After the Crisis: Healing from Trauma after Disasters

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Executive Summary

Considerable work has been done over the past thirty years concerning the role of behavioral health systems in disaster response. State and federal governments and national disaster response organizations have provided leadership in addressing mental health needs in both disaster preparedness and response. Some attention has been paid to the needs of people diagnosed with mental illnesses, who may be at higher risk for distress following disasters, and whose stress symptoms may manifest in ways that mimic exacerbation of psychiatric illness. In particular, they may be at risk for developing post-traumatic stress symptoms over time. This increased risk may be due in part to lack of resources or to characteristics associated with the diagnosis, such as an increased sensitivity to stress. However, a growing body of evidence suggests that increased vulnerability probably reflects the high rates of previous forms of trauma, especially childhood physical and sexual abuse, which can range up to 90% or more among this population. Higher rates of post-disaster distress among people with psychiatric diagnoses may also be related to the increased risk of victimization (particularly interpersonal violence) following a disaster. In addition, disasters pose unique problems for people with mental health problems and abuse histories residing in psychiatric facilities and in correctional settings, and those who experience violent crimes in the aftermath of a disaster.

Despite this evidence of increased vulnerability, people with mental health problems and abuse histories often rise above the immediate distress of a disaster to provide leadership and support to others. In the past few years, some of the most exciting and innovative approaches to mental health disaster response have been peer-run and peer-delivered services. Peer-run programs are inherently consistent with established principles of disaster response, since they emphasize outreach, occur in natural community settings, emphasize people's strengths, avoid mental health labels, and are likely to be culturally sensitive because they are delivered by people who are themselves community members. However, information about peer-run programs is not widely available and is only beginning to be integrated into mainstream disaster response.

Another recent development relates directly to the delivery of behavioral health disaster response services. Mental health systems increasingly recognize the prevalence of abuse histories among the people they serve, and are beginning to develop "trauma-informed" systems of care. As these systems evolve, increasing numbers of staff, administrators and consumers develop knowledge and skills directly relevant to disaster preparedness and disaster response. However, because the development of trauma-informed systems is in its early stages, this expertise is not widely incorporated into disaster planning and response protocols.

After the Crisis: Healing from Trauma after Disasters will bring together experts to review the knowledge base, identify gaps, and make recommendations for development of materials and strategies for supporting further development and implementation of trauma-informed and peer-run disaster preparedness and response efforts.

The Behavioral Health System

Considerable work has been done over the past thirty years concerning the role of mental health systems in disaster response. Through the *National Association of State Mental Health Program Directors* (NASMHPD), state mental health systems have stepped forward to accept the lead role in responding to the psychosocial consequences of disasters, adopting a community-wide public health approach and emphasizing the importance of addressing behavioral health needs within all disaster planning and response activities[1]. State disaster response efforts have been monitored and reviewed, plans have been written and implemented, and the importance of coordinating with other groups and agencies involved in disaster response has been highlighted[2]. The federal government has also taken a leadership role in this area. Guiding principles for state and local mental health authorities and providers serving people diagnosed with serious mental illness have been developed[3], tools for mental health disaster preparedness and planning have been published[4], and psychological issues confronting disaster relief workers in the aftermath of disaster response efforts have been addressed[5].

Individual-Level Issues

Attention has been called to the particular needs of "special populations," including mental health consumers, children, older adults, people with hearing impairments, and people with substance abuse problems[6]. It has been noted that people diagnosed with severe mental illnesses appear to be at increased risk for distress following disasters, and that their stress symptoms may manifest in ways that mimic exacerbation of psychiatric illness. In particular, they may be at risk for developing post-traumatic stress disorder or symptoms over time. However research findings are inconsistent, with some studies showing no differences in post-disaster distress symptoms between groups with and without diagnosed mental health problems[7].

Increased risk of post-disaster distress for people diagnosed with severe mental illnesses may be in part due to lack of resources or to characteristics associated with the diagnosis itself, such as increased sensitivity to stress. However, increased vulnerability probably reflects the high rates of previous forms of trauma among this population. Very high rates of prior abuse, especially childhood physical and sexual abuse—ranging up to 90% or more of some populations—have been documented among people served in state hospitals, outpatient mental health programs, substance abuse treatment programs, homeless shelters, and other mental health service settings[8]. Although the neurobiology of psychological trauma is in its early stages, the impact of violence on the brain is clear and trauma—especially childhood abuse—has been shown to be cumulative[9,10]. For people with severe trauma histories—the majority of people with psychiatric diagnoses—the experience of a disaster may lead to retraumatization, relapse or disruption of ongoing recovery. Although little research has been done on this topic, anecdotal evidence suggests that the specific dynamics of disasters, including the sense of loss of control, chaos, and abandonment, can be experienced as a re-enactment of old trauma and may contribute to increased risk for suicide and other unexplained post-disaster problems.

Systems-Level Issues

The impact of disasters on people residing in mental hospitals or other behavioral health residential settings has not been well studied, but reports of disruptions in continuity of care,

dislocation and loss of contact with families and support systems in the affected communities sometimes occur. Higher rates of post disaster distress among people with psychiatric diagnoses may also be related to the increased risk of victimization (particularly interpersonal violence) following a disaster. Although research findings are mixed, several studies suggest an increase in the overall rate of violent crime, including domestic violence, after disasters. Moreover, there is substantial evidence that violent crimes have a significant impact on disaster victims, especially women. Women who are abused are significantly more likely to develop post-disaster PTSD and depression, marital distress is strongly correlated with post-disaster symptoms, and (unlike men) married women may be at higher risk for PTSD than single women[11]. Moreover, there have been consistent reports of post-disaster conditions that exacerbate the psychological damage of violent crimes, including criminal cases being dismissed due to loss or destruction of evidence, victims being displaced out of jurisdiction and being unable to file crime reports, disruption of services leading to victims being released without support or follow-up, and the displacement and loss of information about known sex offenders. All of these conditions can create fear and anxiety among crime victims. Despite knowledge about these conditions, the professional community has been slow to develop targeted services for this group.

The Criminal Justice System

People with severe trauma histories and mental health or substance abuse problems, both men and women, are as likely to end up in jail or prison as in the mental health system. Moreover, rates of prior trauma, including childhood abuse, are as high or higher for people in the criminal justice system as for people in the mental health system[12]. As a result, retraumatization is also a concern in criminal justice settings, exacerbated by the scarcity of mental health resources available in most correctional settings. Increases in medical admissions for trauma-related physical or psychiatric reasons may occur. In some cases, retraumatization may lead not only to psychological distress but also to behaviors that cause unrest in facilities (e.g., suicide attempts) or that are likely to result in re-arrest (e.g., substance abuse).

Disasters may also pose unique problems for incarcerated populations. Prevalence rates of mental illness in jails and prisons range from 8% to 16%[13,14,15,16]. Estimates of the prevalence rate of trauma reach as high as 80% for women presently incarcerated in jails and prisons[17,18,19]. The literature also indicates high rates of co-occurring mental health and substance use disorders among this population, with some prevalence estimates as high as three-quarters among both male and female detainees[20]. Review of the disaster response literature demonstrates a significant lack of research on the service needs of justice-involved individuals. Further, virtually no description of how disaster response can be successfully integrated with service linkage into or out of the criminal justice system exists.

Individual-Level Issues

Continuity of care is a major concern for justice-involved individuals who must relocate during disasters. Inmates whose families are affected by a disaster often have difficulty finding out what has happened to their spouses or children, or may be faced with particular problems in reunification with their families. The disruption of social support systems affects both incarcerated populations and inmates re-entering the community. In addition, criminal justice personnel, like mental health providers, are often among the first to respond and the last to leave

in a disaster, and are often relied upon for some of the more difficult disaster response tasks. Collaboration between mental health and criminal justice is therefore a critical element in the development of trauma-informed disaster preparedness and response.

Systems-Level Issues

In the event of a disaster, the justice system will likely be impacted across the spectrum, from initial police involvement through the court system to jail and prison incarceration. In communities with large numbers of evacuees, both police and evacuees will be at a disadvantage. Police will not be familiar with evacuees, evacuees will be less likely to have treatment resources in place and there will be fewer resources for police to divert individuals. Increased workload may result in untrained and over extended officers handling calls for emotionally disturbed individuals, thus increasing the risk of inappropriate police response. Courts will face similar issues as the police. In addition there may be less latitude in considering diversion when individuals have no treatment or other ties to the community and residences.

Already overtaxed jail mental health services will incur an additional burden through efforts to screen, assess and gather clinical documentation in order to make appropriate diagnosis and provide appropriate treatment. Prison based services will not be taxed as acutely as jail services, but future re-entry for justice-involved individuals will be a challenge. Identifying an appropriate community to return to will be difficult and prisons will likely meet resistance in any community that is identified.

Additionally, jail management will be more difficult due to the uncertainty of the future faced by incarcerated evacuees. These uncertainties are likely to increase anxiety, fear and acting out behavior among those who are incarcerated, resulting in challenges for community re-entry and continuity of care for justice-involved individuals. Obtaining timely aftercare appointments, benefits and medication once in the community will also be a challenge.

Development of Peer Disaster Response Services

It has increasingly been recognized that people with severe mental health problems and abuse histories often rise above the immediate distress of a disaster to provide leadership and support to others. In the past few years, some of the most exciting and innovative approaches to mental health disaster response have been peer-run and peer-delivered services. Notable examples include programs in New York, Pennsylvania, Oklahoma, California, and most recently, in Louisiana, Texas and Florida[21].

Peer-run programs are inherently consistent with established principles of disaster response. These approaches emphasize outreach, occur in natural community settings, emphasize people's strengths, avoid mental health labels, and are likely to be culturally sensitive because they are delivered by people who are themselves community members. Mental health peer support programs may include a variety of forms and services, including mutual support groups, drop-in centers and recreational programs, warm lines, housing programs, and information/referral and advocacy, all of which can play a role in disaster response[22]. Peer support programs also emphasize the development of a wide range of social supports, including providing "community families" for those whose natural families are unavailable. In addition to mental health peer

programs, a wide variety of other self-help and mutual support groups can also be called upon (e.g., groups for survivors of sexual abuse or sexual assault, 12-step groups, etc.).
Although mental health peer support programs have not traditionally been focused on either trauma or on disaster response, newly emerging initiatives are beginning to bring these perspectives together. This approach has much to recommend it. Peer support initiatives appear to be well received by recipients, are cost-effective, and are generally well accepted as a supplement to other disaster intervention efforts. Because they are based on values of empowerment and experiential knowledge, peer programs may provide a particularly supportive environment for addressing trauma. However, peer support is itself a relatively new endeavor within the mental health system, and may encounter barriers to full participation in disaster relief efforts[23]. In addition, information about peer-run disaster response efforts is not widely available and is only beginning to be incorporated, in a very small number of cases, into mainstream disaster preparedness and disaster response programs.

Furthermore, no peer response models exist for justice-involved individuals. Additional barriers present in criminal justice settings may further complicate the development and implementation of any peer-run program, as well as affect its level of acceptance among criminal justice professionals. Despite these potential barriers, specific outreach to the criminal justice population is important not only for justice-involved individuals to help recover following disasters; it is paramount for ensuring a successful community response to the mutual benefit of individuals and the communities in which they live.

Development of Trauma-Informed Systems of Care

In the past few years, another development has occurred that relates directly to the delivery of mental health disaster response services. With significant leadership from NASMHPD, and informed by the groundbreaking SAMHSA *Women, Co-Occurring Disorders and Violence Study*[24], behavioral health systems across the country are recognizing the role of trauma in the lives of people they serve, and are beginning to develop "trauma-informed" systems of care[25]. Although most states have a long way to go to develop the programs and staff necessary to address trauma effectively, virtually all have acknowledged the importance of this task, as evidenced by the unanimous passage of a NASMHPD position statement on trauma[26].

As trauma-informed systems evolve, increasing numbers of staff, administrators and individuals with the lived experience of trauma develop knowledge and skills directly relevant to disaster preparedness and disaster response, particularly for people with diagnoses of serious mental illness. Many states have adopted some form of state policy on trauma, begun staff training, started to revise policies and procedures to more adequately acknowledge and address the abuse histories of people served, and made progress in retooling existing services towards meeting nationally recognized criteria for trauma-informed systems. The development of peer disaster response programs that acknowledge and address people's prior histories of abuse is one example. However, because the development of trauma-informed systems is in its early stages, this expertise has not been widely incorporated more broadly into disaster planning and response protocols.

Purpose of Meeting and Expected Outcomes

The meeting being convened in April 24 & 25, 2006, by the Center for Metal Health Services (CMHS), and two of its national centers, the *National GAINS Center* and the *Center on Women, Violence and Trauma (CWVT)* is designed to address the following questions:

1. What body of knowledge now exists concerning retraumatization in individuals with a history of serious mental illness and/or a history of physical and sexual abuse? What services implications can we derive from this body of knowledge?

2. What models currently exist that incorporate principles of peer-run programs and trauma-informed services in addressing the impact of disasters on people in psychiatric facilities and other mental health settings and in jails, prisons, and other criminal justice settings? How specifically do they address the retraumatizing aspects of disasters on people with prior histories of abuse and interpersonal violence? What new models, if any, should be developed or adapted and tested?

3. What are the best ways to prepare for and respond to the likelihood of an increase in violent crime (especially interpersonal violence such as domestic violence and rape) during and after disasters? What are the best ways to support victims of crime under these circumstances?

4. What recommendations can be made for the mental health and criminal justice systems to insure that individuals diagnosed with mental illness impacted by disasters: a) receive seamless care from the community upon re-entry or discharge; b) obtain access to disaster relief benefits; c) are reunified with family or significant other supports; and d) receive care that acknowledges and responds to prior trauma histories?

5. What specific tools or materials could be developed that would make this information and these models available to the mental health and criminal justice systems and increase the likelihood of their use in disaster planning and response?

6. What recommendations can be made to *CMHS*, the *National GAINS Center* and to the *Center on Women, Violence and Trauma* about incorporating these learnings into each center's future agendas and activities?

The meeting will bring together experts in the field to review the current knowledge base, summarize major learnings, identify gaps in knowledge, and make recommendations for development of materials and strategies for supporting the further development and implementation of trauma-informed and peer-run disaster preparedness and response efforts.

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