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# CONSEQUENCES OF DISASTER: THE MENTAL HEALTH PERSPECTIVE

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# History of Federal Role in Disaster Behavioral Health in America

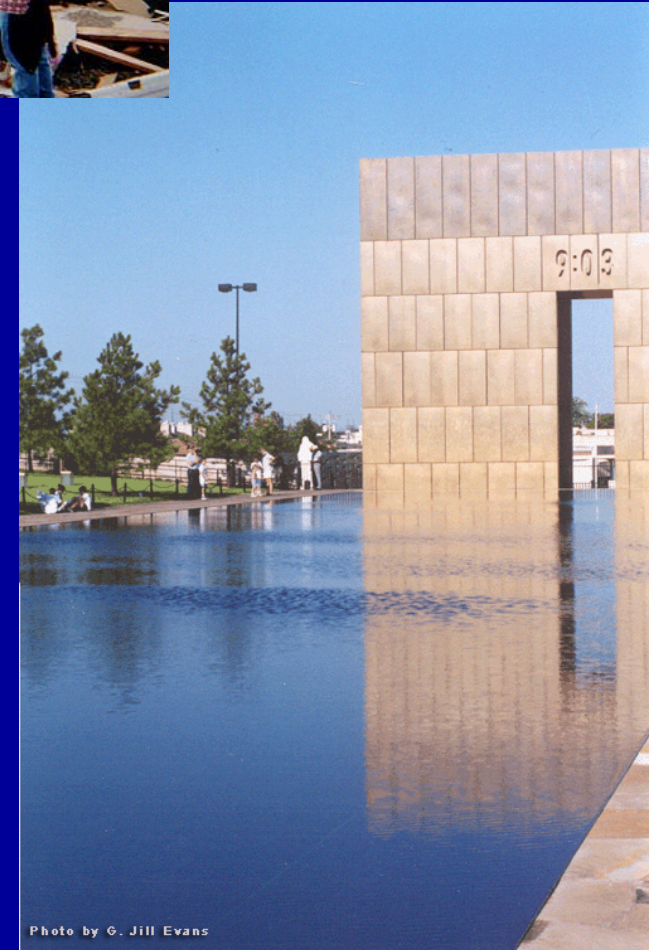


Photo by G. Jill Evans



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## Summary...

- More support for services than planning
- Terrorism planning began following Oklahoma City and expanded following 9/11
- Katrina and pandemic influenza have highlighted need and shortcomings in preparedness and response
- Currently, most funding for preparedness is coming from CDC & HRSA





## Summary...

- Capacity building grants from SAMHSA have made a contribution—sustainable?
- NIMH's convening role is its major role
- NCPTSD/NCTSN have emerged as the leading Federal Agency and federally supported program bringing science to practice in disasters





## Summary...

- Crisis Counseling Program continues to be the primary source of Federal support for behavioral health following major disasters
  - Funded by FEMA, administered through SAMHSA
  - Growing program with long history
  - Does not support formal treatment
  - Questions about applicability to long term/broad scope disasters





## Early History (Pre OK City)

- FEMA supported provision of crisis counseling services, but not planning
- Planning requirements were never enforced
- NIMH/SAMHSA state mental health planning initiatives did not include disaster planning
- NIMH shifted from service, training, research (basic and applied) to research (primarily brain)
- VA (NCPTSD) began shifting focus from exclusively veteran PTSD to mainstream disaster behavioral health
- Minimal interest at CDC and HRSA





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# Oklahoma City Began To Change Us



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## History (Post OK City)

- All disaster health preparedness increases
- SAMHSA budget requests to expand focus on WMD repeatedly rejected
- Dept. of Education begins focus on school planning to prevent and respond to violence and disasters





# History (Post OK City)

- NIMH disaster mental health research (especially intervention research) struggles (primarily methodological issues)
- VA (NCPTSD) increases contributions to disaster behavioral health
- SAMHSA increase focus on human caused disasters





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# 9/11 Changed Everything



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# Post 9/11

- All preparedness increases. Terrorism (including bio) become the new American reality
- NIMH research in disaster mental health struggles
- SAMHSA sponsored state summits... significant focus on planning and governmental integration and establishes Disaster Technical Assistance Center





# Post 9/11

- Evidence based contributions increasingly begin to emerge from DoD and VA
- VA (NCPTSD) becomes major contributor/advisor to CMHS and the field—convener of experts, bringing evidence to practice
- SAMHSA funds capacity building grants to 33 states (out of existing funds—no additional support)





## Post 9/11

- NCTSN becomes significant player in children's disaster issues
- CDC and HRSA become major funders of expanding state public health and healthcare systems...eventually place major focus on behavioral health. Both support behavioral health training in states. HRSA establishes behavioral health benchmarks.





## Today...

- More guidance and interest in preparedness/response than ever before
- SAMHSA's 33 grants have expired. Agency faces overall funding problems
- The bulk of DHHS funding for disaster behavioral health preparedness comes from CDC and HRSA. Both face potential reduced funding in the future





## Today...

- NIMH continues to fall behind as contributor to the evidence base but continues to use convening authority
- Little programmatic or strategic integration of CDC, HRSA, SAMHSA, and NIMH
- NCPTSD/NCTSN emerge as leaders in fostering collaboration and bringing science to practice





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# The State Of The States



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# History...

- Preparedness/response has been determined by interest, fiscal and human resources, and political will
- Virtually no Federal support for preparedness (until *very* recently)





## Current Status...

- Dramatic variations in interest, capacity, sophistication, organization, and quality
- Generally, increased collaboration with public health (the WMD driver)
- SAMHSA capacity expansion grants made a significant difference in some states—sustainability unclear





# Current Status...

- Where assertive disaster behavioral health expansion is occurring, it is usually supported by state health authorities (using CDC & HRSA funding)
- Several states provide models of integration among BH, PH, EM, and others
- States struggle to accommodate existing trauma stakeholders (e.g., CISM, NOVA, Red Cross, etc.) with expanding, conflicting, and incomplete intervention evidence base





# Current Status...

- State differences in behavioral health service structures create large and unique challenges in horizontal and vertical planning integration
- Increasing number of states have state crisis teams (expanding intra-inter-state mutual aid potential)





## The Big Struggle For All States...

1. *How do we manage what amounts to an expanded mission (target population, organizational effort, enhanced collaboration) and in the context of declining resources?*
2. *Can we sustain progress we have made with now ended SAMHSA grants? Can CDC and HRSA funds be sustained?*





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# Why Is Developing and Implementing Establishing Real, Living, and Integrated Disaster Behavioral Health Capacity So Difficult?

*Eight Cracks in the Foundation*

*Five Areas Lacking Consensus*



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# Eight Cracks in the Foundation



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# Crack #1

Lack of understanding that the psychosocial factors are the most significant human impact in disasters

- Behavioral health footprint is far greater than the medical footprint
- Psychosocial impact is the very purpose of terrorism
- There is a psychosocial component in every part of disaster preparedness, response, and recovery
- The cost of adverse psychosocial consequences are greater than any other health impacts





## **Quote:**

**“I understand and empathize with your concerns about mental health in an overwhelming public health emergency.**

**However, the issues I have to deal with, and the decisions I have to make, in the first twenty-four hours are life and death issues.**

**The mental health concerns, while important, do not rise to that level of importance.”**

*Source: Public Health Official, CDC conference, January 2004*





**The behavioral choices people make to stay in place, evacuate, seek/not seek medical care, search for loved ones, etc. are very real life and death decisions.**





## Crack #2

Lack of understanding of the broad scope of roles behavioral health can play (in addition to direct intervention)

- Consultation to leadership
- Risk and crisis communication
- Needs assessment
- Program evaluation, etc.

(NIMH Consensus Workshop)





## Crack #3

**Leadership**—Absent, inconsistent, lacking big picture

- Executive and legislative branches
- Federal, state, local, GNO, academic
- Requires ability to integrate/balance/advocate science, real world response complexity, political realities, and compassion





## Crack #4

Progress, innovation, and  
integration is personality  
dependent

- When the personality leaves the progress,  
innovation, and integration suffer





## Crack #5

Lack of adequate resources

- Human resources
- Funding
- Time





## Crack #6

- Culture
  - We are a culture that seeks easy, cheap, immediate, one size fits all, doable by anyone, solutions to complex problems
  - We do not seek, value, or learn from the lessons of other countries
  - We view ourselves as self sufficient and unlike others





## Crack # 7

Failure to include the public in planning. Resulting in...

- Inaccurate assumption about human behavior
- Reduced compliance, trust, confidence
- Lacking understanding of factors influencing comfort with and confidence in planning

(Source: *Redefining Readiness*, NY Academy of Medicine)

We can learn from MH consumers/advocates: ***“With us not for us.”***





**“...the American public has had little or no role in helping government and private organizations develop terrorism plans...”**

*(Redefining Readiness, NY Academy of Medicine, p.59)*





## Crack #8

We Lack Models/Preparedness  
for National Disasters  
(e.g., Influenza pandemic)



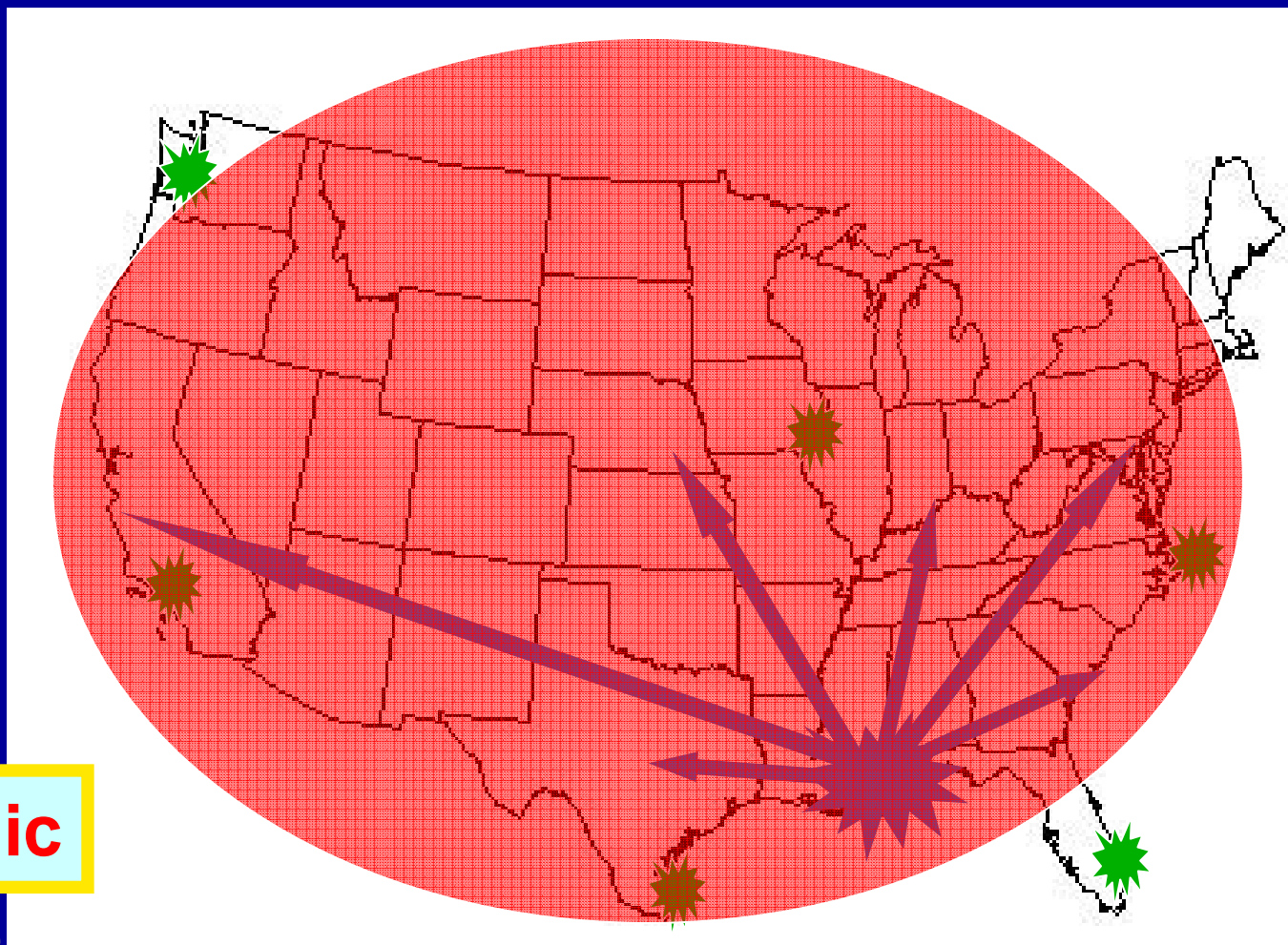


# Disaster Scope...

Typical Disaster

Katrina

Pandemic



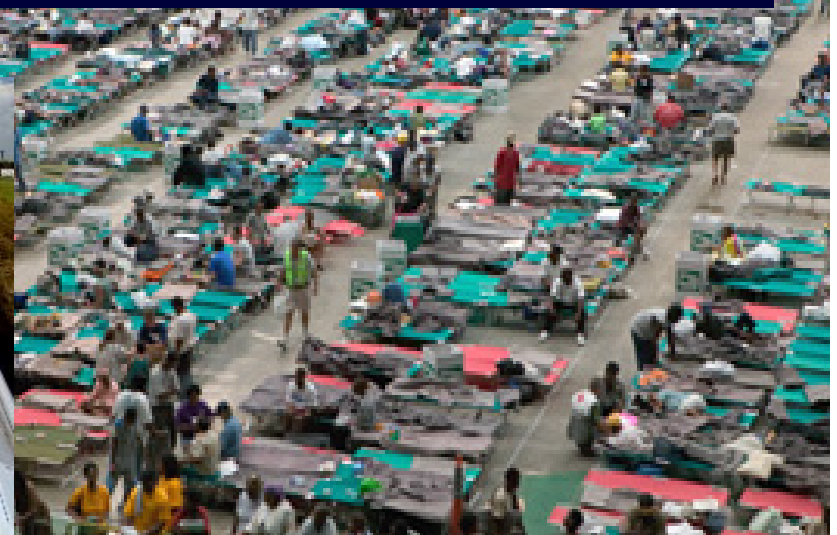


# National Disaster... Who Owns It?

- Legislatively
- Financially
- Strategically—Resources, Personnel
- Culturally/Socially
- Existentially



GAFF PHOTOS



# Five Areas Lacking Consensus





# Area #1—What Are We Trying To Do With Our Interventions?

- Treat a disorder?
- Prevent a disorder?
- Comfort and support?
- Accelerate recovery?
- Change the trajectory of psychosocial response?
- Promote mental health/resilience?





## Area #2—Planning/Response Within What Context?

- Mental health & substance abuse?
- Hospitals and other health care providers?
- Public health?
- Schools?
- Natural support systems (e.g., faith community)?
- Cultural competence?
- Others?





## Area #3—Services Provided By Whom?

- Mental Health professionals?
- Trained paraprofessionals?
- Healthcare professionals?
- Clergy/chaplains?
- Teachers?
- Peers?
- Self help?
- Others?





## Area #4—Programming Using What Strategies?

- What interventions work for whom, when, and under what circumstances? (e.g., crisis counseling, psychological first aid, CBT, etc?)
- Population based?
- Risk based?
- Primary prevention?
- Promoting/training leadership?
- Consultation to leadership?
- Training?
- Communicating?





## Area #5—Strategies Based Upon What?

- Evidence based?
- Evidence informed?
- Experience?
- Belief?
- Marketing?
- Consensus?





# The Bad News...

- The behavioral health evidence base is not expanding as rapidly as needed
- The behavioral health field continues to speak with many competing voices
- All health planning (including mental health) continues to be stove piped with inadequate horizontal integration
- Resources (of all types) for behavioral health preparedness and response continue to be minimal and fragile





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# So, In The Midst Of, And In Spite Of All This, What Should We Do?

***Move Ahead!***

***(Being Assertive, Cautious, and Inclusive)***



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# Resources....

- Fiscal
  - Look to CDC & HRSA funding within states
  - Partner with Emergency Management Authority and other Department/Agencies
  - Seek foundation support





# Resources....

- Expertise
  - CDC, HRSA, SAMHSA (and state equivalents)
  - Disaster Technical Assistance Center
  - National Center for Post Traumatic Stress (NCPTSD)
  - National Child Traumatic Stress Network (NCTSN)
  - National Mental Health Association (*Blueprints*)
  - Read the literature
  - Seek State-to State, community to community help





# Recommendations

- Expand evidence base
- Bring science to practice
- Embrace a wide view of what social and behavioral sciences can contribute
- Advocate for increased political understanding, and policy reflection of, the centrality of behavioral health impacts





# Recommendations

- Struggle for consensus
- Adopt a public health approach (per IOM)
- Fight our cultural bias toward one-size-fits-all, quick, cheap, immediate, short term fixes of complex and serious problems
- **Prepare relentlessly** (*Rudy Giuliani*)





# Two Special Opportunities/Responsibilities

1. Primary Prevention
2. Increase Focus on Resilience





# Preventing The Disaster...



**Death & Physical Trauma**

**Psychological Trauma  
(4-500:1 Larger  
Than Medical)**

**Social/Community Disruption**

**Public Health Effects**

**Adverse Economic Impact**





# Levee Design/Community Planning...





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# Mine Safety...



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# Liquid Natural Gas (LNG) Tankers Close To People...



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# East Africa Embassy Bombings: Same Time/Same Bomb



## Nairobi:

- Many deaths
- Many injuries
- Many psychological casualties



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## East Africa Embassy Bombings: Same Time/Same Bomb



### **Dar Es Salaam:**

- Few deaths
- Few injuries
- Minimal psychological casualties

**The Difference? Architecture!**



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## Preventing/Reducing Exposure

**We Must Learn More About How  
To Get People Out Of Harm's Way**



# Do We Know Enough About Why People Do Not Evacuate?

Don't receive warnings?  
Physically unable?  
Logistics?





# Do We Know Enough About Why People Do Not Evacuate?

Historical distrust of authorities?

Commitment (possessions, animals, family)?

Denial?



**Different Reasons Call  
For Different Strategies!**





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# We Should Expand The Science And Practice Of Resilience



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# Resilience...

What is it?





# Resilience...

How is it impacted by a prolonged centrifugal disaster?

How do we deliver strength-based interventions? What are they? By whom?





# Overview of Baseline Survey Results: Hurricane Katrina Community Advisory Group (Kessler et al.--August 29,2006)

- N=1043
- 84.6% experienced significant financial difficulty
- 36.3 experience extreme physical adversity
- All but a very small percentage experienced at least one major psychological stressor (e.g., death of a loved one, extreme financial loss, etc.)
- 40.6% reported at least five or more serious hurricane related stressors (more commonly reported in minorities and disadvantaged)
- Serious mental illness twice as high as in previous year





## Yet...

- Suicide rate unchanged from before hurricane
- 85% said that the experience helped them develop a deeper sense of meaning or purpose in life
- 83.8% said the hurricane helped them understand that they have inner strengths they did not know they had
- 83.4% said they have a lot of faith in their ability to rebuild their lives
- Not clear how long this will be sustained





# Opportunities...

- This small tail can wag a very big dog!
- To lead mental health in the directions recommended in the Surgeon General's report
- To reestablish mental health as relevant to all the people
- To help mental health realize its potential by promoting both resilience and treatment





# Opportunities...

- To provide mental health professionals with new tools
- To establish behavioral health as a homeland security issue
- To promote hope, perspective, and community





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