



The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER MENTAL HEALTH AND SUBSTANCE ABUSE

CALL FOR INFORMATION

The Dialogue is an arena for professionals in the disaster behavioral health field to share information, resources, trends, solutions to problems, and accomplishments. Readers are invited to contribute profiles of successful programs, book reviews, highlights of State and regional trainings, and other news items. If you are interested in submitting information for *The Dialogue*, please contact Kerry Crawford at dtac@esi-dc.com.

Achieving the Promise—Transforming the Mental Health System Through Technical Assistance

On July 29-30, 2004, SAMHSA DTAC staff attended “Achieving the Promise—Transforming the Mental Health System Through Technical Assistance,” sponsored by SAMHSA’s Center for Mental Health Services (CMHS). This conference, led by CMHS Director A. Kathryn Power, brought together for the first time all technical assistance (TA) centers currently funded by CMHS. More than 50 centers from across the

country attended, and a wide variety of special populations and service areas were represented, including child trauma, Native Americans, the homeless, and older adults. Participants were charged with evaluating how they could best support the vision and goals of the President’s New Freedom Commission on transforming the mental health system at the national and local levels. Following are the goals of the Commission:

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Goal 1: Americans Understand that Mental Health is Essential to Overall Health

Goal 2: Mental Health Care is Consumer and Family Driven

Goal 3: Disparities in Mental Health Services Are Eliminated

Goal 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice

Goal 5: Excellent Mental Health Care is Delivered and Research is Accelerated

Goal 6: Technology is Used to Access Mental Health Care and Information.

Leadership from each TA center participated in small group discussions to assess best practices and current challenges in areas crucial to the

development and operation of TA service delivery. Work groups evaluated effective leadership, benefits of and strategies for collaboration and partnering, promoting evidence-based practices, and building and maintaining a competent workforce.

Although the TA centers varied in structure and organization, their challenges are similar. Developing reasonable and measurable service delivery goals, establishing and nurturing meaningful partnerships, evaluating the efficacy of services provided in a more targeted manner, and utilizing technology to broaden the reach of TA, resounded across the entire group as the top areas in which centers should concentrate their efforts.

Refining strategies and systems in these areas would best promote the importance of the New

Freedom Commission Goals by modeling a holistic approach to service delivery, and it was widely held that the ultimate goal of the country should be to mirror the public health model for the mental health system. These practices are parallel to the steps State systems can take to help facilitate the shift toward a more integrated mental health system.

The meeting also presented an immense networking opportunity for the TA centers. Many had never connected and they are now aware of additional resources in the field that can be helpful not only to other TA centers but also to their customers.

You can find a listing of CMHS-supported TA centers on the SAMHSA Web site:
<http://www.mentalhealth.samhsa.gov/publications/allpubs/KEN95-0010/default.asp>.

TA Resource Center

CALL FOR STATE AND COUNTY PLANS

We know that many of you are in the process of revising State and county disaster plans. With the rising awareness of the importance of including local agencies in disaster planning efforts (disasters occur at the local level), the number of county-level disaster mental health coordinators and plans are increasing. SAMHSA DTAC's resource collection is available for both State and local level disaster response planning efforts. Please provide SAMHSA DTAC staff with the Web link if you would like your plan included, or if the link to your plan has changed, so that it can be updated on the SAMHSA DTAC Web site.

Are your plans not Web accessible? Send a copy! The DTAC resource collection maintains up-to-date copies of all State and Territory disaster behavioral health plans. Plans and resources can be sent to dtac@esi-dc.com.

JOIN "THE DIALOGUE" DISCUSSION BOARD

Do you have a question you would like to share with fellow disaster behavioral health coordinators? Frustrated with thwarted efforts of collaboration with other agencies or organizations? Have you found a resource you think others might find useful in planning?

Send your questions and responses to "The Dialogue" Discussion Board, and we will include your comments and queries in the next issue (January 2005). Our first discussion will be: *What is a subject area that you would like to see developed into an online training? Do you know of an existing curriculum that would adapt well to the Web?*

DID YOU KNOW?

There are approximately 325 recognized Tribal Nations in the United States, located in 31 States. Have you included this important population in your disaster planning efforts? Do you know how to contact your local emergency management Tribal contact? The Federal Emergency Management Agency Web site has many resources to assist you in communicating with your local Tribal Nations, as well as an online course to help build effective partnerships with Tribal governments. Go to: <http://www.fema.gov/tribal> for more information.

Please send your comments to dtac@esi-dc.com. Help us make this an effective method of communication for the field.

SUGGESTED READING LIST

Have you discovered a useful planning document or resource? Or, have you read an interesting book, column, or journal article that you would like to share? Following are two recent suggestions:

- >> *We Shall Not Fail: The Inspiring Leadership of Winston Churchill* by Celia Sandys and Jonathon Littman.
- >> *The Tipping Point: How Little Things Can Make a Big Difference* by Malcolm Gladwell.

Massachusetts: Behavioral Health Preparedness for the 2004 Democratic National Convention

The Massachusetts Department of Mental Health (DMH) and its partners engaged in considerable planning to address the potential behavioral health consequences of the Democratic National Convention (DNC). Massachusetts, and Boston in particular, has prepared for large events in the past. However, the first national political convention post-September 11 presented special challenges.

DMH has always had a dual concern related to emergency management: ensuring that all-hazards plans are in place for its own facilities; and providing an acute behavioral health response to members of the public impacted by disaster. Specific DMH facilities and the State behavioral health system as a whole became vulnerable during the DNC, and the potential for significant numbers of victims with high exposure to trauma also existed if an emergency occurred. This highlighted the need for a comprehensive plan and Incident Command System (ICS) structure.

DMH began threat analysis months before the DNC was held in Boston's Fleet Center. The immediate vicinity was referred to as the "hard zone" for emergency management purposes.

Directly adjacent to the "hard zone" was DMH's Central Office and the Erich Lindemann Mental Health Center. The Lindemann Center housed two locked psychiatric inpatient units, a shelter, a mental health clinic, and a residential program with a total of more than 200 patients and staff. An additional 200 employees worked at the Central Office.

There were also several residential and day-treatment programs in the surrounding area. Travel restrictions and road closures were extensive. The designated area for protestors was nearby with up to 30,000 people anticipated. Weeks of meeting with public safety/emergency management leadership and disaster behavioral health partners yielded a list of major concerns:

- >> Staff would not be able to get to and from work due to roadblocks and closures.
- >> Normal transportation plans for relocation, which rely on DMH vehicles, would not work as roadblocks were likely if an emergency occurred.
- >> Psychological evaluations following arrests are done by the DMH forensic system. The potential for high numbers of protester arrests

following a civil disturbance could overwhelm the system.

- >> Many DMH clients lived near the "hard zone" and there was concern that they might be arrested; either by getting swept up with protesters or being in the "wrong place at the wrong time."
- >> Most of the DMH phone/computer system ran through the Boston "hub." If power were lost in Boston the entire communications system would be compromised.
- >> Police and fire department personnel were granted permission to use the Lindemann Center and grounds as staging areas for the DNC week. More than 100 uniformed people would be on site; many heavily armed.
- >> In event of emergency, the immediate needs of DMH clients, staff, and facilities would severely limit the Department's normal crisis counseling response for the public/victims.

The process to address concerns was simple, but staff and time intensive. An internal emergency management team was convened and met weekly. The team consisted of staff with decision-making authority and staff "closer to the ground" who had emergency management and facility safety duties.

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The process was:

(1) review existing all-hazards plans; (2) amend plans where needed, specific to the event; (3) ensure clear communication mechanisms were in place within DMH and with public safety, emergency management, and public health partners; and (4) have open and ongoing communication with all staff and clients affected by the event.

Action steps were numerous and addressed both macro and micro concerns. DMH's 24/7 emergency contact list was expanded and disseminated. A unified leadership structure was put into place with executive staff responsible for Statewide concerns and the standing Lindemann ICS team responsible for life-safety decisions and coordination with the public safety personnel stationed in the building. This leadership team met daily during the DNC. It received briefings from DMH forensics, psychiatric emergency services, and staff deployed at both the State and Boston Emergency Operation Centers.

DMH communicated with its disaster response partners to ensure that external crisis counseling resources would be available to the public should the department need to focus on its own assets. Forensic units in courts increased staffing and diversion protocols were put in place in

case of overwhelming need for inpatient evaluations. Non-essential staff were allowed to take vacation, or were out-stationed to DMH Area and Site Offices if they chose to work. Business continuity plans identified a viable relocation site for DMH leadership and functions. Psychiatric hospital bed capacity was reviewed. Information was shared throughout with staff and clients via special meetings, e-mail, and distribution of DNC protocols. DMH collaborated with the public health substance abuse services system to offer support and technical assistance in preparedness planning.

DMH proactively coordinated with public safety and emergency management to ensure that they were aware of the specific needs of the Department's facilities in the "hard zone." Old relationships, built over years of participating in drills and providing crisis counseling, produced dividends. DMH was included in real-time communication loops concerning impending threats, DMH identification was accepted for travel through some restricted areas, and transportation was assured for DMH clients and staff in the event that relocation was needed.

Close review of facility and program all-hazards planning allowed the DMH to identify and correct deficits. Corrections mainly dealt with

specifics including: ensuring complete supplies for sheltering-in-place; acquiring two-way radios for every floor; checking power-outage analog phone lines; testing HVAC system shut-down in case of outside air contaminants; and developing enhanced security protocols. Many changes resulted in permanent plan revisions.

We "prepared for the worst and hoped for the best." While some argue that the disruption to the city was excessive, from a safety viewpoint the event was a success. No serious incidents occurred. Protests, by-and-large, were orderly and arrests minimal. Traffic and travel were much easier than anticipated. Many long-time residents felt the city was actually more quiet and friendly than usual!

In hindsight, the out-posting of DMH staff was probably greater than the need. However, most of the actions taken were simply a part of solid preparedness planning. In general, the DNC provided a unique opportunity for an in-depth analysis of DMH's all-hazards plans and affirmed its relationships with public safety and mainstream emergency management organizations.

This article was contributed by Darrin Donato, director of emergency management, Massachusetts Department of Mental Health.

New York: Behavioral Health Preparedness for the 2004 Republican National Convention

The New York State Office of Mental Health (OMH), in collaboration with many other government and private agencies, continues to focus on the metropolitan New York City area as a high-priority region for disaster preparedness. While the attacks on the World Trade Center (WTC) in 2001 are unparalleled in their destructive scope, OMH has a long history of providing disaster mental health services, as well as infrastructure and logistical support, to areas of New York State impacted by natural and man-made disasters. This history includes the earlier WTC bombing, several airline disasters, floods, hurricanes, and blackouts. Despite this long history, OMH has conducted a major recent effort to assure ongoing, maximum readiness.

CENTRAL DISASTER RESPONSE COORDINATION

OMH has an Emergency Preparedness/Disaster Response operation in place, which uses the national Incident Command System (ICS) as its foundation. In order to assure current readiness, hundreds of OMH employees have

recently received new or refresher ICS training. Documentation of procedures and resources has been extensively reviewed, and a full array of drills, exercises, and training continues to be conducted and scheduled.

The OMH Emergency Preparedness/Disaster Response organization is divided into three distinct levels. First, the ICS command headquarters, known as a Departmental Operations Center (DOC), is located at the OMH central office in Albany, NY. It is from this location that agency executive managers oversee all response efforts. The second level of DOCs exists at the five OMH field offices, each located in a separate region of the state. These field office DOCs coordinate response activity for a multi-county region for which they are the primary point of contact for mental health services. Third, OMH operates 29 hospitals located throughout New York State, including New York City. Each of these hospitals functions as an Emergency Operations Center (EOC). An extensive communications network and procedural system has been put in place and is regularly exercised. It allows all these separate emergency centers to

coordinate their activities and function as a single agency.

COORDINATING DEPLOYMENT OF RESPONDERS

OMH coordinates deployment of an extensive network of public and private mental health professionals whose training and experience include the provision of disaster mental health services. As the State's lead agency for the oversight of all mental health services, OMH maintains close, active, and collaborative working relationships with each county's mental health agency. It also works hand-in-hand with the private, nonprofit mental health service providers who are licensed to operate by OMH.

A major component of OMH's response capability can be found in the direct operation of 29 psychiatric center hospitals. Each hospital functions as a fully independent, JCAHO-accredited inpatient and outpatient treatment center. With respect to the potential emergency and disaster mental health needs for metropolitan New York this past summer, OMH spent several weeks

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readying its capabilities to provide services. A comprehensive information base has been compiled and electronically disseminated which identifies essential personnel and how they are to be contacted. Emergency Response Teams are trained and ready at each of the hospitals.

PROVIDING LOGISTICAL AND INFRASTRUCTURE SUPPORT

OMH has also compiled an inventory of the amount and location of agency material assets which are immediately available for delivery to a disaster area. Each of our hospitals has a sizeable number of operating resources. They also have trained staff including not only mental health professionals but also foreign language translators, safety and support staff, finance and administration staff, and food service production workers.

In addition to the professional staff, each hospital maintains inventories of medicine, supplies, personal care items, bedding, food, water,

and transportation. Each hospital is equipped with enough emergency electrical generation equipment to fully power the campus. Each of the hospitals also has an EOC with personnel trained in the ICS. This combination of mental health professionals and capital assets serves as a powerful resource to New York State's emergency management capabilities.

STRENGTHENING INTER-AGENCY AND INTER-GOVERNMENT COMMUNICATION

External to the agency, OMH has made a significant effort to strengthen its relationships with emergency preparedness and disaster response partners. Substantial time has been spent working with the State Emergency Management Organization (SEMO); the New York City Department of Health and Mental Hygiene (DOH/MH); the State Department of Health; and the New York City Office of Emergency Management (OEM). Work groups have authored detailed operating and

procedural agreements. Contact information, crucial to a timely response, has been compiled and is continuously updated. Planning and discussion among the partner organizations continues on a daily and weekly basis. In addition, OMH has taken a seat at the command center tables of these organizations, providing us with a "front line" position as the national events take place in New York City.

While OMH is always prepared to activate its emergency response organization, this year has been used to sharpen our capabilities to serve the metropolitan New York region in recognition of significant events.

This article was contributed by Mike Labate, director of the Planning Division, Emergency Preparedness and Disaster Response, New York State Office of Mental Health.

Sustaining Effective Mental Health Disaster Response Capabilities

Since September 11, 2001, Americans have become keenly and painfully aware of the devastating impact of unforeseeable disasters. Preparation and planning for responding to natural and man-made disasters has become a high priority not only for the Federal Government, but also for State and local governments as well. It is a complex undertaking that involves staff in many government agencies and community-based organizations. To be effective, disaster planning must be in-depth, comprehensive, and integrated, and it must keep pace with the rapidly evolving environment in which terrorism, bioterrorism, and natural disasters pose real and substantial threats.

Better planning can help make appropriate interventions available to those in need. It can also provide an opportunity for a more efficient behavioral health response. To facilitate this process, the Substance Abuse and Mental Health Services Administration (SAMHSA) provided funding to 35 State governments to help them develop effective mental health and substance abuse response systems for use in both natural and man-made emergencies. The grants were to help assure that resources for counseling,

support, and recovery are in place. And they were intended to be integrated into other emergency program support to provide more comprehensive responses including: administration, leadership, continuity of operations, public information, and resource management, to address specific needs in an emergency.

To successfully sustain their disaster response capability, State and community leaders need to clarify their needs and develop a clear, sensible, and convincing plan for putting the pieces in place.

Most States have used the SAMHSA funding to support a full-time disaster response coordinator who has the responsibility for coordinating and collaborating with other State and local agencies, responders, and emergency relief organizations; developing sound crisis preparation plans; conducting drills and

trainings; and implementing emergency management response plans in the event of a major disaster. For many State agencies, however, sustaining a full-time coordinator and ensuring that emergency resources are ready and can be mobilized is an enormous challenge, particularly at a time when most State budgets are stretched to or beyond their limits.

Many promising initiatives are begun with seed money from foundations and government. When that funding runs out, program directors and managers are often left scrambling. Time-limited grants and narrow categorical funding streams make it extremely difficult to build a stable base of support to sustain their work over time. To successfully sustain their disaster response capability, State and community leaders need to clarify their needs and develop a clear, sensible, and convincing plan for putting the pieces in place. This inevitably requires finding adequate funding to keep going. However, it also requires an array of other resources including: political, technical, and administrative.

Good sustainability plans help the developers of programs and initiatives to clarify where

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they are and where they want to go. They help policy makers, opinion leaders, and investors decide how and why to get on board. They help the public and professional communities understand what the initiative is and why it is needed. They give program managers a roadmap for where they are going and benchmarks for determining whether they are successfully reaching their goals.

Developing a sound sustainability plan is a lot like developing a business plan. It begins with a clear concept of what is needed to assure a State's behavioral health disaster preparedness and a plan for putting and keeping the necessary resources in place. This includes:

- >> **Vision** – Having a clear idea of what you want to sustain, which starts with clearly articulating what a strong behavioral health response capability is, what it will achieve, and what programs, services, personnel, and emergency management systems it requires.
- >> **Results Orientation** – Defining the “success” of your behavioral health response capability means being able to measure progress over time and to adjust your resources and activities based on what you learn.

- >> **Strategic Financing Plan** – Projecting the fiscal resources you will need and systematically developing a variety of relevant and realistic financing strategies and funding sources to provide a stable base of support over time.
- >> **Broad-Based Community Support** – Considering whose support is strategically significant and developing appropriate outreach efforts for involving key agency officials and community leaders in the planning process.
- >> **Key Champions** – Rallying leaders from State and local government, business, faith-based organizations and other parts of the community and persuading them to use their influence to generate the moral commitment and financial support to maintain a strong emergency response capability.
- >> **Adaptability to Changing Conditions** – Being proactive in a changing policy and political environment and taking steps to adjust programs and resources to keep pace with emerging natural and man-made threats.

- >> **Strong Internal Management Systems** – Building strong personnel, governance, information management, fiscal management and administrative systems to support emergency preparedness.

Sustainability is about much more than finding dollars to support a coordinator position and a few developed interventions. Successfully maintaining an effective emergency mental health and substance abuse response capability encompasses everything from clearly conceptualizing your work, to engaging the range of stakeholders you need to make it happen, to effectively implementing plans and programs, to wisely managing people and resources. Sustainability planning is not a one-time process. It involves building competencies into your ongoing planning and operations that lead to success and stability over time.

This article was contributed by Cheryl D. Hayes, executive director, The Finance Project.

Crisis Communications and Media Response Training

In the field of disaster mental health and substance abuse response, risk communication and partnerships with the media are key components of disaster planning. Mental health and substance abuse professionals often may find themselves in front of the camera or in a position to provide consultation on media messages. The following will introduce techniques on how to use the media as a proactive resource.

10 WAYS TO KEEP THE MEDIA ON YOUR SIDE DURING A CRISIS

1. Seize control.

You must gain control of the crisis situation immediately. You cannot have your organization come across in the media as either defensive or trying to hide something. Crisis could have all sorts of unfavorable repercussions. Give the reporters all the information they can get from someone else. Let it come from you. Immediately correct any misinformation that has already been reported.

2. Identify a spokesperson.

Have one designated source of information for the media. This allows you to coordinate information and have a “uniformity of response.” Many times the scope of the event will determine who is appointed to be the spokesperson. In a gravely serious incident with national ramifications, it may be determined to have a senior-level corporate official serve as the spokesperson. Make sure the media know who the spokesperson is and how to access him/her at any time.

3. Be accessible.

Take the media’s phone calls, no matter what the circumstances, and conduct briefings periodically. Be aware of the media’s deadlines and know your local reporters. The first time you meet a reporter should not be during a crisis. Make a list of all media calls and return them; then make a record of your responses.

4. Be honest.

If you do not know the answer, say so and then commit to getting the answer as soon as possible.

5. Do not give “off-the-record” comments.

No matter how well you know a reporter or even how much you trust a reporter, never, never, never say anything off the record during a crisis. Remember, there is a “rush to be first—not necessarily factual” in today’s media. If you don’t want it repeated—don’t say it!

6. Do not be intimidated.

Remember, you control the interview process entirely. The best way to handle or respond to negative or hostile questions is with positive answers.

7. Prepare statements.

During your initial “Crisis Management Audit,” you should identify potential areas of crises and develop one-page factsheets on these areas. It is critical during the initial stages of a crisis that a prepared statement contains all the information reporters can gather from other sources. Prepare statements for all news conferences and stick to them.

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8. Develop talking points.

After the “factsheets” have been prepared, the spokesperson should be given the most current, correct, complete, concise, and conversational responses possible. Remember, preparation is absolutely key to succeeding in media response during any crisis event.

9. Rehearse.

Read over statements prior to interviews. Rehearse your spokesperson before a camera, if possible, and concentrate on body language. It says more than words. Practice talking in short “sound bites” to avoid being taken out of context, edited, or misquoted.

10. Create media materials.

In addition to preparing official statements, make sure media kits and background information is available. Do not call them “press” kits. That is an old print term and some electronic media are sensitive to that. If you have pictures that will help enhance the story from your perspective, include them.

10 FACTORS TO CONSIDER FOR ALL PUBLIC STATEMENTS

All of your statements should pass the following public perception tests:

1. Are they both honest in content and compassionate by response?
2. Do they communicate a thoughtful, intelligent content?
3. Do they show genuine concern?
4. Are they solution-based?
5. Are they presenting the “image” of your organization in a good light?
6. Are you going to be viewed as not only a reliable organization, but also a responsible one?
7. Will they show your organization as one with good “core values”?
8. After watching and hearing you, will your various stakeholders view you as being in control?
9. Have you “communicated from the heart” and not just from the head?
10. Will your audience remember having “liked” you and your organization?

PREPARING AND IMPLEMENTING THE “CRISIS MANAGEMENT AUDIT”

- >> After establishing your “Crisis Management Team” ask each member to do an assessment of their area of responsibility to determine areas of vulnerability.
- >> Meet as a group and “prioritize” your vulnerabilities, ranked in order of likely occurrence (e.g., These events could happen to us at any time; These events may happen, but are not likely to in the near future; and, These events are very unlikely to happen at all).
- >> Develop a factsheet on each of these potential occurrences.
- >> Develop responses for these potential crises and practice them with your staff as well as your emergency responders.
- >> Update your “Crisis Management Audit” potentialities each year. Keeping the plan current is the only way to prevent unpleasant surprises from occurring.

This article was contributed by Richard Brundage, president, Center for Advanced Media Studies.

Reflections from the Project Director: The New York Response to 9/11/01

As I write this, it is just before the third anniversary of the attacks on the World Trade Center towers and the Pentagon. During the previous two anniversaries I was tense, jumped when the phone rang, and tried to trust that Project Liberty crisis counselors were everywhere they were needed. I hoped these days would pass uneventfully and that everyone could breathe a deep sigh again when they were over.

This one is different, though. Most of the program has been closed since December 2003 and I have already gone through every file, making sure they are intact for easy access by future historians who may look at what stories the files will tell. I am no longer able to focus my anxieties on the New York disaster area, and so I am forced to consider the dates and destinations of my own travel. Is August 11 significant? I will be leaving from Newark Penn Station (which recently had a bomb scare on a train I have taken often) and is across from the recently identified Al Queda target, the Prudential Financial building. My destination is Washington, DC. Should I be worried? Did I add two days to my trip to China just so I wouldn't be in the air on September 11? I don't

want to live my life around anniversary dates. I need to let it go.

You work quickly to keep up with disaster time and accomplish as much as you can, knowing you will have to dismantle things as soon as you turn the next corner.

That was the biggest lesson that I personally learned from managing this huge-scale mental health disaster response. You work quickly to keep up with disaster time and accomplish as much as you can, knowing you will have to dismantle things as soon as you turn the next corner. You delegate what you can and do a lot of trusting that people are doing what they say they are and doing the right things, even though you are well past the honeymoon stage of altruistic behaviors by the majority. And then you must be kind to yourself and your staff and let go when you see what you are missing. Accept the limitations of your humanness and that of your program. Acknowledge the

accomplishments and let go of what the world takes out of your hands. Maybe it wasn't time for that particular individual or group to hear what was being said or maybe you have led them as far as they are willing to be led.

Throughout this disaster, there were dichotomous opinions, activities and energy pulls on many levels. Many claim that New York is the strongest city in the Nation, maybe even the world. But this horror was beyond its capacity to manage alone. New York is a psychoanalytic and psychodynamic community. But most people needed crisis counseling and not traditional psychiatry. New York has the largest licensed mental health work force in America, but the 9/11 disaster would require a broad spectrum of community members, clergy, and other paraprofessionals functioning as crisis counselors who would understand distress rather than focusing on diagnosing posttraumatic stress disorder.

Even New York was not ready for a disaster this big. The number of deaths were "too many to bear," (Giuliani, 2001); the proud and symbolic towers of strength were in a crumbled, burning heap in the middle of downtown

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Manhattan; thousands of survivors, witnesses, and children were filled with fear and terror and; the concept of safety in the United States was shattered.

Project Liberty's lessons are much more concrete and were very evident shortly after the structure of the crisis counseling program was developed. Later on several problematic issues were brought to light that had been more difficult to discern in the first phase of the program. While not in any chronological order, there is some time logic to the lessons learned by the project that are noted here to help inform future planning.

The need for planning was the first obvious issue to address especially since the threat of additional terrorist strikes has not disappeared since 9/11/01. The country became starkly aware of how few states would have been prepared to respond to a disaster of this magnitude.

The New York State Office of Mental Health, along with the city and county Local Governmental Units (LGUs) had to develop a whole new disaster mental health infrastructure from scratch, while at the same time responding effectively and efficiently to the disaster (It's been compared to fixing a plane while flying it.). This involved developing and implementing

local Plans of Service with New York City and 10 surrounding counties, all of which had separate governmental, mental health and substance abuse authorities.

... it's been compared to fixing a plane while flying it.

The Research Foundation for Mental Hygiene, the arm of the New York State Office of Mental Health that received the grant, had to initiate contracting processes with all of these LGUs and additionally oversee the contracting process with approximately 200 agencies.

Because government units and agencies utilized different mechanisms for payment and reimbursement, various financial structures had to be developed that would comply with the grant requirements, be understood by all the agencies who had to utilize them, and stand up to State and Federal audits that were certain to occur. Many agencies and organizations had difficulty with the alternate finance system. Others did not want to have to reorganize their own system and spend time training/retraining staff in a new format that they knew would only be utilized on a temporary basis.

Crisis counseling, outreach, and disaster public education were new interventions to the mental health community in general, and in New York City as well as the counties. There were, of course, a handful of individuals who had responded to prior incidents, but they were a minority. The public mental health system's focus in most States is on the seriously and persistently mentally ill whose care is generally in the hands of the public system from emergency hospital care to supervised living situations. A system to develop curriculum and operationalize the structure of staff training and provider assistance had to be created in disaster time, which generally means yesterday. The numbers were enormous and estimates always seemed to minimize the need.

The program eventually trained approximately 5,000 crisis counselors who came from various professional fields as well as from grass roots community agencies who were successful in hiring cultural brokers to assist in gaining entrée into closed ethnic groups and special populations. They delivered services in 37 languages and more dialects. Counselors who were used to one-to-one contacts had to learn to speak with families and address groups in public education sessions. The requests for speakers to provide psycho-educational material

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to large businesses were endless in the first year of the disaster response and continued beyond the first anniversary.

The development of appropriate public education materials in many different languages was an urgent need. A public mental health campaign had to be launched. Material for brochures describing the expected psychological effects of terrorism and disasters was researched and reviewed with expert assistance. Translation was slow and difficult. Delivery to agencies with little space; distribution to clients, families, churches, and community organizations; and anticipating storage needs were new functions to learn. This was only one piece of the media campaign that eventually distributed more than 20 million brochures in 12 languages.

The first television commercial was aired in the New York metropolitan area within one month of the disaster. A survey conducted in November 2001 by the Galea et al., (2001) told us that approximately 25 percent of New Yorkers knew about Project Liberty and of those 25 percent, 70 percent heard it from the television commercial. While the political figures who volunteered to address their community in the first commercial caused a controversy that resulted in our subsequently using professional actors for the next five culturally sensitive

commercials, the message was clearly getting across. For a governmental system that spent their time trying to avoid making the news, this type of public relations was unknown. There were details, innuendos in the advertising field, and contracting issues that were not easy to manage in an emergency time frame.

Exercising a disaster plan may also help communities identify those issues that are more difficult to discover until one is in the midst of a response.

Research in the midst of disasters is a controversial issue that has slowed the volume of empirical evidence in the literature to inform the mental health community. While many crisis counseling programs have collected data from previous disasters, there was much to be learned from the unprecedented incident of the World Trade Center attacks. A detailed program evaluation required extensive data collection and evaluation modules that had not previously been developed. While the grant restricts

research for obvious reasons, the analysis of the demographic data, risk categories and event reactions will serve to inform the larger picture of the effects of this enormous disaster.

A complete planning program would help prepare communities to address some of these issues and address those that may be predetermined through contracting mechanisms as emergency services clauses. Exercising a disaster plan may also help communities identify those issues that are more difficult to discover until one is in the midst of a response.

We learned, starkly, that the public mental health system is not prepared to respond to terrorism specifically. This includes our provider community of hospitals, and clinical and community mental health centers who have more experience working with crisis situations than most health care professionals. Responding effectively requires an expansion of focus to the entire population. To do this effectively, mental health and substance abuse authorities and agencies must assume non-traditional public health roles. Disaster mental health funding streams, plans, training, public education, and research must become a mainstream aspect of public mental health policy and practice at every organizational level.

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Responding to an incident of mass violence brings out the good in people and organizations. Qualities such as empathy, compassion, willingness to collaborate, and flexibility are in abundance and greatly facilitate the process of assembling an effective mental health response. By definition, an emergency provides “cover” that enables people and organizations to think outside the box, rapidly overcome the typical bureaucratic obstacles to mounting any new program, and be less risk-averse. This does not remain for the long term. The familiar, slow bureaucracy creeps back into routine systems. People need to understand the need to determine the time frames for working under the “disaster” guidelines. Too often we heard, “The crisis is over. It’s six months later already. We’re not doing it that way anymore.”

Government sponsored training and technical assistance that integrate training curriculums

The trainings also need to include the identification of community-based, resilience-building activities that are both preventative and restorative.

regarding responding to disasters and terrorism may be offered through: universities; clinics; grass roots, faith-based, and community-based organizations; and businesses. These trainings may include the understanding of the need to conduct outreach to the general population, not just individuals who are direct victims or those that present for treatment. The trainings also need to include the identification of community-based, resilience-building activities that are both preventative and restorative. This would

help forward the agenda that mental health is of primary concern especially in the aftermath of terrorism and disasters.

A result of such training could also be the development of a training database of disaster-trained counselors prepared to conduct broad outreach into affected communities in the event of any future disaster.

A reassuring lesson learned was that the combination of crisis counseling, outreach, and public education, which are the services currently funded under FEMA, appears sufficient to meet the disaster-related mental health needs of many affected individuals and that the FEMA crisis counseling model can be successfully implemented in a complex, highly diverse urban environment like New York City.

April Naturale, MSW, LCSW, ACSW, was the statewide director of Project Liberty.

Upcoming Meeting of Interest

2004 ANNUAL ISTSS MEETING

November 14-18, 2004

New Orleans

The International Society for Traumatic Stress Studies (ISTSS) will hold its 20th anniversary meeting November 14-18, 2004, in New Orleans. In recognition of this important anniversary, the meeting will explore a theme of great international relevance: War as a Universal Trauma. To many trauma professionals, the

topic of war trauma conjures up images of soldiers or veterans. In fact, war affects not only combatants but also the men, women, and children in whose country the fighting takes place, exposing them to danger and dislocation, and sometimes destroying the institutions and infrastructure of their societies.

The scope of the 20th annual meeting is broad in recognition of the diverse types of populations affected by war: active duty personnel, veterans, civilian adults and children

exposed to war trauma, aid workers, and refugees and internally displaced people. Trauma types experienced by these populations include combat, peacekeeping, and terrorism and bioterrorism, as well as torture, sexual trauma, and other types of violence that may occur during an armed conflict. Topics will range from basic science and epidemiology to treatment and prevention, as well as policy and other issues of social relevance.