programs, organizational readiness, and external stakeholders. Each component of the HIP attends to a different aspect of the overall readiness structure and has unique activities associated with it. As with any good planning model, the focus areas remain flexible so that the emphasis within and across these areas is ultimately determined by the specific needs and characteristics of the organization in question. Below is a brief description of the issues addressed in each category.

### HUMANITARIAN ASSISTANCE

This component of the HIP focuses on the immediate physical, financial, and social support needs of those affected by a crisis event while simultaneously supporting the return of business operations. Examples of humanitarian assistance activities include bringing insurance adjusters to the worksite to help employees facilitate claims following a disaster, accessing necessities such as batteries and tarpaulins from company locations outside the disaster zone, employee tracking procedures, and specialized benefit programs.

### PSYCHOLOGICAL SERVICES

This component of the HIP is composed of the more traditional mental health and disaster mental health services. Ensuring that enough qualified providers are available to staff through an EAP or community-based mental health center, death notification policies and training, the development of "buddy systems," return-to-work policies and programs, and manager training about the impact of crisis are all examples of things that are considered in this section of the HIP. Some of these services will be provided directly by company staff and some by outside contractors. It is crucial that the capacity of mental health crisis intervention resources such as EAPs and other specialized vendors be assessed in advance of the need.

It is a mistake, unfortunately all too common, to assume that contracted counseling services have the skills and capacity to handle the complex and often wide-ranging needs of a company in the aftermath of a disaster. Methods commonly in use to prevent or mitigate traumatic stress in survivors of or witnesses to mass disasters have recently been subject to a healthy critical examination as to efficacy and even the capacity to do harm. Careful consideration of methodology and practitioners of post-incident counseling intervention must be part of any plan to respond to human needs in the event of a crisis or disaster.

### FAMILY PREPAREDNESS PROGRAMS

The goal of this component is to acknowledge the disaster-related needs of employees' family members. Doing so not only increases employee loyalty but also reduces absenteeism and lost work days. Policies for financial payouts and funeral support in situations involving serious injury or fatality, emergency childcare resources, the development of "good neighbor" programs, and company support for setting up employee family disaster plans at home can all be useful strategies. These may surpass standard benefits arrangements and therefore must be planned in advance as part of a comprehensive disaster preparedness plan. Involving the employees in the development of this component of the plan, by asking them what services would be most helpful to them will help boost morale and strengthen employee commitment.

### ORGANIZATIONAL READINESS

This element of the HIP aligns the company infrastructure with the overall goals of the HIP in the form of policies, procedures, and the formation of a total disaster-ready organizational environment. Companies need to look at how well they track and use data related to workers' compensation, internal communications, and

*continued*

processes for examining lessons learned in a crisis. If these and other focus areas need alteration they can be identified and addressed during this part of the planning process.

### EXTERNAL STAKEHOLDERS

In addition to their employees, all companies have important external stakeholders. These stakeholders will vary from local neighbors to global shareholders. Most companies, no matter how large or small, are active and visible members of their communities. Areas to be addressed in this component of the HIP include community involvement, public sector support, and positive visibility. Initiatives ranging from such activities as creating alliances with the local school district to establishing corporate foundations can all play a role in supporting employees, their community, and the company itself when a crisis occurs. Like most effective crisis-related activities, these initiatives must be thoughtfully planned and begun well in advance of a disaster.

## MAKING A PUBLIC/PRIVATE PARTNERSHIP WORK

If we are able to articulate clearly the operational processes and business benefits of a public/private partnership as part of our disaster mental health planning efforts, we will be more successful in motivating businesses and those in the private sector to join us in disaster preparedness. The end result will be a greater number of people served in a shorter period of time when a crisis strikes. It makes both economic and clinical sense for public agencies and private organizations to work together and learn from each other how to more effectively prepare for disaster. As disaster mental health professionals, the burden is on us to reach out to the private sector with a broad-based model that simultaneously addresses the human impact of crisis on its stakeholders and is sensitive to the demands and limitations that businesses face.

Whether we consider them citizens of our State or employees of our company, the people who are impacted by disaster will need our help. It is up to us to work collaboratively to provide what they need.

*This article was contributed by Kevin Becker, Psy.D., a licensed psychologist and vice president in the Crisis Counseling practice of Marsh Inc. in Boston. He has specialized in psychological trauma and crisis for 15 years and was a cofounder of the Disaster Response Network for Massachusetts.*

# *Reflections from the Project Director: FSM SAMHP Establishes "Minafon Al" For Crisis Counseling*

The Federated States of Micronesia (FSM) is an island nation in the western Pacific Ocean, consisting of the States of Chuuk, Kosrae, Pohnpei, and Yap. With a combined land area mass of only 271 square miles, the 607 islands and atolls are spread over one million square miles of ocean. FSM is geographically located in a "typhoon belt" (typhoons are the Pacific version of a hurricane) that stretches from the Eastern Carolines to Guam to the Northern Marianas and beyond. In just the past 3 years, FSM has received five Presidential declarations as a result of devastating tropical storms and typhoons. These storms produce strong winds and high waves, as well as mudflows and landslides.

Typhoon Chata'an blew through FSM July 2-4, 2002, and President Bush promptly issued a Presidential disaster declaration for the State of Chuuk. The typhoon caused 40 deaths, and thousands were injured or left homeless. Landslides buried victims under 12 feet of mud, and people dug with bare hands, shovels, and crow bars to unearth their neighbors. A Crisis Counseling Program Regular Services grant was awarded by the Federal Emergency Management Agency on September 28, 2002. The FSM Substance Abuse and Mental Health Program (SAMHP) coordinated the grant, and created a model named "Minafon Al," meaning "a new way" to help the survivors. The program began as FEMA provided training at the University of Guam for more than 40 individuals, who received certificates of completion.

> *"Minafon Al" means encouraging people to move ahead and adapt in their healing as a community.*

A sense of resiliency and hope is embedded in the program name as Micronesians have suffered many disasters, and each time they have learned new ways of coping and continuing daily life. "Minafon Al" also includes services that allow disaster victims and professional service providers to engage in a new learning paradigm which empowers individuals to acquire new knowledge of how to deal with disasters.

The strength of the program includes locally and culturally based approaches to crisis counseling that incorporate both traditional and modern professional skills. FSM's close-knit communities help each other cope in culturally appropriate and effective ways. The crisis counselors are part of these local communities, and helped the survivors rebuild homes and farms. Local custom is to provide support and care to affected citizens to help them regain their strength and resilience.

This undertaking would not have been possible without the spirit of teamwork and cooperation from the FSM SAMHP staff. This spirit extended beyond the "Minafon Al" program, and many FSM SAMHP staff have attended trainings provided by SAMHSA on crisis counseling and behavioral health.

*This article was contributed by Kerio D. Walliby, FSM SAMHP administrator, FSM disaster mental health coordinator, and FSM administrator of Micronesia Health Services.*

# *SAMHSA DTAC Participates in 2004 ISTSS Meeting*

SAMHSA DTAC staff participated in the 20th anniversary meeting of the International Society for Traumatic Stress Studies (ISTSS) November 14-18, 2004, in New Orleans. The theme of the meeting was "War as a Universal Trauma." War affects not only active-duty military personnel but the men, women, and children living in countries involved in the conflict. War results in an exposure to terrorism and bioterrorism, torture, sexual trauma, and other types of violence. Workshops and sessions on epidemiology, treatment and prevention, and policy were presented.

SAMHSA DTAC provided disaster behavioral health resources and materials and conducted breakout sessions titled "How to Develop a National Technical Assistance Center," (described in this article) and "Partnering with Tribal Governments in Times of Disaster" (see following article).

Through a case study approach, participants learned how SAMHSA DTAC responds to the need to enhance State and local capacity to plan and deliver disaster behavioral health services in the context of immediate emergency response and beyond. They were introduced to the role of a national technical assistance (TA) center as one that builds the capacity within a given field through the brokering of knowledge and expertise. Participants learned that TA is provided in a variety of ways, but the most commonly practiced methods are:

- Developing, collecting, and disseminating resource materials, products, and expertise.
- Partnering with other expert agencies and organizations.
- Establishing communication channels including phone lines, e-mail, and publications.

With SAMHSA DTAC as the example, participants also learned the importance of planning, implementation, and continuous improvement to the success of a national TA center:

- Planning:
  - Have a clearly defined mission;
  - Conduct a needs assessment to understand specific TA needs;
  - Develop services and products based on identified needs;
  - Identify staffing and other resources;
  - Foster collaborations and partnerships with stakeholders.
- Implementation:
  - Document services and products by developing informational materials such as factsheets;
  - Seek opportunities for exposure such as participation in field events;
  - Conduct marketing and outreach to the field;
  - Engage the field through regular electronic or print communications such as a newsletter;
  - Develop credibility and trust by providing quality service and allowing field members to inform the TA process.
- Continuous Improvement:
  - Track all TA requests and delivery;
  - Develop benchmarks for desired outcomes;
  - Evaluate service delivery through mechanisms such as feedback forms.

SAMHSA DTAC's participation in the ISTSS meeting this year was rewarding. It offered an opportunity to provide information and resources to advocates, attorneys, counselors, educators, journalists/media experts, marriage and family therapists, nurses, physicians, psychiatrists, psychologists, researchers, social workers, and students interested in traumatic stress. It also allowed SAMHSA DTAC staff to learn a great deal from those working in the field which will inform future work.

# *Partnering with Tribal Governments in Times of Disaster*

The 2002 U.S. Census estimated that there are more than 4.3 million American Indians and Alaska Natives (AI/AN) living in the United States. Approximately 25 percent live in California and Oklahoma; cities with the highest percentage of this group are New York City and Los Angeles; and 20 percent of the AI/AN reside on tribal lands or reservations.

When a disaster occurs that affects the reservation communities, support through response and recovery is critical to the well-being of the community and the health of its members. The Crisis Counseling Program (CCP) of the Federal Emergency Management Agency (FEMA) can provide culturally congruent care to Native American communities. FEMA policy has guidelines for programs to follow to support Tribal nations in their post-disaster response and recovery. FEMA supports efforts to enhance relationships between Federal, State, Tribal, and local governments, and currently offers a Web-based course on "Building partnerships with Tribal governments" and emergency management for Tribal governments (for more information see FEMA National Emergency Training Center (NETC) Virtual Campus: http://lstrng1.fema.gov/learningspace5/program/UI/Main/Themes/Kendall/Main.asp).

Native American leaders have identified several guidelines of the CCP that support cultural congruence. For example, use of indigenous staff as crisis counselors enables local people to recognize normal reactions to an abnormal event. Crisis counselors then go to the natural gathering places in their communities and provide information to others in a natural, conversational manner. Local community customs of sharing meals, prayer, song, and dance to honor the land and stories of traditional culture are used to help people gather and support one another.

Three recent CCPs have been identified by AI/AN leaders as culturally congruent and successful in engaging and assisting people to recover from disasters. These programs occurred in Arizona, Montana, and North Dakota. Arizona and Montana had severe wildfires, and North Dakota experienced a flood. By using local people who understand the customs and traditions of the tribe, each of these projects provided much-needed support and built capacity within reservation communities.

## WHITE MOUNTAIN RECOVERY

The White Mountain Recovery Project began after severe fires burned thousands of acres of land in the White Mountain area of Arizona. Within the burned acreage was the Apache White Mountain land. Some of the burned land was considered sacred land where medicinal herbs and roots are grown to assist the people in living a healthy life. In addition, a firefighter was killed in the fire. He was a member of the White Mountain Apache Tribe and was much loved by his community. The community grief and loss over his death affected their recovery. The CCP program was tailored for each community. It was essential to have the spiritual leaders involved and to observe local customs. As part of the recovery process, people participated in a memorial and gathering to support the firefighter's family. They also participated in

*continued*

the Hon-Dah Pow Wow and in an event called Renewal of the Spirit for the small communities of Cibecue and Carrizo to honor the land. The people identified which customs and traditions brought them peace, strength, and hope for a better future.

## MONTANA RECOVERY

The 2002 Montana fires burned from Missoula through Bitterroot, causing tremendous damage and palpable grief for residents of those areas. Fires also burned acres of Blackfoot reservation land and destroyed many homes. Fortunately, the Blackfoot community has a group called "Hotshots," made up of firefighters and emergency medical technicians who support community response when a disaster occurs. Because this group is known and trusted by the community, they were able to foster collaboration and partnership with FEMA and the CCP. When elderly people were in danger and needed to be moved, the Hotshots were there to provide transportation and support. The Montana recovery project was successful because of working through a trusted community group to encourage adherence and provide behavioral health support.

## SPIRIT OF THE PLAINS

During the winter of 1996-97, the snowfall in North Dakota was three times the normal amount. Early spring storms and warm temperatures brought a quick thaw and flooding over this flat northern plains land. The eastern North Dakota city of Grand Forks' 50,000 residents were completely evacuated. The reservation community of Spirit Lake in northeastern North Dakota was pushed farther and farther inland as the banks of Devil's Lake grew and flooded homes and crop land. Many American Indian families moved in together seeking shelter, and in some cases, more than 10 families shared a two-bedroom home. Roads were destroyed and traffic was rerouted by 50 miles. The reservation community of Spirit Lake drew upon the traditional customs of sharing and caring for their community to survive. The CCP hired local people to provide information about normal responses to abnormal events and referral to local services. A popular social event in this community is attending the local bingo hall. The bingo caller was enlisted to provide information about the disaster recovery services while he called out bingo. "B 17, 17 under B" was interspersed with "you can get bleach and cleaning supplies from the Red Cross" or "If your children are having problems sleeping because of the floods, call…." The messages brought both laughter and strong response. By integrating services into the culture of the community, aided by endorsement from trusted local sources, the Spirit of the Plains CCP successfully reached the reservation community of Spirit Lake.

*This article was contributed by Bonnie Selzler, Ph.D., R.N., and is a summary of her November 15, 2004, presentation at the International Society for Traumatic Stress Studies 20th Annual Meeting.*

# *Emerging Research: Suicide Related to Disaster*

Suicide took the lives of 31,655 people in 2002, according to the Centers for Disease Control. Although there is little empirical information available on suicide in relation to disasters, 3 years after the terrorist attacks of 9/11 there is great interest in the subject.

The following peer-reviewed journal articles provide no empirical evidence to suggest that suicide rates change after a natural disaster. All of these studies were conducted on single events, and none were conducted after multiple natural disasters or after war or terrorist-inflicted events.

>> Krug, E.G., Kresnow, M.J., Peddicord, J.P., Dahlberg, L.L., Powell, K.E., Crosby, A.E., et al. (1998). Suicide after natural disasters. *New England Journal of Medicine.* 338(6): 373–378.

This article presents a study conducted between 1982 and 1983 in more than 377 counties in the United States looking at suicide rates 36 months prior and 48 months after a natural disaster. The results indicate an increase in suicide after floods by 13.8 percent, a 31 percent increase within 2 years after hurricanes, and a 62.9 percent increase one year after earthquakes. The increase in suicides held for both sexes and all age groups. **(Note: the results of this study were retracted in 1999).**

>> Krug, E.G., Kresnow, M.J., Peddicord, J.P., Dahlberg, L.L., Powell, K.E., Crosby, A.E., et al. (1999). Retraction: Suicide after natural disasters. *New England Journal of Medicine.* 340(2): 148–149.

This article corrects the earlier article and indicates that there is no significant increase in suicide rates after natural disasters. **(Note: There was apparently a significant flaw in the computer programming conducted in the first study).**

>> Kucerova, H. (1999). Reaction of patients in the psychiatric out-patient department to floods in 1997. *Ceska a Slovenska Psychiatre.* 95(7): 476–482.

This study looked at people with major mental illnesses 2 months post-extensive 1997 floods and reported no recorded attempted or completed suicides.

>> Shen, Y-J. (2002). Short-term group therapy with Chinese earthquake victims: Effects on anxiety, depression and adjustment. *International Journal of Play Therapy.* 11(1): 43–64.

This article looked at a study of Chinese children in Taiwan age 8-12 after a 1999 earthquake indicating that play therapy significantly decreased anxiety levels and suicide risk from the control group. Overall suicide rates were not studied.

>> Shiori, T., Nishimura, A., Nushida, H., Tatsuno, Y. and Tan S-W. (1999). The Kobe earthquake and reduced suicide rate in Japanese males. *Archives of General Psychiatry.* 56(3): 282–283.

This article describes the result of a study conducted by the Medical Examiner's Office, indicating that the rate of suicide (in males only) in Kobe, Japan, following a devastating earthquake in January 1995, was significantly reduced. The results were compared with the 10 years prior to the earthquake. The study also notes the rate of these suicides from high places was significantly reduced, with the possibility of this result being due to the lack of tall buildings from which to jump after the earthquake.

>> Voracek, M. and Sonneck, G. (2002). Suicide after natural disasters and statistical disasters: A comment. *Archives of Suicide Research.* 6(4): 399–401.

This article looked at corrected data regarding the increased suicide rate in the United States after single natural disasters and indicates the

*continued*

possibility of anomalies of pooled rates that should be further studied.

>> Warheit, G.J., Zimmerman, R.S., Khoury, E.L., Vega, W.A., and Gil, A.G. (1996). Disaster related stresses, depressive signs and symptoms, and suicidal ideation among a multi-racial/ethnic sample of adolescents: A longitudinal analysis. *Journal of Child Psychology and Psychiatry.* 37(4): 435–444.

This article indicated that there is a positive relationship among being female, low socioeconomic status, decreased family support, previous suicide attempts, and depression scores in multi-racial/ethnic adolescents. The article identifies these noted variables as predictors for significant depression scores. While suicide itself is not studied, suicidal ideation was a measured symptom.

*This literature review was contributed by April Naturale, MSW, LCSW, ACSW.*

### DID YOU KNOW?

>> SAMHSA has a variety of resources available regarding suicide. The National Mental Health Information Center has several factsheets and reports available electronically at: http://www.mentalhealth.samhsa.gov/publications/Publications_browse.asp?ID=60&Topic=Suicide.

>> The National Strategy for Suicide Prevention is a collaborative effort of SAMHSA, CDC, NIH, HRSA, and IHS. To contact, go to: http://www.mentalhealth.samhsa.gov/suicideprevention.

>> The National Suicide Prevention Initiative, a collaborative effort led by SAMHSA, recently launched a national hotline: 1-800-273-TALK, and a Web site: www.suicidepreventionlifeline.org.

>> The Suicide Prevention Resource Center has many electronic resources available at: http://www.sprc.org.

>> The National Clearinghouse for Drug and Alcohol Information also has electronic resources available regarding substance abuse and suicide at: http://store.health.org/catalog/SC_Itemlist.aspx.

Have you developed any resources addressing suicide in the aftermath of a disaster in your State? If so, please share them with the SAMHSA DTAC Resource Collection!

# *TA Resource Center*

## CALL FOR STATE AND COUNTY PLANS

We know that many of you are in the process of revising State and county disaster plans. With the rising awareness of the importance of including local agencies in disaster planning efforts (disasters occur at the local level), the number of county-level disaster mental health coordinators and plans is increasing. SAMHSA DTAC's Resource Collection is available for both State and local-level disaster response planning efforts. Please provide SAMHSA DTAC staff with the Web link if you would like your plan included, or if the link to your plan has changed, so that it can be updated on the SAMHSA DTAC Web site.

Are your plans not Web accessible? Send a copy! The DTAC Resource Collection maintains up-to-date copies of all State and Territory disaster behavioral health plans. Plans and resources can be sent to dtac@esi-dc.com, or to SAMHSA Disaster Technical Assistance Center, 7735 Old Georgetown Road, Suite 600, Bethesda MD, 20814.

*continued*

## SUGGESTED READING LIST

Have you discovered a useful planning document or resource? Or, have you read an interesting book, column, or journal article that you would like to share? Following are three recent suggestions:

- "War is a Force That Gives Us Meaning" by Chris Hedges.
- "Developing Cultural Competence in Disaster Mental Health Programs," Center for Mental Health Services, SAMHSA.
- "Mental Health Response to Mass Violence and Terrorism: A Training Manual," Center for Mental Health Services, SAMHSA; and the Office for Victims of Crime, DOJ.

## UNTAPPED RESOURCE?

Have you incorporated public transportation into your disaster planning efforts? Do you know what emergency plans and protocols have been developed for your urban subway system, bus companies, or ferry industry? Will you be involved in risk communication and public messaging should disaster strike a transportation system? And, how could your local transportation system assist or advise your facility evacuation plans? This is a growing area of disaster planning, and States have approached the topic in different ways:

- "We Prepare" is an electronic transit-specific disaster education brochure from the Washington, DC Metro, American Red Cross, Department of Homeland Security, and the Department of Transportation/Federal Transit Administration. Available at: http://www.wmata.com/riding/safety/together_we_prepare.pdf.
- MOU between the State of Texas and a local bus company. Please contact SAMHSA DTAC for more information at 1-800-308-3515.
- Washington, D.C., "Metro Emergency Preparedness" guide published by The Washington Post to educate Metro riders on emergency evacuation plans. Available at: http://www.washingtonpost.com/wp-srv/express/meg.pdf.

*continued*

# *Upcoming Meetings of Interest*

## ICISF 8TH WORLD CONGRESS ON STRESS, TRAUMA & COPING

**FEBRUARY 16–20, 2005**
**BALTIMORE**

International Critical Incident Stress Foundation 8th World Congress on Stress, Trauma and Coping is the premier forum for multidisciplinary exchange of ideas and information among those who provide crisis intervention services. The 8th World Congress will provide an unparalleled opportunity to examine the field of crisis intervention—what works, what is evidence-based, and the challenges and opportunities for the future. Topics include resilience, post-combat recovery and re-integration, HIPAA, community crisis response, CISM return on investment, ethics, and recent research findings related to crisis intervention. For more information go to: http://www.icisf.org/8WC.

## NCTSN ALL-NETWORK MEETING

**MARCH 3–5, 2005**
**ALEXANDRIA, VA**

The National Center for Child Traumatic Stress All-Network Meeting will be held March 3-5, 2005, at the Hilton Mark Center in Alexandria, VA. This annual meeting will bring together approximately 300 members from the National Child Traumatic Stress Network (NCTSN) centers to focus on the primary objectives of continuing to build the network, facilitating collaboration, and delivering training on specific content areas.

## NATIONAL HURRICANE CONFERENCE

**MARCH 21–25, 2005**
**NEW ORLEANS**

The National Hurricane Conference is the nation's leading forum for education and professional training in hurricane preparedness. With more than 1,500 attendees from around the country, the conference covers all major aspects of hurricane preparedness, response and recovery. For more information go to: http://www.hurricanemeeting.com.

## PUBLIC SAFETY WORKER GRANTEE MEETING

**APRIL 14-15, 2005**
**ROCKVILLE, MD**

SAMHSA's Emergency Mental Health and Traumatic Stress Services Branch will hold the third annual meeting of the Public Safety Worker (PSW) Grant program April 14-15, 2005, at the Doubletree Hotel in Rockville, MD. The meeting is titled "Preserving the Legacy," and the agenda will focus on providing guidance in the phase-down of the grants, sharing project accomplishments and lessons learned among grantees, and developing a plan to preserve the legacy and contributions of the grantees to the disaster behavioral health field. The meeting will bring together the following programs:

- Safe Horizon, New York
- Mental Health Association of Westchester County, New York
- Arlington County Community Services Board, Virginia
- Fire Department of the City of New York, New York
- St. Vincent's Catholic Medical Center, New York
- South Nassau Communities Hospital, New York
- Mt. Sinai School of Medicine, New York