In the Aftermath of Disaster

Challenges, Successes, and Lessons Learned in Community Response

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  - Houston-Galveston Institute
  - Mental Health and Mental Retardation Authority of Harris County
  - Network of Behavioral Health Providers
- Our New Community Members

Background

- As people dislocated by Hurricane Katrina began to arrive in Houston, Mayor Bill White and Harris County Judge Robert Eckels held daily meetings to share information about new and emerging activities and developments.
- Upon hearing from many community health care and social service providers about the likely psychological impacts of the disasters, the Mayor and Judge formed an *ad hoc* group of service providers and behavioral health professionals to create and document a vision for integrating behavioral health services.
- The document would identify ways to minimize gaps in service and avoid duplication. At the same time, it could guide City and County officials as they reviewed applications for funding.

The Situation in Houston

- The evacuee/survivor population was entering the disillusionment phase of recovery.
- Available resources were not being used as efficiently as possible.
- Local organizations, professionals, and volunteers were strained.
- No common “voice” was articulating or responding to the problems.
- Many ongoing needs in Houston were temporarily set aside.

Need for Rapid Service Expansion

- Mental health and social service systems were underfunded and at capacity before Katrina/Rita.
- Over 150,000 evacuees and survivors sought refuge in the Greater Houston area, most traumatized by the disaster and sudden evacuation.
- Many affected by pre-existing mental illness arrived without medication or medical records, and some people experienced new onset problems.
- Significant destabilization, loss, and grief associated with the fracturing of families and dissolution of home communities was common.
- Few were prepared for immediate resettlement.

A Collaborative Approach

- Developing a cohesive strategy to guide the development of a wide range of component parts in a community response process
- Working from the same model and using similar language across groups
- Recognizing the need to connect with systems already in place along with new systems to communicate this common perspective
- Enhancing communication and accountability while responding effectively to current and future needs
- Reducing duplication of services and identifying gaps
- Helping to dispel misinformation

Organizational Challenges

- Making adequate time for planning, development and implementation while working across multiple groups
- Determining inter-group agreement on processes, interventions, and accountability
- Developing functional leadership approaches
- Maintaining balance between small community based organizations and large institutions, such as universities and medical schools

The Houston Model

- We recognized the reality of mental illness, but focused on broad psychosocial needs, viewing mental health as a dimension of wellness.
- We viewed personal experiences in response and recovery as a process that could continue over a period of months, and perhaps years.
- Our approach—the Houston Model—involved a continuum of activities and services provided by a diverse group of behavioral health providers and others to effectively respond to the needs of people in the aftermath of disaster.

Points of Contact for Evacuees and Survivors

- Schools
- Disaster Case Managers
- Faith communities
- Health care, particularly primary care
- Housing
- Community volunteers
- Social service agencies
- Federal and State agencies

Services Plan

- Capacity Building
  - Providing training and support in disaster mental health for case managers, primary care providers, school personnel, and behavioral health professionals
- Community Resiliency
  - Promoting positive community adaptation by forging partnerships between organizations and individuals, public information campaigns, and support groups
- Clinical Services
  - Expanding the safety net for people in need of more intensive mental health services through outreach and screening, crisis counseling and evaluation, and creation of a *pro bono* behavioral health network

Our Guiding Principles

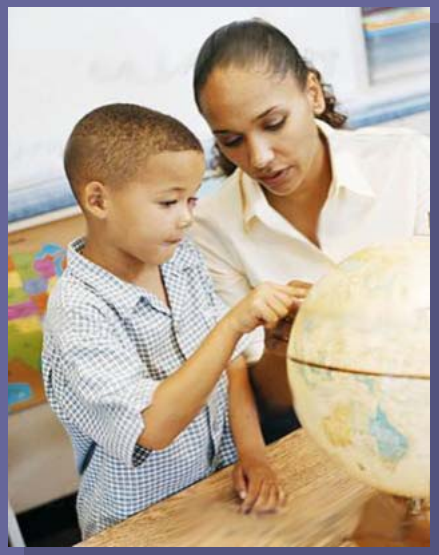
- Promote emotional wellness in response to trauma
- Promote community as a healing place
- Involve community leaders from diverse cultural and interest groups
- Forge sustainable partnerships to support recovery and resilience
  - Organizations
  - Individuals
- Anchor activities in customs, traditions and kinships within natural settings

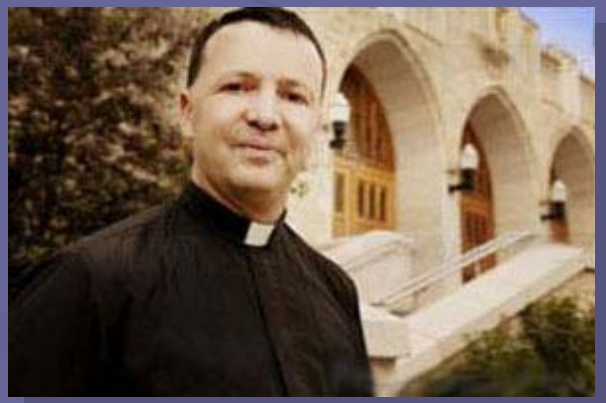
Training Across Settings

Caseworkers, Social Service Personnel, Behavioral Health Professionals

Family Physicians, Other Primary Care Providers

Teachers and other School Personnel





Ministers, Lay Clergy, Community Volunteers

Training Needs

- Many case managers and other providers were “new hires” added on a contract basis to supplement previously underfunded and understaffed organizations.
- Initial training undertaken by many organizations focused primarily on internal documentation and reporting requirements.
- Early community discussions tended to focus on psychiatric case-finding and referral, rather than a broader public health approach.
- Little uniform or specialized training was provided across groups. When training was provided, it tended to involve multiple approaches, materials, and training techniques.

Training Challenges

- Lack of evidence-based models for training in long-term disaster recovery
- Broad range of experience and expertise across training audiences
- High case/patient loads and scheduling demands; competing demands for staff training time, both within the project and within home organizations
- Frequent funding cuts and turnover at organizations responding to the disaster
- Ongoing financial uncertainty among provider and client/patient populations
- Geographic and transportation limitations; necessity of offering training sessions in multiple and varied locations, rather than a centralized location
- Constantly shifting client/patient population, with evolving demands and frequent changes in their funding and processes for obtaining resources

Our Successes

- A body of training materials and a common framework for disaster mental health response across providers, from case managers to primary care physicians and mental health providers
- A *pro bono* counseling program of trained behavioral health providers in service to the Houston community
- An opportunity to open a dialogue on resiliency and post-traumatic growth within the field of disaster mental health
- Increased awareness of community resources, as well as gaps and continued needs in delivery of behavioral health services
- An opportunity to learn from community partners while forming new collaborations

Pro Bono Network

- Based on best practices from across the country
- An extension of the Mental Health Association's existing Information & Referral (I&R) service.
- Involvement and buy-in of local mental health professional organizations and representation of their interests:
  - Free training and CEU opportunities
  - Careful screening and matching between pro bono therapists and clients
  - Flexibility—counselors choose how many clients they will see, what types of clients they will see, etc.
  - Independence—counselors remain in control of evaluation, treatment plan, course of treatment, length of treatment, etc., for each client
  - Motivation and recognition of volunteers

Lessons Learned

- Maintaining an effective response requires ongoing assessment of needs through multiple methods.
- Training and support must remain flexible and responsive to the changing needs of displaced people and their social service and mental health providers.
- Securing funding and implementing an effective response may require education of community organizations and funders about:
  - The trajectory of disaster recovery
  - The variability of long-term psychosocial needs
  - The need for early and ongoing engagement in training and problem solving

Reflections on Clinical Model of Care

- The clinical model of mental health care did not meet the needs of most people affected by the hurricanes.
- Short-term crisis counseling did not provide the level of support needed to address the magnitude of the distress experienced.
- A more useful model is one in which services "go to the person" and address practical and psychosocial needs.
- A "habilitation plan" for moving forward in new directions should be included in the model.

Pre-Disaster Planning Recommendations

- Expand the definition of disaster mental/behavioral health beyond DSM-IV diagnostic language to include a continuum of normal-spectrum, self-limiting responses reactions to disaster. Broader definitions can circumvent categorizing and pathologizing responses.
- Develop an operational vision and materials for providers in advance.
- Encourage collaborative efforts among behavioral health providers, community psychologists and public health specialists with a background in disaster psychology.
- Integrate behavioral health into the overall disaster response in ways that go beyond having clinicians serving as treatment professionals in the medical area. This can include such activities as checking on persons who are not presenting for patient care services or providing trouble shooting and distress mitigation services in shelter operations.
- Train with other specialists to gain a clear understanding of everyone's role. Include an "emotional impact" component so that drills and exercises will have an added degree of realism.
- Add "just in time" orientation and training materials to bring responders up to speed quickly, particularly in the event of large disasters.

Post-Disaster Policy Recommendations

- Maximize effectiveness by working in interdisciplinary teams in response and recovery.
- Describe and promote services carefully, paying attention to cultural considerations as they relate to recovery, service utilization, service formats and settings and provider dimensions. Remember that even under ideal circumstances, mental health services can carry a stigma.
- Recognize the broad view of mental health and disaster recovery as a continuum from emotional well-being, resiliency and post-traumatic growth, up to and including mental illness.
- Recognize and build upon community strengths, emphasizing community as well as individual resiliency. During disasters, people turn to family, friends and faith groups for healing and rebuilding. These social networks are important resources for disaster recovery.
- To the extent feasible, embed behavioral health care within case management, rather than relying solely on a referral model.
- Consider that any encounter with a client is potentially therapeutic or harmful. Therapeutic does not necessarily mean therapy in the typical behavioral health use of the term.

Additional Needs Identified

- Programs or services that could facilitate future partnership efforts in the aftermath of a major disaster include:
  - An integrated plan for disseminating and/or accessing available funding opportunities
  - Searchable website to connect programs and services with common goals, serving common populations, offering complementary programming, etc.
  - Online directory with continuous updates of providers, services, locations, hours, routes, availability, and necessary documentation.

Unanticipated Benefits

- The nature of the disaster and the immediacy of needs led organizations to move beyond their typical agency-to-agency interactions and relationships.
- For all community partners, this was an opportunity to work closely together in a situation where combined efforts could make a difference.
- Success was due in large part to the level of trust and joint commitment that developed, with sharing of plans, budgets, and other information usually held confidential.
- Time spent in volunteer activities and planning sessions prior to funding created a common history and shared perspective.
- The community partners continue to meet and are formulating the mission, goals, and ongoing activities of the group.

Conclusions

- The need for community-wide education about “mental health as inclusive of mental wellness” continues to be high.
- Two years after the disaster, funds set aside for mental health services are not being utilized by people who are still struggling to regain their lives.
- Forcing people affected by disaster into the existing model of mental health care—a model that frequently dictates a DSM-IV diagnosis before services can be accessed—is not effective.
- Over-diagnosis may occur, and, no matter how benign the intent, long-term implications for the individual may be inevitable.
- Future programs should consider a revised model of behavioral health delivery, one that meets broad psychosocial needs and works within the framework of people’s lives.
- Public education campaigns should be considered a crucial element of disaster response and funded accordingly.

"We are a wiser community for our experiences. We are much better prepared for a disaster of our own. As we witnessed and participated in the Katrina experience we also had a chance to come to a deeper understanding of issues of race, poverty, well-being and opportunity here in our own community. As we understand our reactions and expectations, we move to a new place. This is one of the gifts from this experience and its potential is huge."

~ Dr. Stephen Pierrel