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The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER BEHAVIORAL HEALTH

ASK THE FIELD

Note: This issue was written prior to the tragic incident at Virginia Tech.

The Dialogue: The issue of school violence is an important one in the field of trauma. What are some of the best practices for helping communities cope following an act of school violence? In addition, what are some effective prevention and education techniques that can be used in school and community settings?

Curt Drennen: Violence within schools is difficult to get our minds around, to respond to, and to process. That difficulty is magnified when the violence is purposeful and takes the lives of both students and hard-working, respected staff. Colorado has learned many lessons in the aftermath of the shootings at Columbine High School in April 1999. We worked to put those lessons into action as violence again struck. In September 2006, Duane Roger Morrison entered Platte Canyon High School, located in the small, rural mountain community of Bailey, CO. He took six female students hostage and eventually killed a student and himself. In situations such as these, effective disaster behavioral health response to school violence requires what the Colorado Behavioral Health Disaster Response System has been focusing on for the past several years. This includes building collaboration through partnerships and relationships in preplanning efforts, cooperating with other behavioral health organizations at the time of the event to assure that a coordinated and sustained response deployment is implemented, and building solid communication through a unified behavioral health command across responding agencies and groups.

Preplanning and collaborative efforts that take place prior to the event directly impact the recovery of a community. Any schism within a community is magnified by violence in the school where issues of "turf" and responsibility quickly escalate and negatively impact the resilience of the community. Therefore, it is essential that those in leadership positions work

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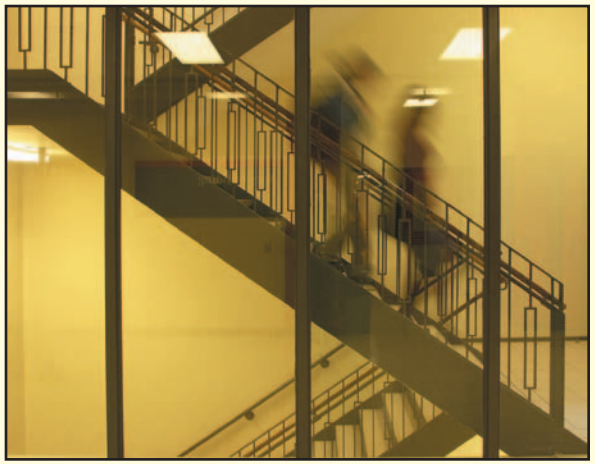
on the development of predetermined response and communication plans, relationship building, and collaborative efforts before an event strikes the community. This preparation minimizes conflicts and increases the effectiveness of the deployment. There is a profound impact on the community when the system responds in a united fashion, most notably when communicating critical information.

Some people question the benefits of early intervention after a crisis situation, yet it has been noted that a community impacted by violence often forms a "trauma membrane." This membrane tends to leave those who are outside of the experience on the outside of the recovery process as well. While outcome studies of psychological first aid (PFA) are yet to be conducted and published, implementing an early intervention utilizing PFA as a structural guide allows behavioral health response personnel to be on the inside of the trauma membrane. The positive impact of a collaborative group (e.g., community mental health, school crisis response teams, victim assistance professionals, American Red Cross) showing up in an organized, united fashion to provide cognitive, emotional, and physical support to the community cannot be underestimated.

Once disaster behavioral health professionals have effectively become part of the community through planning and early response efforts, then the real work of recovery can take place. Practices that are helpful include providing community education early and often; implementing a 24-hour hotline for brief information, intervention, and referrals; increasing the availability of behavioral health services; implementing crisis counseling; educating school and district administrations on the impact of trauma on their teaching staff, as well as educating teachers and parents about the impact of trauma on the academic performance of their students over time; and being a catalyst for fostering resilience in the community. This process is most effective when organizations join together in new partnerships to address the impact of the trauma. All of these techniques and services impact the perception of support, which is a critical factor in recovery.



Prevention and educational techniques are a different form of intervention and must be tailored to the community to match its culture, needs, strengths, weaknesses, and demographics. No single prevention and educational technique will fit all communities. Therefore, it is important that communities come together and address these issues individually. However, each community does not have to reinvent the wheel. Following the violence at Columbine High School, the Center for the Study and Prevention of Violence together with the University of Colorado at Boulder, implemented the Safe Communities—Safe Schools initiative. This initiative provides a template and menu of programs that can be implemented to address school violence. You can access this resource at http://www.colorado.edu/cspv/safeschools/index.html.

Curt Drennen, Psy.D., is disaster coordinator for mental health in the Division of Mental Health Services for the Colorado Department of Human Services, and frequently consults for SAMHSA.

For more information on the tragedy at Virginia Tech, visit the special SAMHSA Web site "Understanding Mental Illness—after the Virginia Tech Tragedy" at http://www.samhsa.gov/mentalhealth/understanding_mentalllness.aspx.

Promoting Emotional Resilience for Disaster and Emergency Incidents: Guidance for Local Public Health Response

Overview: The purpose of this article is to assist local public health personnel in promoting emotional resilience in their own town or city, both for the general public and to plan for the needs of specialized populations. It serves as a brief guide to introduce the topic of emotional resilience, frame the issues, and give some quick tips on how public health response can begin the process and include disaster behavioral health elements into local planning initiatives.

Building emotional resilience among residents is one of the recommended goals for municipalities when designing emergency plans. In the field of psychology, the term resilience is used to describe how people cope with stress and catastrophe. When used in the context of disasters, it describes how people can learn to mitigate the emotional impact of disaster. It is understood that every person who experiences a trauma or traumatic incident during his or her lifetime is affected by it. Research has shown that people impacted by trauma have what are considered common reactions to experiencing the incident. To diminish the long-term effects or lessen the severity of impact on community members, providing incident-appropriate crisis counseling, psychological first aid (PFA), or mental health and substance abuse assessments are an important service resource for emergency response.

Evidence-informed work with individuals and communities that experience trauma shows that common reactions to trauma include the following:

- Increased levels of anxiety and worry;
- Heightened levels of fear and helplessness;
- Shattered or reduced sense of safety;
- Feelings of outrage and anger;
- Physical symptoms when retriggered by memories of the incident, such as sweating, nausea, and sleeplessness;
- Feelings of sadness and grief;
- Loss in belief of importance of life or religious beliefs; and
- Feelings of relief and guilt about surviving the incident, especially when others did not.

Work with those affected by a disaster—survivors, family members, response workers, and community members—shows that if the emotional effects of the disaster are not mitigated, there is a risk that people may experience a reduction in overall functioning. Affected individuals may experience reduced ability or inability to go back to work or school, suffer mental disorders (such as depression, anxiety, and posttraumatic stress), shattered or disrupted relationships, or have difficulty rebuilding their lives. If communities make promoting resilience a component of emergency planning, they can lessen the risk of citizens developing emotional difficulties as a result of experiencing the trauma of a disaster.

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Affected community members become their own population with special needs as a direct result of being part of the incident and will need individualized services. Local public health response is tasked with determining what emotional support services are needed as part of a response to abate the adverse effects. Local public health responders—in collaboration with mental health, substance abuse, and human service providers—can work to do the following:

> Provide educational opportunities—Prior to an incident, educate community members about the effects of trauma and ways that they can protect themselves and foster resilience. Some recommended preventive measures include creating personal and family emergency plans, practicing ongoing self-care and stress management techniques, and becoming involved in community emergency preparedness initiatives at the local level.

> Build response capabilities—Prior to an incident, local public health responders should determine what mental health, substance abuse, and crisis counseling services are already available in the community.

> Plan—Participate in planning efforts to care for populations with specialized needs during disasters and determine which would be most vulnerable.

> Survey—Determine who in the community will most likely need specialized services to assist them with their unique circumstances.

The reason public health personnel should develop a community-wide special population approach as part of preparedness and planning initiatives is to conduct a pre-incident assessment to mitigate risk. It is not easy to predetermine who will need behavioral health services. This difficulty is because few methods have been developed that can accurately assess who will need help. It is difficult to do this because it is nearly impossible to determine how all the variables of a particular disaster will affect each unique member of a community. Although some educated guesses can be made, it has often proven inaccurate to assume which individuals or groups may need help after a disaster. Some affected individuals show amazing resilience against all expectations, while others do not. Such variation speaks to the importance of teaching methods of resilience across the community, and ensuring outreach to populations which may be most at risk.

Members of specialized populations can be individuals with pre-existing mental disorders or substance abuse issues; or can be people with physical disabilities such as the deaf and hard of hearing. Working with populations with specialized needs can be particularly challenging, but is an initiative that must be addressed. The work is challenging because existing research does not prove that members of the traditionally categorized special populations do better or worse than citizens not assigned to these classification groups. Some data indicates that members of special populations who have support systems in place do better than individuals with no prior history of trauma or pre-existing conditions. With this said, specific work can be done on the local level to build resilience in existing population groups in the community.

In terms of an overall public response, one strategy that can be developed for the community is a protocol for providing disaster behavioral health services door-to-door if members are sheltering in place. At the local level, a way to start this process and determine what might work best is to review which groups or individuals living in the community are most at risk and vulnerable. These might be people who are lacking adequate support systems, whose resources are already stressed, or who have prior histories of trauma, emotional illness, substance abuse, or other disabling circumstances. To prepare for an emergency and create effective plans, local public health personnel not only should collaborate with other providers of services and local emergency management, but also should consider how to incorporate these groups with potential specialized needs in building resilience. Another key part of planning is to include members of populations with special needs into the planning

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process to solicit their input, including people with psychiatric disabilities.

Recognizing that all disasters are local, public health officials and their partners can work to develop strategies for populations that may need specialized services and to implement overall resilience education for the community. A multiphase plan that includes working with both the general public and specialized populations serves to inoculate and build the resilience of the entire community. Providing educational material, including information that has already been developed (such as MassSupport—http://www.mass.gov/samh; or SAMHSA—http://mentalhealth.samhsa.gov/disasterrelief) to community mental health centers, doctor's offices, and school systems is another way to assist in building resilience. Training sessions on PFA also could be offered at community venues. Local public health officials can assist efforts by ensuring that elements for providing disaster behavioral health services are incorporated into a city or town's all-hazards emergency plan.

A well-developed system does not need to be overly complex to be effective. The key to fostering resilience and a robust disaster behavioral health response is to engage in preplanning, create relationships with existing service infrastructure, and raise the level of knowledge the community has about emergency response and its emotional impact. It also is helpful to enlist partners at the local, State, and Federal levels that can assist in the process. The goal of promoting emotional resilience is to build communities that are better prepared for emergency incidents and their traumatic impact.

This article was contributed by Ashley Pearson, M.P.A., emergency management director and deputy director of community services for the Massachusetts Department of Mental Health.

Trauma-Informed Systems of Care: An Update

Note: This article was written by Roger D. Fallot, Ph.D., and Maxine Harris, Ph.D., who edited the referenced book, Using Trauma Theory to Design Service Systems.

In considering ways to respond helpfully to those affected by traumatic experiences, a basic distinction has been made between trauma-specific and trauma-informed services. Trauma-specific services are those whose primary task is to address the impact of trauma and to facilitate trauma recovery. Such services may include individual and group interventions designed to ameliorate posttraumatic stress disorder symptoms—exposure therapy, stress inoculation training, and cognitive reprocessing therapy, among others. By contrast, trauma-informed systems and services are those that have thoroughly incorporated an understanding of trauma, including its consequences and the conditions that enhance healing, in all aspects of service delivery. Any human service program, regardless of its primary task, can become trauma-informed by making specific modifications in both administrative- and service-level practice to be responsive to the needs and strengths of people with personal experience of trauma.

In *Using Trauma Theory to Design Service Systems* (Harris, M. and Fallot, R.D. (Eds.). (2001). New Directions for Mental Health Services Series. San Francisco: Jossey-Bass.), we outlined the basic changes in understanding—the paradigm shift—involved in a trauma-informed framework and then described the application of this model to a number of different kinds of services. Becoming trauma-informed means changing the ways we think—about trauma itself, about the survivor, about services, and about the services relationship—as a prelude to changing the ways we act in structuring and offering services. It means moving trauma from the periphery to the center of our understanding. Rather than asking, "What is your problem?" trauma-informed providers may ask, implicitly or explicitly, "What has happened to you?" and, "How have you tried to deal with it?" Rather than adopting a stance of, "Here is what I can do to help you," a trauma-informed approach asks, "How can you and I work together to meet your goals for healing and recovery?" In every aspect of the program's functioning, there is enhanced awareness of the ways in which trauma may have affected people coming for services. There is a corresponding shift in attitude, practice, and setting to welcome, engage, and sustain helpful relationships with consumer-survivors.

Since 2001, we have had the opportunity to consult with numerous States and individual programs that have expressed interest in adopting a more trauma-informed approach in their settings and activities. Several lessons and new materials have emerged from these consultations and discussions. First, we have developed written guidelines for an agency or program to review the extent to which it is currently operating in a trauma-informed way and to make plans for prioritizing and initiating appropriate changes. This Trauma-Informed Self-Assessment and Planning Protocol draws on several domains at both the services level and the administrative level. The review of day-to-day service procedures and settings provides a starting point. In this process, agencies review the extent to which their day-to-day service procedures and settings are welcoming and hospitable for trauma survivors and the extent to which they minimize the possibility of retraumatization. Program administrators, staff, and consumers consider each step of a hypothetical prospective service recipient's experience with the program, from initial to final meeting. They ask a variety of

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questions relevant for their program. What is the usual first point of contact? By telephone or in person? Who is likely to greet the individual? In what way? With what information? How engaging and nonthreatening are these initial contacts likely to be, especially for people with histories of abuse and related interpersonal concerns? Are the physical settings responsive to the needs of trauma survivors? Is there adequate space in the waiting area? Are there private areas for confidential conversations? Questions like this address the full range of service relationships over the course of a person's involvement with the program.

From a large number of conversations with program staff and consumers discussing these questions, we have distilled five core principles to guide the assessment and planning process: Safety, trustworthiness, choice, collaboration, and empowerment. The broad assessment questions are straightforward. To what extent do current service delivery practices and settings do the following:

- Ensure the physical and emotional safety of consumers and staff? (safety);
- Make the tasks involved in service delivery clear? Ensure consistency in practice? Maintain boundaries, especially interpersonal boundaries, that are appropriate for the program? (trustworthiness);
- Prioritize consumer experiences of choice and control? (choice);
- Maximize collaboration and the sharing of power with consumers? (collaboration); and
- Prioritize consumer empowerment? Recognize consumer strengths? Build skills? (empowerment).

As programs move into the planning phase, they discuss and plan specific changes that can maximize these five characteristics of a trauma-informed program.

In addition to this review of routine activities and settings, assessment and planning involve two other domains at the service level. Formal, usually written, policies are examined to ensure, among other indicators, that confidentiality policies are clear and implemented consistently; that policies avoid involuntary or coercive practices; that the program prioritizes consumer preferences in responding to crises; and that a clearly written statement of consumer rights and grievance procedures is routinely accessible. The final service domain addresses trauma screening, assessment, and service planning. Here the program review focuses on universal trauma screening, more detailed trauma assessment as appropriate, and referral and followup procedures that ensure access to affordable and effective trauma-specific services.

The self-assessment then turns to administrative-level domains. Gauging administrative support for program-wide, trauma-informed services is essential. Some possible indicators that programs consider include the following: Formal policy or mission statements that highlight the importance of trauma; forming a trauma workgroup to take a leadership role in trauma-related service development; making resources (time, money, staff) available in support of trauma-informed recommendations; and active participation by senior administrators in the review and planning process. Trauma training and education is the second domain. Programs assess the extent to which all staff have received basic education in trauma, its effect on people's lives, and some of the ways in which trauma-related dynamics may be evident in the work setting. In addition, the extent to which direct service staff has received trauma training related to their area of specialization is considered. Finally, programs examine their human resource practices. They assess the extent to which knowledge of trauma is considered in the hiring, orientation, and performance review processes.

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This comprehensive assessment and planning process ends with a structured exercise to help programs set their own priorities for making trauma-informed changes. Considering such factors as feasibility, impact, and available resources, programs make a sequenced work plan for implementing their planned modifications. To aid programs in monitoring their progress, we have developed a Trauma-Informed Self-Assessment Checklist as a companion document. This checklist includes a five-point scale for each of the above domains, with higher ratings indicating more fully developed trauma-informed practice.

Based on our work with a variety of programs and jurisdictions, we have learned certain lessons about the most effective ways to implement a trauma-informed change initiative. Because these initiatives are designed to facilitate a changed culture and changed system, they go well beyond simply adding a new service and beyond the involvement of direct service staff alone. For trauma-informed changes to take root and become part of an agency culture, participants from all stakeholder groups need to be involved: Upper-level administrators (e.g., executive directors and clinical directors), supervisors or other middle managers, direct service staff, support staff, and consumers. Those programs that are most successful in developing significant and lasting trauma-informed approaches have engaged frequently underrepresented groups in all aspects of planning, implementing, and monitoring the change process.

A corollary of this observation is that considerable attention must be paid in the preplanning phase of instituting a trauma-informed initiative. For example, if an administrative authority (at either the program or larger systems level) decides to implement such a change process, it is important to consider ways to maximize buy in from the constituencies involved. Administrative decisionmakers need to model the kind of collaboration that a trauma-informed approach values. This may mean taking the time to provide information, to anticipate obstacles, to offer needed resources and incentives, and to develop solutions to potential problems. It may mean starting the initiative with a highly motivated part of the agency, or pilot project, that will then disseminate its learning to the larger system. It may mean timing or pacing the initiative to fit with other contextual factors, including programs' financial stability and other concurrent administrative or service system changes that can potentially interfere with a new initiative.

Qualitative findings from our consultations have been promising. In programs that have implemented this process, each of the major constituency groups—administrators, direct service staff, and consumers—have reported positive responses to trauma-informed changes in the system of care. Administrators note greater collaboration, both within and outside the agency; enhanced staff morale; fewer negative incidents; and more effective service implementation. Providers report more collaboration with consumers, an enhanced sense of their own efficacy, and greater support from the larger agency. Consumers report a stronger sense of safety, trust, and engagement in services; more collaboration with service providers; and a special appreciation of the emphasis on empowerment, recovery, and healing. One consumer stated that she had previously felt it necessary to leave part of herself outside the agency door, but the trauma-informed initiative had made it possible for her to "bring her whole self" to the program. Such whole-person engagement with the full experiences of trauma survivors is a powerful expression of a trauma-informed culture. For more information, go to http://www.communityconnectionsdc.org.

This article was contributed by Roger D. Fallot, Ph.D., director of Community Connections Research and Evaluation, and principal investigator on the District of Columbia Trauma Collaboration Study; and Maxine Harris, Ph.D., CEO for clinical affairs and co-founder of Community Connections. Dr. Harris is also executive director of the National Capital Center for Trauma Recovery and Empowerment.

The After the Crisis Initiative: Healing from Trauma Following Disaster

Disaster response systems, much like the mental health system, often reinforce a person's belief that they cannot do for themselves. The impact of disaster as well as the sometimes disabling aspects of a mental illness can often create the inability to care for one's self, family, and community. Resources for self-direction can be limited or nonexistent. Stigma replaces sympathy. Both victims of disaster and people with mental illnesses begin to be seen as the problem as support and resources are exhausted. This increases pre-existing issues of substance abuse, crime, hopelessness, and helplessness as well as creates a new class of disempowered and disenfranchised people—evacuee populations.

The urgent need for the After the Crisis initiative (ATC) was highlighted by the impact of Hurricanes Katrina and Rita in communities along the gulf coast. The key activities of the initiative are focused on the development of technical assistance strategies and support networks that are dedicated to addressing the long-term mental health and trauma needs of disaster survivors.

The ATC initiative formed a consortium, the activities of which are targeted toward creating change and building disaster response capacity. The initiative's network is composed of a broad array of experts, many of whom are trauma survivors and have had personal experience with disaster in their communities. Collectively, membership of the initiative includes representatives from the community, State, and national levels. The ATC initiative has formed a Peer Support and Response Committee (PSRC), which is focused on developing individual and community-level support strategies to increase community disaster response capacity.

The ATC PSRC believes that a peer-support network is a powerful force that promotes community connection and hope in the lives of survivors of traumatic stress and retraumatization during and after a disaster. The goal of the effort is to foster recovery by establishing productive communication, building long-lasting, effective relationships, and developing a peer support and response curriculum to promote "peers helping peers." The committee initiated the dialogue among leaders of several successful peer-support programs across the country, along with leaders from various national consumer technical assistance centers. These leaders; along with local, State, and Federal officials; have met in a variety of settings to discuss how important it is to include self-help and peer support as part of the services deployed in response to disasters. This dialogue has provided the impetus for the development of a peer-support and response training curriculum designed to develop community capacity to respond to the mental health needs of individuals in times of disaster by providing key support mechanisms to foster recovery.

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PEER SUPPORT AND RESPONSE IN TIMES OF DISASTER ROUNDTABLE MEETING

Coordinated by leadership from the CMHS National GAINS Center and the Howie T. Harp Peer Advocacy Center, the ATC initiative sponsored a 2-day Peer Support and Response Roundtable meeting January 25–26, 2007, in New York City. The purpose of this meeting was to follow up on recommendations made by the ATC Expert Panel and continue the work of the ATC PSRC. The meeting brought together national consumer leaders and advocacy organizations to develop a set of core principles that would guide the development of a national disaster peer support and response training curriculum, outline core modules and content for the curriculum, and discuss strategies for supporting its delivery and providing infrastructure support to States, localities, and consumer organizations.

Stakeholder organizations that participated in this meeting include the following: CMHS National GAINS Center; Howie T. Harp Peer Advocacy Center; Mental Health Association of Southeastern Pennsylvania; National Empowerment Center; Consumer Organization & Networking Technical Assistance Center (CONTAC); Boat People SOS; Oklahoma Mental Health Consumer Council; Meaningful Minds Louisiana; New York Association of Psychiatric Rehabilitation Services (NYAPRS); and Mental Health Empowerment Project.

Peers are often the most effective engagement tool in a community of marginalized citizens. Peer support may be the only available way to effectively address the needs of people with mental illnesses in times of disaster. Among participants, consensus was reached on the following core principles.

- Services should be peer-run and embrace the concept of mutual support.
- Training should promote practices and strategies that are trauma-informed, culturally and linguistically sensitive, and which create recovery-oriented environments.
- Peer response should have the capacity to provide linkage to necessary services.
- Peer responders should be integrated members of local- and State-level disaster response plans, working in partnership with mental health and other relief organizations.
- Peer response training must also focus on prevention by emphasizing both individual and family preparedness and community disaster preparedness.

NEXT STEPS

The following next steps have been identified.

- Complete a consensus statement further summarizing the results of the initial meeting.
- Gather information from existing peer support and response training curricula.
- Strategize about how to integrate this information into one core curriculum and identify areas of curriculum that need to be developed.
- Further develop and finalize the peer support and disaster response model training curriculum.
- Potentially pilot test the peer support and response training curriculum in at least one community.
- Identify strategies to promote the inclusion of peers in the disaster planning and service delivery models.

The overall scope of the national network must include both community and institutionally based mental health service providers, in collaboration with stakeholders and providers from the criminal justice, substance abuse, and public health systems that are attuned to issues associated with culture, gender, and socioeconomic status.

For additional information about the ATC initiative, go to http://www.gainscenter.samhsa.gov/atc.

This article was contributed by Chanson D. Noether, M.A., director; and Noel C. Thomas, M.A., program coordinator, After the Crisis initiative of the National GAINS Center.

William Wendt Center for Loss and Healing: Working Toward Acceptance

William Wendt

IN GRIEF, INDIVIDUALS AS ONE

Most people have experienced a substantial loss during the course of their lives, or witnessed friends and relatives suffer after the loss of a loved one. The impact of illness, loss, and bereavement may have a profound effect on an individual's ability to function during the weeks, months, and even years that follow. Feelings such as disbelief, guilt, anger, fatigue, and frequent mood changes are all common reactions. Deep sadness may lead to hopelessness and general feelings of despair which can easily permeate into other areas of life.

Although grief counseling addresses the universal feelings and reality of loss that everyone shares, each person's grief experience is unique. Some people may be hesitant to share these feelings, may not want to burden others, or may feel they should get over it more quickly than is reasonable to expect. Of course, no counselor or therapist can mend or take away these feelings as they are part of the healing process. Nevertheless, the therapists at the William Wendt Center for Loss and Healing are adept at assisting people during times of mourning. They are not afraid to witness the pain people might share, or to lend support during the important journey of recovery from loss.

The Wendt Center provides mental health services, training, and education to ease the impact of illness, loss, and bereavement. Staff members respect individuals and their experiences, understand the pain of loss, and offer support during times of illness and death. They understand the need for people to reach out in times of need and the feelings that come when seeking assistance from peers or professionals. The center welcomes those who are seeking informational, educational, emotional, or other types of support that relate to life changes due to illness, loss, or grief.

A COMMUNITY SHARES IN RECOVERY

As a community-based agency in Washington, DC, the Wendt Center exists in an area with one of the highest homicide rates per capita in the United States. The center's Homicide Outreach Project Empowering Survivors (HOPES) does community outreach, follows up with covictims for up to 1 year, and provides mental health services for both groups and individuals. This program also provides indepth training to professionals so that they can assist their own clients during such sensitive times.

The Crisis Response Team at the Wendt Center has more than 70 trained volunteers, including local clergy, who work closely with metropolitan area police in their immediate response to reports of homicide. Volunteers are deployed to accompany police as they notify family members of their loved one's death. Often, they work with next of kin to provide both emotional and practical support such as funeral preparations, burial arrangements, and even candlelight vigils.

The Recover program provides short-term crisis support specifically for those who have been affected by sudden or traumatic deaths. As part of their outpatient mental health program, the center's staff delivers skilled counseling during reactions to trauma and loss. Through Recover, therapists provide a wide spectrum of support services after a homicide, suicide, accident, or other type of sudden death. Such assistance includes violence intervention by working with families to cope with anger and grief. Survivors of trauma receive support

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services from the time of loss throughout the process that follows. At times, these processes may include identifying the deceased, claiming remains, and assisting with an investigation. A wide range of support services (including family, couples, individual, and group therapy, as well as child-focused counseling) are available. These services are geared toward helping people accept their new realities after trauma. Families with financial constraints can benefit from sliding-scale fees or free services, if they qualify.

EVOLUTION OF A DREAM

The Wendt Center has a story that began more than 30 years ago. In 1975, Reverend William A. Wendt and Reverend Robert D. Herzog founded the St. Francis Burial and Counseling Society, a program which provided affordable and dignified funeral services. This approach to confronting the reality of death alleviated people's anxieties; it demystified the topic of death and dying, and allowed people to open their minds and hearts and to share their grief with others.

In 1992, the center launched a children's program, which led to the development of a school-based grief program in 1997. In 1999, the St. Francis Center officially became the William Wendt Center for Loss and Healing, and in 2001, the center moved to downtown Washington, DC. Along with a commitment to serve those diagnosed with HIV/AIDS, the center joined the National Child Traumatic Stress Network (NCTSN) to collaborate across America with other agencies that provide treatment in the area of child traumatic stress. "People think it must be hard or depressing to work here," says Executive Director Susan Ley, LICSW. "Initially, it is. But to witness the joy in people's recovery after loss—to see the joy in a child, skipping down our hallway after some time has passed—well, it is very rewarding work."

After more than 30 years of service, the Wendt Center employs some of the most gifted and compassionate therapists in the field of trauma, grief, and loss. Offices are currently open in northwest and southeast Washington, DC, with a new northeast office to be added soon. Their central locations ensure convenience for people "in the neighborhood." Most importantly, they continue to work within the memory of Rev. Wendt's belief that "no one should have to grieve alone."

The William Wendt Center for Loss and Healing incorporates into their services expertise in mental health and grief work, crisis intervention and recovery assistance, and commitment to local communities during times of loss. There is a sense of triumph that results from the numerous programs and services available at the Wendt Center. For more information, visit the center's Web site at http://www.wendtcenter.org.

Mental Health Consumers as Key Resources in Disaster Planning and Response

"None of us is as smart as all of us."
—Japanese proverb

"Because we are a resilient community that has been through a lot, we have a lot to offer."
—Consumer of mental health services

The updated Mental Health All-Hazards Disaster Planning Guide calls for inclusion of mental health consumers in the planning process. Consumers are a valuable and proven resource both in planning for and responding to disasters. They have demonstrated success in providing support to those impacted by the Oklahoma City bombing, the September 11, 2001, terrorist attacks, Hurricanes Katrina and Rita, and other disasters.

Today's mental health care, based on values of recovery and resilience, offers principles that should guide mental health disaster planning. The most important of these are the engagement of consumer input at all levels of mental health disaster preparation and the focus on strength-

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FEDERALLY SUPPORTED CONSUMER TECHNICAL ASSISTANCE CENTERS

- **Consumer Organization and Networking Technical Assistance Center (CONTAC),** http://www.contac.org.
- **National Empowerment Center (NEC),** http://www.power2u.org.
- **National Mental Health Consumers' Self-Help Clearinghouse,** http://www.mhselfhelp.org.

FEDERAL AND OTHER RESOURCES

- **National Coalition of Mental Health Consumer/Survivor Organizations,** http://www.ncmhcso.org.
- **After the Crisis Initiative: Healing from Trauma after Disasters—A collaborative initiative between the National GAINS Center at Policy Research Associates (PRA) and the National Center for Trauma-Informed Care, supported in part by SAMHSA CMHS,** http://gainscenter.samhsa.gov/atc.
- **From Relief to Recovery: Peer Support by Consumers Relieves the Traumas of Disasters and Facilitates Recovery from Mental Illness—Resource paper presented at the After the Crisis Initiative: Healing from Trauma after Disasters expert panel meeting, April 24–25, 2006, Bethesda, MD,** http://gainscenter.samhsa.gov/atc/text/papers/peer_support_paper.htm.
- **The Needs of People with Psychiatric Disabilities During and After Hurricanes Katrina and Rita—Position paper and recommendations,** http://www.ncd.gov/newsroom/publications/2006/peopleneeds.htm.
- **Peer Support Disaster Preparation for People with Psychiatric Disabilities—Webcast,** http://www.connectlive.com/events/samhsa. **Also available as a DVD at** http://www.mentalhealth.samhsa.gov **or 1-800-789-2647.**
- **Revision of WRAP data-gathering tool—Developed by Carolyn Archer, Oklahoma Mental Health Consumer Council, 3200 Northwest 48th Street, Suite 102, Oklahoma City, OK 73112, (405) 604-6975.**
- **Dealing with the Effects of Trauma: A Self-Help Guide—SAMHSA publication, DHHS Pub. No. SMA-3717,** http://mentalhealth.samhsa.gov/publications/allpubs/SMA-3717.

based approaches in helping consumers who are affected by disasters. By including individuals who have psychiatric disabilities in disaster planning, States and localities benefit from the experience, hope, and voice of people they assist in emergencies. This helps ensure that the disaster response is appropriate and of actual support to these individuals.

By including consumers, States and localities ensure that the needs of consumers are included in planning and in the resources they can offer. Consumers as peer-support specialists can provide outreach and support services such as assessing needs and providing information about accessing the range of response services and supports. Peer support groups and organizations are a locally available, culturally competent workforce that can significantly expand the available human resources. They can work in both one-to-one and small-group situations, and their efforts can include, peer-run groups in relocation sites, person-centered planning, dropin centers, peer support and counseling, and "warmlines." To be fully successful, both consumers and States require training and support in how best to respond to disasters and how to effectively involve consumers.

Numerous resources are available to guide States in finding and involving consumers in their disaster planning and response. Many States have both statewide and local consumer organizations. Also, there are three federally funded national consumer technical assistance centers.

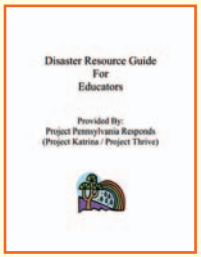
This article was contributed by David Romprey, technical project manager, National Empowerment Center Oregon and Oregon Peer Response Network; Paolo del Vecchio, associate director for consumer affairs, SAMHSA Center for Mental Health Services (CMHS); and Carole Schauer, senior consumer affairs specialist, SAMHSA CMHS.

Recommended Reading

CLOUDY DAYS & STARRY NIGHTS: BUILDING NEW LIVES AFTER HURRICANE KATRINA

A Project H.O.P.E. Creation
Written by Sheila Rochefort-Hoehn
Illustrations by Charles Schwien

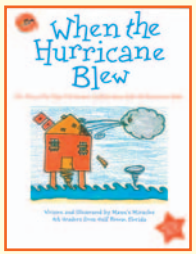
Cloudy Days & Starry Nights is an illustrated storybook about a family evacuated from their home after Hurricane Katrina. It was written by Sheila Rochefort-Hoehn, who is currently working as a crisis counselor for Project H.O.P.E. in Orlando, FL. This colorful book tells a story of resilience as the family finds ways to celebrate Mardi Gras away from New Orleans. The book highlights the diversity and culture of the area affected by Hurricane Katrina and addresses questions and fears concerning children who survived the storm. The front cover contains practical advice for caregivers on how to deal with disaster and help children cope. The back cover lists facts about hurricanes, as well as New Orleans culture and history. It is suggested that parents read this book with their children to promote discussion about fears and emotions associated with hurricanes. It is a hopeful story that would be educational and interesting for children not affected by the hurricane to learn more. For more information, contact SAMHSA DTAC at dtac@esi-dc.com.



DISASTER RESOURCE GUIDE FOR EDUCATORS

Provided by Project Pennsylvania Responds
(Project Katrina and Project Thrive)

The Disaster Resource Guide for Educators was created by Project Pennsylvania Responds, made up of the two Pennsylvania Crisis Counseling Assistance and Training Programs for Hurricane Katrina. It is a collection of materials designed to educate teachers on how to present the topic of disasters to children. This collection is made up of materials gathered from the Federal Emergency Management Agency, the American Red Cross, SAMHSA, various universities, and other sources. The resources cover a range of disaster issues related to children. There are materials covering family preparedness, information on common reactions and signs of stress in children after a disaster, as well as information and tools to assist teachers and parents in helping kids to work through their feelings after a traumatic event. All materials identified in this collection are available online. Collected at the end of the resource guide are a number of coloring and activity books that deal with disaster issues. Using fun activities such as these is a good way for teachers or caregivers to bring up and work through this serious topic. The resources in this collection are informative and well-selected. The full guide is available online at http://www.ccrinfo.org/katrinaproject/documents/educators%20disaster%20resource%20guide.pdf.



WHEN THE HURRICANE BLEW: THE STORY, THE TIPS, THE GAMES CREATED BY HURRICANE KIDS FOR HURRICANE KIDS

Written and illustrated by Mann's Miracles fourth graders from Gulf Breeze, FL

When the Hurricane Blew is an illustrated book created by a team of fourth graders (affectionately called Mann's Miracles) of Gulf Breeze Elementary. In September 2004, Gulf Breeze, FL, was devastated by Hurricane Ivan, which tore through their community with wind speeds of up to 150 mph. After the hurricane passed and classes resumed, the fourth graders decided to share their memories of the storm with each other

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and the rest of the school through a series of woven charts. It had such a positive impact, that the children decided to publish the story as a book, along with tips, pictures, and games, for other children who have been or will be affected by a hurricane. The book features a heart-warming story that will help children understand what is happening around them. It also contains tips for what to do before and after the hurricane, and games to keep children entertained during an evacuation or power outage. Mann's Miracles has also founded their own nonprofit corporation called the Hurricane Kids Network, which uses the royalties from their book to help children in other communities who also have been affected by hurricanes. *When the Hurricane Blew* is available for purchase at http://www.hurricanekidsnetwork.org.

THE GREAT GULF COAST CUISINE COOKBOOK

By Hurricane Katrina Survivors

The Great Gulf Coast Cuisine Cookbook was designed and created by members of Project H.O.P.E. in Jacksonville, FL, after the 2005 Hurricane Katrina catastrophe. This cookbook is a fun and innovative way of keeping tradition and culture alive, as well as building a sense of community among such an extensively displaced group of people. The recipes in this cookbook were contributed by Hurricane Katrina survivors from the gulf coast area who are now located throughout the Jacksonville area. Aside from tasty recipes like crawfish etouffee, smothered pork chops, and shrimp New Orleans, the cookbook also contains inspirational words of wisdom, a list of social service agencies and programs, emergency numbers, and other information that would be useful to hurricane survivors. For more information, contact SAMHSA DTAC at dtac@esi-dc.com.

COPING WITH THE HOLIDAYS: PROJECT RECOVERY

By Project Recovery—Mississippi

This helpful pamphlet is one of a series of informational materials developed by Project Recovery in Mississippi. The colorful pictures and simple message give survivors information about the types of reactions to disaster and the effect that holidays can have on recovery. In addition to tips and warning signs, the material reinforces the message of crisis counseling and frequently mentions the helpline number so that people affected by the disaster can get the assistance and services they need.

Conference Highlights

THE 22ND ANNUAL MEETING OF THE INTERNATIONAL SOCIETY FOR TRAUMATIC STRESS STUDIES

The 22nd Annual Meeting of the International Society for Traumatic Stress Studies (ISTSS) took place November 4–7, 2006, in Hollywood, CA. The theme was The Psychobiology of Trauma and Resilience Across the Lifespan, and focused on three major areas of interest to the field: A lifetime perspective on traumatic exposure risk, factors that influence resiliency as well as problems in the wake of traumatic exposure, and perspectives on the influence of genetic, biological, and psychosocial factors on posttraumatic response.

Presentation tracks featured a broad range of both research and clinically oriented topics. Tracks focused on subjects related to assessment, practice, early intervention, resilience, biomedical issues, media training, and children's issues. Research presented in a keynote address titled, Gene X Environment Interactions in Mental Health, offered some exciting insights into the implications of gene-environment interactions on intervention strategies in the field of mental health. Other presentation highlights included: Perspectives on Loss, Grief, and Resilience; Responding to the Clinical Complexities of Trauma—Promising and Novel Approaches for Screening and Early Interventions; and Resilience-Based and Trauma-Focused Interventions for Children Following Katrina: Clinical Issues.

The 23rd annual meeting is scheduled to take place in Baltimore, November 15–17, 2007. Details and registration information may be found at http://www.istss.org/meetings/index.cfm. Materials from the 2006 meeting can be found at http://www.istss.org/meetings/2006archives.cfm.

THE AMERICAN PUBLIC HEALTH ASSOCIATION'S 134TH ANNUAL MEETING

The American Public Health Association held its 134th annual meeting in Boston, November 4–8, 2006. More than 13,000 public health professionals attended the meeting which covered a wide variety of topics, including sessions that focused on mental health, substance abuse, and the public health and behavioral health impact of disasters. There was a significant behavioral health presence at the meeting with many attendees particularly interested in disaster-specific sessions. SAMHSA DTAC staff attended the meeting and participated in both mental health and substance abuse panel presentations.

The SAMHSA DTAC presentation titled, Public Health Arena: Substance Abuse Needs…Lessons Learned from the 2005 Hurricane Response, was part of the State Systems of Care substance abuse panel presentation. This presentation examined the differences between increased substance use, abuse, and dependence following disasters and offered substance abuse lessons learned from the 2005 hurricanes. The issue of substance use and abuse following disasters has received increased

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attention during the last 15 years. However, while the field of disaster behavioral health has benefited from large-scale studies describing the epidemiology of mental health disorders, still relatively little is known about the extent to which substance use, abuse, and dependence increase after disasters. An increase in substance use, abuse, and dependence following disasters constitutes a public health concern and can be linked to stress reactions, history of substance use, prior or current trauma, and other mental health conditions. Often, little is understood by service providers who assist disaster survivors about the unique needs of those in recovery.

Additionally, the 2005 hurricanes damaged or destroyed the substance abuse treatment infrastructure in many areas of Louisiana and Mississippi, forcing the closure of treatment centers and methadone clinics across the gulf region. During the evacuation, many patients who were previously receiving methadone maintenance therapy (MMT) either experienced withdrawal or had to negotiate dosages with new MMT providers. Attendees were encouraged to refer to the SAMHSA guidelines on emergency MMT dosing. The presentation closed with the following lessons learned regarding substance abuse from the 2005 hurricane season.

- Public health collaboration with substance abuse is critical.
- When possible, integrate substance abuse services into other health services.
- Post-disaster behavioral health responses need to incorporate access to MMT.
- Substance abuse prevention needs to play a greater role in post-disaster behavioral health service planning and delivery.
- Shelters need to allow access to 12-step recovery meetings and addictions professionals.
- Emergency licensing and credentialing standards need wide dissemination.
- Continued monitoring of the disaster behavioral health impact may be needed to assess long-term substance use and abuse effects.
- "If we don't ask, they won't tell." Post-disaster, behavioral health epidemiological studies, both short-term and long-term, need to incorporate measures assessing substance use, abuse, and dependence.

The SAMHSA DTAC presentation titled, Public Health Arena: Behavioral Health Needs…Lessons Learned from the 2005 Hurricane Response, was part of a panel focusing on the mental health impact of disasters. The presentation emphasized the importance of behavioral health preparedness and collaboration with other systems. Attendees were encouraged to think of behavioral health services as a critical part of the public health response to disasters. The 2005 hurricanes illustrated the need for behavioral health preparedness in response to survivors of disaster and to ensure continuity of operations of behavioral health service systems. The presentation also focused on the practical approaches that behavioral health, public health, and emergency management can take to enhance preparedness for catastrophic regional disasters. Core disaster behavioral health response principles were discussed as well as an overview of the national behavioral health response to Hurricane Katrina. Recommended approaches include continuing to integrate the behavioral health response into the mainstream response, improving systems for effective inter-State support through Federal-State and State-to-State partnerships, and utilizing an all-hazards approach to planning.

Announcing SAMHSA's Health Information Network

SAMHSA has a new clearinghouse, the SAMHSA Health Information Network (SHIN), which encompasses the National Clearinghouse for Alcohol and Drug Information (NCADI) and the National Mental Health Information Center (NHMIC). While it may have a whole new look, the goals remain the same—to serve behavioral health professionals and the public. Now you can get what you need from both clearinghouses by calling one number.

SHIN has an information specialist-assisted line for response to inquiries and requests related to SAMHSA programs, initiatives, and grants: 1-877-SAMHSA-7 (1-877-726-4727), Monday–Friday, 8:30 a.m.–5:30 p.m. ET, excluding Federal holidays.

Upcoming Meetings

FIFTH ANNUAL NEBRASKA DISASTER BEHAVIORAL HEALTH CONFERENCE

JULY 12–13, 2007
OMAHA, NE

Topics to be covered on the first day include: Responding to incidents of school violence; behavioral health implications of radiological incidents; organizational preparedness for pandemic or public health disasters; and self-care and the responder. A multidisciplinary audience is welcome on the first day of the conference. The second day of the conference will provide specialized advanced cognitive-behavioral therapy training for licensed professionals working with individuals after a disaster. This portion of the conference will only be open to practitioners with previous cognitive-behavioral therapy experience. Continuing education credit will be available for several professions. Registration information is available at http://www.disastermh.nebraska.edu.

CONTINENTAL DIVIDE DISASTER MENTAL HEALTH CONFERENCE

AUGUST 6–7, 2007
COLORADO SPRINGS, CO

The objective of this conference is to help bridge the divide between practitioners and scientists in the field of disaster behavioral health to increase the effectiveness of the care provided to those affected by catastrophic events. This conference will bring together professionals involved in providing assistance following a disaster with scientists who are researching issues related to disaster planning and prevention, response, mitigation, and recovery. For more information, or to register, go to http://www.uccs.edu/codivide. For other questions regarding the conference, contact Debbie Sagen at dsagen@uccs.edu or 800-990-8227, ext. 3843; or Beth Roome at elizabeth.roome@state.co.us or (303) 866-7410.

NATIONAL ASSOCIATION FOR RURAL MENTAL HEALTH'S 33RD ANNUAL CONFERENCE

AUGUST 9–11, 2007
KANSAS CITY, MO

The theme of this year's conference is, There's No Place Like Home: Jazzin' Up Rural Mental Health. The goals of the conference are to celebrate the rural identity and the fact that there is "no place like home" in rural and frontier communities; to continue paving the road for rural mental health services that are available and affordable to all; and to come together and share what works, learn how to

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fund, staff, and evaluate services, and network with other rural providers and researchers. Special focus areas this year include: All-hazards and disaster behavioral health response; returning veterans in rural and frontier areas; racial and cultural integration; children's, adolescents', and women's mental health; integrating mental health, primary care, and substance abuse; evidence-based practice; translating research into practice; research issues specific to rural and frontier areas; workforce development and training; community collaborations and systems transformation. Proposals for workshops, papers, posters, and roundtable presentations from researchers, policy analysts, consumers, family members, service providers, and volunteers are currently being sought. For more information, go to http://www.narmh.org/conferences/2007_conference.html.

FEMA E354 BASIC CRISIS COUNSELING COURSE

AUGUST 13–16, 2007
EMMITSBURG, MD

The purpose of this course is to prepare U.S. State and Territory mental health authorities and federally recognized tribal organizations to successfully complete Crisis Counseling Assistance and Training Program (CCP) grant applications to respond quickly and appropriately to disasters. The training curriculum is designed for personnel who are responsible for preparing the CCP grant application following a qualifying Presidential declaration of disaster.

AMERICAN PSYCHOLOGICAL ASSOCIATION 115TH ANNUAL CONFERENCE

AUGUST 17–20, 2007
SAN FRANCISCO

The purpose of the annual convention is to provide a forum in which members may present their scientific and scholarly work; present a general program that will be informative and of interest to all members of the association; facilitate the exchange of experience relating to the applications of psychology; and provide a place where the business of the association can be carried on efficiently. For more information, go to http://www.apa.org/convention07.

INNOVATIONS IN DISASTER PSYCHOLOGY 2007: PUBLIC HEALTH EMERGENCIES

SEPTEMBER 6–8, 2007
VERMILLION, SD

The University of South Dakota Disaster Mental Health Institute will hold this conference, intended for disaster mental health, health, and mental health professionals. The overall objective is for the participants to learn more about how to apply disaster psychology to public health emergencies. For more information, go to http://www.usd.edu/dmhi/conference.cfm.

THE AMERICAN PUBLIC HEALTH ASSOCIATION 135TH ANNUAL MEETING

NOVEMBER 3–7, 2007
WASHINGTON, DC

The American Public Health Association (APHA) Annual Meeting is usually attended by approximately 13,000 public health professionals, including mental health and substance abuse professionals. Many sessions focus on disasters and disaster behavioral health. SAMHSA DTAC staff participated in last year's APHA meeting and gave both a mental health and a substance abuse presentation on lessons learned from the 2005 hurricanes. For more information, go to http://www.apha.org/meetings/highlights.

INTERNATIONAL SOCIETY FOR TRAUMATIC STRESS STUDIES 23RD ANNUAL MEETING

NOVEMBER 15–17, 2007
BALTIMORE

This meeting is attended by the top researchers, clinicians, policy makers, and others in the field of trauma and posttraumatic stress disorder, focusing on disasters and disaster behavioral health. For more information, go to http://www.istss.org.

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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 Kathleen Wood at kathleenw@esi-dc.com.