2011
VOLUME 7, ISSUE 2

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 BEHAVIORAL HEALTH

SAMHSA DTAC Director's Corner

The New Year started off on a rather somber note for many of us in the disaster behavioral health field; the mass shooting in Tucson, AZ, in which six people were killed and 13 were wounded. The buzz of the media quickly brought to light the possibility of behavioral health issues in the shooter, and the tragic death of a 9-year-old girl, further intensified this tragedy. In order to cope with this news and to better prepare ourselves for future tragedies, many of us in the disaster behavioral health field were prompted to action. For example, our team posted several resources on online forums such as in the SAMHSA Disaster Technical Assistance Center (DTAC) Discussion Board, as well as within our Disaster Behavioral Health Information Series resource collections. In this issue of *The Dialogue* we also highlight an excellent resource created by Sesame Workshop geared to help families talk with children about coping when a loved one dies. Our colleagues have also contributed articles about how to adapt trauma interventions when working with refugee communities, how to recognize and treat vicarious trauma, and how to develop long-term recovery groups. As always, please remember that SAMHSA DTAC is available to any U.S. State, Territory, or individual in need of information, assistance, or training related to all-hazards disaster behavioral health preparedness, response, and recovery. Please feel free to contact us toll-free at 1-800-308-3515 or email us at *DTAC@samhsa.hhs.gov*.

Warmest Regards,

Amy R. Mack, Psy.D.
SAMHSA DTAC Project Director

Adapting trauma interventions for refugee families

Contributed by Abigail H. Gewirtz, Ph.D., LP[1], Johara Mohammad, MFT[2], Paul Orieny, Ph.D., LMFT[3], and Fatima Tuba Yaylaci, B.A.[4]

The U.S.A. provides a safe haven to tens of thousands of refugees each year who are fleeing armed conflict, instability, and related risks such as hunger and deprivation. Refugee families face significant acculturation challenges often compounded by traumatic stress associated with torture, rape, and other atrocities. Moving to the U.S.A.'s fast-paced, highly industrialized society requires new and radically different roles within families. Parents may—for the first time—be learning to read and write, to access medical and mental health care, and to raise their children as Americans. Children may become their parents' caregivers as they acquire language faster than their elders. The different roles can easily cause tension and conflict between parents and children.

Decades of research have shown that children in highly stressed families are affected not primarily by the source of the stress (e.g., war or poverty), but by the effect of the stress on parenting practices. When parenting is impaired, children's behavior suffers, and they are at increased risk for a variety of poor outcomes. Fortunately, evidence-based parent training interventions can improve parenting. A recent study reporting 9-year followup data from a randomized controlled trial of a 14-week parenting group for single mothers showed that improvements in parenting and child behavior were maintained almost a decade later among the group of mothers who participated in the program compared with those who did not, with perhaps the most surprising indicator of the program's success being an increase in socioeconomic status—the result, possibly, of a cascade of gains within the family system.

When parenting is impaired, children's behavior suffers, and they are at increased risk for a variety of poor outcomes. Fortunately, evidence-based parent training interventions can improve parenting.

Parenting programs provide the opportunity to engage immigrant families to strengthen children's outcomes and support learning about parenting in America. In the Minneapolis-St. Paul metropolitan area, home to the largest population of Somalis in the U.S.A., we have been working with Somali and Oromo mothers to modify and pilot Parenting Through Change, a 14-week Parent Management Training–Oregon Model (PMTO™) program. The intervention is empowerment-focused, providing key skills that are core to parent training, including problem

continued on page 3

[1] Assistant Professor, University of Minnesota's Department of Family Social Science and the Institute of Child Development

[2] Bush Foundation Community Leadership Fellow, Minneapolis, MN

[3] Psychotherapist, Center for Victims of Torture in Minneapolis, MN

[4] Ph.D. student in child psychology, Institute of Child Development, University of Minnesota

continued from page 2

solving, teaching through encouragement, effective discipline, positive involvement, and monitoring of children. We summarize some key modifications to the curriculum and "lessons learned" that may be useful for those responding to refugee families following disasters.

A first step was to ensure that the program's content did not in any way conflict with cultural or religious (in this case, Islamic) values. This helped to engage families as well as reduce stigma. Providing traditional food during the group encouraged mothers to feel "at home." A cultural broker, who also interpreted, provided a bridge for the communication of key ideas and experiences. Active learning techniques (role play, discussion, and visual material) helped to minimize the use of verbal and written language or "'teaching to" mothers in favor of practicing skills in group and at home. Culturally meaningful examples provided a normative context within which mothers could raise relevant issues such as the challenges involved in parenting multiple children and the effects of traditional gender roles on their parenting experiences. Mothers requested to conduct group at a slower pace than is typical, possibly reflecting cultural differences in preferred pace, as well as to allow for time to provide rationale for the skills taught. An orientation session was offered to engage mothers, normalize parenting struggles, and introduce key themes.

Guidelines for Working with Refugee Populations

Helping refugee families after disasters requires assessment of cultural needs as well as of their prior exposure (and vulnerability) to traumatic events. Based upon our work with East African refugees, we propose the following basic guidelines for disaster responders and communities who are working with refugee populations:

- Build trust by partnering with key community leaders before offering services to refugees. Be willing to learn from the community and culture.
- Include representatives of the refugee community or communities when developing disaster plans. Even among refugee communities from similar geographical locations there may be key cultural and religious differences.
- Don't expect families to trust government or emergency medical services workers; refugees from countries where government agents committed atrocities are understandably wary of "officials."
- Increase trust and cooperation by providing a structure for community members to communicate and support each other. Social support is critical in the wake of a disaster—and even more so for families who come from homelands where the village truly raised each child. Among Somali families, family, clan, and community affiliations provide essential support.
- Communicate with cultural brokers (who also can be interpreters), as they can help disaster responders to view the disaster through the cultural and religious lens of the refugee community. Particularly in the case of natural disasters, culture and religion might influence the meaning or interpretation of an event, and hence families' responses. Families who interpret a natural disaster as the wrath of an angry God, for example, may respond in ways that appear odd to an "outsider" with a very different understanding of such an event.
- Tailor existing interventions (e.g., Psychological First Aid) to the needs and values of the target community.

Much time was spent discussing and developing a rationale for the use of parenting ideas that many Americans take for granted. Highlighting and building on mothers' strengths—key group activities—had to be accomplished in a culturally congruent way; overt praise is considered to invite the "evil eye." Emotion-regulation skills were also taught, which were critical for parents suffering from traumatic stress. Traumatic stress symptoms (re-experiencing, avoidance, and hyperarousal symptoms) were seen to interfere with parenting by disrupting parent-child communication, particularly around parent-child conflicts.

Groups have been well received, with 85% retention. Data from two mothers' focus groups confirmed the interest in and need for parenting programs and highlighted future programming ideas. ■

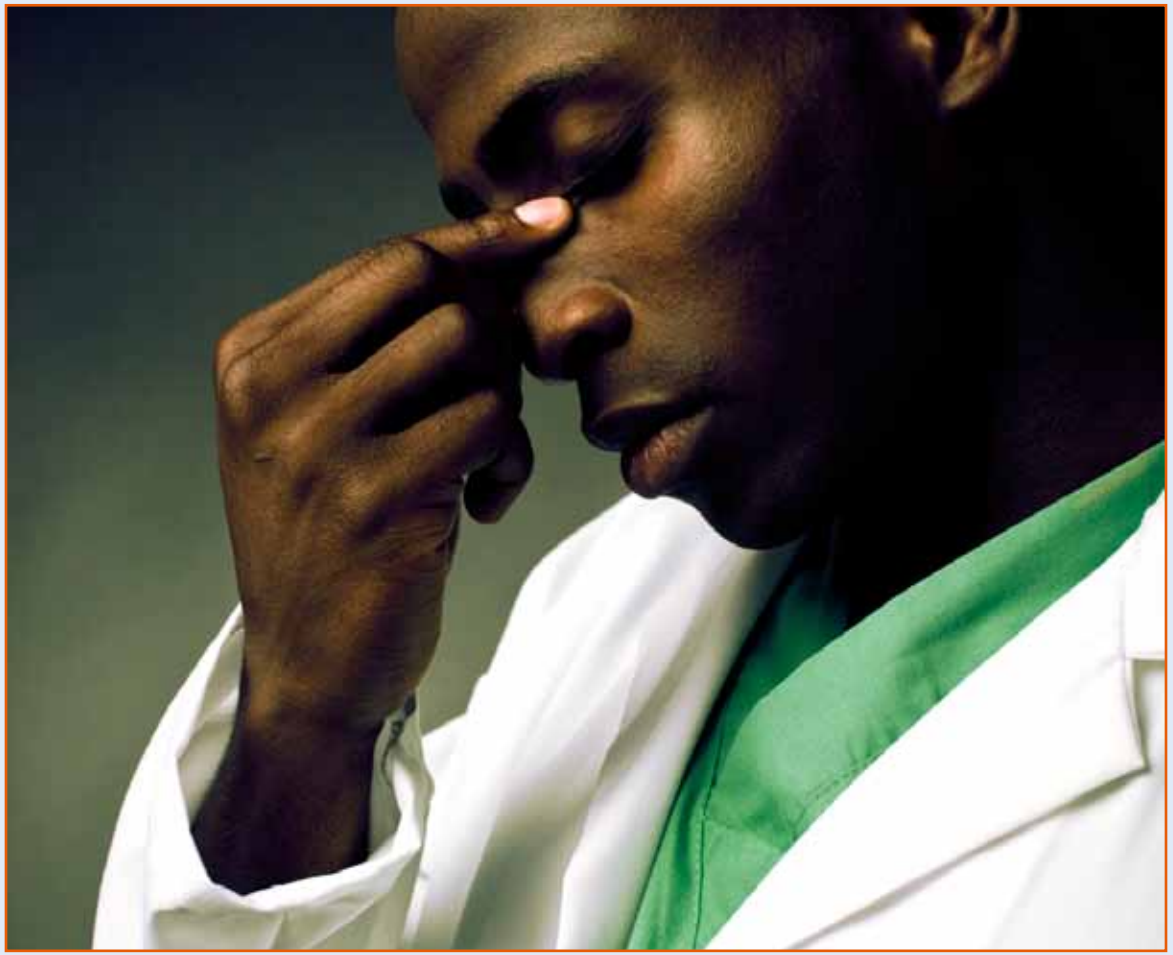
Special Feature
Vicarious Trauma

Contributed by Nora Baladerian, Ph.D.[1]

Vicarious trauma or secondary trauma is recognized as the impact of seeing, hearing, and smelling signs of the aftermath of disaster and interacting with victims of trauma, regardless of the source of the trauma. These images and experiences can contribute to overwhelming feelings of helplessness, emotional pain, fear, confusion, terror, etc. Symptoms of posttraumatic stress disorder can impact responders and/or witnesses. Vicarious trauma should be considered a standard job exposure risk to be addressed.

Literature informs us that vicarious trauma affects five major areas of one's life: a personal sense of safety, trust, self-esteem, ability to engage with intimacy, and a sense of control. When one's occupation or activities involve working in disaster scenes and with disaster survivors, he/she is "taking a chance" that mental health problems may occur. Proactively addressing the risk of mental health problems is essential in attempts to reduce the impact of exposure to traumatic

continued on page 5



When one's occupation or activities involve working in disaster scenes and with disaster survivors, he/she is "taking a chance" that mental health problems may occur.

[1] Consulting Psychologist, Westside Counseling Center and the Disability, Abuse and Personal Rights Project; Owner, Mental Health Consultants; Licensed Psychologist.

continued from page 4

stimuli. In addition, knowing a variety of strategies and techniques that can be implemented in the aftermath of a disaster, as well as keeping up with newer discoveries, should be part of a disaster responder's regular educational program. In many cases, it is not the knowledge of the strategies that is a barrier, but the implementation. The most prominent factor that creates the opportunity for mental health problems to develop is the failure of disaster responders to make the time for self-care.

Prevention

It is the responsibility of the administration of any agency to identify and prepare for the reality that the risks of any job may affect those doing it. For example, window washers are aware that equipment failures could lead to injury or death. In the same way, those responding to disasters or other emergencies must recognize and plan for the possibility that some may develop psychological problems.

Stigma regarding behavioral health (mental health and substance abuse) problems is rampant. Although there have been some excellent programs and campaigns to eliminate such attitudes and fears, stigma remains a strong and effective barrier to identification and treatment. Agency administrators should make effective and regular efforts to normalize behavioral health issues. Disaster response workers who are willing to discuss their feelings can lessen the impact of traumas they witness or experience and avoid more severe symptoms of depression, anxiety, or other aspects of posttraumatic stress disorder.

Disaster response workers who are willing to discuss their feelings can lessen the impact of traumas they witness or experience and avoid more severe symptoms of depression, anxiety, or other aspects of posttraumatic stress disorder.

The agency's administration should encourage self-care and can use local community resources to come to the work site to give in-service trainings on such. Administrative efforts to reduce the incidence of vicarious trauma among staff include workplace strategies. These strategies may consist of work assignments that are individualized to utilize each staff member's strengths and work schedule flexibility that helps workers balance their home and work life responsibilities. Open discussion during staff meetings of how administration is working to ensure a psychologically healthy environment can in itself reduce stress, in addition to helping staff to share, learn, and adopt new ideas. Cumulative stress builds when there is no opportunity to change focus during the work day. Therefore, it is essential that administration encourage and enforce labor-code standards for break times and lunch times.

Symptom Identification and Onset of Symptoms

Early detection and intervention is key to avoiding deepening of vicarious trauma. Thus, it is important not only for disaster workers but also for those in charge of the provider agencies to be aware of the signs of the onset of vicarious trauma. The box on the following page lists the most common signs that an individual may be experiencing secondary trauma. Note that these signal only that "something" is wrong, and they may be a signal of a different problem, such as onset of non-work-related anxiety, depression, or other condition. Nonetheless, if you familiarize disaster response workers as well as agency administration with these changes, they will be more likely to take appropriate steps to intervene

continued on page 6

continued from page 5

Signs of Vicarious Trauma

This type of trauma may begin with slight and then more serious changes in mood, energy, desire to come to work, and increased impatience with self and others.

You may notice the following signs:

- Onset of a sense of sadness
- Beginnings of depression
- Complaints of difficulties with sleep (going to bed, getting to sleep, and staying asleep) resulting in daytime (workplace) fatigue
- Nightmares or night terrors
- Changes in appetite (eating too much, eating for solace, eating less)
- Changes in social relationships (isolation or reduced interest in intimacy)
- Changes in relationships at home
- Noticeable change in level of anxiety
- Increased worry about oneself or one's family members
- Increased worry at work

The individual may report or experience the following symptoms:

- Onset of stress-related illnesses
- Headache
- Abdominal (gastrointestinal tract) distress
- Cold, flu, etc.
- Change in sense of humor
- Less enjoyment in life
- The sense that things that used to be of interest are no longer "worth it"
- Lack of self-care
- Slowed work productivity
- Lack of energy
- Intrusive thoughts of traumatic scenes
- Development of phobias (new fears of driving, heights, elevators)
- Marital discord
- Development of "super-responsibility" at home and at work

as early as possible if they notice the changes in themselves or someone else on their disaster response team.

When these changes are noticed in colleagues, or supervisors become aware of them, it is essential to meet with the individual to address the situation as soon as possible and encourage treatment options to be used, including both self-care activities as well as taking the time to meet with a psychologist or groups that deal with stress reduction.

One measure is re-evaluating one's priorities. This story is a good one to illustrate the point: A professor placed a huge empty mayonnaise jar on the table and filled it with golf balls. He asked the students, "Is the jar full?" Yes, they answered. He then poured in as many pebbles as would fit and again asked if the jar was full. Yes, they answered. He then poured sand into the jar and repeated his question. The students hesitantly agreed the jar was full. He then poured in 2 cups of coffee! The students were now sure the jar was full. The golf balls could represent family and loved ones, and they would not have fit if poured in last. The pebbles represent your career, income, and reputation. The sand is your stuff: house, car, clothes, and the 2 cups of coffee are those that you always have time to share with a friend, no matter how full your life becomes. Any of these items could fill the jar. In the right order they all fit together for a full and balanced life.

When disaster response workers are experiencing symptoms of vicarious trauma, it is time for treatment to begin. This should be funded by the agency and kept confidential. If a therapist is involved and the disaster response worker needs to be on a temporary leave from work, the therapist can provide the authorization.

Whether one is preventing or treating vicarious trauma, a variety of healing methods exist. There is no one-size-fits-all therapeutic approach, and how we think and feel differs based on many factors, including our culture, beliefs, attitudes, and preferences. ■

Formation of Long-Term Recovery Groups

Contributed by Jean Peercy[1]

The formation of a community-based long-term recovery-group (LTRG) is vital to the recovery of individuals and families after a disaster. There are many different issues that affect individuals and families during the long-term recovery process, and an LTRG can help the community address these issues in a holistic manner.

As a community moves from short-term recovery into the long-term recovery phase, the physical impact in the community may become more difficult to see. As outside resources decrease, there is often an increased impact on individual and family financial, emotional, and spiritual well-being. Many times after a disaster, a community will experience an increase in alcohol and drug abuse, domestic violence, sexual assault, and suicide. So it is important for communities to begin developing long-term recovery plans during the short-term recovery phase so that these varying needs can be addressed, and the community can begin looking forward to a "new normal."

An LTRG needs to come together quickly after a disaster to maximize staff, volunteers, materials, and monetary donations that are available in the aftermath of the disaster. The more varied the agencies and programs that are involved in the LTRG, the more varied and comprehensive the recovery response can be. The group's membership should also reflect the diversity of the community that was impacted, and should include local governmental, for-profit, and nonprofit agencies and program representatives that have resources available for the recovery. Many national agencies and programs will also help in the development of the LTRG and may be able to provide resources such as staff, volunteers, material, training, and best practices, but it is important to remember their resources are limited.

As the membership of the LTRG is identified, a decision will need to be made by the local community regarding whether the LTRG should function as a committee or an organization. Both structures work well, but the form that is chosen will have an impact on how the decisionmaking

continued on page 8

[1] Disaster Coordinator, Lutheran Disaster Response; Chair, Disaster Recovery Committee of National Voluntary Agencies Active in Disaster (NVOAD)

Ponce, PR, February 2, 2009—The Long Term Recovery Committees held their first General Conference in Ponce, where representatives of the Federal Emergency Management Agency (FEMA), local and Commonwealth governments, the private sector, and community and faith based groups shared emergency preparedness information, website tools, available resources, and current initiatives to effectively respond during emergency operations. Photo couretesy of Ashley Andujar/FEMA.

With a diversified membership, the LTRG will have intimate knowledge of the issues that will affect the recovery of individuals and families, and ultimately the community.

continued from page 7

and funding processes of the LTRG are handled. The structures are described below in greater detail. Regardless of which structure is chosen, the LTRG will need to include an administration to identify issues, processes, fundraising, and accountability. The group will also need processes for case management; construction management; volunteer management; donations management; emotional and spiritual care of clients, staff, and volunteers; media relations and communication; and advocacy for clients on local, State, and national issues.

A committee structure is less formal, with the various participating agencies funding and managing their own clients. In this case, when an agency's resources are inadequate, the client's needs are considered "unmet needs," and the client's case is then presented to the other agencies for help in meeting the need, whether financial, volunteer, construction, or emotional. Many times, a memorandum of understanding (MOU) needs to be established for thorough understanding of how the procedures will be handled between agencies. In some instances, the client may need to be presented more than once at the resource table before his or her case is complete. Project oversight and coordination will also need to be addressed, and with multiple entities involved, this can be challenging.

An organizational structure, on the other hand, is more formal and may require having its own 501 (c) 3, which takes time to develop and obtain. In order to create this structure, the agencies that are involved in the LTRG may pool resources or staff. The funding of client needs is usually done internally from resources received and managed through the LTRG, with project coordination and oversight done internally. One challenge that is often experienced is a concern from member agencies of losing their individual identities; to offset this concern, the LTRG should include materials that reflect what member agencies have contributed (individually and collectively) when reporting and communicating to partner agencies and the community.

A well-developed LTRG can and should look for different avenues of funding, grants, and programs, which will demand reporting and accountability. With a diversified membership, the LTRG will have intimate knowledge of the issues that will affect the recovery of individuals and families, and ultimately the community. The LTRG should be structured to best suit the needs in the community and maximize the resources available. As the recovery continues, the LTRG may also be interested in exploring continuing education and helping its clients become a well-prepared community. ■

RECOMMENDED RESOURCE

When Families Grieve

Sesame Workshop, the organization best known for its television show *Sesame Street*, has developed a set of tools called *When Families Grieve* to help adults and children cope when someone they know and love has died. According to the *When Families Grieve* homepage, this program "presents families' personal stories about coping with the death of a parent, as well as strategies that have helped these families move forward."

When Families Grieve features multimedia resources, including video clips with the Sesame Street Muppets and a story highlighting how one child remembers a loved one who has died. It also offers a guide for parents and caregivers to help them make the most of video resources in communicating with their children. The program also features a *Facilitator Guide* for behavioral health providers to use in working with individuals and groups. The guide lists several activities that *When Families Grieve* helps to facilitate, including "talking with children about death, helping children to express different emotions, remembering loved ones together, and beginning the process of moving forward." For each section of the program, the guide includes a summary of the story in the video, discussion questions, and activities and ideas to lead individuals, families, and groups deeper into video topics.

"Give Your Heart a Little Time" is one of the many videos available on the *When Families Grieve* website.

For more information on *When Families Grieve*, or to find out how to request a FREE *When Families Grieve* kit, please contact *grief@sesameworkshop.org*. All materials included in the Sesame Workshop When Families Grieve kit are available in English and Spanish. ■

http://www.sesameworkshop.org/grief

When Families Grieve Facilitator Guide

Upcoming Meetings

2011 National Hurricane Conference

April 18–22, 2011; Atlanta, GA

The purpose of this conference is to improve hurricane preparedness, response, recovery, and mitigation to save lives and property in the United States and the tropical islands of the Caribbean and Pacific. The conference is a national forum for Federal, State, and local officials can exchange ideas and recommend new policies to improve emergency management.
http://www.hurricanemeeting.com

Partners in Emergency Preparedness 2011 Conference

April 26–27, 2011; Tacoma, WA

The conference will be a forum to discuss the partnerships between businesses, schools, governments, nonprofit sectors, emergency management professionals, and volunteer organizations.
http://capps.wsu.edu/emergencyprep

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

May 11–13, 2011; Orlando, FL

This conference will provide an opportunity to discuss topics on emergency preparedness, risk mitigation, global risks and health, and pandemic and biological threats.
http://www.wessex.ac.uk/11-conferences/disastermanagement-2011.html

International Oil Spill Conference

May 23–26, 2011; Portland, OR

This purpose of this conference is to provide a forum for professionals from the international community, the private sector, government, and nongovernmental organizations to highlight and discuss innovations and best practices across the spectrum of prevention, preparedness, response, and restoration in the event of an oil spill.
http://www.iosc.org

19th Annual National Voluntary Organizations Active in Disaster (VOAD) Conference

May 24–26, 2011; Kansas City, MO

The conference will provide a forum for individuals representing Federal, State, and local VOADs to discuss collaborative disaster planning, disaster case management, pastoral care, and community resilience.
http://www.nvoad.org/avc

The International Emergency Management Society 18th Annual Conference 2011

June 7–10, 2011; Bucharest, Romania

The purpose of this conference is to improve preparedness and mitigation, to prevent disasters, and to ensure that the response and recovery regarding the psychological aspects of emergencies are consistent with the best available techniques.
http://www.tiems.org/index.php/tiems-2011

continued on page 11

ANNOUNCEMENT

Disaster Behavioral Health Specialist Position Open

SAMHSA DTAC has a job opening for a full-time Disaster Behavioral Health Specialist. The successful candidate will be part of a national TA center dedicated to the provision of disaster behavioral health preparedness and response TA to Federal partners, State and local disaster behavioral health stakeholders, and disaster behavioral health grantees. A master's degree in a related discipline is required, with a minimum of 5 years' experience in at least one of the following disciplines: mental health, substance abuse, social work, crisis counseling, public health, or disaster behavioral health preparedness and response. For the full job description and information about ESI, please visit *http://www.esi-dc.com/careers.htm* and click on Disaster Behavioral Health Specialist. ■

continued from page 10

World Conference on Disaster Management

June 19–22, 2011; Toronto, Canada

The purpose of this conference is to provide information on emergency management, business resiliency, risk management, pandemic planning, natural disasters, emergency response, and emergency health.
http://www.wcdm.org

National Association for Rural Mental Health (NARMH) 37th Annual Conference in partnership with AgriWellness

June 22–25, 2011; Dubuque, IA

The NARMH conference will bring together two organizations that serve the behavioral health needs of rural people to discuss effective programs and practices, explore new dimensions and directions, and dialogue about rural behavioral health and agricultural policy. The purpose of this conference is to promote accessible behavioral health services for at-risk populations affected by rural crises in agricultural communities.
http://www.narmh.org/conferences/2011/default.aspx

National Emergency Management Association 2011 Annual Conference

August 12–16, 2011; Des Moines, IA

This conference will provide a forum to discuss national and regional emergency management strategies with other emergency management professionals and experts in the field from around the country.
http://www.nemaweb.org/index.php?option=com_content&view=article&id=96&Itemid=211

The Fifth National Emergency Management Summit 2011

September 12–15, 2011; New York, NY

This conference will increase knowledge on how to prepare for disasters, use scarce resources wisely, implement responses more effectively, and create new partnerships, as well as discuss issues regarding pandemic planning and readiness, use of social media, and engagement of ethnic and socially diverse communities.
http://www.emergencymanagementsummit.com

American Public Health Association 139th Annual Meeting and Exposition

October 29–November 2, 2011; Washington, DC

The purpose of this conference is to unite the public health community in order to enhance their knowledge and exchange information on best practices, latest research, and new trends in public health.
http://www.apha.org/meetings/AnnualMeeting

Webinars and Trainings

Integrating All-Hazards Preparedness with Public Health

This webinar by the National Association of County & City Health Officials (NACCHO) features four demonstration sites that integrate all-hazards preparedness into traditional public health activities. This webinar has been archived at http://webcasts.naccho.org/session-archived.php?id=684.

Planning for Pandemic Influenza: Issues and Best Practices

This webinar by NACCHO features discussions on local challenges relating to vaccine distribution, isolation and quarantine, risk communication, hospital and personnel surge capacity, and community engagement. This webinar has been archived at http://webcasts.naccho.org/session-archived.php?id=505.

Psychological First Aid: The Role of MRC Volunteers in Disaster Response

This webinar by NACCHO provides an overview of the disaster mental health field and the role and evolution of psychological first aid. This webinar has been archived at http://webcasts.naccho.org/session-archived.php?id=823.

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

This webcast by the Maternal and Child Health Bureau within the Health Resources and Services Administration features resources and tools for pediatric disaster planning, lessons learned from the H1N1 pandemic, and perspectives from national stakeholders and partners in planning. This webinar has been archived at http://www.mchcom.com/liveWebcastDetail.asp?leid=414.

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

This site offers free Internet-based trainings developed by the UNC CPHP on public health preparedness topics such as disease surveillance; basic epidemiology; bioterrorism; diverse populations; disaster planning, response, and recovery; and emerging and reemerging diseases. The trainings can be accessed at http://cphp.sph.unc.edu/training/index.php.

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 SAMHSA DTAC at *DTAC@samhsa.hhs.gov*

ABOUT SAMHSA DTAC *Established by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Disaster Technical Assistance Center (DTAC) supports SAMHSA's efforts to prepare States, Territories, and local communities to deliver an effective mental health and substance abuse (behavioral health) response to disaster. SAMHSA DTAC provides disaster behavioral health preparedness and response consultation; develops resource collections addressing disaster behavioral health planning, special populations, and emergent topics; and supports collaborations between Federal entities, States, local communities, and nongovernmental organizations. To learn more about SAMHSA DTAC, please call 1-800-308-3515, email DTAC@samhsa.hhs.gov, or visit us on the web: http://www.samhsa.gov/dtac/*