3. Projects of Cooperating Agencies and Organizations

Tohoku University Graduate School of Medicine,
Department of Preventive Psychiatry

Tohokukai Hospital

Miyagi Danshukai

Activities Related to Disaster Psychiatry and the Health Field Conducted by the Tohoku University Department of Psychiatry

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After receiving a contribution from Miyagi Prefecture in October 2011, the Tohoku University Department of Preventive Psychiatry (hereafter, "Department of Preventive Psychiatry") was established under the umbrella of the Tohoku University Department of Psychiatry. It has worked to provide support and conduct research in the aftermath of the Great East Japan Earthquake. The primary active members in FY 2017 were as follows: From the Department of Preventive Psychiatry, Takahashi, Shoji, Usukura, Kano, and Saito; from the Psychoneurology Department, Matsumoto; and from Hospital Psychiatry, Sakuma, Ueda, Hamaya, and Sunagawa. Much of our work was conducted in collaboration or cooperation with the Miyagi Disaster Mental Health Care Center, and we also work as part-time employees of the Center.

With regard to our support efforts for supporters working in their home regions, we continued our support work for four social welfare councils (Kesennuma City, Onagawa Town, Shichigahama Town, and Yamamoto Town). We continued to offer regular health checkups at support bases, health counseling at the workplace, advice for HR supervisors, and training for employees, among other things. The problems of each workplace are different, and we devised and implemented training regimens and support systems specifically suited to each. In the future, we would like to assist social welfare councils in organizing their internal structure such that they are able to continue to offer workplace mental health support in the wake of a disaster, especially after external aid wanes.

At present, we are slowly strengthening our efforts to broaden understanding of and support methods to address psychological trauma. Due to experiences surrounding the Great East Japan Earthquake, understanding of problems arising from psychological trauma, including post-traumatic stress disorder and complicated grief, has slowly expanded. However, the roots of these problems run deep, and touch on a variety of issues beyond happenings directly related to disaster experiences, including abuse and violence. We believe awareness of psychological trauma is critically important. On May 5 and 6, 2017, we held a "Cognitive Processing Therapy for Trauma Training Session" in Sendai City. Aimed at psychiatrists and clinical psychologists, we invited four professors to give lectures and provide training on the newest treatment methods for trauma. Additionally, we started the Miyagi Trauma Treatment Research Group and held joint study sessions twice over Skype with Fukushima Medical University.

We held several training sessions at multiple levels to spread the cognitive behavioral approach to a wide range of subjects. Our "Exercise Training for the Mind and Heart" sessions were held twice last year and primarily targeted lay supporters. The first session focused on communication skills, while the second focused on problem solving techniques. Persons from a wide range of professions (mostly from Miyagi Prefecture) participated each time, and we plan to continue spreading basic knowledge of the cognitive behavioral approach in the future. For specialists who wished to learn the cognitive behavioral approach in more detail, we invited Professor Yutaka Ono to hold "Psychological Support Skill-Up" lectures twice. This year, we used case studies to educate participants on an easily applicable cognitive behavioral approach that can be used in situations where structured cognitive behavioral therapy is difficult to implement. In addition, we spread our "Skills for Psychological Recovery" (SPR) program, a support program that uses the cognitive behavioral approach and is specially designed for the disaster recovery and reconstruction period. We held the training session over a two-day period in December and invited Tomoko Ohsawa to serve as lecturer. We enjoyed enthusiastic participation, including from veterans in the mental health field in Miyagi Prefecture, and we believe the training session was quite enriching.

In order to devise better youth mental health policy, we continue to work to strengthen the relationship between mental health care organizations and the school system. In cooperation with Miyagi Prefecture and

Aoba Ward of Sendai City, we held training sessions, etc., for faculty at high schools and vocational schools that involved supervision of meetings with students, knowledge and responses to mental illness, and heightening of communication skills when interacting with students, parents, and other faculty members. Additionally, this year, we have begun our project from the Japan Agency for Medical Research and Development (AMED), "Research on Mental Health Development and Growth in Childhood and Puberty" (principal investigator: Masafumi Mizuno).

On February 3, 2018, in Sendai City, we held "A Training Session for Collaboration Between Schools and Mental Health Care: Diagnosing and Working Together on Mental Conditions of Puberty and Young Adulthood," which incorporated both a lecture and group work. Individuals including school counselors and faculty participated. In addition, we implemented a survey that gathered good cases where mental health care agencies and schools in Miyagi Prefecture collaborated.

This year, at the request of prefectural municipalities and the Miyagi Disaster Mental Health Care Center, we have dispatched lecturers to training and lecture sessions. Primarily, these have been suicide countermeasure projects inside the prefecture and workplace mental health training sessions. In addition to these efforts, we have participated in academic conferences and symposia where our presentations on the current status of mental health vis-à-vis disaster damage, and our research results have served to transmit information and raise public awareness within and without Miyagi Prefecture. We have continuously engaged in public awareness activities for disasters, including serving as lecturers at Miyagi Prefecture DPAT (Disaster Psychiatric Assistance Team) training sessions, reports of support activities for the Kumamoto Disaster at the Japanese Society of Psychiatry and Neurology, and lectures in Kumamoto Prefecture itself. Additionally, we regularly attended conferences of the Research Division of the Miyagi Disaster Mental Health Care Center, supported its research projects, and assisted with its data-gathering projects. Finally, we collaborated on the Miyagi Disaster Mental Health Care Forum put on by the Center.

With regard to our research activities, we submitted our research on the mental health of employees of social welfare councils (Ueda et al., 2017) to PLoS ONE, and our research showing an increase in patients admitted to the Kesennuma Regional Psychiatric Hospital following the disaster (Sakuma et al., 2018) to Asia-Pacific Psychiatry. Additionally, at the 16th Meeting of the Japanese Society for Traumatic Stress Studies, Sakuma's presentation on "Long-Term Progression of PTSD Symptoms Following Large-Scale Disasters" won the Best Presentation Award, and Shoji's presentation on "Research on Psychological Recovery Skill Intervention" won an Outstanding Presentation Award. Finally, in collaboration with the NEC Solution Innovator, we are engaged in a research initiative to develop a health promotion support program for community residents that makes use of information communication technology (ICT) and incorporates the cognitive behavioral therapy approach.

In the future, we will hold our relationship with the Miyagi Disaster Mental Health Care Center in high regard, and in order to achieve the expansion of community mental health care in Miyagi Prefecture and the development of preventive psychiatric approaches, we will continue our comprehensive support, education, and research activities, including support for hometown supporters, spreading of the cognitive behavioral approach, spreading of support for psychological trauma, strengthening of the relationship between mental health care agencies and schools, spreading and raising of public awareness of disaster psychiatry, and development of countermeasures and policies for suicide and workplace mental health.

Support in Disaster-Affected Regions by a Organization that Treat Alcohol Addiction

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Introduction

There is a prayer, known as the "Serenity Prayer," that has been passed down inside the alcohol addition self-help group (hereafter, SHG) A.A. (Alcoholics Anonymous).

"God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference."

This prayer is attributed to American theologian Reinhold Niebuhr [1)]. Because of this prayer, the misunderstanding that A.A. might be a religious group has not yet been dispelled. Nevertheless, if one were to speak without fear of inciting that misunderstanding, they would find it difficult to not acknowledge that Western-centric Christian culture and the birth of SHGs are inextricably linked [2)]. The people who communicated to the world that alcohol addiction is an illness from which people can recover were not healthcare professionals; they were the patients involved in the founding of A.A.And in the present day, many specialized medical organizations that do not have access to means more effective at achieving recovery than those of SHGs ultimately end up sending their patients to them. In this article, I would like to focus on supporting the founding of SHGs and highlight their necessity.

1. Support in FY 2017

(1) Outline

The nature, breakdown, and numerical count of each of our support activities in FY 2017 can be seen in Figure 1.

"Network coordination activities," essentially a prerequisite for any sort of support, remain a cornerstone of our activities.

As for our specific support activities, we were involved most frequently in SHG founding work (as discussed in the introduction) and our established support work, "Mutual support group support," which we continue to carry out in the Motoyoshi area of Kesennuma City, Ishinomaki City, and Natori City.

Repeatedly engaging in practice in a particular area is an effective method to strengthen our relationship with it; therefore, we continue to propose case studies to various areas. These actions have borne fruit, and we had four times as many case studies this year as we did last year.

Training projects for supporters have decreased in number compared to two years ago, but they still occur at an approximate frequency of once per month.

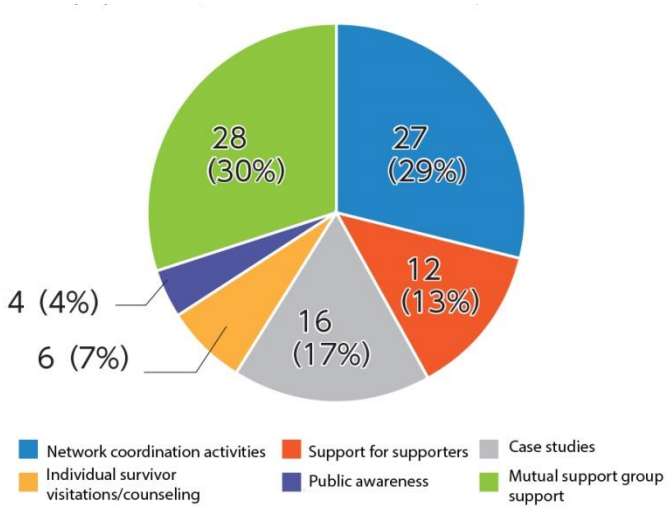

Figure 1: FY 2017 Support Activities and Numerical Breakdown

(2) Cultural Barriers

Our hospital has been involved in SHG founding support in coastal areas since 2013, alongside MDMHCC and the Miyagi Danshukai, NPO. These efforts included support activities that brought up the question of why there are so few SHGs in coastal and rural areas.

Soon after the earthquake, the distribution of material goods stopped. I have heard stories of American and European people taken aback by footage of disaster survivors quietly and naturally lining up at the doors of large supermarkets that they did not even know would open.

When our disaster survivors are asked about the hardships they have been through, they often say "There are others who are suffering much more…" We have all seen how reluctant they are to give voice to their own struggles. Here lies a clear difference between our culture and that of the West. Though we do not voice the ideas that "we will not shame ourselves" or that "we will not complain," our culture nevertheless holds them in high esteem.

Christian culture, with its ideal of surrendering oneself to some higher existence, teaches people that their individual mistakes and weaknesses will be forgiven. This is quite different from the prevailing attitude in cultures where whether an individual's mistakes can be subsumed or eliminated from the community is of critical importance.

A culture's tolerance of alcohol is reflective of its subsuming capability, and expulsion, imposed on individuals who test it beyond its limits, is a severe punishment. I have experienced the reality of that ideal in support, too.

(3) SHG Founding Support

That SHG activities should be voluntarily engaged in by the people who need that help goes. In order to maintain their temperance, residents of a particular area who suffer from alcohol addiction form a group and meet weekly on the same day and at the same time to interact with other patients like themselves. That is the basic structure of a SHG.

However, it has not been easy for this basic structure to form in coastal areas.

Thus, we first devoted our efforts to incorporating stories of addiction from actual alcoholics into our alcohol problems training courses for community supporters. We aimed to have these supporters carry with them specific images of the affliction itself and how people recover from it in their activities.

In order for an SHG to really take hold in a community, participants from a particular region are certainly necessary, as I have explained before. However, implanting a culture of "coming out," where one can share one's "shame" or "weakness," is also very important. If we consider how sensitive addicts can be to others' opinions and judgment of them, we can imagine just how difficult that might be.

It is not uncommon for first-time patients to say things like "What's the point of exposing my shame to everyone?" That attitude cannot be deconstructed with logic. Showing people who are skeptical the smiles of other individuals who have been through the same things as they have is most

effective. “Talking about it makes it easier.” That practice will help change the act of “exposing one’s shame” to “gathering the courage to change what I can.” “Complaining” becomes “speaking honestly.”

Supporters who listen to the stories of former addicts, etc., often experience a change in their perception of behaviors that their culture views negatively.

Repeating this sort of experience naturally motivates supporters to want to communicate these ideas to addicts. In this way, supporters, addicts and other concerned parties invited by supporters, and Sendai Danshukai members have come to meet once a month for “Meetings for Temperance.”

The primary organizer of these meetings is the city government. Another important key to the founding of SHGs in a disaster region is the securing of a venue. Because the government assists us in holding our “Meetings for Temperance,” we enjoy the benefit of being able to use the facilities of public organizations in good condition.

As a result, we were able to move to the independent holdings of “Meetings for Temperance” as regular meetings of Danshukais in the Motoyoshi area of Kesennuma City and Natori City.

An important part of being a supporter is ultimately yielding to the individual experiences of each participant.

At present, in Ishinomaki City, the Miyagi Disaster Mental Health Care Center, Ishinomaki Regional Center organizes “Meetings for Temperance” with the support of the city itself and plans to continue to do so.

Because of the traditional rule of SHGs, A.A. cannot engage in organizational activities, but I would like to point out that motivated members have started their own SHGs in disaster-affected regions independently.

2. The Significance of the Basic Act on Measures Against Alcohol-Related Harm

Seven years have passed since the disaster, and municipalities in various areas have shifted from recovery projects to their usual business. However, the question of how to incorporate post-disaster measures against alcohol-related problems into this usual business remains an important project.

In 2013, the Basic Act on Measures Against Alcohol-Related Harm was passed, and in 2016 the Basic Plan for Promotion of Measures Against Alcohol-Related Harm was drafted. At present, in accordance with this basic plan, administrative regions throughout Japan and certain designated cities are in the midst of promoting the formulation of promotion plans of their own.

The changes brought about by this legislation happened to coincide with work on the question of how to incorporate post-disaster measures against alcohol-related problems into the usual business of various municipal areas.

In order for regional municipalities to become aware of and work towards a solution for this issue, it is important for them to make use in peacetime of the post-disaster alcohol-related problem support work we engaged in ourselves over the last seven years.

One important element in solving this problem are SHG resources in coastal areas.

3. Practical Training for Alcohol Addiction Treatment

From May 2012 to August 2014, we held practical training courses for alcohol addiction treatment for employees of the Miyagi Disaster Mental Health Care Center and employees of coastal area psychiatric hospitals at our facility. Altogether, 97 people took part in these trainings. Furthermore, since January 2014, we have offered training for municipal mental health workers inside Miyagi Prefecture, and we will continue to do so until February 2018.

By deepening our understanding of the treatment of alcohol addiction and the findings of our program, we hope to be able to put our discoveries to use in our work in the community as well as to be able to communicate a clear, specific treatment image to subjects when they are referred to specialized treatment programs. Additionally, because this training allowed us to become acquainted with practitioners in the community, it has strengthened our ability to collaborate with them.

In the sense that we are currently running a specialized program, we are the only medical organization in the prefecture that specifically deals with the treatment of alcohol addiction. When coming up with countermeasures, it is critical that we consider how best to expand both our collaborations with the community and the community’s ability to respond to such issues.

Making use of the "weak point" of this issue—the fact that it cannot be treated and recovered from exclusively through the actions of any one medical organization—we began to implement our training programs following the disaster, which we believe has led to a strengthening in peacetime anti-alcohol measures.

Over the last six years, 176 employees from various affiliated organizations have taken our training. Their training evaluation questionnaires indicate that 98% of them believed it was "very helpful," and the remaining 2% found it "slightly helpful." We received 0 responses saying that the training was, on a 5-point scale, either "neither helpful nor unhelpful" or "unhelpful." In the future, we plan to continue this training as one that teaches practical techniques usable in actual situations.

4. Regarding our Seven Years of Support

(1) Outline

The total number of support activities we have engaged in over the last seven years is 803, and the total number of employees who have participated in these is 1,518.

As can be seen in Figure 2, the number of support activities per year has decreased yearly, but in FY 2017, due to efforts to strengthen SHG founding support, we had 88 support activities, more than in the previous year.

Figure 3 lists the areas and communities to which we traveled for support activities, and the number of activities performed in each.

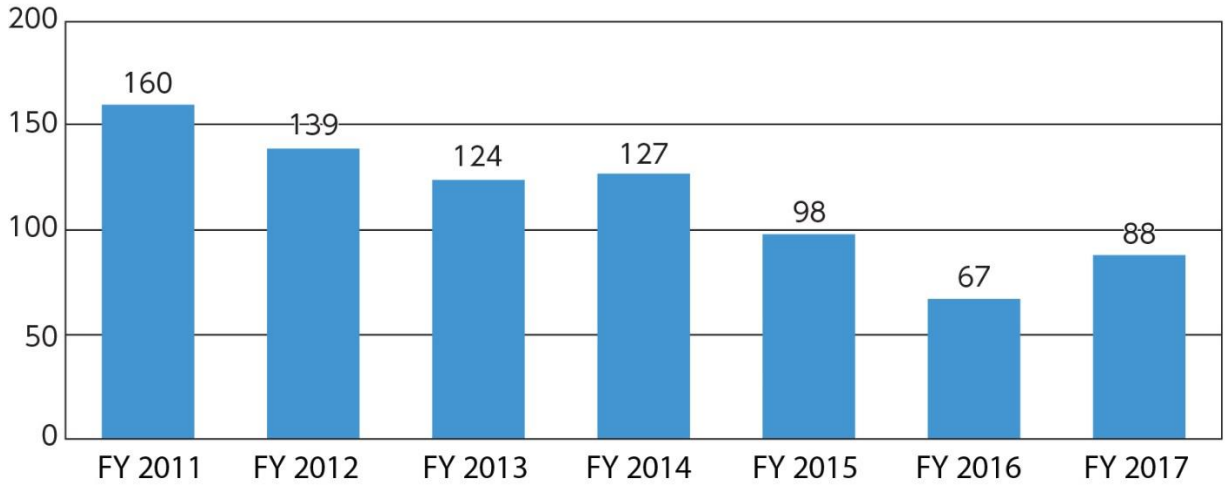

Figure 2: Changes in Support Activity Counts by Fiscal Year, March 2011–March 2018 (*N* = 803)

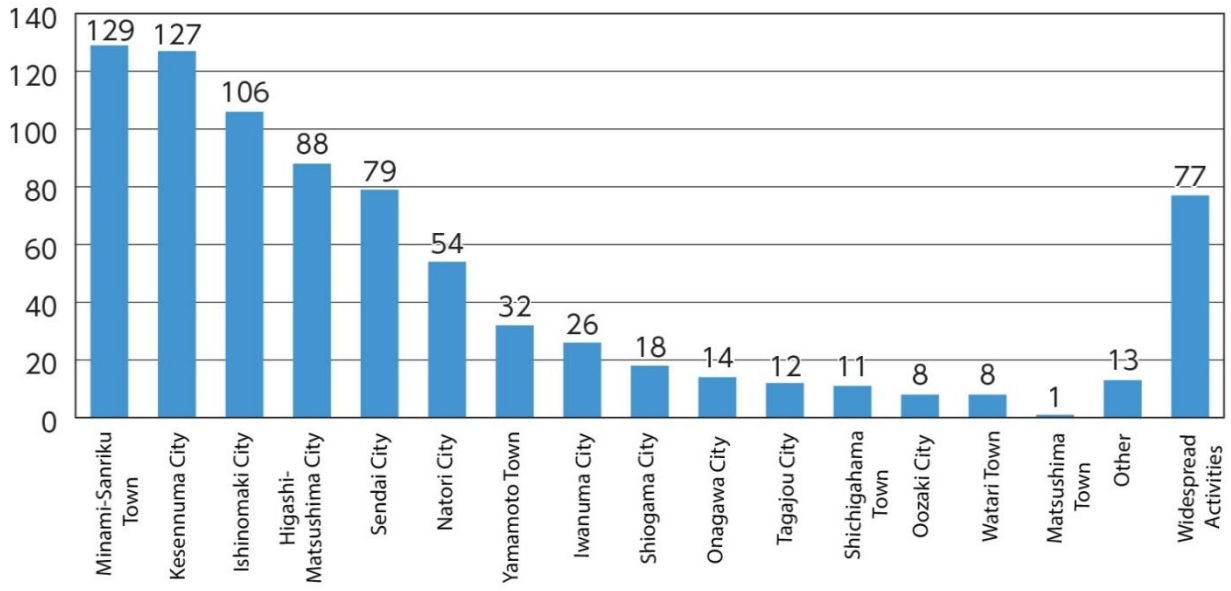

Figure 3: Support Activity Counts by Region, March 2011–March 2018 (*N* = 803)

Figure 4 gives a breakdown of each of our support activities. “Network coordination activities” are the starting point of our activities, with 208 cases. “Case studies” and “Support for supporters training” rival each other at approximately 150. As can be seen in Figure 5, a change-over-time graph, “Individual survivor counseling support” was most active in the three years immediately following the disaster, which is where nearly all of the 108 cases occurred. After the third year, “Mutual support group support” essentially took its place, and the attention we paid to that gave us 103 cases.

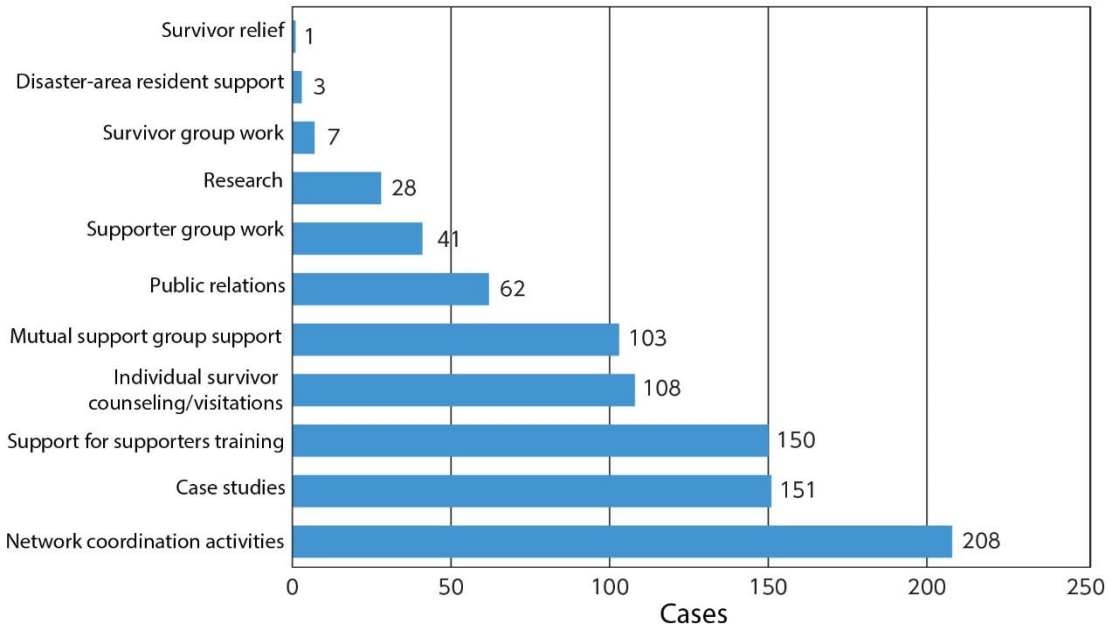

Figure 4: Support Activity Counts by Type, March 2011–March 2018

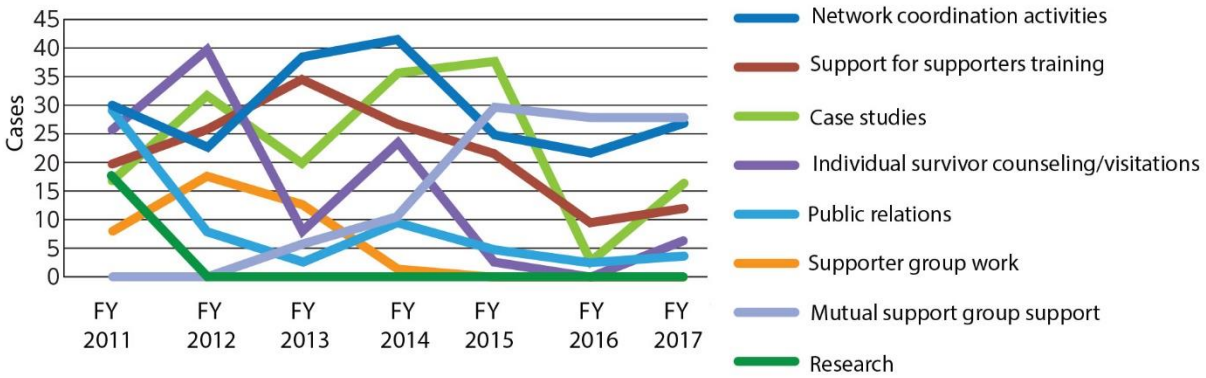

Figure 5: Changes in Support Activities by Type Per Year

(2) Regarding Supporter Group Work

We had a total of 41 cases of “supporter group work” support over the past seven years—by no means a large amount. In fact, all of these cases took place in the first three years following the occurrence of the disaster in 2011; we had 0 such cases after 2014. However, we believe that these cases represent an important yardstick with which we can characterize the nature of our support activities in the early years following the disaster; we will therefore discuss them in this article.

The beginning of the continuous disaster-area support activities of this hospital too place in a “Good Sleep Café” run in the emergency temporary housing set up in a particular town. At the time—three to four months after the disaster—we learned that the primary issue troubling community residents who had been affected by the disaster was lack of sleep. We believed there was something we could do to help. Thus, every two weeks, inside the emergency temporary housing area, we set up a café where

survivors with trouble sleeping could come to get tea, have someone listen to their worries, and, if needed, receive mood stabilizers or sleep-inducing drugs from a psychiatrist, all free of charge.

In September 2011, half a year after the disaster, the support groups and supporters who had gathered from around the country slowly began to leave. We also closed our "Good Sleep Café" around this time. However, when we offered to provide continued support to the town's public health nurses, we received a request for support for survivor lifestyle supporters who could perform support for residents of temporary housing.

We implemented an emergency hiring plan, recruited residents from the local social welfare council, and began our survivor lifestyle support activities. We employed a framework wherein survivors were able to support other survivors.

Normal residents without any particular specialized skills underwent training before participating in support activities.

The day that we received the support request from the public health nurses of the town, we had to tell everyone of the news as soon as possible, so we had them all assemble for a pow-wow.

At our hospital, we implement a daily group work program. We used its methods to have our supporters speak in turn about the things that were currently bothering them. As they spoke, we saw that the faces of our supporters had turned hard, calcified by exhaustion.

The origin of the group work carried out in medical facilities as a treatment for alcohol addiction is in the SHG.

It is nothing but an environment in which people can verbalize their problems, worries, and symptoms, and have the wisdom they use to solve them become part of a "problem book" and a community by and for them.

A support staff member said that they were so "worried" about Mr. C, a resident of temporary housing that had become addicted to alcohol, that they "couldn't sleep at night." A facilitator told them, "That's because you care so much about Mr. C. How would it feel if someone cared about you?" The staff member responded "Good…" in a shaky voice. "Isn't that proof that you're helping treat Mr. C's loneliness?", the facilitator responded.

This exchange doesn't happen in SHGs, but by using technique-based support and dealing with the supporter's own mental health in this way, we continue to empower supporters.

By creating a community where Mr. C wouldn't feel alone, that staff member eventually helped him stop his drinking.

Given the scale of the Great East Japan Earthquake, the reach of private support is limited.[3] We believe that from the perspectives of cohesiveness, functionality, and efficiency (enabling the providing of knowledge to multiple people while simultaneously working with their emotions, worries, and other mental health issues), and as a method that empowers disaster-affected regions to help themselves, group-based approaches should be used in disaster scenarios.

5. Conclusion

After our first group work session ended, we asked support staff to share a comment each on their experiences.

"I thought I couldn't do anything, but I realized I was actually helping." "By speaking and listening to others speaking as well, my heart grew lighter." "It helped me realize that things aren't that bad. I feel better." The expressions on our supporters' faces relaxed, and some even began smiling.

It is undeniable that by founding a SHG, these individuals were able to speak and hear of each other's experiences, and thereby help each other recover.

Shinichiro Kumagaya, a pediatrician and Associate Professor at the University of Tokyo Research Center for Advanced Science and Technology, says that "Independence is increasing the number of things you depend on," and "Hope is sharing your despair with another."[4]

Independence and dependence or addiction are not at odds with each other and hope and despair are not antonyms. These paradoxes can connect to the wisdom individuals can gain on their own issues. If you think of alcohol use as a symptom of a disability wherein one finds it difficult to connect with other people, stopping alcohol use is merely symptomatic treatment. It then becomes clear what exactly ought to be treated.

There are approximately 14,000 psychiatrists in Japan, and I have never even seen a figure for how many of them are involved in the specialized treatment of alcohol addiction. In contrast, the estimated total number of alcohol addicts is said to be 1.09 million, of which over 1 million are believed to be untreated. If we were to liken the situation to an ascent of Mount Everest, treatment is Base Camp, and several hundred Sherpas—mountain guides—are helping the patient become able to attack the summit. Base Camp itself will not function without the Sherpas. With Base Camp as their home base, climbers move back and forth between the first through the fourth camps, acclimating their bodies to the low oxygen environment. In the climb towards recovery, there is no summit. The back and forth, up and down process to and from the safe home back at the SHG camp is recovery. It is critical that we use this big picture perspective to determine what is most important.

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Projects for Alcohol-Related Problems in FY 2017

Takao Ohira - President

Non-Profit Organization Miyagi Prefecture Danshukai

Introduction

Seven years have passed since the Great East Japan Earthquake. The reconstruction of houses has allowed many to move from emergency temporary housing to disaster public housing. However, the physical, psychological, and social problems caused by this disaster continue to grow ever more serious.

We of the Miyagi Prefecture Danshukai believe it to be quite possible that in a disaster-affected region, the various problems survivors have to bear and their inability to be sure about their futures might lead to the worsening of alcohol-related problems. Thus, we have worked in collaboration with the Miyagi Disaster Mental Health Care Center (hereafter, "Mental Health Care Center") and governmental/medical organizations to undertake various projects related to our establishment of programs to educate the public on alcohol abuse and to hold regular temperance meetings.

1. **Outline of Activities in Each Prefectural Region**

(1) Regular Temperance Meetings in the Motoyoshi Area of Kesennuma City.

<Visitations temporary housing ⇒ meetings to discuss temperance ⇒ regular meetings of the Danshukai>

After the disaster, in FY 2012, we began to get involved in alcohol abuse awareness and the formation of a Danshukai in the Motoyoshi area of Kesennuma City. Thanks to the passionate discussions of participants and the contributions of other individuals affiliated with the project, in May 2014, we were able to change our little "Talks about Temperance" meetings into regular temperance meetings—the Motoyoshi regular meeting—overseen by the prefectural Danshukai and held on the third Monday of every month. Since then, we continued to hold these meetings once per month through FY 2017. We were also generously gifted the use of the volunteer room at the Motoyoshi Health and Welfare Center, "Rest," by the Motoyoshi General Branch.

The attendees of these meetings included the participants and their families who had attended the previous "Talks on Temperance" meetings, public health nurses, local medical organization affiliated personnel, the Mental Health Care Center, the social welfare council, and staff from the Tohokukai Hospital Community Support Division. Some came all the way from Sendai.

(2) Ishinomaki Alcohol-Related Problems Training Session

In February 2015, we began this project in collaboration with governmental and medical officials as a part of the post-disaster alcohol-related problem countermeasures enacted by the Ishinomaki City, Kahoku Town General Branch Office. We met on the second Thursday of each month at the Kahoku General Branch Office Health Center, and used the regular temperance meeting model, with the addition of the comparison of guidelines and examples.

Attendees include participants and their families, the Mental Health Care Center, governmental officials, local support organization staff, and staff from the Tohokukai Hospital. These people discussed their feelings and thoughts, and more than 15 people turned out to each meeting. Valuable experiences were had, including the meeting of new friends in a new place, and new relationships through deep mutual support. In our discussions of our directions for FY 2017, we brought up the idea of selecting a location easier for participants and their families to access and realizing future "lunchtime meetings" for the Danshukai. Additionally, given the rise in the number of individuals suffering from alcohol-related problems in the Ishinomaki area and the worsening effect the move into disaster public housing may have on their problems, we changed our meeting place in May 2017 to the "Conference Room" of the Ishinomaki City Health Counseling Center. Throughout FY 2017, the

Ishinomaki City Alcohol-Related Problems Training Sessions were held on the second Thursday of every month. They continued to be based on the regular temperance meetings model, and included comparisons of guidelines and examples, as well as honest discussion of each participant's self.

(3) Natori Area Regular Temperance Meetings

This project, begun in March 2015, happened in response to increasing demand for regular temperance meetings in Natori City, Iwanuma City, and Watari Town.

In FY 2015, we met at 2 PM on the second Monday of every month in the Natori City Health Center. In line with our theme of "Let's listen to the stories of people who have stopped drinking alcohol," we began by first listening to the personal stories of participants. At the time, the project was primarily overseen by the local government, with the Danshukai participating in a cooperative capacity.

In FY 2016, we held "Meetings for Temperance" (every second Monday) in a similar fashion, with the local government as the primary organizer and the Danshukai cooperating.

After discussions regarding the nature of the project moving forward into FY 2017, we decided in April 2017 to shift to adherence to an original goal of the project since its founding: Regular meetings of the Danshukai. Natori City provided us with a conference room on the second floor of the Natori City Health Center as a venue for our activities, and we began to hold regular Natori area temperance meetings every month. Attendees included local participants and their families, Natori City Health Center employees, Mental Health Care Center staff, public health nurses from the Iwanuma City Social Welfare Council, and Tohokukai Hospital Community Support Staff.

2. Looking Forward

We of the Miyagi Prefecture Danshukai believe that our activities are yet insufficient in comparison to the extent of the damage caused by the disaster. However, we strongly affirm our duty as participants in our collaborative groups to "continue speaking about experiences and recover together."

Looking forward, we plan to strengthen our relationships with governmental and medical officials and heighten the mutual trust between ourselves and the supporters who work so tirelessly in the difficult conditions present in disaster regions. We wish to end this report with an affirmation of the fervent hope that our efforts may lessen even slightly the plight of those affected by alcohol-related problems.