Building Bridges:
Mental Health Consumers and Representatives of the Disaster Response Community in Dialogue

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Acknowledgments

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Disclaimer

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Introduction

Natural and manmade disasters have heightened awareness of the critical need to support effective mental health responses. Disasters disrupt stability and structure by altering normal economic and social activities both of individuals and of whole communities. They have had, and will continue to have, serious mental health consequences: bringing a sense of loss, grief, depression, and change to those impacted. The focus of the mental health response is generally twofold. First, mental health assessment and crisis counseling need to be readily available to all residents and evacuees impacted by disasters. Second, those individuals with serious mental illnesses need appropriate services and supports for their ongoing recovery.

In recent years, self-help and peer support, through Federal and State government funding, have become part of the array of services in response to disasters. Such services may include outreach, individual and family crisis counseling, group counseling, public education, community support groups, referral, home visits, transportation services, and warm lines. In concert with the growing self-help and mutual aid models nationally within the arena of mental health services, mental health consumers have initiated peer support services in response to the Northridge earthquake, the Oklahoma City bombing, the 9-11 tragedy, and recent hurricane disasters.

Although there has been a concerted mental health response to these disasters, there has been little opportunity for mental health consumers and representatives of the disaster response community to discuss what is needed to promote recovery in such situations. A face-to-face dialogue between representatives of the disaster response community and mental health consumers provides an opportunity to bridge the gap. Developing trust and building mutual understanding and respect between mental health consumers and representatives (providers, administrators, policymakers, and others) of the disaster response community are necessary to create effective alliances. Establishing and maintaining productive communication increases the likelihood of beneficial relationships that support recovery models for those at risk in, and consumers impacted by, disasters.

In an effort to foster recovery by establishing productive communication and building effective relationships, the Center for Mental Health Services (CMHS), within the Substance Abuse and Mental Health Services Administration (SAMHSA), hosted a facilitated roundtable meeting to bring together mental health consumers, policymakers, providers, and others involved in the disaster response community. A planning committee of two mental health consumers who have had experience with peer support in disasters, two persons from the disaster response community, and CMHS staff met by teleconference before the meeting, to identify participants, recommend a facilitator and a site, and develop a dialogue meeting agenda.

The meeting was held August 9 to 10, 2006, in Washington, DC. Twenty invited participants shared their experiences, perspectives, and insight with one another and with representatives of CMHS/SAMHSA. About half of the group comprised consumers

affiliated with consumer-based organizations, a national consumer technical assistance center, and disaster response services. Other participants represented a State mental health authority and a disaster technical assistance center. Still others worked with disaster response, public relations, and workforce issues. On the basis of their discussions, participants developed recommendations and identified opportunities for improved disaster responses to people with mental illnesses. This report summarizes the meeting and the recommendations that emerged from the dialogue.

Setting the Stage

Paolo del Vecchio and Carole Schauer of CMHS/SAMHSA welcomed the group and described the meeting as an opportunity for all participants and the Federal hosts to learn from one another. Mr. del Vecchio reviewed the objectives for the meeting:

- To develop improved mutual understanding, respect, and partnerships between mental health consumers and representatives of the disaster response community;
- To develop a set of recommendations on how increased collaboration between consumers and representatives of the disaster response community might occur, and other strategies to promote recovery in the context of behavioral health response to disasters; and
- As a followup to the meeting, to prepare and distribute a monograph describing both the process and outcomes of the meeting.

Ms. Schauer thanked participants for their willingness to take part in the dialogue, and spoke to them about prior CMHS dialogues. She introduced them to the "Building Bridges" series of reports, which began with a dialogue between consumers of mental health services and professional groups such as psychiatrists and social workers. The series also has addressed topics such as primary care, criminal justice, and the needs of youth within the mental health service system. She urged participants to approach the meeting as a forum from which they could learn and be inspired to action themselves—as well as make recommendations for others.

Cathy Cave served as facilitator for the meeting, and began by asking all participants to rise and greet everyone else in the room. When participants again settled into their seats, she invited them to introduce themselves to the group by sharing the experiences that informed their participation in this dialogue about disaster response and consumers of mental health services. This introduction lasted the entire morning.

Participants in the dialogue included survivors of the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City; the September 11, 2001, attack on the World Trade Center and Pentagon, 2005 Hurricanes Katrina and Rita, and other weather disasters. Dialogue participants also had served in the Federal and community response to those and other events; these participants spoke of the effect of witnessing the devastation and its effect on human lives.

Dialogue Themes and Findings

Participants were asked to reflect on their own experiences and to identify individual as well as system and context issues that promote or hinder recovery. In sharing their stories, participants identified themes that would continue throughout the dialogue and inform the recommendations of the group.

Factors That Promote Recovery

Participants identified a number of person-level and system-level factors that promote recovery from disaster.

Individual Factors

Individualized assessment and response

- Ensure meaningful inclusion of each person in their own care and treatment. Listen carefully, and allow people to identify their needs.
- Welcome testimonials and the healing power of people sharing their stories—both of recovery from mental illness and of surviving disaster.
- Recognize that although many people may be traumatized by a disaster, not everyone will be incapacitated. Individual responses can also vary in the beginning and over time.
- Ensure a "no wrong door" strategy for accessing services.

Testimony is important to open minds.
—Consumer

. . . if you're a mental health consumer, you're not recognized as a real person—you have your diagnosis, you have your place.
—Consumer

Empowerment

- Understand that disasters disempower people, and build on their strengths to empower them again.
- Recognize that consumers have something to offer—and are helped by offering support to others.
- Recognize that peer services are real services.
- Attend to basic services such as transportation. Peer communities can be particularly helpful in addressing these needs.

I went to Logan Airport on September 11, 2001, to meet with family members of the passengers who were killed. I saw them just after they heard the news, and then again

three years later, and was struck with the importance of survivor support for one another.
—State Disaster Mental Health official

A holistic approach to persons in their communities and context

- Preserve connections. Allow persons to receive services in their own community whenever possible. Recognize the importance of friendships in recovery.
- Utilize local community members for outreach; they are more knowledgeable, more trusted, and likely to be more effective.
- Utilize natural and existing resources, such as community leaders and community centers.

When I first arrived in Louisiana, I was struck by the absence of people. The displacement had a resonance for me with the Holocaust, with slavery.
—Responder

There is a huge difference between Asian communities affected by Hurricane Katrina. In Bayou La Batre, where most people stayed or returned, residents began to dream about building back beyond what they'd had—there was talk of creating a community center. On the other hand, East Biloxi lost two-thirds of its residents. People are dispirited. No one talks about rebuilding; they are completely uncertain about the future.
—Service provider

Dislocation can be as traumatic as the disaster.
—Consumer/survivor

System Factors

Familiarity with community resources and needs

- Be aware of group homes, jails, prisons, nursing homes, and adult homes, as well as the specific needs of individuals within those settings.
- Include local expertise in the community response, because local people may be better aware of available resources and better able to include consumers in disaster response.
- Use a broad spectrum of local media, and engage media effectively.
- Engage consumers of mental health services in disaster planning.

We brought professional case managers to the scene and hired local case managers as well. The local folks did much better, in large part because professionals came in with a preconceived model [of service delivery].
—Provider

In the Asian tradition, we rely on communities and communal support…Community leaders are the first responders by default, and will be there for the long haul.
—Consumer/advocate

Cultural competency

- In outreach and collaboration activities, use inclusive messages that bridge class, race, and social divides.
- Recognize that isolation often accompanies mental health concerns, and conduct active outreach to mental health consumers.
- Offer assistance in a manner appropriate to community needs, expectations, and traditions. Be aware of prior trauma in the community.
- Include consumers, consumer leaders, and consumer–peer support information in all training manuals.
- View consumers and their families as part of the workforce.

Recovery from disaster and recovery from mental illness have a lot in common. Those who have challenges need people the most.
—Service provider/advocate

During the sniper attacks on Washington, DC, some communities felt, "Don't come in here telling us how to feel—we're getting shot at all the time."
—Service provider

You can't make any assumptions about any community.
—Provider

Three thousand mostly African American postal workers were told to keep working in their street clothes while the Hart Senate Office Building was evacuated and workers were coming into the postal facility in Hazmat gear [after anthrax was discovered in the mail]. The disproportionate treatment continued the traumatization.
—Provider

Factors That Hinder Recovery

Using their own first-hand lived experience, participants identified factors on the individual and system levels that hinder recovery.

Individual Factors

Stigma

- In disasters, consumers of mental health services can be subject to repeated relocation or to placement in a specialized institution, based on assumptions about their needs. Consumers may not seek services for fear of being labeled.
- Professionals may resent consumer delivery of services in disasters.

[After the hurricanes,] mental health consumers who had been living independently were taken out of their homes and put in special needs shelters.
—Consumer

My doctor told me to be very careful about my diagnosis—to hide it—because I may be fired.
—Consumer/advocate

We can have all the resources we need, but if the people with the resources are not trained in anti-stigma [approaches], it won't matter.
—Consumer/advocate

In New York, the experience of peers coming in and doing crisis counseling changed the expectations and attitudes of the professionals.
—Provider/advocate

Isolation

- Survivors relocated from disasters lose touch with family and community supports.
- Survivors may have uncertainty about short- and long-term plans for the future.
- Economic dependence limits survivors' choices.
- Homeless persons and rural communities may be difficult to reach.
- Consumers and disaster survivors don't know where to turn for help when media messages are fragmented.
- Survivors may not seek services because they feel guilty.

Patients from a hospital's acute psychiatric unit were placed in an inpatient unit. But what about the people who were ready to be discharged? Where could they be discharged to? Shelter managers had the power to refuse them.
—Mental health provider

There has to be some education of the media about the effect of news media repetition on people with histories of experiencing trauma.
—Consumer/advocate

System and Context Issues

Lack of Federal, State, or local coordination

- Institutional barriers may block real and meaningful community involvement at the local level.
- Funds for assistance may not reach the people on the ground, and may instead be allocated to and by administrative entities that may not be attuned to community needs. Resources may not be available at the small-agency level.
- Federal disaster management agencies are not well integrated with mental health agencies.
- National policy intentions and local activity may not be synchronized, due to a lack of understanding or oversight, or both.
- Disaster planning is often not included in State budgets.
- Disaster management and response agencies often do not include consumer advocacy organizations in planning.

Traditional mental health care and traditional disaster relief agencies develop huge institutional barriers to the participation of community organizations and peer groups. . . . Communities have to have their capacities built up, so they can take over when big organizations leave.
—Disaster relief worker

Part of the solution is the creation of allies.
—Advocate

Consumers—and consumer needs—overlooked in planning

- Disaster manuals are developed without consumer input.
- Peer support resource lists, which could be invaluable in times of crisis, are not developed.
- Languages of local communities, limited English proficiency, and disabilities may not be considered in disaster planning.

It's a struggle to get the State to recognize what consumers can provide.
—Provider/advocate

Difficulty in accessing needed Federal supports

- Federal data requests and information requests are very labor intensive—during a time when direct service and service coordination also require immediate attention.
- Crisis counseling funds are application based and should be eligible for automatic formula-based funding.

Limited effective service delivery

- The definition of crisis counseling services generally does not include peer support.
- Mental health consumers are defined by past diagnosis. Those newly affected by a disaster may thus not be eligible for services.
- Disparities in resource allocations can result from inappropriate target population definitions.
- Differences in the use of professional language among different service sectors (e.g., consumers v. clients v. patients) can hinder communication and planning.

Every disaster is different. There are common factors, but there are always new territory, new challenges, and changes at the State and Federal levels.As providers, we need to be flexible enough to roll with these changes and not lose sight of who we're providing services for.
—Provider

Anyone can be traumatized or triggered. Also, anyone can lead.
—Mental health provider

Inadequate oversight of peer or volunteer services

- Crisis counselors are often deployed without the support of mentors.
- Many organizations do not employ a certification process for volunteers, and no widely recognized system for credentialing volunteers exists.
- Untrained volunteers are often deployed in disaster areas. A limited understanding of the service or structure can create confusion on the ground.
- Communities and organizations rarely plan and prepare for the mental health care needs of responders.

Everyone who sees a disaster is affected by it—including responders.
—Service provider

Limited understanding of disasters and disaster response

- There is a general lack of information and understanding about what services are needed at what point in a disaster response.
- The experience and learning from prior disasters are not accessible to those planning for future response.
- Adequate outcomes studies of the effects of disaster response services—including peer services—have not been conducted.
- Opportunities to improve the mental health service infrastructure, created by disasters (within the community or among agencies), are too often neglected.

After the Oklahoma City bombing, most people diagnosed with post traumatic stress disorder were not at resolution of symptoms

after 7 years. Also, every year for 7 years, the number of first responders who self-referred increased.
—Disaster Response official

Workforce issues

- A national plan to address mental health workforce needs is being developed.
- Consumers and families do not participate in training mental health professionals.

During a strike among mental health care workers, the consumers took on additional responsibility. Consumers are not helpless…and can be called upon to help.
—Mental health provider

Cross-Cutting Themes

Mental Health Consumers as Resources in Disaster Response

Because we are a resilient community that has been through a lot, we have a lot to offer.
—Consumer/advocate

The valuable role mental health consumers could play as active participants in disaster response was a theme that emerged early in the discussion, to which participants returned again and again. Participants shared stories of mental health consumers who had emerged as strong advocates for themselves and for others in response to disaster and trauma, of the human need to reach out in emergency, and of the potential for healing that resides in the experience of giving aid.

Consumers and providers spoke of the valuable service provided by mental health consumers serving as peer support specialists in communities across the Nation, on an everyday basis and in response to disaster. In Oklahoma City and through Project Liberty in New York City, consumer-provided services have expanded the workforce and volume of services available to all survivors of disaster.

Project Liberty is seen not as an end in itself, but as a workforce strategy. It's a way to acclimate consumers to working and provides experience to people interested in human services work
—Service provider/advocate

Dialogue participants spoke to the need for local expertise in response to disaster, the role of trusted community members in outreach to mental health consumers, and consumers of mental health services as trusted members of consumer communities and sources of local expertise.

Participants expanded the traditional definition of disaster as they spoke, bringing to the table empathy for the personal loss that can result from mental illness. Participants spoke of a daughter's loss of medical school; of having their life "fall off a cliff"; of the trauma of hearing, "over and over again, 'I used to be a teacher,' 'I wanted to finish college…'" This broader sense of disaster lent additional urgency to the participant's desire to see the needs of mental health consumers met during times of disaster—and to see mental health consumers as part of the force meeting those needs.

Some participants suggested that mental health consumers might even be particularly qualified to respond to disaster, because they have often personally survived great loss, dislocation, and trauma.

Having suffered personal disasters, those who have moved through mental health issues may be better prepared to help others [respond to community-wide disasters].
—Mental health service provider

All I know how to do is to reach out to those in pain, because most of my life I've been in pain.
—Consumer/advocate

Disaster Response Activities as a Source of Trauma

In the face of a desire to help—and the competencies to do so—the actions of the disaster response community are not always helpful and, in fact, can retraumatize those with histories of trauma. Mental health consumers shared their frustrations at being shut out of disaster response, of offering valuable services, and of being ignored.

The role of stigma surrounding mental illness was referenced repeatedly. Stigma was identified as a central reason that the aid offered by consumers of mental health services was declined, and the aid given to mental health consumers was often inappropriate. Participants reported that, after disasters, mental health consumers who had been living independently were institutionalized or sent to special needs shelters; that methadone users were detoxed because of the loss of methadone services; and that mental health consumers had been refused entry into general shelters after Hurricanes Katrina and Rita. Some participants said that in disasters, disaster responders often use medical model approaches for persons with mental illnesses instead of recovery-based approaches that focus on strengths, empowerment, and peer support.

In addition to outright discrimination, participants cautioned that the bureaucracy around accessing services and assistance can simply reinforce the sense of lost control. Even well-intentioned persons and actions can cause harm. As one participant put it,

"The excitement to help can be a hindrance to recovery." Volunteers and professionals who identify too strongly with the role of rescuer can inadvertently interfere with survivors' abilities and desires to resume responsibility for their own lives, circumstances, and choices.

Disasters disempower people. People need to be empowered. They have qualities and skills to take care of themselves. Remember that.
—Provider/advocate

When working with survivors, we must remember not to do for them what they can do for themselves.
—Consumer/advocate

Disparities in Access to Mental Health Services

[In New Orleans after Katrina], the widest river was the divide between the haves and the have-nots.
—Provider/advocate

Participants said that the discrimination experienced by consumers of mental health services is not only based upon the stigma of mental illness—disparities continue along the lines of race, class, culture, language, age, and other differences. These disparities can limit access to necessary services and can amplify the trauma of disaster.

Some members [with mental illnesses] of the Gulf Coast Asian communities aren't mental health consumers because they don't have access to services—often, there are no mental health professionals in the area.
—Provider/advocate

Participants spoke of the need for cultural competence in all aspects of disaster response. Using local community members to provide services whenever possible was offered as a way of advancing cultural competence. Community leaders have already earned the trust of their neighbors; therefore, supporting them in coordinating services within their communities begins the process of rebuilding the community.

Participants asserted that outreach to mental health consumers would be necessary in response to disaster, given the isolation in which many mental health consumers live. Planning and conducting this outreach were suggested to the community of mental health consumers as a form of cultural competence.

Disaster Preparedness and the Mental Health Community

Although participants expressed their appreciation for the ongoing dialogue, they noted the importance of engaging others such as the Department of Homeland Security (DHS) and the Federal Emergency Management Agency (FEMA). Participants spoke of the need for local and State mental health service providers and consumers to be known to these and other disaster response agencies and included in their deliberations and planning. Participants also acknowledged the need for the mental health community to better understand the perspective, structure, and language of disaster response

> ***People who do not understand the command structure can get in the way of efficient service delivery.***
> —Disaster services provider

Much of the discussion of mental health services focused on peer support. Participants noted the need for a clear definition of peer support services, to include how these services might relate to the crisis counseling services funded by FEMA. Participants also noted the need for evaluation of peer support services in the wake of disaster, in order to make the case for including these services in disaster planning.

In addition to ensuring that plans are in place for providing mental health services, participants spoke of the need for mental health service providers to be prepared for disaster, on personal, organizational, regional, and State levels. A number of recommendations were developed to address preparedness and coordination (see below).

The Role of the Media in Disaster Response

Participants addressed the role of the media in alerting persons to danger, informing persons of available resources, and reporting on disaster. Participants shared their concern that the resources provided by the media for positive education are not used to their full potential, and that the types of reporting typically provided in the wake of disaster could be retraumatizing to disaster survivors.

Participants urged a broader understanding by disaster mental health response professionals of media outlets, including local resources and information hubs—such as consumer drop-in centers. Advance planning for disaster response was also recommended, as well as including representatives of the media in disaster planning.

Recognition of Opportunities

Dialogue participants also focused on the opportunities sometimes provided by a disaster. Participants reported their experience of having preexisting needs identified and addressed through the influx of services that follow disasters.

Participants also suggested that the competencies expressed by consumers in the wake of the disaster could shift perceptions of mental illness and the strengths of mental health consumers on individual and community level. A participant reported that one small rural community "began to start dreaming of rebuilding beyond what was there" before the hurricane. Dialogue participants upheld a similar hope for strength in healing for all touched by disaster and disaster response.

Recommendations

The second day of the dialogue focused on consolidating the themes and individual ideas into specific recommendations. Dialogue participants made recommendations to support the preparedness of consumers of mental health services and to promote the provision of culturally appropriate, quality services and supports to these individuals. A number of recommendations also focused on consumers of mental health services as an overlooked resource in disaster response and ways to promote broader understanding of how consumers of mental health services and consumer-run organizations can provide valuable support and assistance to the citizens of communities affected by disaster.

1. Engage Consumers of Mental Health Services in Disaster Preparedness

Consumers of mental health services must promote disaster readiness at the individual, organizational, regional, and State levels. Consumer organizations can promote personal readiness and, where appropriate, serve as coordinating centers for local preparedness. SAMHSA's Disaster Technical Assistance Center (DTAC) is a valuable resource in these efforts.

SAMHSA Consumer Technical Assistance Centers (TACs) should work with the DTAC and States to develop disaster preparedness plans.

Consumer organizations and other advocates for consumers of mental health services must ensure that the needs of consumers of mental health services are included in local, regional, State, and Federal disaster planning, which include, in particular:

Providing for outreach to consumers of mental health services, in order to assess need and provide information about accessing a range of services and supports.

Ensuring that appropriate officials have access to national pharmaceutical stockpiles and medication lists when accessing the stockpile.

Consumer representatives should participate in disaster planning wherever possible, in order to ensure that the needs of consumers of mental health services—as well as the resources they offer—are addressed. Strategies include:

Consumers at local, State, and national levels should develop ongoing relationships with disaster response representatives, including those from FEMA and DHS.

Representatives of disaster planning and preparedness organizations and State disaster mental health coordinators should be invited to attend and participate in, for example, meetings of networks of consumer organizations and conferences.

Consumer organizations should seek to collaborate with, and be integrated into, State medical reserve corps, where they are available.

Representatives of consumer organizations should seek to have input into the ongoing revision of the FEMA Crisis Counseling Assistance and Training Program (CCP) guidance and the revision of the *Mental Health All-Hazards Disaster Planning Guide*.

Local and regional media outlets should be involved in disaster planning and preparation. Dialogue between providers and consumers of mental health services and representatives of the media may increase understanding of the needs and concerns of all parties. Media planning should include traditional and nontraditional media, including local information sources such as churches and community centers.

2. Promote Consumer Community Resources

Consumers of mental health services and consumer-run organizations will be more capable of contributing to disaster response—and more likely to be accepted within the disaster response community—when their resources, expertise, and abilities are clearly catalogued and communicated. Strategies to accomplish this goal and to promote disaster preparedness and expertise among the consumer community include:

2.1 Consumer organizations should network on the State level, in order to catalog the resources, skills, and expertise available and to use this information in the following ways:

- 2.1.1 To develop a plan from cross-training various agencies and to share or reallocate resources and expertise in the case of disaster.
- 2.1.2 To identify local or statewide gaps that can then inform plans for additional training and development for consumer organizations.
- 2.1.3 To increase the knowledge of FEMA/DHS, State Departments of Health/Mental Health, emergency management systems, and other appropriate agencies.

2.2 Consumer organizations should avail themselves of training on the National Incident Management Systems/Incident Command System (NIMS/ICS). Such training will be useful in understanding the perspective, language, and structure of disaster response, and can increase the knowledge and abilities of peer volunteers in the event of a disaster.

2.3 SAMHSA should develop and deliver training on the NIMS/ICS model to the Consumer TACs, for dissemination to State, regional, and local consumer organizations.

2.4 SAMHSA's Consumer TACs, in collaboration with the DTAC, should develop a disaster readiness self-assessment tool that can be completed by consumer organizations. Certified consumer organizations should participate in disaster drills.

2.5 Consumer organizations should become familiar with the National Voluntary Organizations Active in Disasters (NVOAD), in order to increase their understanding of the roles and resources of the member agencies. Relationships with these organizations should be cultivated, to promote collaboration between consumers of mental health and NVOAD member agencies and to promote the role of NVOAD member agencies as advocates for the consumer community.

2.6 Brief descriptions of the resources available through consumer organizations—including previous experiences with mental health consumers providing services to peers and the general public during disasters—should be highlighted and communicated to the media, emergency management organizations, other service organizations, and disaster planning agencies. Previous experiences include:

- 2.6.1 Northridge, Oklahoma City, and New York City, employing peer support specialists in response to terrorism or disaster, or both.
- 2.6.2 The New Orleans group home whose residents successfully evacuated themselves to Houston after Hurricane Katrina.

3. Promote Peer Support Services in the Aftermath of Disaster

Dialogue participants were unanimous in their promotion of peer support services in the aftermath of disaster. Peer support specialists are a locally available, culturally competent workforce who can significantly expand the available human resources. Consumer organizations and Federal agencies have roles in promoting the use of peer support specialists:

3.1 In conjunction with FEMA/DHS, CMHS/SAMHSA, State Departments of Health/Mental Health, and other agencies as appropriate, a certification system for peer volunteers should be developed.

3.2 Federal, State, and local mental health agencies should advocate for the employment of consumers with mental health services as peer support specialists in times of disaster—and in general. The DTAC should work with the other CMHS/SAMHSA TACs to promote the role of consumer organizations in any local response to disaster.

3.3 In collaboration with the DTAC, the Consumer TACs should compile information and materials about peer support in disaster response in a centralized coordinating center. This information can be used to make the case

for peer support services, to capture emerging best practices, and to create a database for research on peer support services in disaster response.

3.4 In the context of disaster response, peer support services must be described in a manner that is in accordance with the requirements of FEMA's CCP. Oversight is required to ensure that the program is implemented as funded.

3.5 SAMHSA should develop a peer support information service, modeled after the Disaster Behavioral Health Information Services. Consumer organizations throughout the Nation should cooperate in making information and resources available to this effort.

3.6 Information on peer support—its history, its use in previous disasters, its relationship to CCP, and its potential—should be included on the DTAC Web site.

3.7 Peer support services in response to disaster should be specifically included in the guidances of appropriate SAMHSA grant applications.

3.8 Financial officers in consumer organizations should receive training in CCP rules and policies.

3.9 Wellness Recovery Action Plan (WRAP) training is recommended as a model of support and service delivery that can be easily adapted for use in case of disaster.

4. Improve Disaster Response Strategies

4.1 Cultural competency must be promoted on all levels of disaster response. Utilizing community resources wherever possible is suggested as a strategy for promoting cultural competence among responders.

4.2 The current requirement that a State must be applying for a regular services program in order to request an extension to the 60-day service program should be removed. Development of a regular services program application is a significant effort to undertake in the immediate aftermath of a disaster, especially for cases in which regular services may not be necessary at the State level.

4.3 Funding for crisis counseling services in the wake of the disaster should be automatic and population based.

4.4 The CCP program should be revised to allow for case management services.

4.5 A mental health needs assessment toolkit that can be administered in the aftermath of a disaster by peer support specialists should be developed and disseminated.

4.6 Federal mental health block grant requirements should be revised to require specific expenditures for disaster planning or preparedness, as a use of Federal funds, and in the State's required maintenance of effort expenditure to provide mid- and long-term mental health responses.

4.7 Research on mental health services in the aftermath of disasters, as well as the role of peer support services, is needed. Current research shows that the need for mental health services increases after a disaster and continues after other service needs have been met.

5. Strengthen the Mental Health Workforce

5.1 The size of the mental health services workforce—in general, and in a number of specialties—must be increased.

5.2 The workforce improvement plan (developed by the Annapolis Coalition under contract with SAMHSA) should be widely disseminated.

5.3 Consumers of mental health services and their families should be included in estimates of potential workforce resources.

5.4 Using peer volunteers to support consumers of mental health services can provide valuable experience to these volunteers, which can increase their employability.

5.5 Employment opportunities for consumers of mental health services should include appropriate supports and opportunities for advancement.

Other

The Louisiana response to Hurricanes Katrina and Rita is suggested as a study case for the advancement and utilization of peer support services in disaster response. Those convened for the SAMHSA Disaster Dialogue with consumers of mental health services are suggested as an advisory group to such an initiative.

Conclusion

The dialogue between mental health consumers and representatives of the disaster response community helped to identify concrete steps they recommend to improve disaster response for all. The needs of mental health consumers and of the disaster response system were articulated during the dialogue through the sharing of experience and hopes for the future.

Despite its focus on disaster and disaster response, the dialogue was ultimately hopeful. Mental health consumers and representatives of the disaster response community came together in their desire to help people recover, and the special expertise of mental health consumers in recovery was recognized and honored.

Disasters bring a sense of wanting to do something, wanting to act as a human being, wanting to help your neighbors. The need to be of assistance is shared by mental health consumers, simply because they are alive and human beings.
—Consumer/provider

References and Related Publications*

Publications

Fisher, D., Rote, K., Miller, L., Romprey, D., & Filson, B. (2006, July). From relief to recovery: Peer support by consumers relieves the traumas of disasters and facilitates recovery from mental illness. Resource paper presented at the After the Crisis Initiative: Healing from Trauma after Disasters Expert Panel Meeting, April 24–25, 2006, Bethesda, MD. http://gainscenter.samhsa.gov/atc/text/papers/peer_support_paper.htm

Revision of WRAP data-gathering tool, developed by Carolyn Archer, Oklahoma Mental Health Consumer Council.

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Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. (2005). *Dealing with the effects of trauma: A self-help guide.* DHHS Pub. No. SMA-3717. Rockville, MD: Author.

Federal Resources

After the Crisis Initiative: Healing from Trauma after Disasters—a collaborative initiative between the National GAINS Center at Policy Research Associates (PRA) and the National Center for Trauma-Informed Care, supported in part by CMHS/SAMHSA.
http://gainscenter.samhsa.gov/atc/

FEMA Crisis Counseling Assistance and Training Program—overview and information
http://www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/progguide.asp

FEMA Emergency Management Institute—online training and disaster preparedness resources
http://www.training.fema.gov/EMIWeb/

Peer Support Disaster Preparation for People with Psychiatric Disabilities Web cast at http://www.connective.com/events/samhsa/. Also available as a DVD from www.mentalhealth.samhsa.gov or 1-800-789-2647.

SAMHSA's Center for Substance Abuse Treatment Improvement Exchange
http://tie.samhsa.gov

* This list of references and related publications is not exhaustive, nor does it imply endorsement by SAMHSA.

SAMHSA's National Mental Health Information Center
www.mentalhealth.samhsa.gov

Substance Abuse and Mental Health Services Administration
www.samhsa.gov

The Needs of People with Psychiatric Disabilities During and After Hurricanes Katrina and Rita: Position Paper and Recommendations.
http://www.ncd.gov/newsroom/publications/2006/peopleneeds.htm

Other Resources

Consumer Organization and Networking Technical Assistance Center (CONTAC)
www.contac.org

Disaster Technical Assistance Center (DTAC)
www.mentalhealth.samhsa.gov/dtac/

National Air Disaster Alliance/Foundation—an organization of survivors and family members of casualties of air accidents and terrorism.
http://www.planesafe.org

National Empowerment Center (NEC)
www.Power2u.org

National Mental Health Consumers' Self-Help Clearinghouse
www.mhselfhelp.org

National Voluntary Organizations Active in Disaster
http://www.nvoad.org

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