Mental Health in Disasters and Other Crises
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Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode. After the presentation we will conduct a question and answer session. To ask a question please press star 1.

During the question and answer session we will request that you say your name organization and state please. This conference is being recorded. If you have any objections you may disconnect at this time. I would now like to turn the meeting over to Miss Alycia Downs. Ma'am, you may begin.

Alycia Downs: Thank you. Good afternoon and welcome to today's COCA conference call entitled Mental Health and Disasters And Other Crises.

We are very excited to have Dr. Marc Safran present on this call. Dr. Safran is a Career Medical Officer in the United States Public Health Service and a graduate of CDC's Epidemic Intelligence Service Training Program. He is currently CDC's longest serving psychiatrist.

Dr. Safran's work has addressed a wide range of cross-cutting public health challenges including infectious and chronic diseases, suicide and public health emergencies. And for many years he has led efforts to incorporate attention to mental health and disease into CDC's public health efforts.

We'll be using a PowerPoint presentation for this call that you should access from our Web site. If you've not all already downloaded the presentation please go to www.emergency.cdc.gov/coca. Click on Conference Call Information Summaries and Slide Sets and you can find the PowerPoint there.

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This presentation does not involve the unlabeled use of a product or products under investigational and there is no commercial support. I will not turn the call over to Dr. Safran. You may begin.

Marc Safran: Thank you Alycia and good afternoon everyone and thank you all for joining us for today's call.

I'd like you to go to the title slide now. And I'm going to ask your help in making this an interactive session although you won't be able to talk during the first half of the session.

I need you to actually on each slide, each slide is designed to basically encourage you to think about a particular concept and how it might relate to your particular situation and role in an actual crisis or disaster.

And so when you're looking at these slides I want each of you to jot down at least 1 point next to each slide. And if we've move on to the ground rules now, that next slide you'll see that I'm going to basically present for the first half.

But I consider this really an interactive and joint presentation among all of us. So the second half of the presentation will be all of you sharing ideas and basically sharing either experiences that your organization has had and that you want to share with others for some guidance or just challenges that you'd like to pose to others and also sharing new things that you've thought of during the course of this call that maybe you haven't thought of before regarding how mental health may impact upon your role in an actual crisis or your organization's role.

So that said, one other thing I want to make clear is that in order to make this work and because we want to have an open dialogue and we want to encourage thinking outside the box, no one is bound to limit themselves to statements or views there are approved by their organization. And these slides that I'm sharing and anything I'm going to say isn't necessarily approved by CDC Public Health Service or Department of Health and Human Services or the US government, so want this to be a clear open discussion.

And moving onto the objective slide. What I'd like everyone to try to focus on is - and over the course of the presentation I'd like each of you to try to write down at least a couple of examples of how mental health and/or mental illness may income impact the outcomes of disasters and other crises and also to identify at least one aspect of your own organization's emergency planning or an organization that you're familiar with that may not adequately take into account issues related to mental health.

And finally I want you to consider a strategy that you can use in your professional role to be able to recognize and respond to issues related to mental health.

And particularly you're not going to be able to respond to or recognize all of the issues. No one will. But the idea is to have some kind of strategy that will remind you to remember to at least consider and look for these issues.

So moving onto the next slide. We talk about mental health all the time. But it's important to just think for a second about what mental health is.

And there are many definitions. The Surgeon General has defined in the past mental health to be a successful performance of mental functions in terms of thought, mood and behavior. And it's noted that this result - that mental health results in productive activities, fulfilling relationships and ability to adopt and to cope.

I want you to look at this slide really carefully and think about that. Because ultimately in any crisis or disaster not only will the impact of the crisis or disaster upon the people in the population that you're trying to help be impacted by mental health, but your own, I mean all of us - each of us has mental health, each of us will in some way be impacted.

And each of the people that we work with and each of our colleagues and organization's ability to respond will be impacted by mental health.

Sometimes it will be impacted in positive ways, sometimes in negative ways. But if we're not thinking about that we can totally miss an important part of the picture.

So I want you to think for a second about how mental health has or might impact your organization in a crisis.

Now moving onto the next slide, mental disorders. Mental disorders are specific conditions. They're medical conditions that have been defined the overtime and that actually are health conditions just like any other illness that are often treatable, very treatable.

But what I want you to think about here is what impact mental disorders can have, particularly if they're not treated or not adequately treated.

And so there are many definitions of mental disorders. But right here we'll just think of mental disorders as health conditions characterize by alteration and thinking, mood or behavior that are associated with distress and/or impaired functioning.

Think about that. And think about how basically experiencing symptoms of a mental illness can impact upon your organization's response you're, you know, any one - any individuals response or an organization's response. Think about how it can impact on the people who are being exposed also to the crisis or disaster. So those are key points.

And there is the diagnostic and statistical manual that detail specific mental disorders. And many of them are familiar with depression bipolar disorder, post traumatic stress disorder - - many others.

The - now we're moving onto the next slide. The prevalence of mental disorders in the United States has also been widely estimated at a variety of different figures. Well from the Surgeon General's report on mental health, we'll use that number that was arrived at. And it's basically 1 in 4 Americans

in any given year will have a mental illness if you include alcohol and substance abuse.

If you don't include alcohol and substance abuse it's 1 in 5. But either way you're talking a large segment of the population.

So again, and this may seem really basic but when you're planning your organization's or your personal response to help in a crisis or a disaster, are you thinking about the fact that 1 in 4 of the people that you're going to be trying to help has a mental illness and how that might impact?

And you're going to be considering the fact that 1 in 4 people in your organization probably have a mental illness.

And - now the fraction of people - we'll go on to the next slide. Another thing that probably many of us are not thinking about is the fact that it's estimated that about 2/3 people with mental illness do not seek treatment. So how will that impact upon the crisis and the people being exposed to it and how will that impact on your organization's response?

And this is a real tragedy because mental illnesses are treatable. And most people will benefit from at least in some way from treatment. And so it's in non-disaster times it's important and disaster times becomes even more important.

Now moving on again, the next slide. There's a picture of the brain that you're looking at right now. And this is to remind all of us that the brain is a very complex - this time it's a very complex organ just like any other organ but yet we tend to neglect that aspect of health that deals with - that involves the brain.

And so in a crisis this becomes even more important because everyone's brain is affected differently by stress. And everyone's brain is affected differently also by things that disrupt their normal routine.

I mean think for a second about your own normal routine and think about what things that you might end up doing or not doing in a crisis that might impact on your ability to carry out your emergency roles as best as you can. And then think about that for everyone else.

Now the next slide shows a picture of a large number of medication pills. And that's to remind us that medications, they're just one part of treatment for some mental illnesses. But there's for people who are taking medicines that have helped to stabilize their illness and that are doing well with their medicines, what's going to happen in a disaster or emergency when people may no longer be able to access medicines either at the pharmacy or they may not be able to get refill prescriptions because communication is down, what will happen?

And think of - need to think of how that might impact even some of your own team that you're counting on to respond.

So and this is a very tricky issue here because, you know, on one hand, you know, we have concern that sometimes people prescribe too many medicines and you have medicines that people overdose on because they have these huge - people, you know, may have huge supplies of medicines that just sit. Also they may get diverted.

But that - but the problem is that lots of people who are responsible about the medicines and would never misuse them or never, you know, wouldn't

attempt suicide or would never sell them to anyone else, lots of people basically, you know, because we're so cautious we keep everyone to exactly the amount of medicine they need till the next visit.

What happens in an emergency when maybe they can't get medicine now for two weeks? So maybe they wouldn't have -maybe they would have handled it okay but now we've created a separate emergency for that person because no more medicine.

So again, this is just one example. I'm trying to - for this part of the call just harp on some really basic examples that are just meant to get you thinking about how these things impact you.

Now if you look at HIV AIDS, the next slide, the reason I have this slide up there is to remind us that we're giving out public health information all the time for any disease.

And in a crisis or a disaster we'll often set up our hotlines and Web sites to give out information to help people through that crisis.

We've learned in the past from various experiences, particularly our experience with the National HIV AIDS Hotline back in the 1990s which was the largest public health hotline in the world that we can't exclude mental health. And we can't just neglect it in giving out information.

And at that time that was an information hotline. And because it wasn't' a counseling hotline it was just an information hot line, it was thought that it was okay to not train the people staffing the call in how to work with people with mental illness or with mental health needs or how to refer them, how to refer people for mental health help.

And so that wasn't done. And there were problems. The hotline wasn't handling the calls well. And it turned out that about 12 - I think it's about 12% of the calls when we evaluated turned out to be mental health related or - and the (staff hand) on the calls were having a hard time because they weren't trained.

So when we added that training it made a big difference and it basically helped the people who were handling the calls to feel better about their work.

And it was, you know, basically you look at that way, 12% of 1.5 million calls a year were now being handled with people who knew how - by people who knew how to handle those calls.

So basic point again, something that you would think everyone would have thought of, but even in a big hotline like that which was one of the best in the world we thought that was something we missed. So something to think about in your emergency planning and hotline.

Next slide is about - it shows some reminders back from the anthrax crisis. And it's to remind us that when terrorism happens -- it can take any form -- but oftentimes one of the biggest ways that terrorism will impact every one is the mental - the emotional effects on people.

Of course it will kill people and it's very dangerous and that's a huge - I mean obviously we're trying to contain whatever -we're trying to protect the population against terrorism.

But we also have to keep in mind that the mental health impact is huge.

And Anthrax fortunately did not reach the whole population but it created havoc and fear across the country even, you know, for those who were not killed and did not have loved ones who were killed.

So think about how we're going to handle the mental health piece of the next crisis.

The next slide that we move to is there only to remind you. It's about adult domestic violence. And its to remind you that, you know, usually we think about crises as - and disasters as big things affecting huge numbers of people. But sometimes they can be big things affecting just a family or one or two people.

And domestic violence is just an example of how oftentimes these are public health issues that are off our radar screen. And at the - basically at one time only half of all medical students in the US and Canada were ever even trained about adult domestic violence formally. And that was a big issue.

So the point is any issue could be a big issue and could become exacerbated in a crisis.

The next slide deals with suicide clusters, another type of crises. And one of the things that - one of the things that's clear in suicide clusters is oftentimes they go unnoticed initially because people aren't looking for them or don't want to notice them. And then when they are notice often people don't know how to deal with it what to do next.

And sometimes some of the things that people do to respond to these actually make them worse.

And suicide clusters are just one example of where the way that we communicate our messages can be very important if we're to avoid actually further traumatizing populations and actually exacerbating the contagion of the problem.

My next slide is to remind us of this hurricanes and the more devastating on a large scale across wide areas -- that type of disaster that disasters that do that -- and to think about in those situations - and, you know, those of us who've been out, you know, responding to the aftermath of a hurricane, we know that all of the systems that we count on or most of them are knocked out.

And, you know, the question is, you know, what - certain things that people count on whether it's the mental health system or just routine healthcare may not be available.

So what do we do and just who will we talk to?

Now the next slide is to bring us back to sort of a peaceful tranquil regular everyday setting today or any day just when there's no disaster going on in your community.

This is a time to be thinking about who are the people that are going to come together, you know, in the face of a disaster?

I know that as clinicians interested in emergency response you all know this. But how many of you actually know who all the key mental health players are that you would involve in your disaster response or in, you know, in your response to the emergency?

And really what I want to encourage is for everyone to think about who those

players are. And don't just know one because you never know in a disaster that person or that organization could be out of commission for whatever reason.

So now is the time to be going to lunch with the folks that you'd be working with in mental health, getting to know them, getting to understand about their part. Because if you're not a mental health expert you may not be able to necessarily figure out how to address every single mental health problem that's going to come. You probably can't.

But at least if you can learn to recognize and refer or at least consult an emergency that's going to help a lot.

Now in terms of resources there are lots of resources out there. I'd - the next slide just gives you the CDC mental health Web site. It gives some links to some very helpful or some actually interesting public and private sector Web sites.

And then the next slide after that is - includes some resources from the Substance Abuse and Mental Health Services Administration which is the Lead Mental Health Services agency in our country.

And SAMHSA shared with me these Web addresses that may be helpful to you in a crises. One of them gives information actually about the mental health coordinators. And I'll be talking a little bit more about those in a minute. And there's information about other resources.

But also SAMHSA contracts with private services to provide a National Suicide Hotline and also a Treatment Referral Hotline.

In addition, the SAMHSA Web site and also the CDC Web site has links that there's - gives links to actual lists of mental health resources in the state. So these are starting points.

Keep in mind that the hotline numbers I give you from time to time it's possible they could change just because they're privately contracted outlines. So you periodically may want to just check the SAMHSA Web site and make sure there've been no changes there. But these have been - these numbers have been in existence for a while.

The next slide is about state and territorial disaster mental health coordinators. And these - every state is a little bit different.

Some states have a very active state or territorial disaster mental health coordinator and actually have a very active state mental health authority which the coordinator may be part of in some states.

And in such states the state mental and behavioral health managers and coordinators, they will actually partner with other statewide emergency response professionals. And they'll be involved in the exercises. And they'll actually be part of the plan for the response.

And SAMHSA actually - that's a SAMHSA program, the state mental health coordinators and that SAMHSA gives mentoring to them. But each individual state makes its own decision as to what role these will play and what level of support. But these would be key people certainly to talk to and be aware of in your state.

And the next slide is meant as a challenge slide. It actually doesn't include all - it's not meant to include all of the key people that you need to know in your

local area.

But here's just a couple of examples of key mental health Resources that you might want to be aware of. And certainly the Red Cross often plays a big role in mental health emergency response that local hospitals may, local emergency services and a lot more.

And so the question is who are those players in your community and in your states? And would you know how to get in touch with them in a crises?

Now moving onto the next slide I want you to be thinking now when you're assessing a situation in a crisis or any kind of disaster and you're figuring out whether it's in your local organization - whatever organization you're a part of whether you're a clinician in a private practice -- whatever role you're playing, when you're assessing a disaster or a crisis situation, are you thinking about mental health as a part of that?

And what - I want each of you to sort of come up with a way that you can remind yourself to include mental health in that assessment and to basically - to also know how you're going to try to get help if possible if you get into a mental health situation that's beyond what you have the expertise to address.

But really at this point I think each of you will have your own unique situation and your own unique experience.

And I thought I would do something as I mentioned in the beginning that's different than what we usually do in these calls in that I really thought that rather than me talking for the whole hour I thought it would be much better to use the second half to actually have each of you share, you know, we all share with each other, some ideas.

So I'd like to refer you back to the objective slide back near the beginning. And it's the one that basically reviews those objectives.

And so I want you now when we open up the phone lines, to come forward with examples, unique examples that people may not have thought of or ones that were really important to you or ones that you've just thought of about how mental health and/or mental illness may impact the outcomes of disasters and other crises.

And also when you've been writing down those aspects of your own organization's emergency planning that me not adequately take into account issues related to mental health, now's the time to share them.

And also if there's any particular strategies that you found helpful professionally to help you to recognize and respond to issues related to mental health.

Keep in mind what's right for one person or one organization or state won't necessarily be right for another. So these are just sharing of ideas. It's not - and don't be reluctant to share just because you're not sure if the question you're raising is a (soft) one. This is going to be a open dialog now.

So - and certainly also if anyone has any questions for me this is a questions and answers and discussion is what we're going to be focusing on now.

So I thank you for sticking with me for that first half of the talk. And now to me the most exciting part is what's to come now.

So we're going to open the lines. And I'll be - and when you do introduce

yourself just to help give us some perspective of who you are and where you're coming from, if you could just share your name and organization that you're with and your state or if for some reason those three don't apply then at least two of those and maybe tell us something else about you and your role. Thanks a lot and let's open up the lines.

Coordinator: Thank you. We will now begin the question and answer session. If you would like to make a comment or ask a question, please press star 1. And please clearly record your name, organization and state.

To withdraw your question or comment you may press star 2. One moment for any questions or comments please. And again, if you would like to ask a question it's star than 1.

Marc Safran: Keep in mind we purposely kept everything very basic so that it would be applicable to all fields.

And because these are the kinds of things that even though they may see obvious they often get forgotten in a real crisis.

So just feel free to open up and share your thoughts and experience or questions.

Coordinator: Your line is open.

Question: Thank you. Thanks very much for hosting this program. I think it's really wonderful to be disseminating this information and getting people together to talk about it.

I'm wearing two hats. I've I'm in the Department of Psychiatry at a medical

school as well as very active in disaster relief for the American Red Cross.

And one of the things that I was really glad to hear that you raised was the issue of trying to help identify the mental health resources in communities and to disseminate that information.

I can tell you that as a disaster responder going into areas, mental health leads, we often spend an enormous amount of time trying to identify community mental health resources to assist us as we are triaging and trying to bring services to people.

The - of course sometimes the mental health services themselves have been disabled. But a lot of times there are existing and functioning mental health services. But it is my experience that 90% of the time even when you reach out into the community, the community does not know who is taking the lead and who is responsible.

A lot of the people that require the greatest services are those with the least resources.

And so trying to organize a way for mental health responder to identify a mental health resources would be enormously helpful. And even if state leads are identified I can't imagine trying to get through on their phone line during a disaster.

So I'd be a real interested in hearing about existing resources for identifying that or ideas on how we might disseminate - identify and disseminate it more.

Marc Safran: Those are great points. And the question how to basically identify and disseminate the local resources better. And the Red Cross, thank you for all

the work that you do.

Of course the Red Cross ends up being at the core of a lot of the local responses.

One thing of course that sometimes happens is if a disaster hits a community so badly it's possible that even the local chapter of the Red Cross could be, you know, pretty much destabilized at that point. And so that's where the national organization of the Red Cross, you know, they come in and all - it's wonderful.

But I think your point is good. If we just count on the state to come in and fix the problem that won't help. Each local community needs to basically have an organization and know what the resources are too. And the idea is to link everything together.

But I - before I think you're still on the line. Before, (Joan), before you leave, did you have any suggestions as to how that might better be done or was that more of a question for everyone?

Question cont'd: I know that with increased preparedness efforts over the last several years communities have been urged to identify their mental health structure in the community and what the plan of action will be. I know some communities are doing it, others probably less so.

But when the disaster hits, a lot of times, of course you've got your local mental health responding. But that tends to be insufficient. So you have a lot of people coming in who are unfamiliar with the community.

And as I said in my first comment, even when my experience over and over

again, is even when you connect with the local mental health people, they oftentimes have no idea what the community plan is for a disaster mental health response.

So it is an enormous amount of work networking trying to figure out what that is in order to deliver services.

One would think that at a - initially at a state level and then perhaps even at a national level there could be a clearinghouse for this information. I understand it would be challenging to keep it updated. But it would be better than starting from scratch when you go into a community.

Marc Safran: That make sense. And that would be a good thing to I think for us.

The - and you raised another good point. And thinking about it, you know, one of the complaints actually I've heard from states as well as local communities is, you know, when all the people just suddenly come in and overwhelm a place and don't really know about the local needs and don't - and actually don't even know sometimes about who's actually in charge. And sometimes it can create havoc that way I know.

But so that's a good suggestion. So we'll - I can pass that on. And I'm wondering if anyone on this call actually has further suggestions or even maybe even working on something like that maybe we don't realize. But I will pass that on. I will pass that suggestion on.

But other comments, other callers? I thank you very much for sharing that. That's very good.

Coordinator: Yes. Our next line is from the Midwest Public Health in an Emergency. And

he‘s an officer. Your line is open.

Question: Thank you. Dr. Safran, that was a great presentation. Can you hear me okay?

Marc Safran: Yes. Thank you Captain.

Question cont’d: I’m on the hands free. I just wanted to pass along, my opinion is towards mental health issues, you know, you’re going to have the - and I’m not sure that correct term now. You may be able to - the worried well, they’re going to show up, you know, in any kind, whether it’s a biological, chemical or a natural disaster. You’re going to have the people that have, you know, the psychosomatic type symptoms that show up and just want to be seen. And then you’ve got the grieving that’s going to go on afterwards.

And in my opinion, the recovery of mental health illnesses going to take longer, you know, like 9/11. People are still suffering from the post traumatic issues with that.

So what kind of long term? You know, we always think of immediacy here in the United States. You know, we’ll get it fixed and it will be done and over with.

But, you know, when you’re triaging people for actual physical illness, triaging for mental issues, is there any kind of cookbook that’s been created that could help a layperson to look at, say okay, we don’t see a physical injury here.

Is there some kind of step book that could be used or created to help people to align people with the right resources so if we know that they need, you know, a Chaplin type situation, if they could go that, if the need mental health

because their medications like you pointed out so correctly, their medications like you pointed out so correctly their medications have run out, see how we could triage them and get them to the different points that they really need to be at instead of grouping everybody for mental health issues to sit and stand in line which would seem to me to be a waste of time? Has anything like that been created?

Marc Safran: That's a good comment. I know that there's several - well several different things and on several different fronts. Basically there's various models or variations of various models that have evolved around mental health first aid and training that could be given around that, the idea being that just like we have first aid that people can learn for - to do for, you know, minor cuts and bruises and more serious injuries.

There also should be a foremost first aid for mental health. And so there are models out there for that.

There's also the issue of various organizations, the American Red Cross, the Public - the SAMHSA and Public Health Service have each been, you know, working and trying to figure out how to better address those issues.

And if you look on those are - well at least the SAMHSA Web site and a little bit on the CDC Web site -- not a lot at the SAMHSA Website -- I think - I don't know if the Red Cross has information now on their site. The World Health Organization at one time has information on their site. But this is an area that's actually actively getting attention. People are actually working to bring these models out there and get people to basically be able to use them.

So that - because we know that in a severe crisis -- and you raised a couple of different points actually Captain. I mean there was the one point that you

raised about needing sort of a - some basic how to, you know, things to do in a crisis. And then it was also the triage issue which actually is something that we've been working with in our public health service emergency response teams, you know, preparing for how to triage in a crisis. And actually that's a complex issue.

And we don't want to of course - and you brought up the worried well. And that's actually an interesting issue there.

We have to be careful. It's a very - the worried well that it sounds easy. But it's actually a much more complex challenge than it would seem because one of the problems is in an emergency, we don't always know right off of bat who really actually is experiencing severe mental health problems. I mean we don't always know who the worried well are and who the people are who really, really need help. It's hard to initially know.

And sometimes - and keep in mind, it's not like an injury to the arm where you can tell if it's bleeding or broken or not. Sometimes it's not that easy to tell at first glance and without a lot of training.

So the challenge to these models is to basically try to tell people things and teach people things that they can use in these emergencies to do the best they can.

But it's important not to stigmatize and also to keep in mind in a crisis sometimes the confidentiality issues, you know, may still be important to people. And even though, we may think oh, it's a crisis, it's a severe emergency and so confidentiality doesn't matter, they may be someone who's got a severe mental health issue who just isn't telling you because they're kind of keeping it to themselves. And maybe you don't really know why they're

there and why they're kind of hanging around but maybe there's something really serious.

And an example sort of on a different - actually this reminds me of a situation I once was exposed to when in a hospital I was on call late at night. And it was - oh it was just one of these awful night's where you're up all night and it's just I'm really tired.

And then at some point I heard a page overhead that they were looking to know if anyone in the hospital spoke Spanish. They needed someone who did. And then they were asking around. I was doing a consult in the area. They were asking around.

And I thought well most - at the time I thought will my Spanish isn't, you know, the best and they probably have someone to speak Spanish better. But it turned out they didn't.

And what they told me was - I said sure I'll do it. So they told me that a oh, you just need to talk to this person. It's a woman who's here to visit her husband in the emergency room. And she's just, you know, worried about them. And she's - and we're trying to tell her it's after visiting hours and she needs to go home.

And I guess they were saying that her husband was in the hospital was admitted somewhere, whatever. And she was in the emergency room trying to get to see her husband. And they wanted me to basically explained that she'll have to come back tomorrow or something like that. And they said she only speaks Spanish.

So I started talking to her. And what it turned out was that - and this is -

turned out that she actually was not there because she wanted to visit her husband in the hospital.

She was there because she had been beaten by her husband and she was concerned - I mean she was basically injured and beaten by her husband. And she had nowhere to go. And she was there seeking help in the emergency room.

And they were just basically labeling her as just this person who was just worried about her husband and needed to just be told to go home and come back in the morning.

So my point in bringing that up is that we always have to be careful about who we label the word well.

But on the other hand it is true that if we don't have a good triage system and we just, you know, basically we only have limited resource in emergency we need - there are a lot of people that will come that don't really need help. We need to figure out who does and who doesn't.

So I'm kind of long winded answer but your points are really good. And hopefully we'll get better at this in the future.

Question cont'd: Am I still on?

Marc Safran: Yes you are Captain.

Question cont'd: I just wanted to ask one last thing and I don't know this. Does the SNS, the Strategic National Stockpile, do you know if their stocking any medications, anxiety relief, you know, antidepressants, anxiety relief, you know, like a

Xanax type situation that, you know, in a mass situation you could well imagine some people are going to need to be calmed down. Do you know if those are being stockpiled?

Marc Safran: You know, that's a really good question. I actually once a long time ago knew the answer to that and I actually don't know. So that's actually a good thing that I need to find out. I don't know and I will find out for you.

And if you - if there's a way that...

Alycia Downs: Yes. If the inquirer can just send an email to COCA at cdc.gov. That is coca@cdc.gov. We'll coordinate with Dr. Safran and get that answer for you.

Question cont'd: Yes I really - my job, I'm the Public Health Emergency Officer for the 16 state Navy region here in the Midwest. And we're really coordinating a lot with pandemic influenza, possibly outbreaks and other public health issues that could arise and, you know, in the event of a natural manmade or a terrorist disaster.

And all these issues are just bubbling around with mental health aspects of it. So your comments and everything have been very much appreciated. Thank you so much.

Marc Safran: Thank you so much Captain. And see that's a good example how here even, you know, I don't even know what the exact psychotropic meds that we have in our stockpile right now. And so it shows you all this can - there can be things that we don't know.

So we need to - that's part of the point of this call is to get us to think about those and that we will know in a real crisis. But thank you again for that

Captain.

The next question, caller.

Coordinator: It comes from New Hampshire Disaster Behavior Health Coordinator. Your line is open.

Question: Thank you. And I appreciate your presentation today Dr. Safran. I represent disaster behavioral health coordinators. There's one of us in every state. And when I say represent, I think we're all different and unique in our own ways from being, you know, part-time to full-time, different sources of funding, different locations.

I myself then located in the Department of Safety Homeland Security and Emergency Management. Most of my counterparts are in either public health or behavioral health.

We were, some have been around for many years and others are fairly new. SAMHSA initiated through a capacity enhancement grant the development of 35 systems around the country after the events of 9/11.

And typically I think we see our role is to respond to certainly the large scale events like the terrorism related events or bioterrorism threats, natural disasters, but even small scale incidents as you pointed out, a single death of a child in a school can have a - ramifications and impact so many different people.

We really partner with I think local responses which typically whether that's a hospital or a school system or a city or town aren't built to manage the behavioral health response to a community's needs because, you know, it's

very expensive to. And typically they need resources beyond their own.

And a lot of local responders might be impacted by the event themselves or they are victims or survivors in their own way.

So and this is where, you know, state resources and in some cases where there's a presidential declared disaster through FEMA, federal resources.

In our state we have about over 650 behavioral health professionals who have volunteered to respond to disasters. And we typically partner with some of those groups you mentioned -- Red Cross, community mental health centers, other existing critical and stress debriefing teams, you know, behavioral staff from schools and hospitals.

And when we're requested by a local municipality to offer assistance through these volunteer teams we do. And so far it's been a really win, win relationship I think for our team members who want to contribute to the recovery of their communities as well as for the communities to be able to receive outside help.

So in a nutshell that's sort of what it is. We do get a lot of support from SAMHSA DTAC. And if you want to know who the state coordinator is, if you go to the SAMHSA DTAC Web site there's a list of the contact information for the disaster behavioral health coordinators in every state.

Marc Safran: Thank you very much. I really appreciate your coming on this call to share that. And everyone, you do have that slide with the DHAC Web address, DTAC I'm sorry, Web address in your slide packet. And I recommend that all of you look at that and find out what it is that your state coordinator is doing around behavioral health and how you might relate to that. Thank you very

much.

Question cont'd: Thank you.

Marc Safran: Next question.

Coordinator: Yes, Virginia Department of Mental Health.

Question: Hi, can you hear me? Hello, Dr. Safran?

Marc Safran: Yes I can hear you very well. Thank you.

Question cont'd: Great. And I am also with the Virginia Department of Mental Health. And I managed the 9/11 mental health response to the terrorist attack on the Pentagon.

And I'd just like to say ditto to my friend from New Hampshire because I was calling in to make the same points that it's really important for people to understand that under the national response framework there is a system in place to deliver disaster behavioral health services. And it does come from the state and local mental health authorities.

And many of the states are now developing volunteer cadres or trying to find better mechanisms for coordinating volunteers. So it's really important for people who want to participate in the response to be coordinated with these agencies who do have the legal responsibility to respond.

And I'd like to thank you very much for all the great publications CDC has produced under disaster behavioral health science 9/11. In Virginia, we have relied on a lot of those publications and we have developed a lot of our own

for our state.

And I recommend anybody listening to go to their state Web sites because they'll probably find their state has also developed a lot of disaster behavioral health materials that have been adapted from CDC and SAMHSA materials specifically for their state.

Marc Safran: Thank you very much. And one, can I ask you one question while I have you on the line? This is very helpful. I don't mean to put you on the spot but can you think of if, you know, as a state mental health coordinator, is there one if you were going to share one suggestion with folks out and the fields who are trying to prepare their, you know, basically how to be ready for a disaster and how to consider mental health is other than knowing who their state coordinator is and knowing who the other players are, is there one other thing that we might have missed in this call that maybe you could think of that you'd want to tell them also?

Question cont'd: I'm a consultant. I worked for the state coordinator whose (Beth Nelson). The best thing for anybody to be prepared is to get some basic information.

And again, there's a lot of great trainings already developed. And I would start with their state coordinator to find out which trainings would be best for their community.

And I would start, you know, helping get themselves trained because there's plenty of free material out there and we should all be sharing these resources.

Marc Safran: Thank you. Thank you very much. Next question.

Coordinator: Is from Pennsylvania, Office of Mental Health.

Marc Safran: Thank you very much for calling in.

Question: Oh, thank you for sponsoring this training and for your willingness to dialogue about what the disaster mental health coordinators do in each of the states and for including us in your slide.

I think it's important for folks to know that everybody's going to be needed when there's a huge, a large scale disaster. And the importance of knowing what's already in place is vital so that it prevents the conversion of spontaneous volunteers.

A lot of times people want to help and they show up and then they don't know what to do. So I think having a call like this enables people to have some ideas on where to start.

And I would start with the disaster mental health coordinators in each of the states. And they work with their state emergency management agency and their state department of health, their state homeland security department. And all these things are critical to build a framework that then gets sent to the national response framework.

But everybody's needed. And I think, you know, as the Captain had some really good questions about what's in place and what can be done.

And I think there's a lot of resources again on the SAMHSA Web site, the CDC Web site knowing that people have normal reactions, but their reactions are normal to these abnormal situations for the most part and how to help them understand that.

So those are the kinds of things we do at the state level as we build a volunteer system of response.

There's a number of other things that you'll learn about as when you look at mental health consumers in our state were training mental health consumers to be on our disaster mental health response teams. Because as one of them said to me, I don't know where to get a cup of coffee when nobody else does.

So we're working with all different kinds of agencies to try to give people to look at what their medication issues might be if there's a large scale disaster. We're working with special populations in terms of trying to get them ready to prepare for disaster.

So there's a lot of work going on at the state level that includes the county and the local mental health response.

I know the first question are asked, you know, about those kinds of community mental health resources.

So there's a lot going on. And probably the best way to link and find out is to - and you also be able to tap into some resources if you do that. So I think that's all I probably have to say for right now.

Marc Safran: Thank you very much. And I really do appreciate that you and the other coordinators who actually came together to help me put together those bullets on that slide, I thank you for that, the one about the states and just want to say that we're only going to have time for maybe one more question.

But before we go to that last question I just want to say that there are a lot - this call was just meant to touch on the surface, was just meant to touch on the

surface of this and to get everyone motivated to move forward and to start to think about this more and plan further.

Also, keep in mind one other thing -- I don't think it was mentioned in this call -- but keep in mind that as (Jane) mentioned it's important to realize that many responses to a disaster that may seem pathological actually might be normal responses. And it's important - that's why it's important to have good training and to kind of be able to understand the difference and also to understand that just because something is called mental health help it's not always the right kind.

And it's important to - that we have good, you know, quality appropriate mental health assistance in disasters and that we, you know, do things that might actually re-traumatized people or harm them or so.

So I don't want to scare anyone, you know, away from trying to do good things. But just keep in mind that there are risks and benefits to everything we do.

So this isn't as easy and, you know, as it always seems. But let me take one more caller, I think one more question or comment.

Coordinator: From Los Angeles Department of Public Health.

Marc Safran: Doctor?

Question: Hi. Thank you so much. This has been really good. We've been working - I'm in chronic disease prevention so we've been working with our emergency preparedness unit to work on medication availability afterwards.

But also I had been on a disaster medical assistance team that saw no need for any mental health issues to be addressed by them. So I think it needs to be an integral part of the disaster medical assistance teams.

And also the national and - NIMS, National Instant Management System, I don't remember anything on mental health in there.

And it - so it really needs to be put into the incident command system at all levels. Thank you.

Marc Safran: Thank you very much for those comments. And we just basically need to build I think mental health into all of our country's emergency preparedness for all emergencies and for any type of group crisis whether its small or large.

We - it's the time of leaving mental health out and thinking of mental health as just some separate thing, it's just not a time that we're in anymore, not a - we can't afford to do that. We have to address mental health.

So I thank you all for taking the time to participate in this call. And I want to just encourage everyone to do good things to help build mental health into your plans for future response to whatever crises or disasters we may encounter in the future.

Alycia Downs: Well Dr. Safran, thank you so much for providing our listeners with this information and for this fruitful discussion. I'd also like to thank our participants for joining us today.

In case you didn't get the chance to ask your question, please send an email to coca@cdc.gov. That's C-O-C-A@cdc.gov. And we will coordinate with Dr. Safran to get you answers to your questions.

The recording of this call and the transcript will be posted to the COCA Web site at www.emergency.cdc.gov/coca within the next week.

You have one year to obtain continuing education credits for this call. All continuing education credits for COCA conference calls are issued online through the CDC Training and Continuing Education online system, www2a.cdc.gov/tceonline.

Thank you again for participating today and have a wonderful day.

Coordinator: Today's conference has ended. You may disconnect at this time.

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