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networks

RESPONDING TO TERRORISM: PUBLIC MENTAL HEALTH SYSTEMS MOVE TO FOREFRONT

By Susan Flanigan

As the terrorist events of September 11, 2001, unfolded, Charles Curie was days into his new job as a consultant, awaiting Senate confirmation as administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA). Federal employees were sent home well before noon, but it was not until later in the day that Mr. Curie exited the Parklawn Building in Rockville, MD. Fighter jets flew overhead as he walked to his room at a nearby hotel. "In this surreal aftermath of the attack, I truly felt my responsibility for the mental health and substance abuse services for our entire nation," Mr. Curie recalls.

In his previous position as deputy secretary of Pennsylvania's Office of Mental Health and Substance Abuse Services, Mr. Curie directed the state's mental health response to natural disasters using the crisis counseling program available through SAMHSA's Center for Mental Health Services (CMHS) in partnership with the Federal Emergency Management Agency (FEMA). He knew the value of those programs and understood that the first 6 to 12 months following a tragic event are critical times for providing mental health and substance abuse services. Mr. Curie also knew that states would need leadership and technical assistance from his agency.

National Summit

On November 14, Mr. Curie welcomed more than 600 participants to the National Summit on Terrorism in New York City. Teams of mental health professionals conferred to discuss strategies and refine state action plans to deal with terrorism. The nation is "creating new definitions of what normal means," he told participants. "For the first time, the issues of mental health are on everyone's mind and perhaps will be for a long time." Both public and private sector (*continued on page 3*)

STATE MENTAL HEALTH AGENCIES RESPOND TO SEPTEMBER 11: *Experiences, Discoveries, and Lessons Learned*

By Susan Flanigan and Meighan Belsley

Early on the morning of September 12, following the tragic events in New York, Virginia, and Pennsylvania, Robert W. Glover, Ph.D., Executive Director of the National Association of State Mental Health Program Directors (NASMHPD), established a national clearinghouse to coordinate and organize emergency state mental health disaster volunteer efforts for the affected areas. Within days, 35 state agencies offered the services of more than 1,100 trained mental health professionals. On September 28, NASMHPD held a conference call convening the eight affected states and the District of Columbia to discuss their experiences and to assess the anticipated short and long-term mental health service needs related to the September 11 disaster. The Commissioners from Oklahoma and Colorado joined the call to offer their expertise on their experiences from the Oklahoma City bombing and the Colombine tragedies. "This was just the beginning of what has become a huge national priority; the adequate preparation and (*continued on page 2*)

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MESSAGE FROM NTAC

Greetings from the National Technical Assistance Center (NTAC) staff. In this issue of *networks* we focus on the tragic events of September 11, 2001, and the initial and ongoing mental health disaster responses by Federal and State Mental Health Agencies. Mental health disaster planning processes are now inclusive of terrorism and bioterrorism. This new picture of disaster response planning and its implementation has just begun to be developed and, as such, the articles in this issue are but a snapshot in time. However, it is important to capture, for historical purposes, some of the key events and experiences that so greatly changed our world on that day and will continue to affect our agencies and constituents in such a significant manner in the years ahead.

This issue of *networks* was difficult to produce for a variety of reasons. For one, it is about our response to an intentional and unanticipated act of war, such as the majority of us have never witnessed. The loss of innocent lives, in such a horrifying and unprecedented manner, has left deep scars that will take many years to heal. For another, the psychological effects of this tragedy have had special significance for the mental health field. We are the recognized experts who possess the scientific knowledge and the clinical expertise to deal with acute crisis, sudden loss, severe stress, and profound grief. The events on September 11 immediately placed us in a leadership role at the same time we were grappling with these events as American citizens and human beings.

This tragedy affected all our colleagues and customers. All the stories we have been privy to, from our national vantage point, deserve to be heard. Much can be learned from the successful strategies and unintentional mistakes that directed our actions in the days that followed September 11th. It is essential to understand what worked, as well as, what didn't work, but it is more important to always remember the incredible courage, selflessness, creativity, and resilience exhibited by the responsiveness of our national and state offices and staff, providers, the volunteers, and, of course, by the victims themselves.

We would like to thank the numerous contributors to this issue of *networks*. Susan Flanigan, former CMHS disaster coordinator, wrote the lead article and spent tremendous amounts of time and initiative in gathering information from the key stakeholders. Dr. Robert Glover, Executive Director, shared his time during multiple interviews to discuss NASMHPD's multifaceted role in the disaster response efforts. Charles Curie, Jim Stone, Martha Knisely and Brian Flynn also generously gave of their time to discuss their experiences. We are also most appreciative to Jenifer Urff, Senior Policy Counsel, who wrote the Focus on the States article. And we would like to recognize John Kotler for his editing skills as well as the NTAC staff who did their usual yeoman job in producing this issue of *networks*.

—Kevin Ann Huckshorn, R.N., M.S.N., I.C.A.D.C., NTAC Director

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State Mental Health Agencies Respond *(continued from page 1)*

planning for a new disaster category, terrorism and bioterrorism, for which we are not prepared," stated Dr. Glover.

From this discussion, it became clear that some aspects of state disaster plans had been successfully applied to this tragedy. For example, James Stone, M.S.W., reported that the New York Office of Mental Health implemented an action plan within two hours of the attacks, and in particular, he credited the resulting communication command system developed in preparation for Y2K.

The District of Columbia mental health system's response involved successful partnering with the media to share information about the types of stress DC residents could anticipate and how to talk to children about the crisis. The mental health office extended service hours; responded to an increase in calls when the media published a hot-line number; issued a four page pamphlet, "When Terror Strikes," to help families and community service workers; and served as a clearinghouse for requests for help and information.

Several states discovered gaps in their capacity to respond to a large crisis, particularly the capacity for communication. For example, New York's disaster plan had included the use of pagers and cell phones as its primary communication source. However, the centralization of pager and cell phone operations existed within the World Trade Center which was destroyed in the towers' collapse. This experience had all participants questioning the dependency on a single source of communication in the event of a future disaster.

Martha Knisley, Director of the DC Department of Mental Health, described the mental health challenges amid the active military presence in the streets of Washington. During the early hours of September 11, misinformation circulated and people felt threatened as the city shut down. This experience may have contributed to some children's symptoms of Post Traumatic Stress Disorder following these events, which became evident in schools. *(continued on page 7)*

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behavioral health providers are exploring new territory and helping to create the field of all-hazards emergency response, with mental health and substance abuse services on the front line. "The biggest challenge the federal government faces is allocating limited resources. We must respond to the urgency of these issues to the general public, and continue to address our important, ongoing mission of providing quality mental health and substance abuse services to persons with serious mental illness and emotional disturbances," he says.

Mental Health Impact

Recent figures show that 55,377 persons received crisis-counseling services at a cost of \$14.6 million in the nine areas (CT, MD, MA, NJ, NY, PA, RI, VA and DC) eligible for crisis counseling funding in response to these events.¹ The state mental health agencies (SMHAs) in these areas estimate that as many as 2.8 million persons could be served by the CMHS/FEMA crisis counseling program. These states conduct ongoing needs assessments for services beyond the scope of the crisis counseling program, which does not fund ongoing mental health services or any substance abuse services. In September, SAMHSA obtained \$28 million in supplemental funding for behavioral health needs beyond the federal crisis counseling program, including substance abuse treatment and prevention. States submitted applications to SAMHSA, and \$6.8 million was provided for the first 60-day response followed by \$21.2 million distributed for recovery and intermediate needs of up to one year. Additional federal funding is being explored for mental health and substance abuse services beyond one year.

Mental health issues among the 55,000 persons receiving services include anxiety and fear; hypervigilance; sadness and grief; stress and anxiety due to personal and economic losses sustained as a result of the attack; and burnout among emergency workers, first responders, law enforcement officials, and members of construction crews working at Ground Zero. The most commonly reported symptoms include difficulty sleeping, stomach problems or appetite changes, fatigue, and difficulty concentrating and making decisions. Such symptoms are also typical reactions to natural disasters. Other similarities between terrorist acts and natural disasters include the powerful impact (DeMartino, 2001) on those affected and a loss of the illusion of invulnerability. Disaster stress typically resolves within 18 months. Yet terrorist events typically result in higher rates of post traumatic stress disorder (PTSD) in addition to depression, anxiety, and traumatic bereavement over a longer period of time. (Center for Mental Health Services and Office of Victims of Crime [OVC], 2000).

Lessons from Oklahoma City

The need for mental health services for survivors, family members, responders, and other persons affected by the 1995 Oklahoma City bombing continues to this day—far longer than services are typically needed in the aftermath of natural disasters. Even after the

federal programs ended December 31, 2000, other organizations continued to provide mental health services. According to Ted Wilson, chaplain of the Oklahoma City Fire Department, as of February 28, 2002, the American Red Cross was still funding counseling for 60 persons affected by the bombing. Wilson continues to conduct critical incident stress workshops in the state and has worked with more than 600 persons in the workshops since 1996. He knows the divorce rate of the Oklahoma City Fire Department increased by 300 percent after the bombing, and five first responders involved in the search and rescue have since committed suicide. "It's not our place to tell someone that it's time to quit grieving," explains Wilson of the need for continued services. "Everyone processes grief differently."

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"I can't stress enough that states take care of their mental health work force," observed Gwen Allen, M.S.W., M.P.H., former director of Project Heartland, the crisis counseling program established in response to the Murrah Federal Building bombing. All Project Heartland counselors participated in a weekly debriefing by an outside psychologist who was also available for individual sessions. Ms. Allen recommends that states hire mature, credentialed staff to work in such high stress situations.

In Oklahoma City, younger crisis counselors with less life experiences were more prone to being traumatized from the work. She suggests that crisis counselors have six-hour workdays because "there is too much pain saturation," and that they are limited to one year on such projects.

Despite efforts to take care of the Project Heartlands' 70 mental health staff members, the long-term mental health response to the Oklahoma City bombings has taken its toll. All six mental health professionals who were involved with Project Heartland from inception to closing have experienced chronic health problems, among them lupus, multiple sclerosis, a brain tumor, heart problems, and symptoms involving balance which have no firm diagnosis.

To synthesize the knowledge and experience gained from disaster, trauma, and terrorism research during the past two decades, the Center for Mental Health Services and the National Center for Post Traumatic Stress Disorder contracted with Fran Norris, Ph.D., Georgia State University, to review information and research related to disaster mental health response from 1981 to 2001. Dr. Norris (2001) reports on common risk factors; the range, magnitude, and duration of the effects (*continued on page 4*)

¹The Robert T. Stafford Disaster Relief and Recovery Act (P.L. 100-707) is the enabling legislation for the crisis counseling program.

CALENDAR OF EVENTS

April 24-26. The National Public Health Leadership Development Network. **Ninth Annual Conference.** St. Louis, MO. Contact Anne Kirchhoff at kirchha2@slu.edu; visit www.slu.edu/organizations/nin/annualconference.html

April 24-26. Health Care Compliance Association. **Fourth National HIPPA Summit.** Washington, DC. Call (888) 580-8373; email info@hcca.org or visit www.hcca-info.org

May 1-31. National Mental Health Association. **May is Mental Health Month.** Alexandria, VA. Call (800) 969-NMHA; visit www.nmha.org

May 1. Freedom From Fear. **National Anxiety Disorders Screening Day.** Contact Jeanine Christiana at (718) 351-1717; visit www.freedomfromfear.org

May 19-22. Federal Emergency Management Agency National Flood Insurance Program. **National Flood Conference.** New Orleans, LA. Contact Catherine King at catherine.king@fema.gov.

May 30-31. International Hurricane Center at Florida International University. **Hurricane Andrew 10-year Anniversary Conference.** Miami, Florida. Contact Ricardo Alvarez (305)348-1607; email alvarez@fiu.edu

June 5-8. National Mental Health Association. **Annual Conference. Prevention, Resilience and Recovery: United for Mental Health.** Washington, DC. Call (800) 969-6642; visit www.nmha.org

July 9-11. University of South Florida. Louis de la Parte Florida Mental Health Institute. **Techniques for Effective Aggression Management [TEAM] "Basics."** Tampa, FL. Contact John Ward, Ph.D., at (813) 974-1930; email ward@fmhi.usf.edu

July 14-16. National Association of State Mental Health Program Directors. **Summer Commissioners Meeting.** New York, NY. Contact Roy Praschil at (703) 739-9333, ext. 120; email roy.praschil@nasmhpd.org

September 29-October 1. Disaster Mental Health Institute at the University of South Dakota. **Innovations in Disaster Psychology: Psychosocial Aspects of Responses to Terrorist Attacks.** Rapid City, SD. Call (800) 522-9684 or (605) 677-6575; email dmhi@usd.edu

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of natural and human-caused disasters; and psychosocial resources following disasters.

Learning from Experience

The large-scale loss of life, the ongoing threat of bioterrorism attacks, and the fact that there is no clear end point to potential threats create challenges for responding agencies. In October during the first three weeks of the anthrax scare, the DC Department of Mental Health conducted 18,000 contacts in response to the postal workers' anthrax exposure. Martha B. Knisley, director of the Department, told National Summit participants that this "was a terrorist event; we learned about anthrax as we responded to the crisis. First responders become lab technicians, mental health workers, pharmacists, and physicians. As people waited outside D.C. General Hospital for their anthrax test, mental health staff worked the line."

Officials from SAMHSA, NASMHPD, and other national mental health organizations anticipate that the mental health and health impact of the September 11 events will ripple through the mental health and public health fields for three to five years. At the National Summit, Rear Admiral Brian W. Flynn, Ed.D., former director of the CMHS Office of Program Development, Special Populations and Projects, noted that the Department of Health and Human Services established the following priorities for responding to the events of September 11: meet the needs of the affected states; fund mental health services and supports; help states and counties prepare for bioterrorism; foster government/public collaborations; engage the primary care community; address stigma; expand current programs for longer-term response; and track behavioral health implications.

During this time of heightened awareness, Beth Nelson, M.S.W., CMHS Emergency Services and Disaster Relief Branch, advises states to update disaster response plans to include an all-hazards approach as well as the roles and responsibilities of each responding organization; explain mental health needs following different types of disasters and the ability of local and state agencies to meet those needs to agency administrators, lawmakers, and the public about; inform these groups how they can help better prepare to respond to the mental health needs after a disaster/terrorist event; develop memoranda of understanding with potential mental health response partners (e.g., American Red Cross, faith-based organizations, private providers, local mental health associations); deliver training based on the guidance from FEMA/CMHS/OVC partnership; and use exercises to evaluate preparedness and identify additional resource needs.

The Center for Mental Health Services has established the Program in Trauma and Terrorism, directed by Robert DeMartino, M.D., who also serves as the point of contact for the HHS Command Center for Bioterrorism. Dr. DeMartino describes the effect of terrorist attacks: "There is a broad impact on those directly affected and those delivering services. These awful events interrupt lives with an impact that is mainly psychological, but also *(continued on page 5)*

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physical and economic.” Although there is no simple model for responding to terrorism’s psychological impact, Dr. DeMartino emphasizes the importance of educating the public to take actions that will reduce the likelihood of victimization. He urges public officials to “to deliver messages that inform without frightening and educate without provoking alarm.” Under Dr. DeMartino’s direction, SAMHSA created “Communicating in a Crisis: Risk Communication Guidelines for Public Officials.” [See Suggested Reading.]

Assessing Future Needs

Data collection and needs assessment provide critical information both for funding disaster mental health responses and tailoring ongoing program response. Although disaster assessment tools exist, there is no accurate formula for estimating long-term needs. There is little consistency among states in reporting key data. Compiling aggregate national data is a complex task, and a recognized issue with no current solution. Mr. Curie hopes to identify resources for regional summit meetings to address issues such as ongoing needs assessments, training needs, and how the response to terrorism is affecting state and local public mental health budgets.

“The best advice I can give to the states is that preparedness is the key,” states Dr. Flynn. He explains that “the field faces unique challenges due to the lack of (1) research on risk and protective factors, (2) a mental health model for national disaster, (3) sound intervention research and consensus on best practices, and (4) consistency in collecting and reporting data. There is also concern about the effectiveness of training practices as well as changes in mental health practices in both the public and private sectors.”

Mr. Curie observes that there have been some unexpected outcomes, including the nation’s focus on readiness and resilience and the role of behavioral health. “September 11 has given us the opportunity to talk about mental health and its role in our daily lives,” he explains. “People who never talked about mental health or substance abuse are now conversing about these topics. These personal experiences are shared by a much larger audience and have the potential to assist in decreasing the stigma and discrimination that, historically, have been difficult to fight.” ♦

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SUGGESTED READING

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For more information on this topic and additional mental health resources, please visit NTAC's web site:
www.nasmhpd.org/ntac

New York Emphasizes Early Involvement in Disaster Planning

The terrorist attacks of September 11 may have come with no warning, but years of planning for disaster recovery and an emergency contingency plan developed in connection with Y2K helped ensure that New York's Office of Mental Health (OMH) was prepared for the logistical and service challenges ahead. "We were as ready as we could be," says James L. Stone, M.S.W., OMH Commissioner. "We knew how to set up a command center, how to function if communications technologies failed, how to mobilize trained clinicians and organize area hospitals."

Although no one can anticipate a tragedy of the magnitude that New York City experienced on September 11, Stone and Joseph L. LeViness, OMH Coordinator of Disaster Services and liaison to the state's Disaster Preparedness Commission, say that state mental health agencies can—in fact, *must*—prepare for the worst. They recommend that state mental health agencies take the following steps:

Establish your state mental health agency as an integral part of the state's overall emergency management system.

When LeViness began working for OMH 10 years ago, the agency was not an official member of the state's Disaster Preparedness Commission. "For years, disaster recovery was about clean up," LeViness says. "Mental health was only an afterthought." Three years ago, OMH successfully lobbied for an amendment to state law making it a full partner on the Commission. "You have to have this status going into the disaster recovery effort," Stone notes. "You cannot create the necessary levels of credibility in the midst of a crisis."

Develop strong working relationships with other states agencies.

"Effective relationships have to be in place well before disaster strikes," Stone says. "You can't develop those types of relationships on the fly." Most important, LeViness adds, states should decide in advance which agencies will play lead roles in different aspects of the recovery effort.

Have a network of trained professionals ready to respond when a disaster strikes.

Within two hours of the September 11 attack on the World Trade Center, more than 1,000 trained providers were on their way toward key service delivery sites in New York City. Some of these providers were trained and mobilized by the American Red Cross, LeViness notes, but Red Cross providers alone could not have provided the appropriate emergency response. Finding and training the appropriate professionals is more complicated than it might initially seem, LeViness adds. For one thing, few clinicians—especially those in the public mental health system—are trained in grief and bereavement counseling. In addition, LeViness says, "There's not a lot of information out there

about terrorism and how to treat victims of terrorism." OMH has recruited expert consultants from the Middle East and other parts of the world where acts of terrorism are more frequent to assist in long-term planning.

Involve "non-traditional" agencies in your disaster recovery planning.

"We didn't know much about grieving and bereavement, but local hospices and aging agencies did," LeViness says. "They were also much more attuned to cultural traditions and values that are so important to grieving families." Both Stone and LeViness note that states should not underestimate the valuable contributions of faith-based organizations. "Churches, synagogues and mosques provide a real comfort to people in difficult times. They can also be extremely valuable in conducting outreach, disseminating information, and making referrals," Stone says.

Think outside the box of natural disasters.

Most states have mental health plans in place to respond to natural disasters such as floods and hurricanes, but there are some important differences between these disasters and acts of terrorism. "For one thing, acts of terrorism usually occur with absolutely no warning, making it more likely that there will be a massive loss of life," LeViness says. "In addition, the anger people feel is more intense because the cause can be traced to a human aggressor." Stone and LeViness note that the outpouring of compassion is also greater following a terrorist attack, and they recommend that state disaster plans incorporate a strategy for screening, accepting, and diplomatically declining offers to help. "The hardest job is to find the right mix of volunteers in the right place," LeViness says.

Recognize that a plan is just a plan.

Even the most carefully designed and well-intentioned plans may need to be adjusted or scrapped altogether in the face of unanticipated disasters and terrorist attacks. "Flexibility is the key to a successful response to any disaster," Stone says. "Don't be surprised or feel demoralized if you have some false starts."

New York is in the process of moving from implementing its actual disaster plan to developing a long-term continuum of care. Stone and LeViness emphasize that the psychological impact of September 11 may linger for years. "Post traumatic stress disorder (PTSD) usually doesn't appear for at least nine months, and may appear for the first time two years after the traumatizing incident," Stone says. Other mental health and stress-related issues may require long-term counseling and support.

For additional information, contact James Stone, M.S.W., or Joseph LeViness, New York Office of Mental Health at (518) 474-4403.

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It also demonstrated the importance of addressing how information should be conveyed to children during disasters.

Terry Cline, Ph.D., the Commissioner of the Department of Mental Health and Substance Abuse Services in Oklahoma, offered observations and recommendations that emerged from "Project Heartland," which was created to respond to mental health needs after the Oklahoma City bombing. These included: (1) a significant increase in the demand for services around the one year anniversary of the bombing; (2) the need to rotate mental health providers after one year due to the stressful nature of the job; (3) the needs of first responders and rescue workers, a very vulnerable population; (4) services for non-traditional offsite environments; and (5) confidentiality issues when working with fire fighters, police, and other personnel concerned that seeking support services will be negatively viewed by supervisors.

NASMHPD recently received a contract from the Center for Mental Health Services to review state disaster plans. With

the consultation of Dr. Brian Flynn, who has 23 years of expertise in disaster planning and response, NASMHPD will review the strengths and weaknesses of state plans, convene a national experts focus group, and develop disaster planning guidelines.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded a total of \$39 million for substance abuse, behavioral and mental health services to the affected states. Participants at SAMHSA's National Summit on Terrorism included mental health professionals from 42 states, the District of Columbia, five U.S. territories, two Native American Tribes, as well as 100 representatives of national public service, faith, and community and membership organizations.

On January 29, 2002, the U.S. Department of Health and Human Services (HHS) announced the release of approximately \$1 billion to assist states in responding to public health emergencies, including chemical, nuclear, and biological attacks. Although HHS has not specifically identified mental health as an issue that states must address in their plans, these funds could be available for mental health services at the discretion of the governor. ♦

www.disasters

American Psychiatric Association: Coping with terrorism sections provide tools, resources and other links. Online library and search capability for access to topics related to psychiatry and disaster-related crisis intervention. www.psych.org

American Red Cross: General health and safety information related to natural disasters, a list of available services including disaster preparation and recovery; and links to local Red Cross chapters. www.redcross.org

Centers for Disease Control: Anthrax Information and Public Health Emergency Preparedness and Response; Interim Smallpox Response Plan and Guidelines. www.cdc.gov

Center for Mental Health Services: Information on Disaster Relief and Crisis Counseling, including a videotape produced by the Texas Department of Mental Health, *Hope and Remembrance*, covering the importance of rituals and memorials in healing from disasters and traumatic events. www.mentalhealth.org/publications/publications.asp

Federal Emergency Management Agency: Information on obtaining disaster-related assistance, contacts for crisis counseling services and other disaster related resources; links to other Federal websites. www.fema.gov

International Critical Incident Stress Foundation: Dedicated to the prevention and mitigation of disabling stress through education, training, and support services for emergency services professions and training in emergency mental health services for mental health and health professionals. www.icisf.org/

National Alliance for the Mentally Ill (NAMI): Information on mental health and mental illness; includes a link to *Resources for Responding to Trauma and Terrorism*. www.nami.org

National Center for Posttraumatic Stress Syndrome (PTSD): Facts, Published International Literature on Traumatic Stress (PILOTS); database and information on PTSD and trauma, including treatment, veterans, disasters, etc. www.ncptsd.org/

Natural Hazards Center at the University of Colorado at Boulder: Search HazLit, an online database; annotated bibliographies and reports on the psychological impact of disasters, information on Quick Response Research Grants for social and behavioral scientists to gather disaster data. www.colorado.edu/hazards

U.S. Department of Justice: Victim Assistance Information, September 11th Victim Compensation Program and information, information links. www.usdoj.gov

New Report: **Asian and Pacific Islanders Americans**

The latest installment in NTAC's Cultural Diversity Series, *Meeting the Mental Health Needs of Asian and Pacific Islander Americans*, is now available. This report describes the cultural characteristics and mental health needs of the Asian and Pacific Islander American communities, discusses barriers to mental health care, and provides recommendations for the development of policies and programs to address their mental health needs.

NTAC's Cultural Diversity Series seeks to provide state mental health officials and other public mental health stakeholders with accurate, cutting-edge information about the mental health needs of the nation's increasingly diverse population and to provide strategies and resources for addressing those needs. The series includes reports on the mental health needs of African Americans, Latinos, and persons who are gay, lesbian, bisexual and transgender. Upcoming reports will focus on the mental health needs of American Indians and Native Alaskans, and persons who are deaf.

To download many NTAC publications and obtain order forms, visit www.nasmhpd.org/ntac, or call (703) 739-9333.



The National Technical Assistance Center for State Mental Health Planning provides focused, state-of-the-art technical assistance and consultation to State Mental Health Agencies, State Mental Health Planning and Advisory Councils, consumers and families to help ensure that the best practices and most up-to-date knowledge in mental health and related fields are translated into action at the state and local levels.

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