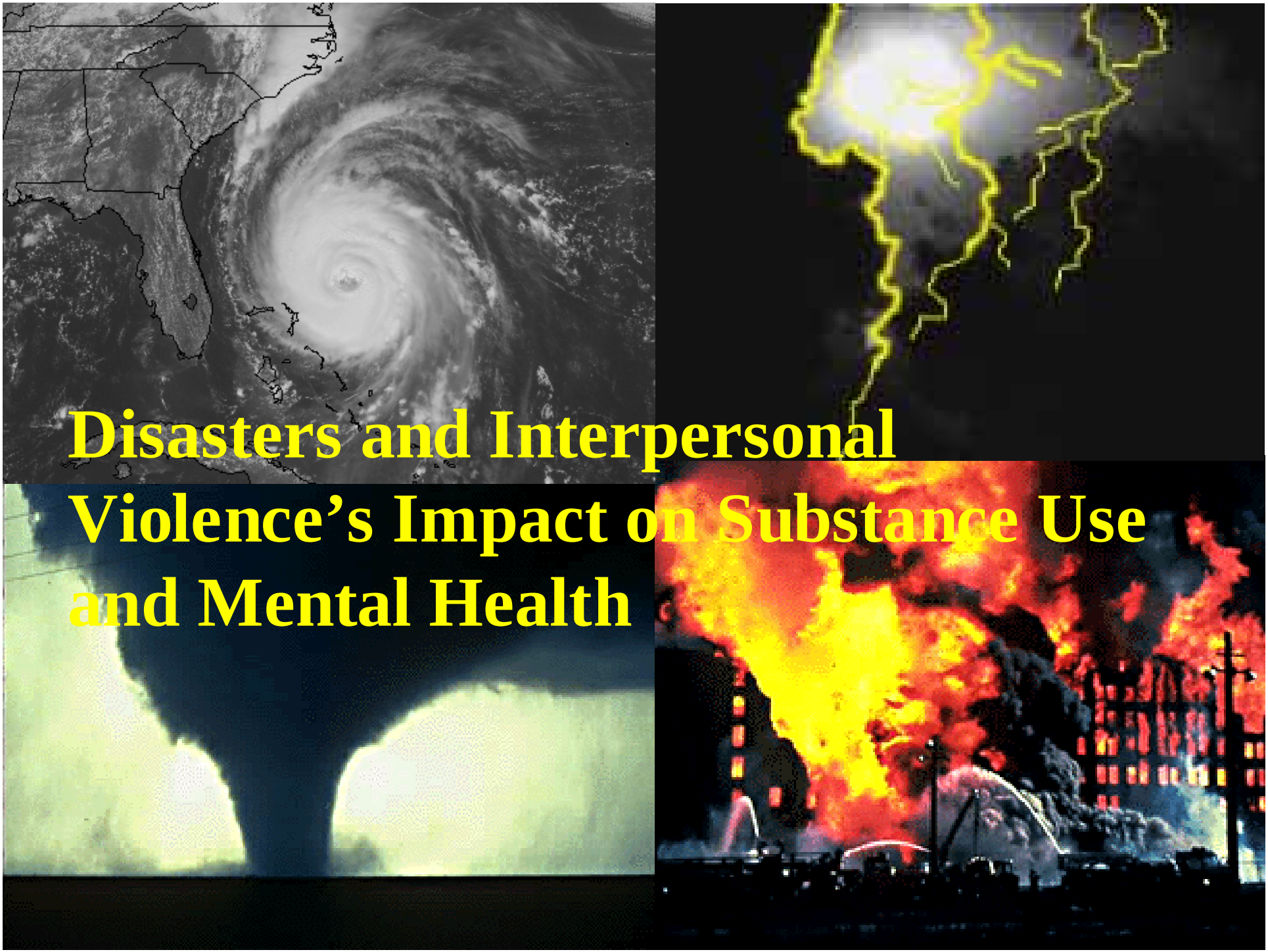
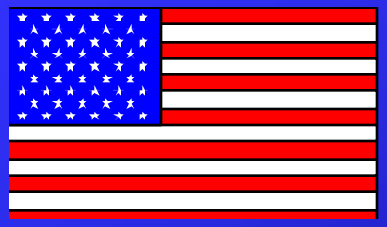


Disasters and Interpersonal Violence's Impact on Substance Use and Mental Health



Mitigating the Impact of Disasters and Violence: Public Health Opportunities & Challenges

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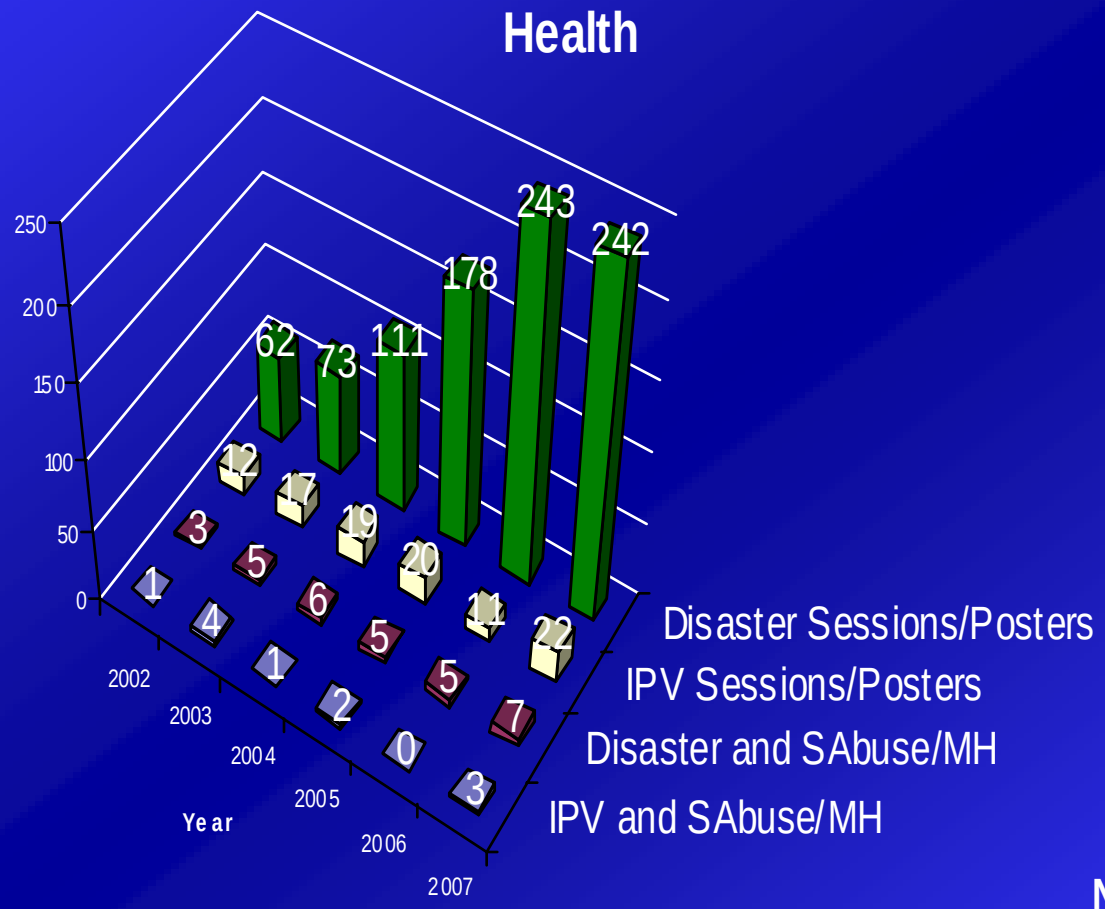
Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

During this session you will learn-

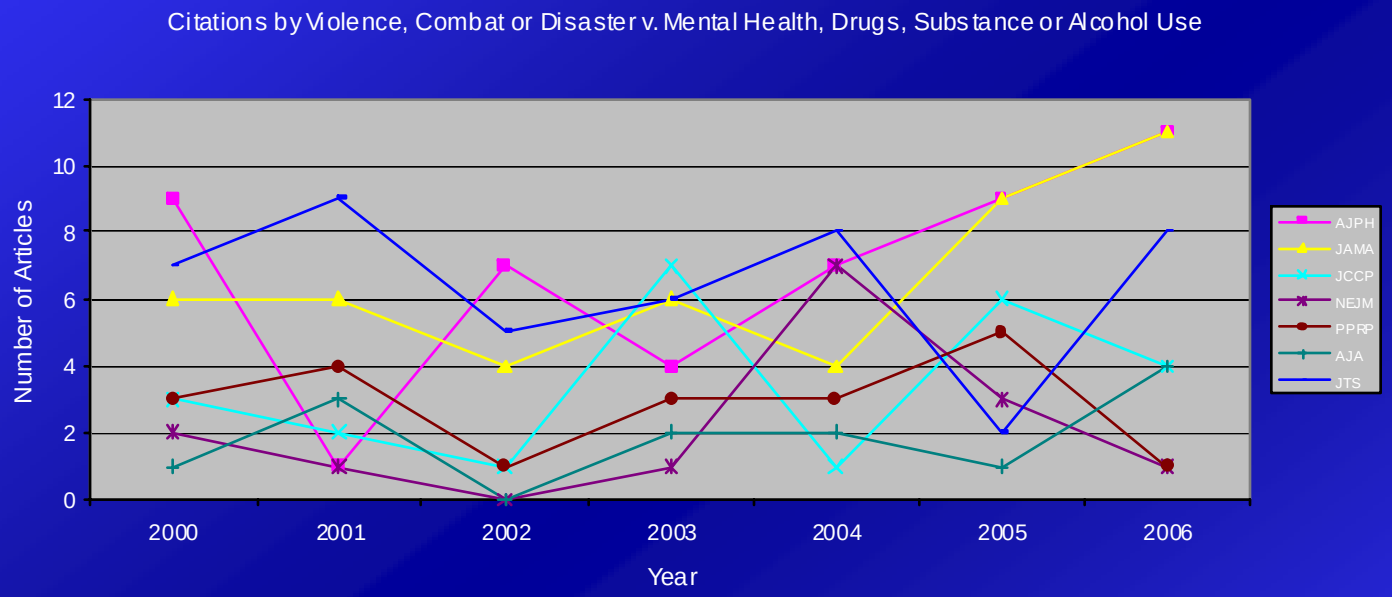
- Markers of the public health field's growing interest and resources on this topic;
- Definitions of disaster, trauma & interpersonal violence
- What the data sources tell us about disaster, trauma, & interpersonal violence;
- How data can be used, within the public health framework, to drive policy development;
- Evidence of the Federal commitment to mitigate the impact of disasters, trauma, & IPV on substance use and mental health.

Interpersonal Violence and Disaster v. Substance Abuse and Mental Health



Number of APHA Sessions/Posters by Topic

Public Health Research Emphasis



(AJPH)	**American Journal of Public Health**
(JAMA)	**Journal of the American Medical Association**
(JTS)	**Journal of Traumatic Stress**
(JCCP)	**Journal of Consulting and Clinical Psychology**
(NEJM)	**New England Journal of Medicine**
(PPRP)	**Professional Psychology: Research & Practice**
(AJA)	**American Journal on Addiction**
(JDD)	**Journal of Dual Diagnosis**

Disaster, as defined by the World Health Organization, is:

- A severe disruption, ecological and psychosocial, which greatly exceeds the coping capacity of the altered community.
- A disaster may be natural, such as a hurricane or fire, or it may be man-made, such as a terrorist attack.

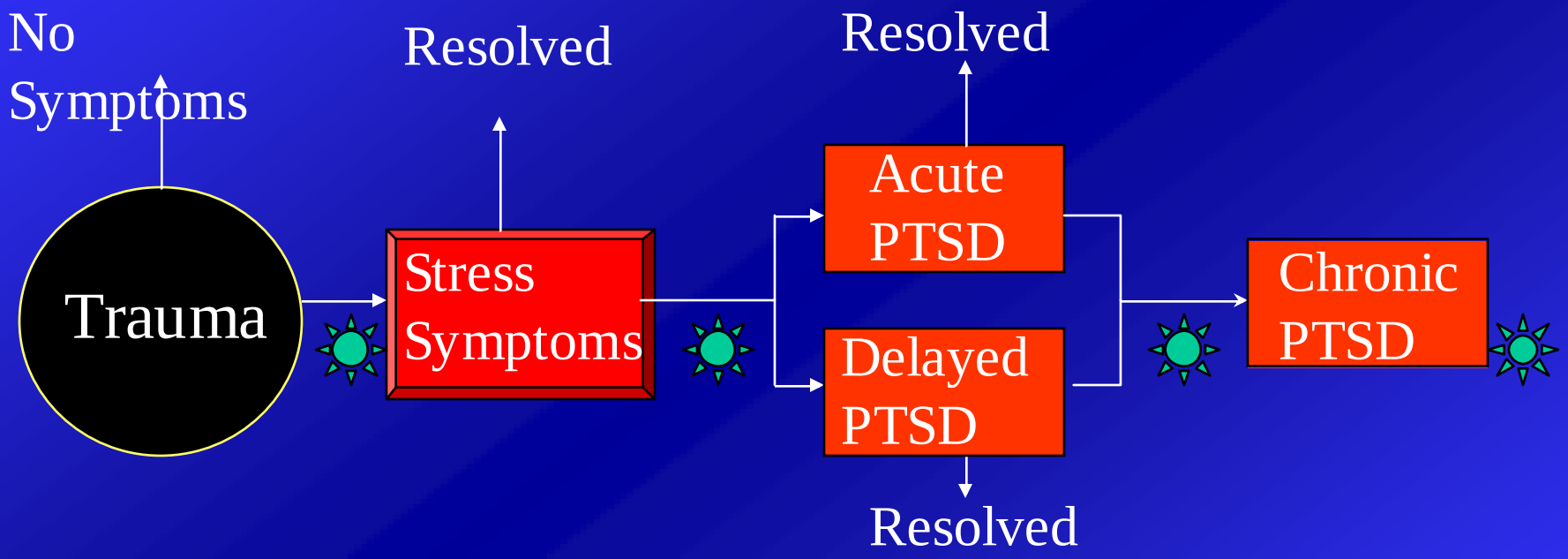
Collective Reactions
Typical phases of disaster:

Adapted from CMHS, 2000.

Definition of Trauma

- An event that involves actual or threatened death or serious injury or threat to one's physical integrity;
- Directly experienced, witnessed or learned about events.
- Examples of trauma include: IPV, serious accident, serious injury, sudden unexpected death, one's child has a life-threatening disease.

"No Wrong Door"—SA Delivery System and Trauma



= Intervention points for the Substance Abuse Delivery System following a traumatic event

PTSD = Post Traumatic Stress Disorder

Time Course of Response to Trauma

- Acute Stress Disorder

Lasts for a minimum of 2 days and a maximum of 4 weeks

Occurs within 4 weeks of the trauma

- Post Traumatic Stress

Acute- < 3 months duration of symptoms

Chronic-> 3 months of symptoms

Delayed onset- 6 months between trauma & symptoms onset

Substance use prevention & treatment capacity loss pre & post Katrina

Lost Capacity by Treatment Modality			
LEVEL OF CARE	BEDS	ADMISSION CAPACITY	TOTALS
Medical Detox	20	1,465	
Medically Supported Detox	6	438	
Social Detox	24	1,251	
In-Patient Residency (short-term)	104	1,549	
Community Based (long-term):			
•TANF	55	207	
•Half-way Houses	116	470	
Recovery Homes	91	91	
TOTAL 24-HOUR CARE			5,471
Out-Patient	20		7,600
Prevention Programs	25		41,600
TOTAL LOST CAPACITY			54,671

Pre- Katrina

2004-2005:

Served 47,379 Individuals In Treatment

Served 167,624 Individuals In Prevention

Post Katrina

2005-2006:

Served 34,665 Individuals In Treatment

Served 72,416 Individuals In Prevention

Katrina: 6 months later

- Overall, 24.1 % of respondents reported “fairly often” or “often” they were unable to control important things in their lives;
- Data indicate that women, blacks and persons of lower income were more likely to experience stress;
- Higher stress levels may disrupt sleep patterns, consumption of breakfast, and may lead to increased cigarette smoking and alcohol consumption, which may be detrimental to mental health.
- Less than one in five survey participants sought the help of a mental health professional.

More recent 9/11 terrorism findings indicate:

- Exposure to terrorism can be physical or psychological. Evidence indicates that cumulative effects of exposure to multiple traumatic events is more harmful than a distance, single event;
- Specific to 9/11 less attention was given to the relationship between substance use & trauma in adults.
- At a 6-month follow-up after 9/11. PTSS had declined, whereas substance use persisted.

According to Vlahov et al Population estimates following 9/11/01 tell us

- 265,000 people increased their use of any substance:
  - 89,000 smoked more cigarettes;
  - 226,000 consumed more alcohol;
  - 29,000 used more marijuana

Am J Epi 2002: 155:988-96

Vlahov et al, reports further that

- Among those who already smoked cigarettes before 9/11/01, 41% smoked more cigarettes after the events;
- Among those who drank alcohol, 41% drank more alcohol after the event

NYC's Dept of Mental Health & Alcoholism Services 9/11 priorities

- Provided crises intervention to survivors, bereaved families and Ground Zero workers;
- DMHAS and other providers developed a long-range plan to provide services to those affected by the attack;
- Conducted a telephone survey between Oct-Nov 01which revealed that: 7.5 % reported PTSD symptoms; 9.7% reported current depression.
- Symptom prevalence declined overtime, however, *symptoms persisted more than 3 months in vulnerable populations, such as drug users.*

Anti-anxiety Drug Use Jumps

- Use of lorazepam increases
  - 19% in New York
  - 16% in D.C.
  - 6.3% Nationally
- Use of diazepam increases
  - 14% in D.C.
  - 8% in New York
  - 3% Nationally

Impact on alcohol consumption following disasters

- After Hurricane Hugo beer consumption rose 25%;
- After the Oklahoma City bombing, alcohol consumption in the year of the bombing was 2.5 times greater than a control community

Definition and Consequences of Interpersonal Violence

- CDC defines IPV as an actual or threatened physical, sexual, psychological or stalking violence by a current or former intimate partners (whether of the same or opposite sex.)
- The risk of PTSD from the index trauma associated with previous violent assaults persisted over time with no change
- The effects of trauma from non-assault violence decreased by an estimated 8% per year

Gender Differences and IPV

- Females are more likely to develop PTSD from exposure to trauma
- Women's higher risk of PTSD is not attributable to sex differences in history of previous exposure to trauma

Breslau et al, Am J Psychiatry 156:902-907 (1999)

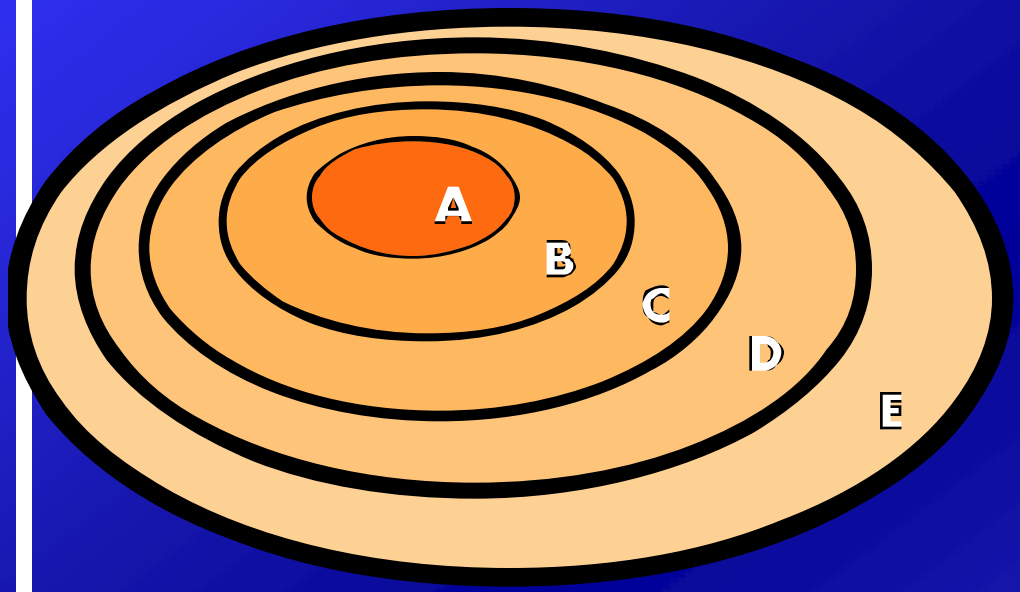
Consequences of IPV

- IPV is also associated with a variety of negative health behaviors. Studies show the more severe the violence, the stronger its relationship to negative health behaviors by victims such as using or abusing harmful substances, smoking, drinking alcohol and driving after drinking, taking drugs
- Women with history of IPV are more likely to display behaviors that present further health risks such as substance abuse, alcoholism, and suicide attempts

What Data Are Needed ?

- **Pre-Disaster Perceptions, Preparedness, Preferences**
- **Practical Information to Inform Recovery Efforts**
- **Learning to Prepare and Minimize Adversity**
- **Different approaches require data:**
  Population vs. Individual Data Levels

Key Concepts (cont.)
Risk factors–Population Exposure Model:



A. Injured survivors, bereaved family members

B. Survivors with high exposure to disaster trauma, or evacuated from disaster zones

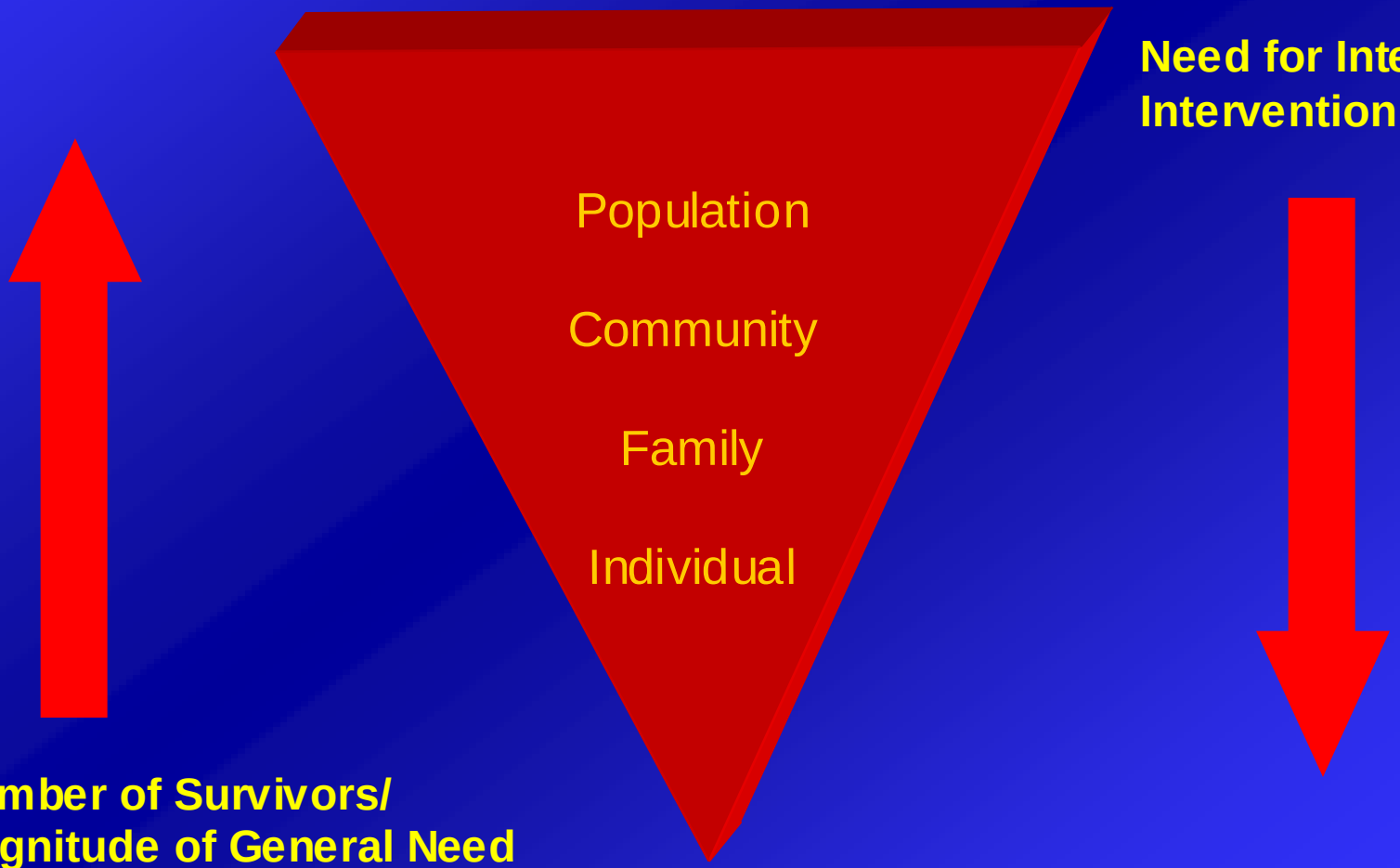
C. Bereaved extended family and friends, first responders

D. People who lost homes, jobs, and possessions; people with pre-existing trauma and dysfunction; at-risk groups; other disaster responders

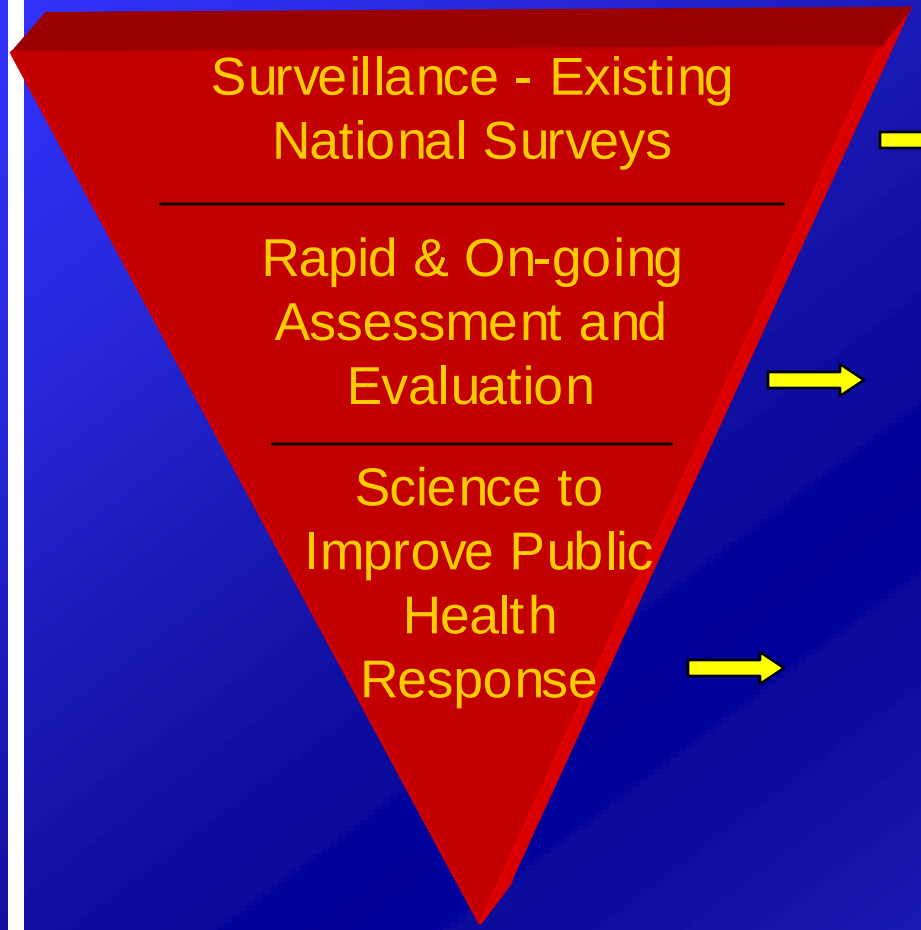
E. Affected people from the larger community

Adapted from DeWolfe, 2002.

Distribution of Need and Level of Intervention



Disaster Preparedness and Response – Data Needs



Public perceptions and behaviors over time and in response to significant events, campaigns, news announcements, etc.:

Impact of events over time and in relation to rescue, response and recovery efforts

Information to improve public health response, promote resilience to stress, manage population distress, and prevent and cure mental disorders

Taking the data to policy and program steps

- Need for Federal, State, and community data in advance of event;
- Need for role definition to develop policies in advance of an event and on the spot;
- Data and lessons learned guide action, policy development, and workforce involvement and roles

Lessons Learned To Drive Policy and Practice Systems following Disasters, Trauma, IPV

- Nature, duration, proximity and severity of the traumatic event
- Preparedness and training of staff within the treatment delivery system
- Ability of substance abuse and mental health staffs to recognize symptoms of stress within staff and among patients

As an Example – following 9/11

- Methadone maintenance clinics south of 14th St were declared off-limit and were inaccessible to patients;
- Guest-dosing arranged for other facilities:
- Service providers must have emergency plan in place for methadone patients in the event of a disaster

San Diego Fires

Los Angeles Times. (2007, October) Retrieved October 26, 2007, from: lhttp://www.latimes.com/media/photo/2007-10/33469039.jpg

Lessons Learned: SA and Mental Health Intervention of Disaster, Trauma, IPV

- Increased demand for services from people with lifetime histories of substance use disorders
- Increased demand for services from people with current substance related disorders
- Increased symptoms, medication or substance use does not mean increased psychiatric pathology, substance abuse or dependence;
- Ignoring symptoms may mean ignoring pathology

Symptoms and Pathology

- Increased symptoms, medication or substance use does not mean increased psychiatric pathology, substance abuse or dependence
- Ignoring symptoms may mean ignoring pathology

If we don’t ask, they won’t tell

- It is important for SA treatment providers to recognize that traumatic events leave their imprints of patients
- Disasters, terrorist attacks, and other generalized traumatic events such as IPV may activate pre-existing PTSD or compound the effects of previous trauma
- If clinicians don’t inquire about the effects of a traumatic event, many patients will not discuss them

SA Treatment Programs and Trauma Issues

- SA Treatment programs should routinely assess patients for histories of traumatic events and for the diagnosis of PTSD
- SA Treatment programs should offer therapeutic experiences designed to focus on histories of trauma and of PTSD
- SA Treatment programs should be prepared to address disasters and terrorist attacks

Public Health Campaign for Early Intervention Strategy - *Disasters and Terrorist Attacks*

Addressing distressing symptoms:

- Fear
- Panic
- Stress
- Dysfunctional coping

Public Health Strategies and Specific Populations

- General populations
- Vulnerable populations
  - Histories of previous trauma
  - "Ground Zero"
  - Substance abuse histories
  - Mental health Issues
  - 1st responders

Substance Abuse Providers and Disaster or Terrorist Attack - *General Population*

- Educate about stress, coping and substance use
- Appear on local radio, TV or in local newspaper describing ATOD and Mental Health components of disaster preparedness and reaction
- Work with faith community, Red Cross, and other community groups to offer discussions and information about PTSD and ATOD

Substance Abuse Providers and Disaster or Terrorist Attack - *Special Population*

- Address Administrative Issues
  - Treatment Program Disaster Plans
  - Staff knowledge and preparedness
  - Treatment Program Operations
- Address Staff Morale Issues
  - Support
  - Concerns about Self and Family
  - Safety
- Address Patient Issues

Substance Abuse and Mental Health State Systems: Team Structure

- Substance abuse and mental health agency;
- State Emergency Management Agency;
- Homeland security
- Governor's office;
- Private and faith organizations;
- Service providers and associations,
- Advocacy and recovery groups

www.samhsa.gov

1-800-662-HELP

CSAT National Helpline

1-800-729-6686

Publication Ordering including CSAT's Disaster Recovery Resources CD