

Status Report:
Meeting
the Mental Health
Needs of the
Country in the
Wake of
September 11, 2001



THE
CARTER CENTER



Eighteenth Annual Rosalynn Carter
Symposium on Mental Health Policy

November 6 and 7, 2002

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MEETING THE MENTAL HEALTH NEEDS
OF THE COUNTRY IN THE WAKE OF
SEPTEMBER 11, 2001



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OPENING REMARKS

Rosalynn Carter

Chair, The Carter Center Mental Health Task Force

Our country has experienced one of the most painful events in our history, and we still are sorting out the effects, especially the psychological impacts on all of us. We are not the same as we were before September 11th, and we never will be the same. We will never have to say to what year we refer.

Most of us remember where we were at the time of the tragedy. Jimmy and I were in the car on the way to The Carter Center from home. We got the message through the Secret Service radio. I was coming for the first day of the annual meeting of our fellows for mental health journalism. When we got here, we found that some of the fellows and advisory board members had come in the night before. A few others had gotten up very early in the morning and made it to Atlanta. But some of them were stranded in airplanes on runways or in airports. Two of our fellows were from New Zealand. Of course, they were as shocked as we were about what was happening. And we had no explanation for them.

When Jimmy and I arrived at The Carter Center it was quiet. People were not frantically running around or hysterical. Everyone was glued to television sets. After we had watched for what seemed an eternity, Jimmy decided that we needed to call the staff together. So we all met, and he reminded us that our country is strong, that we have been through adversity in the past and always overcome it, and we will again. He also said that we should keep our heads up and not be defeated by the tragedy. So we all went back to work, maybe calmed a little. We had our meeting with the journalism fellows and, while this is always a wonderful meeting, I do not think many of us had our minds solely on what was being discussed that day.

The problem of mass violence is a reality for countries all over the world. No country is immune. Disasters and traumas are part of the lives of millions of people on earth. The causes of all this violence are many. They are complex and hotly debated. But it is clear that civil society is now a frequent target. We have to assume that all institutions serving the general public are potentially at risk. This means that the mental health world is going to have to fashion preventive strategies for a broader audience that includes all areas of our lives. A reminder of this comes from all the stories about children in New York who still have nightmares, are still afraid to go out in public places, and who still suffer from severe anxiety. We have to fashion strategies for schools, for law enforcement people, for the religious community, for the general public, for all health officials, so that we can be prepared. All of us were affected emotionally by that tragedy. Mental health must be a part of all of the preparation activities at the national level, state level, and in communities across our country.

MENTAL HEALTH DURING LARGE-SCALE CRISIS

Honorable Rudolph W. Giuliani

I think we have to assume, given what is going on in the world and what already has happened, that we are going to have to deal with situations like this in the future. What we are probably going to deal with is much like this event, but in a somewhat anticipated way—a little bit different, a little bit more surprising, a little bit more unusual. The way these terrorist groups operate relies on the element of surprise.

Bringing together experts in the area of mental health to find out what we can learn from the way in which we reacted to September 11th—how we can improve and some of the things we are going to have to do to readjust—is a very big contribution to the security of this country.

I thought I would give you some of my views on how mental health is affected and how we can deal with it, given the new reality.

A lot of people say that America is now much more dangerous than it was before September 11, 2001. Or they say that the *world* is more dangerous than it was before September 11th. People say that, but I do not think they really mean it. If you analyze it, the world actually was

September 11th happened, and I believe that things began to become safer immediately, because we then confronted reality.

just as dangerous before September 11th as it is today. We just did not recognize it fully. We had a cloud in front of us in which we saw

the world the way we wanted to see it. And we ignored some of the realities in the world and of the risk that existed for us.

Or maybe we believed, as people do before they mature, that we were immortal and invulnerable because America was so isolated and so strong that this could not happen to us—whatever “this” was. Maybe not on the scale of the attacks on the World Trade Center and the Pentagon and the attack that was foiled over the skies of Pennsylvania by those brave people, but attacks like those taking place throughout the world,

going back to the late 1960s and early 1970s. Actually, there was every reason to believe that it would happen to us, rather than it would not.

But then September 11th happened, and I believe that things began to become safer immediately, because we then confronted reality. We are always much safer confronting reality than we are ignoring it or hiding it. I didn’t think about this until weeks later, because I did not have time to do anything but react, from the moment I rushed down to the World Trade Center until I went to a Yankees World Series game in November. That was probably the first time I relaxed after September 11th for two minutes.

When I first went down to the World Trade Center, I realized that we were dealing with something very different from anything we had dealt with before. And I will tell you exactly when I realized it. I was having breakfast. I got a call. I was told that a twin-engine plane had crashed into the towers and that there was a fire. I rushed down from midtown Manhattan to the site, thinking it would be a difficult emergency, but comparing it in my mind to the hundreds of earlier emergencies we had had that involved building collapses or hostage situations or plane crashes.

When I got to St. Vincent’s Hospital, roughly one mile north of the site, I saw a lot of doctors and nurses out on the street with stretchers ready for people. My mind quickly said, “War zone, not city.” This is a scene I would see in a battle, not in a city. “There are too many doctors, too many stretchers, and they seem too anxious. They must know something I do not know.”

When I arrived at the Fire Department’s command post, I was told to look up. Things were falling. I realized that one of the “things” falling was a man who had jumped from the 102nd floor. I stopped for a moment. I had to absorb what I saw, because I first had rejected it. It was a person. I had thought it was debris.

When I realized it was a person, I grabbed the police commissioner's arm and I said to him, "We are in uncharted territory. We never prepared for this."

I was actually wrong about that, because we had prepared for it, and we had prepared for it in a way that I recommend that we prepare now. We had prepared for everything we had thought about. We had prepared for anthrax, sarin gas, bombings, hostage situations, plane crashes. We had done drills, two of them in which we had gone out on the street and reconstructed what would happen if there were a plane crash or a sarin gas attack. We did drills around the table, and we wrote down plans for how we would act. That was enormously valuable to me and all of the people who worked with me, because we could go back to a reference. We could go back to something that we had thought out in a calmer time.

Even though we were acting on instinct, the instinct was educated by planning. And even though it was not exactly an incident we had planned for, there is not much difference between what you have to do if a building

collapses—the response of hospitals, public health, even police and fire—or an attack by an airplane on a building.

I urge you and everyone that we should prepare. I named a chapter in my book *Prepare Relentlessly*. Relentless preparation is advice I have given to people who run organizations. You can never prepare too much. The more you prepare, the better you will handle the situation.

When I walked into The Carter Center lobby, I saw the booklet *Communicating in a Crisis*. If you have to deal with a crisis, it is better to have thought your way through it before than to have to do it for the first time in the middle of the crisis. Organize and figure out what to do.

Two things that gave me great assistance on September 11 would have escaped notice during the days they were happening. People would say to me, "I do not know how you do it," or "I do not know how you are able to get through it." Two things make me feel that it was not I who got through it—it was the people who helped me who got me through it. One thing was relentless preparation—all of the drills, the exercises, the planning, the plans that had been put down on paper. We had had many emergencies to handle in the past, whether it was a building collapse or a crime or a subway derailment, a blackout in a large section of the city, Washington Heights, that had occurred several years earlier in the middle of summer.

We had had experience as a team dealing with these things, so that helped a lot.

The second thing that helped, most important of all, was teamwork, having really good people to rely on. One of them is Neal Cohen. I remember when I first appointed Neal as public health commissioner, the only criticism—because Neal was a superb candidate—was that he was a psychiatrist, and would a psychiatrist know enough about the other aspects of public health, the ideologies and the other disciplines.

Even though we were acting on instinct, the instinct was educated by planning.



Neal did know quite a bit about all of those. In fact, it was Neal who helped discover West Nile virus. On September 11th or 12th or 13th, I would turn to him and I would ask him, “Am I communicating correctly? Can we get some help? Can we bring some people in who can talk to me and everyone else about how we should communicate with people?”

I can remember thinking how fortunate it was that we had selected a psychiatrist, because we really needed a psychiatrist. I need one now!

There is nothing wrong with getting help.

But the reality is, it brought a lot to that situation, where we needed someone who had an understanding of the impact on people’s minds and emotions from the things we said, how we said it, how we did it. And without Neal there helping 24 hours a day, I do not think we would have responded nearly as well.

That is what I mean about teamwork—having people who have as much or more strength as you do, and often more strength in areas that you would not know as much about.

As soon as we could, Neal and I brought in two experts in grief counseling and communicating to talk with me and with the police commissioner, who had to speak a lot about what was going on, and the fire commissioner, who not only would have to speak a lot about what was going on, but who also would have to absorb the loss of 343 of his people, including some of his closest friends. That was the most traumatic example, but not a person on that team, including the people who worked for Governor Pataki, had not lost a very close friend. There was not a person sitting around the table planning how to deal with this emergency and having to react on a daily basis who was not going through personal grief because they had lost at least a couple of friends, and in some cases a large number of friends.

So it was very, very important to get that help. Here is the part that should be emphasized: There is nothing wrong with getting help. You face this all the time. You have to get people over the stigma that they are weak because they need help.

We could have had criticism for bringing in mental health advisers. But when I said we were going to bring in several people to talk to us about how to respond, not a single person objected. There was no “That is going to look bad” or “It is going to look like we are weak.” Everyone realized that this was beyond any one person to have to deal with, and we sure as heck needed help.

We should institutionalize that. We do need help. We need help figuring out how to communicate in the middle of the worst attack in the history of the country. And we need to know how to communicate in this very strange time, when the State Department announces that we are under risk of attack and that the risk is going to last for a very long time. You listen to it and then you read it, and you try to find specifics about what the risk means. And you cannot find it. You are told you should just generally, in an undifferentiated way, be afraid. It can happen anytime, anywhere, anyplace.

Well, that is going to create enormous problems for all of you. If that is not going to make you nervous and upset, nothing is.

But we have to learn to deal with that. I think the best way to deal with it is to figure out how we can get help for people in a way that really helps them. For me, having experts who could talk to me and assist me was enormously important.

Dr. Kerry Kelly from our fire department is a speaker at this symposium. Dr. Kelly had worked with firefighters and their families long before September 11th, when they had to go through the horrible process of accepting the fact that



they had just lost a firefighter who died in the line of duty. And very, very special issues come up as a result of that.

Just before September 11th, we had a young firefighter die of a heart attack right after fighting a fire. We had had three who died in a fire on Father's Day. But the idea of facing 343 members of the New York Fire Department all killed at the same time and then having to deal with each one of their families—the realization was that we could not give them the personal care and comfort that we normally would have given them.

If a firefighter or a police officer, or a person who works for the city, dies in the line of duty in New York City, the family is embraced. The family is made to feel that they are not isolated. The family is given a realistic sense of just how important their loved one was and the heroic or dedicated thing he or she did. It was impossible to do that in this situation. So we tried very hard to organize people to try and help. Dr. Kelly did an absolutely magnificent job.

Those are things that we now have to learn how to do and practice—how to deal with mass fear, mass grief, mass mourning. The more we can think these things through and figure out how we are going to respond, the better we are going to handle it and create effective methods for dealing with it.

Then there is the aftermath of what happened on September 11th to all the people who are still suffering from it, including me. I have never really been able to describe completely what happened or the things that I feel about it. Talking about it has been helpful for me.

HBO filmed a documentary about September 11th roughly two months afterward. I realized in the middle of my four hours of interviews that I had not talked about this to anyone until then. And I also realized about halfway through the interviews that this was a therapy session—except it was on camera. It got me a little nervous, actually, but I realized that it was very valuable to talk about it.

The HBO producers interviewed a hundred people, and I talked to a lot of them afterwards. Some of those who had been interviewed came

up and thanked me. They said, “I really was glad I was interviewed, because I had not talked about this before, and it was helpful to talk about it.”

I thought, “Well, that really illustrates the whole wisdom of therapy,” which is to talk, to get out your fear and your problems and put them in perspective and realize that you are afraid, or you are upset, or you cannot really process it, you cannot really understand it.

Why is it that every time I go down there, I keep looking for the two buildings? I close my

eyes and say, “I think they are still there.” Why is it that when I go down there I feel anger all the time? I do. When I go down there, I feel really, really angry at

the people who did this to us. But I let myself feel it, and then I move on to the things that are constructive, the things I can do now.

People need a lot of help. There are a lot of issues to deal with and to try to figure out, in an organized way, how we deal with the aftermath. What does it mean to us, and then how can we prepare in the future for the kinds of attacks that may take place? How can we deal with mass fear?

Our public officials probably would be well served by spending some time doing what you are doing, so they communicate as precisely and as effectively as possible.

We have to accomplish two things, and they appear to contradict each other. If we do not understand that they contradict each other, we will do both of them wrong. The first thing we have to communicate is that America needs to be better prepared. There is no question about that. We need to be better prepared, and we cannot become complacent. We cannot have the impact of September 11th dissipate because time has gone by and now everything has gone back to normal, and therefore people do not prepare for a possible bombing or anthrax or smallpox. They do not get the antidote. They do not organize themselves. They do not do the things that they are supposed to today—and then all of a sudden, we have a surprise attack and everything is in chaos.

So people should be trying to organize the police departments, fire departments, health services, emergency services. We have to figure

You have to get people over the stigma that they are weak because they need help.

out how to put together this vast web of public safety that often overlaps and is confusing, so that it figures out how to work with each other. All of that is necessary, and voices out there have

At the same time that we are preparing for the worst, we have to put the risk of terrorism in proper perspective.

criticizing us for not being prepared enough so the motive is there to prepare.

All of that produces tremendous fear and anxiety, like the warning from the State Department that there will be an attack.

The second thing we have to do is to relax. That's where the contradiction enters. At the same time that we are preparing for the worst, we have to put the risk of terrorism in proper perspective. The reality is that terrorism is not the worst risk that we face. Every day we face much greater risk than the risk of terrorism. Those risks do not hobble us and do not stop us from doing the things that we are supposed to do. By and large, they do not have an impact on our mental health, except in very individual, unusual circumstances.

No matter what happens in Iraq and no matter what the reaction to that or the ongoing effort against terrorism, we are never going to lose as many to terrorism as we do to drunk drivers. In 2001 drunk drivers killed four or five times more people than terrorists killed, and they killed them with something that is preventable. Drunk driving is far more preventable than terrorism.

Fear does not lead people to stay home because of drunk drivers. Fear does not lead them to avoid their automobiles simply because there is a risk. Now, people may get into an automobile, but they will not get into an airplane because they are afraid of terrorists. Actually they are in much more danger in their automobiles than they are in an

airplane. This is all a question of human psychology. It is all a question of understanding how to manage fear.

The most important thing to explain to people about managing fear is that courage is not the absence of fear, it is the management of it. A person who feels no fear and does something is not courageous. I say this very often. A firefighter who runs into a fire and is not afraid is not courageous. He is insane. If you do not feel fear during a very dangerous situation, then you are actually disconnected from reality. If you feel the fear and you do what you have to do, you are a courageous person.

That is what Americans have to do. They have to feel the fear of additional terrorist acts, do the things that are necessary as responsible public officials, business leaders, health care leaders to prepare—and then put it in proper perspective so that we can move on with our lives. Mental health experts and doctors can help us do that. They can help us try to figure out how we do that as a society. And if we do it, we are going to become much stronger as a result.



Questions & Answers

Q How can we leverage resources that are going into preparedness for a terrorist attack—but probably will not happen everywhere—to foster public health in general and at the same time prepare?

A Mayor Giuliani - Preparing for terrorist acts can bring enormous side benefits. If you can convince a community to do drills and exercises in which they measure their preparedness for, let's say, a biological attack, by the mere act of doing that, you will expose the weaknesses that they will have to deal with and overcome. Then they would have a much better emergency response to anthrax. If they have a much better emergency response to anthrax, they will have a much better response to influenza and other things that affect us on a day-to-day basis.

If you figure out how to deal with the worst thing that could ever happen to you and put together a plan for dealing with it, then you are going to deal with the lesser things that happen to you much more effectively. That is the way you will leverage it.

There is more interest now than there was before in preparing for terrorist acts. You can motivate people to do that, and that will help them focus on the other things that need to be done in the area of public health because they are interconnected with each other.

With the Syndromic Surveillance System we monitored symptoms from hospitals for warning signs of a biological attack. One symptom was people going to the hospital in larger numbers and reporting flu-like symptoms. That system was enormously important when the first case of anthrax was reported in Florida. And then it was important when we had anthrax at NBC, ABC, CBS.

We could have fallen into the fear and helped to create, as public officials, an epidemic of fear. SAMHSA's pamphlet *Communicating in a Crisis: Risk Communication Guidelines for Public Officials* points out that whatever the public official says—whether it is a mayor, a governor, a president, a health care leader—how you say it is going to have a big impact on public reaction.

We knew the anthrax was not an epidemic because we could keep going back to these reports. "Sure, there is a case at NBC or ABC, but people are not flooding the hospitals all around midtown Manhattan with reports of symptoms that would suggest anthrax." We always knew that we did not have an epidemic, so we could convey that. That system assisted in helping to find West Nile virus. It was not established with any thought of finding West Nile virus, but because the system existed, it alerted us to the early warning signs. These preparations have tremendous additional benefits.

Q You commented on the importance of what you say and how you say it. Another element is when you say it. What went into the transition for you when you switched from talking about rescuing people to recovering bodies, a very sensitive point for New York as well as the nation?

A Mayor Giuliani - It was somewhat planned and somewhat intuitive. We talked about it a lot. As I said, I got advice about how to say it.

There was some disagreement about when to do it. At one point I was going to do it earlier. I went to a large meeting of families of firefighters who wanted information about their loved ones. The meeting was in a huge room with a balcony at a midtown hotel. To walk into that room, which I had been in hundreds of times for gala events and parties and fundraisers, and to see a couple of thousand people who were the mothers, fathers, wives of people who were missing—and about three-quarters of them not ready yet to accept what was at that point reality—I realized that we had to slow down the way in which we described it. If they were not ready for it, then other people were not ready for it.

We tried to change the language slowly and then talk about it as relief or recovery, and then we changed the emphasis as we moved along. But some of it was also just intuition. It was just feel. It was helpful to go to so many of the funerals because I could feel when people were ready for more information.

Questions & Answers

The other thing I found out, which I am sure you all know, is that there is no one way to respond to the loss of somebody you love or the fear of a possible additional terrorist act. Some people respond to it, and very quickly they are able to put it all together and want to move on. Maybe later they are able to feel the grief. Other people feel it right away, so I decided to try to deal with it with Neal's help and the help of some other people.

I tried to deal with it by saying to people, "We are giving you options." I will give you an example. We had to set up a system for getting death certificates. In many cases the death certificate would entitle them to benefits that they might lose if they did not get the death certificate right away. But to get the death certificate meant having to acknowledge that the person was dead and gone. It was very hard to figure out how to do that on a mass basis.

We organized a group of lawyers who volunteered to help make it a very easy process. We brought in extra people to help make sure that it all happened efficiently, so the families

were not burdened with a horrible bureaucratic process. But people reacted to it differently. I announced that we had this service available, it was at the family center, and you could take advantage of it when you wanted to and when you were ready to do it. Some people took advantage of it right away, and some people waited almost a year to acknowledge the fact that their loved one was gone. Rather than say, "Here is the program and you have 20 days to do it," it seemed to me that the better thing to do was to leave open the option. I saw so many different ways that people dealt with grief. As a public official or a public mental health official, you really have to figure out how to leave options open, because people are going to react differently.

I want to thank you for focusing on this subject. I have gone to many symposiums about September 11th and its effects and dealing with terrorism. Not one dealt with the mental health aspects. This should be emphasized a lot more. It is very important, maybe critical.



PANEL I: CHILD AND ADOLESCENT MENTAL HEALTH

William R. Beardslee, M.D.

We face daunting challenges as a country, and we face daunting challenges because we are responsible for the mental health care of children. We know more and more about what works to help children when they are ill, and what works to prevent difficulties from developing, because of advances in the neurosciences, developmental epidemiology, and research on treatment—and also because of the activities of the advocates for those who suffer from mental illnesses.

The interdependence of our lives in the modern world requires that we live more and more together. We depend heavily on one another for the basic necessities of life—food



and shelter—and even more heavily on one another for the essentials of companionship, learning, and finding common ground.

These connections are threatened by terrorism. The threat from terrorism involves what actually happened in the attacks—and also the fear that more attacks will come. Terrorists attempt to strike at the very heart of a democracy and to destroy, through fear and violence, the essence of who we are and what we are. They attempt to keep us from coming together. And our children are particularly vulnerable.

But we have much that we can do—and much that we must do—to combat terrorism. We must reaffirm our faith in democracy and the actions that show we are unwilling to compromise our values. We must learn from those who have

suffered through terrorism, endured, and survived. We all must learn from the best available evidence provided by those who have done the research or cared for the victims of terrorism. We must learn how healing from terrorism is similar to healing from related conditions—depression, posttraumatic stress, and so forth—and how it is different. Above all we must consider how to build strength and resilience in our children and their parents. In the long run, this will serve us best as we face the huge uncertainties in the years to come.

Perhaps the most important development in mental health and medicine over the last 20 years has been the requirement that we use only evidence-based treatments supported by data from randomized trials and from carefully evaluated approaches. Now also we must learn how to apply such approaches in large-scale programs.

In this panel on child and adolescent mental health, four experts in response to terrorism share the most important evidence-based findings, combined with humanitarian care and innovative approaches.

Some things work. Some things do not. We need to know what works and what does not. We need to think about how to deliver supports to schools, to health care clinics, to families, to neighborhoods, to houses of worship, and to other structures where people come together. We need to know how findings that have worked in one setting—in this country or abroad—can be transposed to other settings. And we need to know how findings derived in one culture or in one language are applicable to another culture or another language. As all people in America are threatened by terrorism, how we can bridge our extraordinarily diverse cultures and populations must be forefront in our minds.

Above all we must consider how to build strength and resilience in our children and their parents.

Meetings such as this can serve a vital purpose, because another intent of the terrorist is to break us apart and to keep us from talking. We need to talk openly to one another. We need to remember that we are deeply challenged in that the very things we hold most dear—open communication, respect for diversity, democracy, the challenges of discourse and free speech—are threatened. But I think it is equally important to remember to take the long view. We have been challenged as a nation by extraordinary threats in the past—during our revolutionary times, during the Civil War, during the Depression, during World War II, during the Cold War, and during the war in Vietnam. We made it through those times, and we can make it through these times—by affirming our basic commitments to one

another, by recognizing that what we have is shared and is precious, and by finding hope and meaning in the future in our various religious faiths, families, and communities.

We will make it through this time and beyond by affirming those faiths, by the deepest meaning structure we have, by affirming the positives and strengths in one another and in our communities, and above all in our ability to care for the generations that follow—our children and grandchildren—hence the focus on children at the beginning of this conference. We will make it through by affirming our values. It is appropriate that we are meeting at The Carter Center, because both Mrs. Rosalynn Carter and President Carter have long stood for these values, for decency, and for human rights.

UNDERSTANDING AND ADDRESSING REACTIONS TO TERROR AND TRAUMA

Farris Tuma, Sc.D.

The terrorist attacks of September 11, 2001, and their anthrax aftermath may not have changed everything, but they have changed how the nation views public health—and we need to continue to change the way we view public mental health. We are more aware of how unpredictable and unsettling acts of terror can be and that they interfere in profound ways, with consequences extending beyond directly exposed individuals.

We have learned—and we continue to learn—some painful yet valuable lessons about these consequences from prior disasters, including events such as the 1995 bombing in Oklahoma City, the attacks in New York and the Pentagon, and terrorism in other parts of the world. We also have learned about the human response to psychic trauma from work with victims and survivors of other kinds of violence and trauma. We know that in one's lifetime in this country, exposure to one or multiple traumatic events is a serious public health issue. We can look to past experiences to help us understand and respond to the effects of terrorism—although there may very well be significant differences with implications for mounting responses.

Traumatic events are experiences that overwhelm us, eroding our capacity to cope, to put things in order, to make sense out of the world. Certain characteristics of these events hold greater risk for adverse mental health outcomes—those that instill fear, helplessness, and horror. And catastrophic events hold enormous public health consequences, including death, acute and enduring disruption, distress, fear, illness, and enormous social and economic burdens.

We can discuss the range of effects of terrorism from both a human services and a public policy point of view, focusing on population-level effects and individual effects, as well as from a mental illness or mental disorder perspective—each of these is important.

In a review of more than 130 populations exposed to disaster, including those affected by terrorism and other human-caused disasters, researcher Fran Norris and colleagues report many different effects:

- Specific psychological outcomes such as post-traumatic stress disorder (PTSD), depression, and other anxiety disorders
- Nonspecific distress outcomes, including psychosomatic symptoms and psychological

distress that do not reach the level of a disorder or illness

- Health concerns and problems that manifest themselves in taking increased sick leave and increased physiological arousal or indicators of stress, declines in immune functioning, sleep disruption, and relapse/decline in existing illness
- Increased use of substances, alcohol, and smoking

Norris et al. also note changes and problems in living. These include troubled interpersonal relationships, social disruption, family strains and conflicts, occupational stress, financial stress, and environmental worry, as well as declines in perceived social support, ability to cope, and optimism about the future.

They also point out that such events have consequences specific for children and adolescents, including regression in development (age-inappropriate behaviors) and emotional problems related to anxiety and separation from parents in young children and in older children and adolescents. In older children and adolescents, problems look more like what adults experience and include the range of depression and anxiety concerns, and also aggression, agitation, and disruptive behavior problems.

The research on severity of impact shows that responses vary greatly, largely dependent on the sample or age range of the population affected and the type of event. Children are generally more susceptible to severe impairment, followed by adults and first responders (rescue personnel, firefighters, etc.). The research also shows that acts that involve widespread loss of both life and property, as well as those that take on a more symbolic meaning, are likely to have more pervasive effects that extend into the population, beyond transient distress.

I want to mention two examples of data collected since September 11th that do not focus on children per se, or mental illness, but are useful for thinking about population-level issues in response to trauma. Roxanne Cohen-Silver and colleagues' national survey of people's responses to September 11th supports the commonsense view that:

- The impacts of a major national trauma can extend beyond those directly exposed; psychological reactions such as nightmares,

cognitive and behavioral avoidance of reminders, and heightened anxiety and arousal are widespread.

- These responses are associated with exposure, but also with denial or inactive coping in people who shut down or did not do something to address their feelings.
- Perhaps most importantly, these effects decreased over time.

David Vlahov and colleagues' New York Academy of Medicine study of the New York area (oversampling below 110th Street) reports similar findings over time on symptoms related to memories and unwanted thoughts:

- Four months after September 11th, significant numbers of people reported avoidance behaviors and lack of interest in things that used to engage them.
- Significant problems for large numbers of people also emerged in their ability to be startled easily and their inability to sleep and concentrate.

These data do not describe people with a mental disorder, but they provide some useful information about how widespread responses might be and who perhaps is at increased risk for enduring problems, and they indicate the potential need for services in the community.

We can also learn from experiences outside of the United States. In Israel Dr. Arieh Shalev is comparing how two communities respond to ongoing terror, one community plagued by unpredictable but periodic acts of terrorism and another that has been spared that direct exposure. Early observations from this work indicate that:

- Both direct and indirect exposure—meaning people in both communities—produce symptoms of distress and symptoms that look like PTSD.
- People in both communities reported that exposure and disruption of routines for children and for families were significant stressors, more so in the community with more disruption. That makes sense.
- Yet the distribution of PTSD symptoms in the community is not statistically “normal,” meaning that a minority of people carries most of the symptom load, whereas most others have few symptoms.

Dr. Shalev has observed that not all persons expressing even the full set of PTSD symptoms are otherwise “impaired” or “distressed” when these variables are measured in a clinical interview; they do not report being unable to function, to care for their children, to go to work, etc. They are distressed and fearful, and they have a lot of these symptoms, but they are not meeting criteria for a disorder. Dr. Shalev also observes that the fears associated with the traumatic events—the terrorist activities in that plagued community—are specific; people attribute them to certain situations where the terrorism has occurred. They do not generalize them; people are, for the most part, carrying on.

What do we know specifically about children’s reactions? Children who experience catastrophic events show a wide range of reactions. Some will suffer only worries and bad memories. With good support and the passage of time, those will fade. Other children will be more deeply affected and will develop more enduring problems, including fear, depression, withdrawal, and sometimes anger, as well as age-inappropriate behaviors. These certainly should be warning signs for parents.

Children who develop PTSD or depression or other persistent disorders clearly need, and can benefit from, effective treatment. The bottom line is that children are physically and emotionally vulnerable, wonderfully resilient, but not immune to the effects of trauma.

What can we expect to see in children exposed to catastrophic events? We know that children who lose immediate family members, friends, and relatives are most likely to show immediate symptoms of posttraumatic stress than children who are not bereaved. But research by Dr. Pfefferbaum and others shows that even

Children are physically and emotionally vulnerable, wonderfully resilient, but not immune to the effects of trauma.

children not directly involved in an event can be impacted. Dr. Pfefferbaum’s study of responses up to two years after the Oklahoma City bombing of children geographically removed from the area showed that many (16 percent) were still reporting substantial levels of stress-related symptoms—not necessarily PTSD, but still significant levels of distress that may interfere with healthy development.

Just as with adults, some children are more vulnerable than others. A history of maltreatment or other traumatic experiences, a history of mental health problems, and importantly a lack of good family support do not bode well for child victims of trauma.

I want to underscore what may be obvious—that children take a lot of their cues from their parents. Anytime we talk about understanding children’s responses and potentially intervening, we really are talking about work with parents and families as well.

What type of guidance can we offer based on past experiences? About a year ago, representatives of the U.S. Departments of Health and Human Services (HHS), Defense, Justice, and Veterans Affairs and the Red Cross reviewed what we know about effective early intervention after mass trauma. A year earlier, HHS partnered with the Department of Justice to review what we know about effective interventions for child victims of trauma more broadly. The clear message, with overwhelming evidence, is that we must take great care not to presume illness or disorder in the early days and in our efforts to mount assistance programs after traumatic events. Yes, stress reactions are a concern and should be addressed; yet caution must be applied—formal mental health treatment may be inappropriate for some. We need to think about mental health consequences and how to assist, but should not presume disorder. From a public health perspective, we have clear guidance for a hierarchy of strategies that can be put into place. These include making sure we have safety, security, and physical and mental health triage that in some cases might involve hospitalization or emergency medical care for people.

This guidance also relates to orienting survivors and victims to assistance—what is available to them right now in their community that they can access to meet all of their needs, whether they are obviously related to mental health or just to daily living needs.

The first mental health intervention after mass violence is communication, putting families in touch with their children, putting teachers in touch with parents, and likewise across the community. Our understanding of normal responses to trauma and our history in health communication research provide very important

lessons about what we can communicate to people from a public health perspective. We know that credible, consistent, and clear messages about what to expect physically, emotionally, and behaviorally for children—and also for parents—can be a good thing to deliver, as well as how to provide comfort and how to recognize signs of both transient symptoms and persistent problems, and where and when to seek help.

We also have learned some lessons about what to avoid—these are things that engender mistrust or erode credibility. This focus needs to be part of the planning process in terms of who will communicate what, as we learn about events, in the most credible and reassuring way.

From a clinical perspective, we know that outreach and naturally occurring gatherings to help screen and refer youth, based on their risk by virtue of their exposure, their individual vulnerability, and their acute responses, are a smart thing to do. Good but limited evidence exists about early interventions that help reduce the incidence, duration, and severity of acute and chronic disorders such as posttraumatic stress and depression. We also have preliminary information about the usefulness of early intervention for people who are bereaved, including children.

We know that early interventions in the form of a one-time recital of traumatic events and the emotions that they evoke in us are probably not helpful things to do. Typically they do not reduce the risk of subsequent mental health problems—and in some cases, they may exacerbate problems.

While there is insufficient data to establish specific treatment guidelines for children who experience traumatic events, we can provide guidance on what works for kids based on the existing body of research:

- Children should be evaluated and screened.
- Children with persistent and/or significant behavioral and emotional problems should be referred for treatment.
- Treatment should have specific goals. The primary goal is the resolution of trauma-related emotional, cognitive, and behavioral sequelae.

- Parents and primary caregivers should be involved in the evaluation and screening process and in the treatment to the extent that it makes sense. Parent involvement

depends on the developmental age of the child and the kind of symptoms he or she may have and on the nature of the trauma or the disaster.

- Specific interventions should be used for children only when they have been designed to be used with children and where it is warranted by a particular child's needs. For example, certain kinds of psychotherapy that involve reliving the traumatic experience may be inappropriate in a therapy session with a child who has no PTSD symptoms but may have other behavioral problems or with a child expressing suicidality or using drugs.

The issue of psychopharmacological agents is challenging because of the great gap between clinical practice and empirical research on the right kinds of treatment to introduce and with children of what ages. Nevertheless, we can recommend that administration of medication be guided by accepted clinical practice for treating specific psychiatric conditions and that it be done by people who are trained to do so and who know how to monitor and evaluate the effects of that medication and the child's progress.

In summary, we have made progress in understanding the effects of traumatic events, and this allows us to provide guidance—to shape public health communications and messages about expected and normal responses in the

The first mental health intervention after mass violence is communication, putting families in touch with their children, putting teachers in touch with parents, and likewise across the community.



population, as well as active coping strategies to help people carry on. And we have good information about formal mental health treatment strategies, when indicated, that are successful for many people. The NIMH Web site contains a good deal of information on these issues: www.nimh.nih.gov.

Much remains to be learned about how to enhance resiliency, perhaps looking at research and work that has been conducted internationally and in other cultures where people live

with terrorism on a regular basis. We also need to work harder to bring effective treatment to all who suffer. We have a great deal of interest, energy, and need in the area of early intervention and prevention—scientific progress here holds great promise for improving the nation's health in uncertain times.

It is critical that we integrate behavioral and mental health issues into planning and response initiatives. Terrorism has profound implications for national mental and behavioral health.

Families and children and our society will suffer if our public health planning and response do not embrace mental and behavioral health issues in advance of national tragedy.

Lastly, we should not lose sight of our goal, to make treatment available to all those who suffer, which involves overcoming systemic and social barriers, including stigma, to make sure that evidence-based services are available and actively used.



CHILDREN ACROSS AMERICA: MENTAL HEALTH IN THE TWO MONTHS AFTER SEPTEMBER 11, 2001

Bradley D. Stein, M.D., M.P.H.

I am excited to share with you some of the current work at RAND's Center for Domestic and International Health Security to better understand terrorism's effect on children. The attacks on September 11th affected children across the country. In a national telephone survey we conducted immediately after 9/11, almost one-third of parents reported stress symptoms in their children. Most parents told us that on the day of the attacks they talked extensively with their children about what happened, trying to reassure them. Following many other traumatic events, children so far from the event might not have been considered directly affected by the trauma.

We know that children are particularly vulnerable to many traumatic events, but we know very little about the mental health effects of terrorism on children, for example, how it is similar to other traumatic events and how it is different. To begin to develop a better understanding of terrorism's effect on children, we conducted a second nationally representative survey in November 2001. This survey included interviews with almost 400 adults across the country with a child age five to 18 living at home; many of these adults had been interviewed in September. In November we asked them how their children's responses had changed over time, about their children's symptoms, and about a number of additional topics.

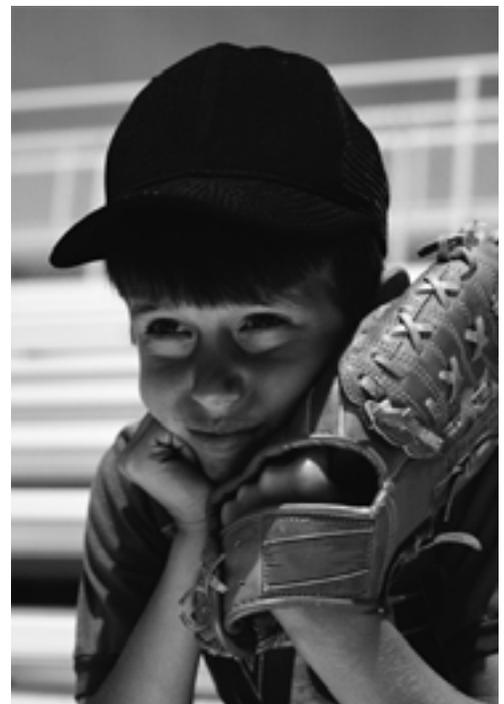
We asked parents in November whether they were seeing symptoms in their children that they believed were because of terrorism. If so, we wanted to know what types of symptoms they were seeing, how common they were, and if they seemed to be more common in different groups of children.

We also asked how parents were responding. If they were seeing symptoms in their children, how much of an issue was it for families? What were parents doing to respond to their children? What were parents discussing with their children?

What about the schools' response? After many traumatic events, including Oklahoma City and New York after 9/11, schools were important in responding to the needs of students and their families. What were schools doing that were far removed from the site of the attacks? What, if anything, were they doing to support children and families in their communities? And finally, what are the implications of what we have learned? How does this information help us think about the steps we need to be taking to help children and families across the country meet the challenges posed by terrorists?

We specifically asked parents how they thought the terrorist events had affected their child in the previous four weeks. We asked about 15 different symptoms that children experience as a result of terrorism. Some of the symptoms are commonly associated with posttraumatic stress disorder (PTSD), one of the most common groups of symptoms following traumatic events. Classic symptoms include nightmares about the event, trouble sleeping, difficulty concentrating, and avoiding conversations or other things that might remind the child about the event.

However, children might also be responding to the ongoing threat of terrorism in ways that might not relate specifically to the events of 9/11. After other types of trauma, children also experience anxiety and depression in addition to PTSD. It was important for the survey to cover a broad range of symptoms or reactions that



children might be having, so we also asked about other depressive and anxiety symptoms, like feeling sad or hopeless, worrying a lot, or wanting to spend more time with the parent.

In November we asked whether parents still perceived that their children were affected by terrorism. Among adults who participated in both surveys, 44 percent reported substantial stress in September, but the number dropped to slightly more than 20 percent in November. Compared to the reduction of symptoms in adults, children's symptoms decreased far less from September to November.

One finding is that the symptoms the parents most commonly endorsed in their children as a result of terrorism were not the classic PTSD symptoms, but rather the more general depressive and anxiety symptoms. This finding highlights what may be one of the important differences between terrorism and other traumatic events.

Children's mental health response to terrorism may not be just a response to the trauma and loss of the events of September 11th. Anxiety and sadness also may be a response to the climate of fear—the sense of danger—that continued to be felt across the country in November 2001.

We also looked at a variety of parent and child characteristics to determine differences in children's response to terrorism. One of the most striking findings was the significant differences in the number of symptoms reported by different racial and ethnic groups. The average number of symptoms reported by Latino parents was almost double the number reported by white parents. Significant differences also appeared in the number of child symptoms reported by parents with different household incomes. Households with fewer resources reported greater numbers of symptoms in their children.

We also wanted to learn about children's sense of danger from terrorism. We asked parents whether their child was currently worried that the child or an immediate family member would be a victim of terrorism. Children's symptoms differed significantly between racial and ethnic groups and between households with different incomes. Children in racial and ethnic minority households and in households with lower incomes were having more symptoms.

Parents told us in November that they were seeing terrorism-related symptoms in their children and that their children worried about being a victim of terrorism. How did parents respond to their children? Using the amount of time that parents and children talked to each other as a gauge, terrorism continued to be an important issue for families in November. When we asked parents about the conversations they had had with their children about terrorism, more than half the parents told us they had spent more than 30 minutes during the previous week talking about terrorism with their child. More than one-third of the parents reported talking with their children for more than an hour. This may not seem like a lot of time, but conversations of that length between parents and children tend to be rare. Not surprisingly, conversations with older children tended to be longer, as did conversations with children with more symptoms.

What were parents and kids talking about? Many parents told us that they had talked some or a lot with their child about the child's fears about his or her own safety. In many families, parents also told us they were talking with their children about ways to be safe, such as taking precautions against anthrax and avoiding public places that might be a potential terrorist target. These conversations were more common in children with more symptoms. No matter what their background, parents were equally likely to try to comfort their child and talk with their child about the child's fears.

When we looked at whether parents were advising their child about precautions they should be taking to be safe from terrorism, we found a similar pattern. Among parents who talked with their child about taking precautions against anthrax, African-Americans and Latinos were twice as likely to report having had such a conversation with their child as whites. Parents in households making less than \$25,000 annually were almost three times as likely to have had such conversations as parents in households making more than \$40,000. The pattern of parents' conversations with children about avoiding public places looks similar. Parents across the country were talking with their

children a lot about the children's worries and also about what they should or should not be doing to be safe from terrorism.

Schools are a major source of support for our children; in some areas in New York, the schools are very active. What are schools in other areas doing? The majority of parents across the country told us that their children's schools were active in providing information or support to the children or their families. Nearly two-thirds of parents reported that their child's school had held a special school assembly or classroom program in response to terrorism, were providing counseling to children in response to terrorism, or provided information and materials to assist parents in trying to help their children cope. These activities appeared to be most common in elementary schools. Middle schools were less active and high school the least active. No differences appeared based on race, ethnicity, or household income.

Several lessons emerge from these surveys about how to help children meet the psychological challenges posed by terrorism. First, the evidence suggests that terrorism probably is different from many other traumatic events in important ways. The psychological reach of terrorism is likely broader, not only in terms of distance—these were children across the country—but also in terms of the range of psychological responses we are likely to see in the children and their duration. The terrorism experience of our children combines the horror and loss of the events of September 11th with the environment of sustained danger and uncertainty that followed and continues to remain with us.

It is likely, however, that many of the symptoms the parents reported were normal reactions to this combination of acute and chronic stressors. This means that as we think about meeting children's mental health needs, we must be careful that we do not fall into the trap of just thinking about terrorism as another traumatic event. We need to think about ways not only to address the acute trauma of the terrorist attacks, but also to help children and families learn how to handle an environment of sustained danger and uncertainty.

It seems clear that terrorism is experienced differently by different segments of our society. Children's experience of terrorism and their response to it is through the prism of all their other life experiences and those of their parents. For example, when we looked at the conversations parents were having with their children, we found that all parents were comforting their children. But when it came to giving their children advice

We need to think about ways to help children and families learn how to handle an environment of sustained danger and uncertainty.

on how to be safe from terrorism, evidence of dramatic differences emerged between different parts of our society.

What does this mean for helping our children? Do we need to tailor our interventions? Maybe. Right now we do not know, but it is certainly something that we need to consider in light of what we are finding. And it is something we certainly need to learn more about.

Our findings have important implications for how we think about interventions and other ways to help children. Often when we talk about interventions, we tend to think of things like crisis counseling, debriefing, or other interventions by mental health professionals. We need to think more broadly. The parents' conversations with their children, the special school programs, and the materials sent home to parents will have a tremendous impact on children's coping and resiliency in the face of the anxiety and fear caused by terrorism.



We need to learn more about what types of counseling and clinical interventions are effective for the few children who need those interventions. But the survey findings suggest that beyond those few children who need those types of clinical interventions, many more children are affected by terrorism. We need to learn more about how to help this larger number of children across the country.

In this effort, parents and schools will be critical. Right now, we know something is happening—but we do not know what. We need to know more about the details of what parents and schools are doing. Is what they are doing effective? Is it helping children? And, despite their best intentions, is any of it harmful? Right now we do not know.

What about others in the community? Other institutions and people play important roles in children's lives—churches, synagogues, mosques, and pediatricians, for example. What roles are they playing? What are they doing? Across all of these groups, we need to think about what kinds of support they need to do a better job. Beyond just clinical interventions, we need to think about how to support parents, schools, and others in the community to help promote better coping and resiliency in children.

An environment of sustained danger and uncertainty seems here to stay. But if we can begin to answer some of these questions, as a nation we will be in a much better position to help our children meet some of the mental health challenges of the unfamiliar world they now face.

TERRORISM: TEACHER REACTIONS AND NEEDS

Betty J. Pfefferbaum, M.D., J.D.

As we learned in Oklahoma City and in natural disasters long before that, schools provide an excellent venue for the delivery of disaster mental health care. Schools are accessible to children and to families. School-based programs are able to provide a normalized approach, and they tend to minimize the stigma commonly associated with mental health care. Furthermore, teachers and other school personnel who work with children are aware of the important developmental differences in children.

Researchers have conducted numerous studies of children in postdisaster situations, both natural and man-made events, but there are virtually no studies of the reactions or needs of teachers. Yet we expect teachers to provide for the immediate physical and emotional needs of children.

Both the Oklahoma City bombing and the September 11th events occurred in the morning—when children were in school. Teachers and other school personnel are pressed into service during events like these with little acknowledgement that they, too, will have been

exposed and will have emotional reactions and needs. Schools and teachers are important aspects of the recovery environment over time.

The importance of teacher reactions was evident in our studies in Oklahoma City, conducted seven weeks after the 1995 federal building bombing, which found that fears associated with their teachers' reactions in the acute environment were related to the students' ongoing posttraumatic stress reactions. In addition, the New York Academy of Medicine study of the response of children to the September 11th events revealed that 20 percent of parents reported that children had received counseling in the first two months after the attack on the World Trade Center. Of those who received counseling, almost 60 percent had received that counseling in their schools.

We conducted a study of teachers in Oklahoma City schools about two months after the 1995 bombing. We examined a convenience sample of almost 900 teachers from elementary school through high school. Most of the teachers were white women whose average age was about 42 years. Many taught in schools near the bomb site.

Most of the teachers were at work on the day of the bombing and with children at the time of the incident. Their acute reactions were intense, similar to those we might expect in other populations. The reactions included a sense of helplessness, fear, worry, arousal, and rapid heart rate. Women reported more intense reactions than men.

The findings with respect to interpersonal exposure in this sample were alarming to us at the time. More than one-half of the teachers reported that they knew someone who was killed or injured in the incident—but most of those relationships were through friends and acquaintances, rather than family members. That is a key point, as we try to understand the reactions of various groups.

Findings regarding television exposure were interesting. Three-quarters of the teachers reported that all or most of their television viewing in the aftermath of the bombing was related to the bombing. This was not surprising given the intense focus on the incident in the national and local media—particularly in the local media, where major television stations did not return to normal broadcasting for four or five days after the incident. We asked teachers how much stress they experienced associated with media coverage. Forty percent said that they felt some or a lot of stress associated with the media exposure. Our findings indicated that media exposure was related to later posttraumatic stress in the teachers. This was true in the children as well, but other factors, for example, the stress related to media coverage and the teachers' acute reactions, were more important than the amount of media coverage in later posttraumatic stress. Other factors undoubtedly influenced later symptoms even more than media exposure, but the media concerns provided us an opportunity for intervention or prevention.

Therefore, we suggest that media exposure at least be monitored, if not limited, following disasters like the bombing. One approach our schools can take, for example, is to develop a strategy for dealing with media coverage. On the day of the Oklahoma City bombing, teachers and schools engaged in a variety of practices with respect to announcements and use of the media. Some teachers brought televisions into their classrooms and watched live coverage of the rescue and recovery.

The relationship between ongoing post-traumatic stress and media exposure does not mean that media exposure causes posttraumatic stress reactions. In fact, it may be that people who are aroused or who are more symptomatic may be drawn to the media, perhaps to obtain information about an

event or to maintain this heightened state of arousal. We need more rigorous studies to address this issue. Our study used

a very brief survey with only two questions about the media. We need studies that explore both positive and negative aspects of the media before drawing any conclusions. And posttraumatic stress symptomatology is not the only outcome we need to examine.

Schools and teachers are important aspects of the recovery environment over time.

Posttraumatic stress reactions did occur, primarily reactions of intrusion and psychological reactivity, but emotions such as worry and concerns about safety are more salient following a terrorist incident. A major goal of terrorism is to create fear and intimidation in the public. In our study seven weeks after the Oklahoma City bombing, 40 percent of the teachers reported that they were somewhat or very worried about their own personal safety.

We asked teachers about the stress they experienced as they were trying to deal with the needs of students; 30 percent acknowledged some or a lot of stress. Teachers overwhelmingly reported satisfaction with the support they received from their colleagues and administrators.

Some reactions are normal after a terrorist incident and do not necessarily translate into need for clinical attention or intervention. Seven weeks after the bombing, 18 percent of the teachers surveyed said that they were experiencing difficulty handling the demands at home and school, yet only 5 percent had sought counseling. We know that parents and teachers tend to underestimate the traumatic responses of children. When teachers are stressed, experiencing ongoing worry, or having functional difficulties themselves, they may be even less able to identify children in need.

Women teachers tended to report more intense reactions acutely and over time, and they were more likely to report impairment in their functioning than men teachers. This may reflect

actual differences in gender in response to incidents like this, but it is also possible that women are more likely to experience the kinds of reactions that we queried in this survey—*anxiety and posttraumatic stress symptoms*. Or women simply may be more comfortable reporting those symptoms. In any case, gender differences should be acknowledged as we try to develop programs for teachers and other school personnel.

The following school-based strategies should be considered following terrorist events. The first is to restore safety and promote security in the acute environment and over time. This key prevention strategy translates into the development, review, revision, and practice of emergency response plans. Practices should include drills that involve everybody in the school—students, teachers, and other personnel. The normal routine should be reestablished as soon as possible after an incident.

Schools provide an excellent venue for screening children who are at risk. A mechanism for referral should be in place for directly exposed children or children who appear to have functional impairment. School-based programs should provide developmentally appropriate interventions using curricular and classroom activities and small group efforts. A focus on coping and building resilience is recommended.

The school system should be engaged at every level. The U.S. Department of Education is on board in this fight against terrorism. Every state's department of education and every school district need to be involved. In Oklahoma City, individual schools were allowed to make decisions about which programs would be brought into the schools, so many classrooms went without mental health efforts following the bombing. Parents, communities, the media, and businesses should also be engaged.

TOWARD A PUBLIC CHILD MENTAL HEALTH FRAMEWORK IN THE AFTERMATH OF SEPTEMBER 11TH

Robert Pynoos, M.D., M.P.H.

Disasters have always been a part of the human condition, deeply affecting large regions and communities and even dramatically changing the course of history. The earliest known written personal account by an adolescent is a letter from Pliny the Younger about his experience in Pompeii during the 79 A.D. eruption of Mt. Vesuvius. He documented his moment-by-moment experience, empathic arousal at the cries of distress around him, and intense conflicts created by the interlocking worries about the survival of his mother, himself, and his uncle, Pliny the Elder. At one point in his account, he described how he no longer felt any fear, being resigned to the fatal expectation that the whole world was coming to an end.

Speaking here in Atlanta, the home of CNN, I think about the importance of the media, both in communicating at a long distance the horror and destruction while, at the same time, clarifying its dimensions and impact.

September 11th has brought to the forefront, like no other recent national tragedy, an appreciation across all the communities of the United States of the psychological reverberations of traumatic experiences and losses and the challenge of living in an environment of danger and threat. One of the most important legacies should be an ongoing commitment by our nation to attend to the impact of traumatic experiences and loss on the lives of children, adolescents, and their families and all the different ways in which these occur.

The Donald J. Cohen National Child Traumatic Stress Initiative was created through strong bilateral congressional support before September 11th. As a result, the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services has funded the National Child Traumatic Stress Network as of Oct. 1, 2001. In response to 9/11, congressional support increased to provide for

more network partners, more services for areas most affected by the terrorist attacks, and more resources to strengthen our national preparedness and response capabilities to assist with the mental health needs of children and families in regard to terrorism and disaster. The network's three components are a coordinating National Center for Child Traumatic Stress at UCLA and Duke University; 10 university-affiliated sites across the country engaged in the development and implementation of evidence-based prevention, assessment, early intervention, and treatment; and 26 community treatment and service centers.

This is a unique federal mental health initiative that leverages collaboration across the network to meet a national mission of raising the standard of care and improving access to services for traumatized children and their families across the United States.

The network partners include academic and community mental health leaders across the wide spectrum of child and adolescent trauma, including domestic violence, child physical and sexual abuse, community violence, accidental injury and death, medical illness and treatment, and disasters and terrorism. The network is not constructed around a specific mental health diagnosis, but rather provides expertise across developmental ages and developmental consequences. A wide range of service sectors is represented, including pediatric, child mental health, child welfare and protection, juvenile justice and law enforcement, and disaster response. The network also serves a wide range of culturally diverse populations in both urban and rural settings. In the aftermath of September 11th, the national network is well-positioned, through its various sites and national resources, to improve our disaster response plans, to increase our response capacity in regional and local communities, and to assist federal, state, and local efforts.



Beyond disaster and war, terrorism requires a rethinking of our public mental health framework to understand its impact on child and family mental health. Most mental health professionals have started with a posttraumatic stress disorder (PTSD) model. This was most apparent in the immediate aftermath of 9/11, when clinical attention and media focus often were confined to discussions about PTSD as a disorder. Of course, PTSD must be one of the foci, but it has been important to place discussion of posttraumatic stress within a wider context of danger and its new societal parameter.

Key features of the ecology of danger include actualized acts of terrorism, ongoing realistic threats, and the occurrence of false alarms. Any public health program needs to address psychological sequelae associated with each of these three dangers. For example, several New York City schools experienced subsequent evacuations after 9/11, including one school in lower Manhattan that was evacuated four times because of bomb threats to a police station nearby. Postdisaster plans often do not provide any protocols for responding afterwards to false alarms by providing the appropriate information and supports needed to help in the recovery from renewed fears of recurrence or increased arousal.

***Following trauma and loss,
large segments of the population
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stress responses.***

Fears of recurrence can be fed easily by myths, rumors, and misconceptions and are not bound by the same trauma-exposure parameters that typically predict PTSD. Schools, families, and communities can have procedures to keep properly informed about these, help with clarifying distortions, and mitigate their unnecessary transmission. For example, within the first week after 9/11, adolescents had spread over the Internet supposed writings of Nostradamus that predicted a catastrophic collapse of two twin towers in the 21st century. It was weeks before the writings were exposed as fraudulent, but by then many adolescents across the United States had fueled their own internal set of catastrophic expectations.

Danger typically increases media activity and commensurate viewing by the public. Modulation of information exposure presents a challenge, especially to directly affected families, where there is a continued need to gather relevant information about missing family members, clarification of the tragic circumstances, issues of accountability, and estimation of the need and type of ongoing protective actions. At the same time, it can be aversive and debilitating to have to view repeated traumatic images, sounds, and other reminders to get this information.

Children have the same basic needs, but modulation takes on special importance. Television can be a major source of unnecessary secondary exposure to traumatic details. While television reporting can be an important source of clarifying information, the briefness of news items and images actually can serve to elicit fear and anxiety reactions that interfere with information processing and enhance danger responses over time. Studies conducted in Oklahoma City and New York City have indicated that the amount of event television watching in school-aged children is correlated with increased severity of posttraumatic stress reactions.

New York City successfully conducted the largest evacuation of schools in the history of the United States. Great credit must be given to the

school personnel and student bodies of the lower Manhattan schools. The fact that, despite day-long odysseys, even into the evening for some students, school personnel were able to assist students in getting home safely was a major public mental health achievement. As Mrs. Carter commented, our first thoughts are about our children. Threats immediately bring up worries about significant others across long distances and are extremely intense. Our studies show that these worries can persist for weeks and months, even after reunion, manifesting in separation anxieties for both children and parents. The New York City Board of Education Needs Assessment documented how significant this has been for children and adolescents after 9/11. It is likely to have been much more so, had there not been such dedication and ingenuity in finally getting children home.

Another aspect of the ecology of terrorism has been the objective signs of heightened security that have been so evident for months after 9/11: National Guard at the airports, police or military personnel at bridges and tunnels, evolving into new security procedures at office buildings and schools, airport check-in, and many other societal situations. These measures are aimed at increasing safety and protective behavior. But this ecology of vigilance to danger can lead in younger children to incident-specific new fears and anxious or restrictive behavior. In adolescents, posttraumatic hyperarousal, together with an ecology of danger and trauma reminders, can lead to aggressive and reckless behavior.

In the developmental neurobiology of danger, children learn to categorize dangerous objects or situations before they develop better capacities for discerning specific risks based on more discriminating information. In the aftermath of trauma, we all feel the pull to rely on categorization of people and threatening situations. It can take some time and active effort to restore a more refined approach to appraisal. For example, children learn the category "dogs" before they learn to discern among breeds. After being badly bitten by a dog, a child may more strongly rely on the category of dog to estimate danger and require help to regain an ability not to see all dogs as threatening. This principle is important to understand in regard to terrorism, because categorization that occurs in regard to intense



issues of accountability can lead easily to wide intolerance of members of cultural groups. Because of the developmental vulnerability of the appraisal process for children and adolescents, they need added support to understand the challenge to their appraisals and to counteract intolerant beliefs and behavior.

Spiritual support and beliefs are extremely important in contending with threats and finding meaning in the face of danger, trauma, and loss. At the same time, catastrophic events can challenge our basic beliefs. History has shown, however, that when such events have a wide destructive impact on a large population, spiritual schemas can become pessimistic and apocalyptic. On the family level, studies around the world have found that, in situations of chronic war or terrorism, demoralization among parents can have a profound effect on their children.

Specific risk factors relate to danger, including children and caregivers with prior anxiety conditions. After the earthquake in Northridge, California, anxious children had much more anxious responses independent of their exposure, as did children of parents who were anxious. Several other risk factors are a history of insecure attachment, parents in high-risk professions, group identity misappraised as dangerous, single

parents, reduced family resources, and prior or current living in dangerous environments. Terrorist events, such as 9/11 or the anthrax bioterrorism, can redefine who has parents in what are now deemed or perceived as high-risk professions—for example, airline personnel or post office employees.

Following trauma and loss, large segments of the population have general traumatic stress responses. A community's real goal is to make sure there is an appropriate public mental health approach that provides surveillance, screening, and identification, so that triage and tiered interventions can be employed properly. Support provided for the more general reactions, shared by many, differs from what is needed to assist children and families with more specific exposures and responses. As studies have shown, there is a tremendous reservoir of unaddressed prior trauma in the lives of many children and families. A public mental health program needs to be able to take that into account and meet their special needs, as the current event may well bring back distressing reactions to their prior experiences.

We know that the impact of loss after disaster or terrorism can be both concentrated in certain pockets and widely spread. Traumatic loss does not follow the type of exposure parameters most predictive of PTSD. It reaches far and wide, across the United States and beyond. We have come to appreciate that traumatic bereavement not only entails normal grief reactions, but also includes continued preoccupation with the manner of death, including its details. This continued intrusion actually can interfere with the more usual, although difficult, task of contending with the impact of the loss itself. Complicated bereavement also carries posttraumatic stress-like risks that are different from the depression, anxiety, and substance abuse that can follow the loss of loved ones. After the loss of a loved one, 15 percent of adults and children may develop depression by one year. This is a serious issue, sometimes affected by other risk factors, such as family histories of depression or prior history in the child. In New York we suggested that experts in depression be included as part of the team providing consultation to the grief counselors in order to monitor those who were most at risk and provide timely and proper treatment.

Adversities that abound after disasters can contribute to many different kinds of effects, including increased domestic violence and child abuse. This requires a public mental health response in which public policy makes a difference. Restoring the community, increasing community resources, reducing unemployment, making changes in living circumstances—all these actions affect mental health. Many times we as mental health professionals do not see ourselves as advocates for these types of disaster responses—but they have a strong and direct bearing on the mental health outcome of

children and families, so we should.

The envelope of fear in New York reached far further than the

Probably the most underrecognized and untreated factor in the United States in efforts to increase academic excellence is the reservoir of trauma and its effects that impact on academic performance.

Ground Zero area in terms of separation anxiety. The separation anxieties go both ways. During the Northridge earthquake, which occurred at night, parents were surprised and taken aback that they could not move well enough to get immediately to their children in their bedrooms. As a result, afterwards parents often wanted their children to sleep in the parents' bedrooms, as much as did their children. In situations of disaster or terrorism, where there are major evacuations or extended separations of children, siblings, and parents—for example, because parents are at work and children at schools—we have found that separation anxieties persist at significant levels among school-age children and adolescents, where it is usually not present, as well as among younger children, where it is more expected.

Incident-specific fears are not just generalized fears. Studies suggest that after disasters or terrorism, children do not necessarily become more fearful in general. School-aged children especially, however, develop specific, intense fears that are tailored to specific details that relate to that particular trauma. The New York City Board of Education Needs Assessment indicated that, especially among six-to 12-year-olds, many children are now scared of subways and buses, which they may take every day. Recall

that subways did collapse, and many children as well as adults were stuck in subways in the immediate hours after the terrorist attacks. Children also knew people who were trapped or worried about others in their families using these forms of transportation. Avoidant behaviors that can grow out of these incident-specific fears can have a restrictive influence on development.

Studies also show that: (1) What the government says about risk to a measurable degree afterwards can affect people's longer-term reactions, as happened in Three Mile Island with the government's pronouncement of a five-mile radius for evacuation, and (2) seeing disagreement about appraisal of threat or safety behaviors between parents and teachers during the course of an event or afterwards adds measurably to children's post-disaster level of anxiety. What is key in the recovery environment is to develop a milieu that promotes respect toward those with quite different ranges of response and recovery times, often due to varying exposures by family members, peers, and school personnel and community. The specific family, peer group, or school has to be helped to sustain the recovery process for those most affected, while recognizing that others may have an easier course. This is not always easy to achieve. Those with less exposure and easier recoveries may be impatient for those who need a longer time, and those most affected and taking longer may feel others are not sufficiently appreciative of their difficulties.

After September 11th, it was hard for many of us to get the media to focus on the needs of traumatized parents, on the special help they needed to parent while recovering from their posttraumatic and grief reactions. As one New York Academy of Medicine study suggested, thousands of parents were directly traumatized, and their children often were the ones using mental health services. Helping this set of parents must become an important focus of our public mental health programs.

Most adolescents both witness and are victims of violence, which increases their risk of posttraumatic stress. Epidemiological studies show what happens in adolescents when they have been exposed to violence and have PTSD: substance abuse, reckless behaviors, high-risk sexual behaviors, gang participation, and

disturbances in academic functioning. Probably the most underrecognized and untreated factor in the United States in efforts to increase academic excellence is the reservoir of trauma and its effects that impact on academic performance.

A public health model has three tiers: (1) general posttrauma response, (2) postterrorism response for the general population and a specific response for high-risk children and their families, and (3) identification of children with prior psychiatric disorders. We established a system like this in 40 high schools in Bosnia and Herzegovina, where we have been working since the war, trying to develop each of these layers.

Tier I deals with fears of recurrence and the disruption of the protective shield. Negotiations take place in daily lives with school-aged children and adolescents about what they can do and what they cannot do as they live with danger and terrorism. Among appropriate protective actions that people can take is moderating the extent of watching TV—reducing unnecessary secondary exposures. Parameters for heterogeneous grouping need to be addressed. In many of our school crisis intervention efforts, we now



make the mistake of immediately grouping in classroom exercises more-exposed children together with less-exposed children. Sometimes that can result in the less-exposed children hearing more than they need to and actually becoming more symptomatic afterwards.

With the right parameters and goals, however, these classroom interventions can help facilitate the type of tolerant recovery environment I spoke of

earlier. With children, as we do with adults, it is important to focus on constructive responses. Every child in America drew a picture of September 11th, it seems, but that wasn't necessarily helpful. We know that drawing a constructive response of how to build a safer place where they live in their own community is very important to anxiety binding, yet most schools did not do that.

First aid measures include simple things like repeated clarifications and consistent care giving. Children need an early, flexible plan to help restore normal sleeping routines that includes flexible negotiation between parent and child right from the start that is neither too permissive nor too restrictive. This must be part of a public health approach. In adolescents it is of critical importance to address reckless behaviors. In schools, concerns may be focused on the risk of alcohol-related accident, gun accident, or suicide behavior. In an anxious and fearful environment, we must think about what is part of a public health approach.

Tier II of a public health approach relates to five areas of treatment: traumatic experience(s), trauma and loss reminders, traumatic bereavement, adversities and current stresses, and developmental progress. No treatment succeeds unless you get the adolescents or school-aged children or preschoolers back onto their developmental progression. It is not enough to reduce their symptoms.

In collaboration with UNICEF, we have helped to implement a large-scale school-based program to assist the recovery of war-traumatized adolescents in Bosnia and Herzegovina. We often have been disappointed that it has been harder

Parents need to know both how to explain their reactivity to their child and how to help the child understand the parents' own course of recovery.

to implement a similar program in the United States for adolescents who have endured years of community violence. In 40 high schools there, using a manualized trauma-grief focused group psychotherapy, we have demonstrated its effectiveness in decreasing PTSD and depression, while maintaining normal grief and decreasing complicated bereavement among adolescents. Designed for a school semester, we have had excellent acceptance by the schools and nearly 100 percent compliance by the adolescents.

We have implemented a similar school-based program in the Los Angeles region among students who are living in a high-crime area. Screening entire junior high and high schools revealed that as a group, adolescents with the worst exposures and most chronic, severe PTSD pretreatment are overrepresented in failing

classes and alternate school classrooms. By treating them for their PTSD, we saw a concomitant vast decrease in failing classes and a significant increase in grade point average. For these adolescents, that meant a major improvement in their lives; they could also once again participate in extracurricular sports and activities. A study of recent immigrant children shows the same kind of academic improvement in treating their backlog of traumatic exposures and chronic PTSD.

We must also realize that after disasters, terrorism, or school violence, the recovery of teachers is vital to the school community. Right now we do little to provide proper services for our teachers and other school personnel. Traditionally disaster-recovery money could be used to help teachers to be able to help their students, but not for direct services for teachers. That needs to be changed. In providing services, we will need to address their concerns about confidentiality.

A family approach means providing many more services than just making information available on symptoms and reactions. There is insufficient guidance about how to help parents parent under situations of danger or trauma recovery. For example, a traumatized parent is going to react to his or her own set of traumatic reminders, sometimes startling, more isolated, or irritated. Parents often are less able to comfort their child at these times. Their responses might then in turn also alarm their children. Parents need to know both how to explain their reactivity to their child and how to help the child understand the parents' own course of recovery. We need to develop and operationalize that kind of practical advice.

As a nation we need to support the many children and families who, because of the direct impact of 9/11 on their family and lives, will take a long time to recover. In doing so, we need to support each child's or family's respect and tolerance for their own unique course of recovery and challenge as we continue to live in an ecology of danger.



Questions & Answers

Q What was the definition of terrorism in the RAND study?

A Dr. Stein - We said “terrorist attacks” and “effect of terrorism,” and we left it up to parents to interpret as they saw fit. The experience of terrorism and its meaning are seen through the prism of people’s daily lives. For some populations in this country, the experience of ongoing fear and danger is something that they deal with on a daily basis.



Q How can we address the needs of underserved communities where many people appear to be at greater need?

A Dr. Pynoos - In the last 15 or 20 years, we have experienced an epidemic of violence in the United States. We provide every police officer, rescue worker, combat soldier, and fireman with a standard of care that has not been applied to our children. We ought to give proper support to children and adolescents who have gone through these exposures to violence with no assistance. That would be an important step—to address the trauma in their current lives and in past experiences. We have made little public policy in that regard in the United States.

Q What is the state of our research in understanding the separation of the children’s experience from that reported by parents, and what implications might that have for understanding the phenomenon and recommending treatment?

A Dr. Pynoos - You get underreporting among teachers and parents in all studies and most fields of child psychiatry, especially those that relate to the internal experiences of the child. We suggest that every family reflect on its experience, the reminders and reactions they are having as a family to different things, so they can give proper child-to-parent, parent-to-child, and spouse-to-spouse support. Techniques may address restoration of the protective shield, but this is probably a mutual task.

Q At the time of the hurricane in Hawaii, it was clear how important it was to have adults who had skills and who were part of a caring community. What have research and experience brought to our field of wisdom about how best to support resilience?

A Dr. Pynoos - We have to break down how you provide finances. In 9/11 some of the child psychiatrists and psychologists who were parents, and schools in the Ground Zero area, did an extraordinary job of organizing with parents and developing methods to help themselves, their schools, and their children—none of which was financed by the mental health system. We need to find better ways to support those efforts in our disaster and terrorism planning efforts so as to have communities better prepared to do so. But it is a hard fight for parents afterwards to secure resources to do what they understand might be very helpful for themselves, their children, and their own schools.

Q To engage schools at the federal, state, and individual school levels, do you have any policy recommendations?

A Dr. Pynoos - One policy recommendation would be to provide funding following disasters, as was done after the Northridge earthquake, to deliver services to teachers to help them with their own recovery, contrasted with the typical situation in which teachers learn only what they need to do to help children. That is not part of public policy at this point.

PANEL II: STATUS OF THE STATE TEAM DISASTER RESPONSE PLAN

Charles G. Curie, M.A., A.C.S.W.

Today, the issue of our nation's mental health has never been more central to our lives. The tragedy of September 11. It has helped us talk about and consider the issue of mental health in ways we did not before.

At 14 months after September 11th, for many Americans the disbelief of that day has been blunted. Yet without question, the American people have been changed. As President Bush noted, "We are a different country from what we were on September 10—sadder and less innocent, stronger and more united." Perhaps for the first time in our lives, our faith that it could not happen here has changed in the frank realization, as Mayor Giuliani indicated, that it *can* happen here. We have always lived with that risk; it was invisible to us until that day.

Without question, in these 14 months following September 11, 2001, we are learning to live in these changed times, these uncommon times. For some, they have been unsettling and distressing times. For others, they have been challenging times, times of commitment and rededication of purpose. How we have responded has depended on the music each of us naturally has within us.

We have a new definition of "normal," and we are helping to shape that new definition. For the past 14 months, we have been struggling to wrap our minds around that new definition.

Other reminders now have reinforced how changed America has been, how changed the world as a whole has been:

- Anthrax attacks just two weeks following September 11th,
- Ongoing acts of terror that took the lives of American soldiers abroad,
- The loss of lives from around the world in the Bali terror bombing, and
- Most recently, everyday people doing everyday activities who died at the hands of the individuals now known as the Beltway snipers.

Terror and threat of terror—facts of life in other places—are now facts of life in our neighborhoods, too. But despite our changed perceptions and perspectives, one truth remains unchanged—the incredible resilience and strength of the American people. People have gone about their day-to-day lives, doing what they need to do day by day, and not paralyzed with fear or dread as individuals or as a nation.



It's been said that action is the antidote to despair. Perhaps that is why the vast majority of Americans have gotten on with the job of getting on since September 11. As telling as anything else are some preliminary findings from SAMHSA's National Household Survey on Drug Abuse—the only survey to have sampled both immediately before and after September 11. Expected spikes in the use of alcohol, tobacco, and illicit drugs for the most part just didn't happen. That speaks volumes about our capacity as a people to rebound and to respond in positive ways.

Resilience alone is not enough, however. Readiness is also critical.

It has been said that the ability to move from a vision of what should be to the reality of having made it happen is all a matter of time. During these past 14 months, moving that vision of what should be to reality has been what the Department of Health and Human Services has been about and what SAMHSA's work has been about, through the summits and the aftermath of September 11th to our programs and grand priorities and to our educational and training materials.

We have spent our time wisely and well with some very good people. Everything we have done since September 11th has charted new territory. Each step we took was on new land. Each word we uttered was heard with new awareness. Each task completed was breaking new ground. Each was a part of our education and the education of the American people.

During the past 14 months, we have had the opportunity to be more proactive than reactive. We have had the opportunity to think strategically about mental health needs in the face of terrorism, bioterrorism, and other crises. It has not been just about creating a work plan. It has been about taking responsibility to make it happen—and we have.

What we have created has been the product of listening to people just like those here today: state mental health administrators, service providers, community leaders, policy makers, consumers, and families. We heard you tell us that states and communities need to change and how crisis planning is done. We heard you tell us that mental health needs need to be part of

emergency preparedness teams and plans. We also heard you remind us that the worst time to prepare for a crisis is in the middle of one.

So we continue something we began at our November 2001 summit, *When Terror Strikes: Addressing the Nation's Mental Health and Substance Abuse Needs*. We continue to help states find the time and resources to reframe and redesign their emergency infrastructures that

place
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We continue to help states find the time and resources to reframe and redesign their emergency infrastructures that place mental health and substance abuse issues in the bedrock of disaster plans.

plans. For that reason, we asked Brian Flynn to work with the National Association for State Mental Health Program Directors to help ensure that mental health and substance abuse issues are embedded in every hazard plan developed in every state and every community.

At the same time, we are making \$4 million in grant funding available to support state readiness in disaster mental health and substance abuse. Based on what you have told us, the grant program encourages states to create systems that are flexible and capable of being responsive to any crisis, whether natural or manmade. The grant applications have come in the door; the deadline has passed; and we are looking forward to making awards in the near future.

We heard you when you told us, in the wake of the anthrax attacks, that bioterrorism is also a growing concern. We are developing a number of new initiatives in this area in the coming year.

We also heard you tell us that you need to know how best to tell America what is happening when a crisis arises. In this changed America now more than ever, our ability to communicate clearly and with vision is crucial. After all, the very first things people hear from a public official are critical in shaping how they react, not just over days, but over weeks, months, and even years. That's why each of us needs to know what to say, when to say it, and how to say it in ways that are truthful, hopeful, and trustworthy. Moreover, we need to say it the first time and get it right the first time.

Without question Mayor Giuliani is the master of communicating in times of crisis, and of doing so with vision and clarity. I was pleased that the mayor took a copy of our booklet *Communicating in a Crisis: Risk Communication Guidelines for Public Officials*. It's a volume that we're formally releasing right here at this symposium. It helps teach the language of safety, security, and hope—critical ingredients in risk communication. It's the product of collaboration among SAMHSA, CDC, and FEMA and is designed to assist public officials—mayors, county commissioners, public health officials, public safety officials, and law enforcement. The efforts of many people who worked to make it a user-friendly tool cannot be overstated. We will make the booklet available not only through SAMHSA, but also through state mental health authorities, emergency authorities, and drug and alcohol authorities.

On the back of the booklet is a "Top Ten List for the Savvy Communicator." The top tip reads like the Hippocratic oath: "First, do no harm. Your words have consequences—be sure they're the right ones." To help SAMHSA ensure that we have the right words and programs, we are hiring an emergency services coordinator for the agency to serve as our point person, our voice in times of crisis.

Over the past 14 months, America has held its breath, cried, mourned, and drawn strength from family, friends, and faith. We are recovering and, without question, we are learning. Over the past 14 months, America has been learning what we

in mental health have known for some time. Mental health is not to be taken for granted in these times of uncertainty. It can no longer be an afterthought. Mental health in today's world is, and will remain for some time to come, at the heart of public health.

Theodore Roosevelt had insight into how best to function in crisis, how to manage risk communications, and how to move forward in changed times such as these:

It is not the critic who counts, not the man who points out how the strong man stumbled, or where the doer of deeds could have done them better. The credit belongs to the man [and, I might add, the woman] who is actually in the arena; whose face is marred by dust and sweat and blood; who strives valiantly; who errs and comes up short again and again; who knows the great enthusiasms, the great devotions, and spends himself in a worthy cause; who, at best, knows in the end the triumph of high achievements; and who, at worst, if he fails, at least fails while daring greatly, so that his place shall never be among those cold and timid souls who know neither victory nor defeat.

So let us stay in the arena. Let us keep daring greatly to meet the challenges of a changed tomorrow. In doing so we can only meet with victory. The people we serve deserve no less. The good news is that we have a strong, solid track record. I look forward to continued partnerships to help promote the resilience and the recovery of America.

PREPARING THE STATES

Brian W. Flynn, Ed.D.

My task is to present an overview of states' preparedness on the mental health spectrum to deal with the world in which we find ourselves after September 11th, 2001.

Let me give you a bit of history. Federal legislation has required states to have mental health components of their state disaster plans for almost 30 years. The Stafford Act seldom has been enforced, although most states have some

type of plan. We have been fortunate over the last 30 years to have had great support from the Federal Emergency Management Agency (FEMA) through the Center for Mental Health Services (CMHS) to provide services to victims and survivors following natural and human-caused disasters. But funding was never made available for preparedness, which has been a long-term source of frustration for those of us who value the services but know we could do a lot better if we were better prepared.

Over the years, without that kind of support for preparedness, the extent to which states have been involved in preparedness has depended on personal interest, fiscal realities, human resources, and political will in the states. Since January 2002, I have been working closely with the National Association of State Mental Health Program Directors (NASMHPD) to implement a contract they received from CMHS to assess where the states are and to provide guidance for moving the states forward in planning.

We asked all the states for copies of their plans, and we reviewed and analyzed them. We held a focus group and conducted a number of phone conversations with state and national leaders in disaster mental health, all leading to the development of *Guidance for States*. *Guidance* is based on the all-hazards planning model of disaster preparedness. Our goal and hope was that this process, and this product, not only would provide concrete guidance for states, but also would provide a focal point, rally resources of all kinds on this topic, and galvanize the country on the importance of preparedness.

What is the state of the states? Almost all states submitted plans. The plans demonstrated enormous variation in almost every respect: their sophistication, format, detail, and scope. Some

related to comprehensive services and institutions and groups and communities within the states. Some dealt only with mental health authority buildings and programs. Other plans included everything in between. There was universal passion and commitment toward preparedness as a goal and a value.

Many states saw the New York summit of November 2001 as a watershed event in bringing together state mental health

authorities, substance abuse authorities, health authorities, and emergency management authorities—in some cases for the first time—to do some planning together. They all felt the summit was an extraordinarily valuable experience, and they look forward to efforts to reinforce the relationships forged there.

The NASMHPD study also found widespread and deep frustration. Those surveyed were frustrated about the low priority of mental health in general, as we move forward as a country in homeland security and disaster preparedness.

They felt that mental health has not taken its rightful and appropriate seat at the table in those discussions. Emergency coordinators, departments of mental health, and commissioners expressed frustration about the low priority of disaster mental health in most states, given the important but competing priorities of other mental health issues in the states, often in an environment of decreasing resources. They also expressed frustration about the lack of human resources to do this job. Fewer than a handful of states in this country have a full-time person within the mental health authority to do preparedness, response, and recovery for disasters and emergencies. More typically, preparedness accounts for part of an employee's time, often only 5-20 percent, with the rest devoted to other mental health authority priorities. Lack of funding was a continual source of frustration and complaint, as people saw what could be done if financial resources

The NASMHPD study found widespread and deep frustration about the low priority of mental health in general, as we move forward as a country in homeland security and disaster preparedness.



were available. Some frustration was evident about the lack of consistency and coordination at all levels of government.

We identified a number of characteristics of innovative states. Most innovative states had experience with disasters with some frequency, so planning was not a theoretical exercise for them. The more innovative states have had funding.

Disaster mental health is on the radar screen in ways that have not been seen before.

For example, after September 11th, some states received funding from the Substance Abuse and Mental Health Services Administration

(SAMHSA) to do needs assessments, and they were able to do wonders with a relatively small amount of money. Staff resources make a difference. States with full-time people were able to do more work. Support from the commissioner was an important factor, as were relationships with other state agencies and departments, including the health department, education, substance abuse, etc. Innovative states tended to look beyond the minimum requirements for a plan and undertake innovative, more comprehensive activities.

Mental health planning increasingly uses the all-hazards planning model, based on a FEMA model used by every state office of emergency management. Our guiding assumption is that the extent to which mental health can replicate and mirror that format and those principles, the easier collaboration will be. The planning model prepares for any kind of event in a jurisdiction. It facilitates integration of mitigation into response and recovery activities. (Every discipline has its own language. In mental health we talk about prevention, and emergency management talks about mitigation.)

Five basic tasks face the states, depending on the state's commitment—or lack of commitment—and their resources. One is to understand the all-hazards model. The second is to decide on the planning process; the process is as important as the product. The third task is to decide on the content of the plan; not every state will be able to do everything. The fourth task is to assure coordination and integration. State emergency management, schools, hospitals, mental health, and substance abuse authorities—almost everybody—are doing disaster and

emergency planning now. These plans will be useful only if we coordinate and integrate them, so that when something happens, we do not leave major gaps or fall all over each other. Finally, an important consideration that must be addressed at the start of this process is how to keep the plan alive and updated, to make sure that mental health participates in exercises. This is the only way to assure that the plan stays viable.

In my view, more than a year after September 11th, there is some good news and some bad news. The bad news is that most states and communities are not well-prepared to deal particularly with the more complex events of terrorism and weapons of mass destruction. The key relationships and resources that need to be forged and in place in many states and communities and on the federal level have not yet been forged. Serious knowledge gaps exist, particularly about the impact of weapons of mass destruction.

I was gratified to learn how far we have come, in terms of what we know from the science, from where we were when I began in this field. But do not be fooled. We have a long way to go, particularly in intervention research. We need far more science and knowledge in that area. On the issue of bioterrorism, we need new instruments for triage when somebody comes to an emergency room. Is this an exposure to an agent or a psychogenic response?

Being prepared will take time, money, and people. The reality is that if somebody were to drop a billion dollars into this effort tomorrow, that solves only one of those three problems; we still need people to work on this and we need time to develop those kinds of instruments.

The good news is that the topic of disaster mental health is on the radar screen in ways that have not been seen before. People are listening. This discussion is taking place in federal departments, in states, in corporations, in academic systems. We are at the beginning of the discussion in many cases, but we are at the table.

Soon to come online are some significant resources to help the states. The *Guidance to States* prepared by NASMHPD will be published as a SAMHSA/CMHS document, a concrete and comprehensive guide to the process, content, and resources for planning. With SAMHSA support,

publication will be followed up by a number of regional trainings and activities that NASMHPD will sponsor to help states jump-start the planning effort.

The National Mental Health Association's Blueprints Project is developing a number of modules that look comprehensively at disaster or emergency mental health in terms of different populations, funding, and planning strategies and how to bring communities together to plan. Its curriculum will be implemented in many communities around the country.

In addition, SAMHSA and CMHS will award grants to 40 states to help them begin to build capacity for preparedness. The grants will provide resources to hire people to do this work and to build coalitions. It is an extraordinarily wise move on the part of SAMHSA and CMHS to try to cover as many states as possible. We do not have the luxury of starting with one or two states and seeing how it works and then moving on. This is a strategy built on recognition of the emergency situation that exists.

There is also the potential—at this point largely unrealized—of state mental health authorities accessing funds given by the Department of Health and Human Services to state health authorities. Not more than a half dozen states have accessed those funds.

In terms of weapons of mass destruction, relationships between the mental health authority and the health authority are critical. I urge all of us to help foster those collaborations, to try to access available resources, and to ensure that mental health planning is proceeding in step with what the health authority is doing.

In summary, I am left with genuine and deep ambivalence. I am frankly worried, more than I have ever been, about the challenges and

potential threats that this country faces. We simply are not as prepared as we need to be. The science is not there. The resources are not there. The public policy is not there.

On the other hand, I have never been more optimistic and hopeful, because so many things are coming online. Resources are becoming available that can begin to move us toward where we need to be. This issue has gotten the attention of the nation. We have an unprecedented opportunity to actualize delivering mental health in a public health model, as was discussed in the Surgeon General's Mental Health Report of 1999. This is what disaster mental health is all about. We have an opportunity to lead the way for the rest of the mental health community, as we move forward in disaster mental health.

This is also a unique opportunity to reduce stigma. Terror terrorizes everybody in this situation. We have opportunities, out of our pain, to accomplish things that we have not been able to accomplish before. And we have an opportunity to expand the field of mental health to where it ought to be. We have an opportunity to lead. It is just as much, if not more, about mental health as it is about mental illness. We know far more about mental illness than we know about mental health at this point. Building systems to respond adequately and getting the research done will show us a lot about health, about resilience, in ways that will balance the field the way it ought to be. As we move forward in preparedness for disasters and appropriate response and recovery, we have an opportunity to help promote health and to combat disease in a way we seldom have had in other fields. I will end on that note of hope.

RECOVERY AND PREPAREDNESS IN THE NATION'S CAPITAL: LESSONS LEARNED BY A MENTAL HEALTH AUTHORITY

Martha B. Knisley

I am pleased to represent the District of Columbia. It not only is an honor to be the first mental health director for the district, but I am the first public official from the district to be asked to speak positively about our work in mental health.

I am keenly aware of what it is like to be out there on the front line with families and with media. And we may have seen a sea change concerning the media in the recent sniper events in the Washington, D.C., area. After about two and a half weeks of the siege, both national media and local media called. I thought they were calling for the next sound bite: "We are going to do 30 seconds on the air on the next hour"—but no, they were not. They were calling to tell me how they were feeling and to ask what they might be doing differently in their day-to-day routine. They were not running away from the event in the sniper attack. So we may have turned a corner there.

Let me set a bit of context. We are a new department, just becoming part of the city government again after having been outside of

any government for five years. The district's mental health system was in receivership. When you are in receivership, you belong to no one. It was awkward, and we were trying to take our seat at the city's table again.

In August just before 9/11, we had a major flood in the District of Columbia. Our city's infrastructure is not very good. Forty percent of our homes were flooded, and our department was asked to provide support. Nobody could find a disaster plan, and nobody even knew where the emergency management agency's office was located. I was getting a sense that we had a lot of work to do. September 11th occurred, of course, and then shortly thereafter, anthrax.

In the district, we feel we are being attacked all the time. Whenever there is an alert of some kind, my beeper goes off and we go into emergency mode. We are in a continuous crisis of some type, often to a degree not known to the rest of the country.

The District of Columbia is unique, but many lessons can be learned from the district because we have extraordinary responsibilities and vulnerabilities. For example, on 9/11 the federal government shut down all the streets. No one could move. We locked our children in our schools. Unfortunately we had not taught our teachers how to respond to more than one event—meaning one child whom they were comforting. And since we have a lot of violence in the district, teachers know how to comfort children who have had loss and trauma. But they did not know how to comfort the whole classroom. They would say things like, "We are being bombed." If you are a first grader, you think that means the school and your classroom.



With anthrax we had a lot of confusion. Communication issues were paramount, and we learned lessons about responding to an unfolding event. From the sniper attacks we learned that our suburbs can be as vulnerable as our city. We lost more adults to other violent acts in Baltimore and Washington during the same period of time than from the sniper attacks, but our suburban communities had always felt safe. Also throughout the year, our gang violence had begun increasing again from its previous rates over 10 years ago. Violence is a way of life in our city.

But immediately on 9/11 the mayor asked me to help craft what we needed to say to the community. I saw this as an opportunity for a department of mental health and a system that had never been asked to speak on behalf of anyone anytime. We used the opportunity as well as we could, talking to the community as much as possible. We formed a community network, thanks to support from the Federal Emergency Management Administration (FEMA), and we got funding from the Office of Management and Budget and funds from the Substance Abuse and Mental Health Services Administration (SAMHSA).

We did an action-oriented needs assessment in the community. Since we had little time to do it, we decided to do structured interviews. With this method we got a great deal of information consistent with what the more formal researchers who had more time have reported from traumatic events. We developed a community support network with 18 indigenous paraprofessional workers in our neighborhoods, who are still out there working, and we are doing our all-hazards plan.

The District of Columbia can serve as a case study of continuous threats and of different types of threats. I urge researchers to join in our resurgence of mental health research practice and policy in the district.

I have been asked to provide you with lessons learned from this experience. The first lesson we learned is that “afterwards” counts as much as the event. The District of Columbia has an ongoing need for recovery and community support. We know a lot already about community support for people with mental illnesses. We know a lot about support for communities that are tragically

underserved; many of our neighborhoods in the district are underserved and have high needs. We understand recovery. We understand that this is a community event. We are still talking to each other on the elevators. As a matter of fact, people are hugging on the elevators. I have never seen so much hugging in all my life as when the snipers were caught.

It is also important to find secondary victims and beyond. For a long time after 9/11, no one talked to our Latino population or gathered their community networks together. About 100,000 workers in the Washington area were out of jobs because no one was patronizing our hotels, our cabs, and our retail establishments. But people who did not have TV or did not speak English did not know why they were out of work, because the communication to those communities was so sparse in the very first days.

People do not self-identify as secondary victims, particularly in communities where there is a lot of violence. What is different today about being a victim from the day before? Everyone who opened mail in the District of Columbia was a secondary victim. People avoided going to their mailrooms. A lot of people did not pick up their mail, and they did not pay their bills for months at a time.

We know quite a bit about building a continuum of care in recovery and in mental illness. But our new 24/7 access help line last month suddenly took a thousand calls a week. We have heard about the stockpile of medications that gets flown into a community in an emergency. But there are no psychotropic medications in the national stockpile. In D.C. our indigenous workers contacted the 4,700 homes within a mile radius of the anthrax-infected Brentwood postal facility the weekend before we began to fumigate the building. Our indigenous workers also walked the communities to alert people to the dangers of West Nile virus. We built a continuum of care that continues today that enabled us to serve our people three important times since September 11th.

Recovery support is in communities, not institutions. We can learn from our work in helping people with mental illnesses. In the early

We built a continuum of care that continues today that enabled us to serve our people three important times since September 11th.

days of community mental health, when we reached out into our community, we learned that one-shot education—like a module in second semester social studies—is not enough.

We know that somatic stress does not show up right away. In D.C. when we go to a certain level of emergency, fighter planes go into the air. At 1:00 a.m., they hit the sound barrier, which sounds like a bomb, and then at 2:30 and at 4:30 the planes go overhead again. How do I know that? Because I was awake at 1:00 and 2:30 and at 4:30. We knew that the symptoms from that subsequent stress go back to the same level as the original stress every time there is a new event. That seems to hold true in the people who are appearing for services.

People do not seek traditional mental health services. The entry points for most people looking for help are primary health caregivers and clergy or other natural caregivers in the community. In D.C. when we broadcast the hotline number in a scroll across the bottom of the television screen, we have a spike of calls and people do come in. But people do not identify as needing mental health services.

Gender differences also matter in recovery. Men want different types of community support from women. For the Brentwood workers, we ran two different types of support groups. We are learning that we must build overall social systems for ongoing support. We cannot just assume that that will occur on its own.

For policy and practice in a state or a city—and for the folks on the front lines asked to do this work—sustainability is a major issue. In our network more than a hundred volunteers are currently credentialed to go out in the event of an attack. How can I pique their interest a year or two years from now? In the district, that does not seem to be a problem, because we keep on having events—but it is an issue.

Can state budgets fund mission expansion? In today's world the public mental health system at all levels is experiencing mission retraction. This is an issue that must be on the table. Preparedness builds on training and practice. Becoming prepared and sustaining preparedness for an emergency must be a continuous process. Over time we will not be prepared if we do not constantly work on it.

The importance of the social context is evident in our Brentwood case study. The Brentwood post office is the upstream facility through which the mail with deadly anthrax passed on its way to the Hart Senate Office Building. The Brentwood post office, a large facility, has a large work force that does not have a significant turnover. In fact, many families have a number of family members working there, and many are second- or third-generation employees. A significant and historical labor-management distrust has built up over time.

In the post office, if you ask for help through the employee assistance plan, the request goes in your personnel file jacket. People do not ask for help.

Ninety-seven percent of the work force at Brentwood is African-American, mostly unskilled labor. We also learned that if you do not attend to recovery support, the issue rightfully becomes a social justice issue. Most of the workers at Brentwood are not D.C. residents. Most live in Maryland. But at a community meeting in April 2002, Brentwood employees came to our staff and asked us to support them, which we do through weekly support groups and through remembrance groups. The opportunity had been missed between October and April, and now it is a major political issue in our community—and rightfully so.

Several significant symbolic events best characterize this experience. The federal government closed the Hart Senate Office Building, but they kept Brentwood open following the anthrax exposure. Brentwood employees were told to go to D.C. General Hospital for examination. I remember seeing employees lined up in the dark behind the fence waiting for buses to go to D.C. General Hospital. Our staff stood in line with these employees at the hospital while 17,000 people were going through to get treatment. It was not a fancy operation. We put up a little cubicle where we could talk to people privately. Our counselors stood there for three weeks with them, two shifts a day. I remember our counselors asking, "Do you want some coffee?" "Do you need anything?" "Do you want to talk?"

The Brentwood employees have said to me and to all our staff repeatedly, “You are the only ones who have been there for us.” It was not just because of our mental health work. It is because of the social justice issues.

A bioevent has no identifying start or stop point. There is no visual image. We do not know what the long-term effects will be. We do not know how the characteristics of a bioevent might correspond with a natural disaster or another terrorist attack. The continuum is undefined for clinical follow-up.

In a bioevent, mental health is integral to the public health response—much more so than it was in 9/11. This is very important. It is an opportunity for mental health. In our community the Department of Mental Health was asked to be part of this response, to be full partners with public health and law enforcement.

What about the lessons we have learned from the sniper event? It is difficult to be a community under siege. When a community is under siege, many groups, including school children, are forced into a situation we call “sheltering in place.” We need to learn more about sheltering in place. Our community had a debate about whether or not children should go to school. In discussions with some of my colleagues in the school system, many said that children should not go to school.

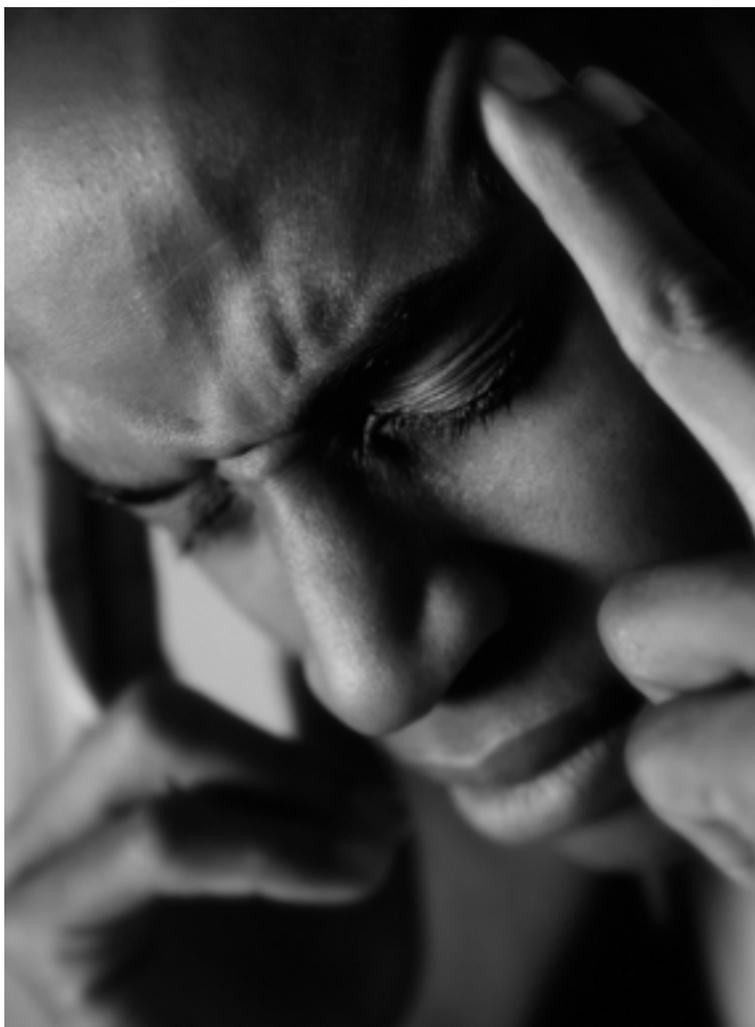
I responded, “Where would you want them to be? The issue is getting in and out of school with safety, but children want and need that structure.”

If we learned nothing else from the sniper events, we can learn what our fear did to our children. We must fear fear itself. The day after the snipers were caught, a reporter from a local radio station asked me what people were feeling. I said they were feeling a great sense of opportunity.

He said, “A great sense of opportunity?”

And I said, “Yes, it is the 21st century in the United States. We all get to go back to Wal-Mart.”

The people really were relieved and ready to go, and the media still wanted to talk about feelings. They missed the point that Americans are very resilient.



Several issues relate to caregivers. We must consider how to take care of our caregivers if we were under siege for a long period of time in our communities. That is the one aspect of our all-hazards plans across the country that probably is the weakest.

We have had many challenges—probably too many to bear in this short period of time. But at least we can identify together how we go forward. It is an opportunity, and I am sad to say that. But my colleagues and I in the district see this as an opportunity for our mental health system to become a helpful part of our community as part of our recovery as a mental health system in the district. Our country needs us now to come together as a mental health community. It needs us to come forward, to stand up, to be counted on. We have a great opportunity. We have an obligation. We have been asking for notice from the world. This is it, sorry to say, but it is true.

INFRASTRUCTURE IS IMPORTANT

Steven P. Shon, M.D.

This topic has been an area of pursuit—almost passion—for me for the last two decades, starting in California.

Infrastructure does not sound exciting, but it is absolutely essential.

Let me describe first how I became interested in this area and how the Texas program evolved to meet the needs for an all-hazards plan and all-hazards system. California has myriad disasters every year, from floods and fires to earthquakes. Early in my career I was involved with the response to those events. I recall the hundred-year flood in the Central Valley, standing on I-5 and seeing nothing but water as far as the eye can see, thinking I was in the middle of the ocean, doing crisis counseling and interventions with folks who had lost everything—every picture, every album, every trace of their family history and things that meant so much to them—and understanding how important those interventions were to individuals like that. I

When you respond at a time of need, when people are the most vulnerable, and not just with those who are seriously mentally ill, that helps people understand how important mental health interventions are.

worked to put a program together in the aftermath of the Loma

Prieta earthquake that collapsed the freeway and stopped the 1989 World Series. I had done the CISD (critical incident stress debriefing) interventions for organizations in which employees had walked into the office and shot and killed their boss and other individuals well over a decade ago in various places in California.

One experience I will never forget is the Cleveland School massacre in the late 1980s in Stockton, California. A former soldier walked onto the schoolyard and opened fire with a couple of automatic weapons. He shot 25 individuals—24 children and one teacher. Five of the children died, four Cambodians and one Vietnamese. That event spawned in California

the gun debate that subsequently swept across the rest of the country. Folks still talk about that today.

The Carter Center's Thom Bornemann then was the program chief for the federally funded program that enabled me to bring folks in who spoke the language. We targeted culturally specific interventions. We used the media from the Cambodian and Vietnamese communities to offer guidance. Buddhist priests came into the schools and into the enclave of families where they lived, and they worked as providers for us. We went into classrooms that were essentially 100 percent Cambodian and used chants and other activities to bring students together to begin the healing process, to talk about the issues, to express in their own way their anxiety, fears, and their responses, and then to work with them in culturally specific ways.

We began the state Office of Disaster Response in California. We were the first state to have a full-time employee and then to expand into an office.

When I went to Texas in 1992, one of my goals was to create an even better response team. We have done that. I want to discuss the infrastructure required to respond to communities to touch individuals when they need it most. We talk about the image of mental health. When you respond at a time of need, when people are the most vulnerable, and not just with those who are seriously mentally ill, that helps people understand how important mental health interventions are.

In 1992 I had been in Texas for two months when I got a call at 9:00 in the evening from my boss, the commissioner, who said, "A tornado has swept through. Can you help us respond?"

At 5:00 the next morning, seven of us flew on a state plane up to Tornado Alley. The tornado had swept across west Texas, and we saw the devastation—everything destroyed in its path, about a mile wide. A number of us on that plane were from the Department of Public Service, the Texas equivalent of the highway patrol and state

police. There also were victim assistance representatives from the governor's office. I included a pastor from one of our state facilities, an expert in pastoral counseling. That event helped shape what we were able to do.

We began our Disaster Assistance and Crisis Response Services in 1992 and became a full-time program in 1994 with a full-time individual, Daniel Thompson, who runs the program, and several others. At that time we were one of only two full-time disaster mental health programs in the nation—California and Texas. Several others have begun since then. We were responsible for responding to all the disasters and critical incidents in the state.

We had lobbied to become an active member of the state Emergency Operations Council in the Governor's Division of Emergency Management. Often mental health is a side issue; often mental health is not even included. We inserted ourselves into that process and became an active member—virtually the lead agency—for what became known as the State Crisis Consortium, composed of agencies on the state Emergency Operations Council (EOC). We are the only program of its kind in the nation.

On the EOC we serve as the lead agency for disaster and mental health services. We are responsible for coordinating mental health services following any type of disaster, whether they are manmade or natural. We are responsible for deploying state emergency response teams to provide services to victims and responders. During the Houston floods, another hundred-year flood, there was nothing but water as far as the eye could see. Response team members had their bags packed, and a helicopter dropped them on the tallest building in Houston, where they began the evaluation process for emergency grants.

Every state disaster plan has a group of annexes, or sections, and we are writing a section for disaster mental health. We are the only state to date that will have its own annex on mental health emergency response. We have pushed and lobbied for it. The events of September 11th and the New York summit months later helped foster recognition of the need for a mental health annex in the state disaster plan in the governor's office.



We are responsible for pursuing and managing Crisis Counseling Program grants for the state following federally declared disasters. This is the funding mechanism by which states can get dollars to provide disaster mental health services. It is crucial that that is well-done and well-managed, or states miss out on an enormous opportunity to provide resources to help its citizens and its victims.

Within the State Crisis Consortium, we at the Texas Department of Mental Health and Mental Retardation are responsible for coordinating all services for victims and responders following disasters and critical incidents. Core members of our consortium are the Texas Department of Mental Health and Mental Retardation's Disaster Assistance Crisis Response Program, the Texas Department of Health Crisis Intervention Network, the Texas Department of Public Safety Victim Services, the Office of the Attorney General Consumer Protection and Victim Services, and the Texas Council on Alcohol and Drug Abuse Consumer Services. It is so important to be allied with the other state agencies.

Going back to that 5:00 a.m. plane ride two months after I arrived in Texas: I was sitting with strangers from the Department of Public Safety and the Office of the Attorney General's Victim Assistance. We had never met each other before. Yet those relationships persist to this day. The work we did together in the six days in Tornado Alley cemented a bond among us all. You will find this happens as you get actively involved with these processes.

As many of you know, the American Red Cross is the federally designated agency to set up shelters. Folks from Red Cross were there. Often there is friction among state and federal agencies. The person from the Red Cross came up to me and said, "Dr. Shon."

I looked at her and she said, "San Francisco."

And I said, "Oh! Helen, how are you?"

She had been in charge of setting up all the shelters in the Bay Area for the 1989 earthquake,

We have bonded because we have worked together in these environments for years, so when something occurs, we respond as a team. This is a critical concept.

when I had been in charge of coordinating mental health services. Immediately we shook hands and gave each other a hug. It cut

through so many things, because the frictions were not there. We had a working relationship.

We strive to develop relationships with sister agencies in our state, agencies whose missions may seem a hundred miles from ours, like the Department of Public Safety and state police. We have bonded because we have worked together in these environments for years, so when something occurs, we respond as a team. This is a critical concept.

Now our State Crisis Consortium is expanding. This is another outcome of the New York summit. We had the opportunity to relook at what we were doing and to expand. Several other agencies are part of our consortium now, including the U.S. Attorney's Office, local agencies such as the City of Austin's Emergency Management, and a variety of others, including education agencies. The concept of collaboration and a network that prepares and looks at issues far down the road before they ever occur are

important. Our program is the lead agency. We chair, convene, and provide direction for the consortium.

In cooperation with the consortium representative from TCADA, the substance abuse agency, our program currently is pursuing a capacity-building grant from SAMHSA. This funding would provide for dedicated staff to build on the current foundation and even expand the network and the role of the consortium further.

The federal Crisis Counseling Program grants available to states following a presidential declaration of disaster are crucial. The application is due to FEMA 14 days after declaration, with certain data in a certain format. States often miss out on an opportunity to bring resources into their agencies that can help the most vulnerable people in need. This grant program has enabled our consortium to take advantage of needed resources.

The Crisis Counseling Program is a preventive mental health program for victims of disasters. It funds everything from CISD to crisis intervention to preventive activities such as working with schools, distributing written materials, videos, etc. to schools. It works with clergy in the area—often they are the first place where people go if they are in need—giving them educational materials, helping them to define what they can do and when they should refer folks to professionals. Finally it provides guidance and supervision to grant staff and works with local agencies to provide services. In 1993 we began a training process for every mental health agency in the state of Texas. We did it by region, and it took us a year and a half. We have gone through that cycle three times now, training on disaster response. All 42 of our community centers and all our state hospitals have teams ready to go if there is a disaster in the area—from a shooting, to flood, to whatever—within a matter of a few hours.

Since 1994, our Disaster Assistance and Crisis Response Services has managed 21 Crisis Counseling Program grants from FEMA and CMHS. We have secured \$12 million—an enormous amount of needed money—and we have provided mental health services to more than 250,000 citizens in our state since 1994.

The State Disaster Mental Health Plan, a comprehensive and complete plan, describes standard operating procedures and guidelines for what centers do in a federal disaster event. NASMHPD has recognized ours as one of the most comprehensive plans. Information about it is presented on our Web site, www.mhmr.state.treatment.us. We currently are developing a training manual for our crisis response programs across the state of Texas. Funding for this manual came from SAMHSA and Texas' general revenue funds.

The governor's office allocated \$100,000 in CDC funding to our crisis response team for training. That would not have happened without our longstanding presence and support from—and networking with—other agencies. Because mental health is so important, we are using that money to do another round of training with the manuals and other materials from NASMHPD and SAMHSA. Seven regional trainings are planned between January and August 2003.

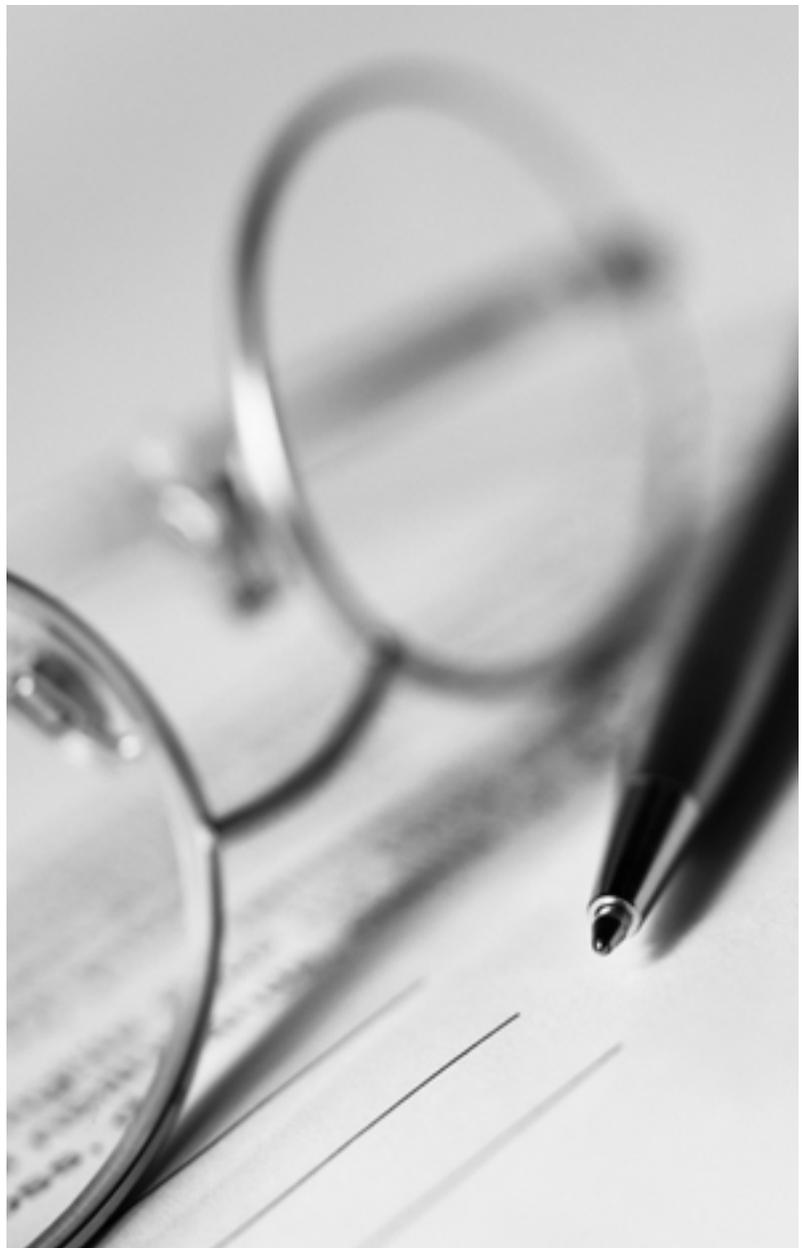
Research has been more focused, particularly since 9/11. It is crucial to have the infrastructure ready and available to use the kinds of tools, information, and research that are coming out. It is not the interesting, sexy thing that people may think about, but if you are not prepared to do it when disaster strikes, everybody runs around wondering what they should do next. If you do not have relationships cemented, it makes the job a hundred times harder.

In conclusion, our Crisis Response Program continues to provide essential mental health services in times of disaster. We currently manage three separate federally funded crisis programs. Our three programs cover 46,000 square miles, roughly the size of North Carolina. We constantly build better collaboration and coordination of services to victims. The training manual will be a big step forward in standardizing our training. We are developing a stronger Web site presence. We have to move into the electronic and communication age with better communication tools. And we are pursuing more grant funding to expand our capacity.

The key elements to success in our state are commitment, collaboration, preparation, and coordination/organization. You need a group of

people who are dedicated and committed. It does not have to be a dozen folks, but one or two committed folks who will carry on through thick and thin, through every level of the politics of the state. To find those people and support them are essential.

Often we talk about collaboration between state and local mental health agencies. Crisis response requires a far broader collaboration with agencies with which you may not be familiar. With preparation, you can manage these kinds of events—the key is making sure that you have good coordination and good organization. These lessons are the most important.



Questions & Answers

The National Mental Health Association is putting together a manual and a set of trainings in the community on how to infuse mental health into disaster preparedness—how to do mental health plans and also how to get us to the table with public health, with security agencies, etc. It is focused on a broad spectrum of audiences, particularly community groups. As part of this project, we did a series of focus groups and case studies. The issue that came up again and again was the importance of coalition and partnership and the absolute necessity to reach outside the traditional mental health community to do this work.

One of the anxieties is that the mental health system is so underresourced. How can we take on another challenge? What can we do as a community, both to partner with these other entities and also to take advantage of the many resources that are out there now for homeland security, for public health preparedness, that mental health does not seem to be able to access?

Ms. Knisley - Reaching out beyond the mental health system, you have to use your imagination and creativity to add value to what you are doing and the resources you are creating. For the District of Columbia, for example, it has resulted in more people coming in for services.

Workers in our neighborhoods and communities are financed by FEMA dollars. Since we kept having emergencies, we kept being eligible for FEMA dollars. That is the downside and the upside. But we used every opportunity to do outreach, and it resulted in more demands on our system. But those were good demands, because we could use the data we collected to document the resources we needed.

I went to public safety officials who were getting the resources into the community. We were in line with everyone else, so I said, "Here is the large number of people who may need to be served." We partnered with public safety. You have to listen to the way they talk, and you have to talk their talk. You have to figure out what it is they are looking for and to be there when they are looking for it. Being at the table, talking their talk, working outside, and being

ready to handle surge capacity through volunteers or prior arrangements are critical. Relentless preparedness is absolutely essential. If you can handle that surge capacity, people will come back to you the next time. They will recognize you, and they will ask for you to be there.

We need to think about this as public health. We do not know a lot about public mental health. If we can incorporate it, through preparedness and all-hazard plans, our new role may mean some job description changes and some different work and preparation. But if your existing staff can become that surge capacity and you can be there, you can build on that momentum.

Dr. Shon - I approach it from two levels. In the state or local authority, the ability to bring people together and to coordinate a process is critical. In disasters the response is always local—and the local area is different in our state in east Texas, west Texas, south Texas, central Texas. They are all very different kinds of communities. The issue is to give the local mental health authorities the tools to be able to pull people together and to help them to plan—not to do it for them, not to impose on the local level how it should be done, but to give them the framework and support. If you can do that, they can bring in the right spiritual entities, the right educational entities, the right health entities, the right law enforcement entities.

The problem often is that every single one of those entities has crises that they deal with day to day. We are overloaded with children in our school system, for example. It is necessary to have the commitment of people who will sustain the energy, who will say, "This is important." Since September 11th, it has been a lot easier—but that will wax and wane. The larger authority needs to provide individuals with the commitment to go into the communities and help them create their structures. Finding the right role and responsibility is part of that coordination.

Questions & Answers

Q In the wake of September 11th, we know that people's needs differ, particularly in relation to age and culture and current mental health status. Can you discuss strategies for addressing people with existing mental health problems who are in your systems and your communities and other vulnerable groups as well? What kinds of strategies would you recommend to identify the most vulnerable in our communities and to work in advance around these needs?

A Dr. Flynn - One suggestion is to look at the CMHS brochure "Responding to the Needs of People with Serious and Persistent Mental Illness in Times of Disaster," available at www.mentalhealth.org.

In my experience in disasters over many years, people with pre-existing serious mental illness often do not become visible in the early days. In fact, they may hang together fairly well. There is a myth that these people will break down first, but that does not happen. One of the most important strategies is to get back online the myriad services that these folks depend on to live in their communities, particularly in large-scale disasters.

We also have a significant training challenge with regard to this population. We have an opportunity in disaster mental health to reduce stigma significantly. But we also have the risk of further stigmatizing people who have serious and persistent mental illness, because sometimes when they go into treatment for disaster-related stress, their symptoms are inappropriately interpreted as an exacerbation of their pre-existing illness. But that is not the case most of the time. They often have the same kinds of stress-related problems that the general population experiences. We need to make sure that we train our providers to differentiate what is happening with that group.

Ms. Knisley - We asked our consumers about specific communications targeted to them. Your materials and communications and messages are very important. Bringing together focus groups of individuals and asking them what they want offers two benefits. First, you can get a lot of good information, and second, you can provide support.

It is important to get into a routine as quickly as you can. During the sniper attacks, we urged people to keep up their routine, to overcome fear as well as possible, not to shut down. For people afraid to get out, we went by and picked them up for appointments or to get them out of the house.

Another important strategy is to include in the all-hazards plans a clear planning process for sheltering in place, making sure that people do not have to be evacuated into mass care, which can be very frightening to people with long-term disabilities. "We will come to where you are, rather than you having to come to where we are." That may be difficult if your whole city is under siege; you will have to be credentialed by your public safety officials to be allowed to be on the street.

Q Among the National Voluntary Organizations Active in Disaster agencies, the American Red Cross is the one nongovernmental organization mandated by the U.S. Congress to respond to disaster. Regarding the surge response, would you address the role that the American Red Cross' Disaster Mental Health Services may play as part of a state disaster plan?

A Dr. Flynn - In almost every disaster, the Red Cross has played a central role. They are often the first on the scene. They have played an enormously helpful role in charting the federal response, because they are the first ones there who can gather data and identify needs.

Historically there has been a lot of variation in states and disasters in the Red Cross' coordination role in the public mental health response. One of the significant challenges we face is to make sure there is a consistent and positive relationship between the Red Cross and state and local mental health authorities. In the NASMHPD "Guidance" document is an example of a draft memorandum of understanding (MOU) between the mental health authority and the state Red Cross chapter.

Dinner Address

MENTAL HEALTH LEADERSHIP IN TIMES OF TERRORISM

Stephen Mayberg, Ph.D.

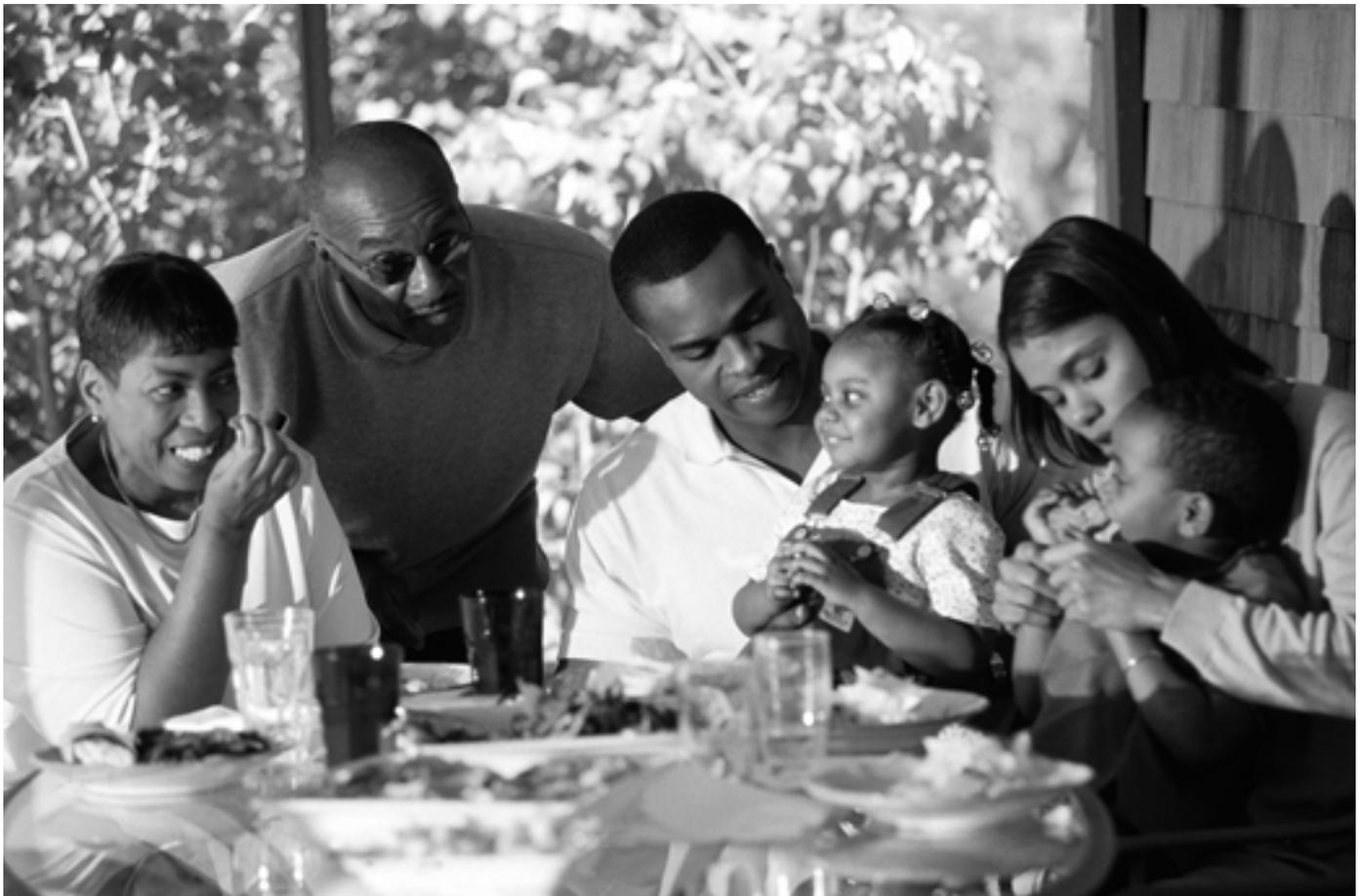
Never in my training or in my mental health experience did I believe I would deal with terrorism, yet I stand here today and acknowledge that it is awesome and awful to be here talking about terrorism. Terrorism is now something that we all need to deal with. It is an issue that we would prefer to deny. We would love not to have to worry about or have to work with the impact of terrorism. Terrorism as the conference topic seems such a paradox because we are here at The Carter Center, and President Carter so recently received the Nobel Peace Prize.

The mission of The Carter Center is to talk about peace, hope, and empowerment. Yet we are talking about war—a new war, a war that no longer allows us to be insulated and isolated as we were before; a war that has forced us to look

at ourselves, our systems, and our cultural fabric to determine how we respond. One thing we know about terrorism is that it forces us to deal with the uncertainties of our society. Terrorism attacks along fault lines—psychological fault lines, racial, ethnic, and economic fault lines—and is a force that has much more impact than we would ever expect.

When I was asked to talk about this subject, I wondered, “Why me? Do I know anything more about terrorism than anyone else?”

Perhaps it is the fact that I have been a state mental health director for 10 years and I have been living with circumstances for years that are, at times, unpredictable, disheartening, and threatening, while trying to manage a system out of control. The question becomes, “How does one lead successfully?”



I have learned that to be a successful leader in the mental health field, one must have certain personal characteristics. First, one must have a very high tolerance for ambiguity, because there are no easy, clear answers. There are, in fact, no answers for some issues. Second, one must have a fortified denial system, because when you objectively look at what the issues are and the number of issues, it can be overwhelming, creating the potential for existential despair.

I am constantly aware that there are things that I need to know and learn, but I do not know what I do not know. I also am reminded that there are people who are a lot smarter than I am and that I should use this opportunity to learn more. Knowledge is evolutionary.

Just as knowledge is evolutionary, so is change. Personally I have to be mindful of the characteristic of patience; change does not happen quickly. Change is incremental, so all of us must be committed and involved for the long term. We cannot fix the cause and effect of terrorism, or homelessness, or problems with children in six weeks or six months. The planning, adapting, and rebuilding takes years and years and years. We have to be prepared for a long battle. Most importantly, we need to be flexible, optimistic, and idealistic. I would like to think I am all those things, so I am speaking as someone who will learn from somebody else—and someone who in six months probably will have changed his mind about his conclusions. Do not hold that against me, but see that as a sign of strength.

Right now, as members of the President's New Freedom Commission on Mental Health, we are looking at the entire United States mental health system. To me, it is significant that I am here at The Carter Center, because the previous President's Commission on Mental Health was convened by President Carter in 1976. There is a sense of continuity that is important. As members of the President's New Freedom Commission on Mental Health, we looked at the charter to the Carter Commission and also at the Carter Commission's recommendations, and we used that information as a model and framework for approaching current, complex problems. We learned that there is need for short-term change, midterm change, and long-term change. Just as in the 1970s, when we were in a period of transition from state hospitals to community

mental health, we now are in another period of transition in our mental health system. We are learning new ways to do business and new ways to help people recover. Symptom reduction is no longer the focus; it is recovery and involvement in community activities. We need to make our system responsive to recovery goals and objectives.

The mental health system's nexus with terrorism is that we are likewise learning something new, that this is a transition time in the United States. We are in the midst of something imposed on us and are part of global issues we may not understand clearly.

With that history of change, coupled with my sense of optimism and denial, I did not imagine that being part of the President's New

Freedom Commission would be as compelling and complex as it has been. I underestimated the pent-up demand for such a forum. As the commission has taken testimony, listened to people throughout the country, and received information over the Internet, we have been struck by how much desire there is for system change. The commission recently released an interim report that has generated interesting feedback. Many people thought the report was too harsh, too critical of the existing state of the mental health system, but just as many people thought the report was honest. The people who were most resistant to the issues identified in the report were people who were more concerned about maintaining the status quo and the current balance of power.

The issues that we identified as being system problems were issues that have been addressed at The Carter Center as well as at other conferences. They are not new issues, just issues that need to be addressed.

One example is the ongoing obstacle of stigma. Stigma still exists. Stigma is still rampant. Who you are and where you live can dramatically influence whether or not you get services or, as the Institute of Medicine states, the kind of services that you get. Our system is fragmented

We are learning new ways to do business and new ways to help people recover. Symptom reduction is no longer the focus; it is recovery and involvement in community activities.

and difficult to negotiate sometimes. Access is difficult; place and race matter. One parent summed it up very well in his testimony to the President's Commission. He said that to him, as he tried to get services for his child, "the system was opaque." This father had no clue about what the system was or how to negotiate it. In Alameda County, California, there are 100 different funding streams and 800 different providers of children's services. How would anybody know where to go? The commission also was struck by the huge gap between what we know and what we do. As our knowledge evolves, we are not integrating it into our practice.

All of these compelling arguments illustrate the need to improve the system. The good news

You need a memorandum of understanding to be clear on how to work together, who is in charge, how to notify people, how to communicate, what is the chain of command.

is that there is good research and there are motivated people. We have seen the involvement and the dedication to make the system better of clinicians, providers, family members, and

consumers. The surgeon general's reports, which include the reports on children and on culture, race, and ethnicity, set out a framework that we can build on to look at mental health—from prevention to treatment—of persons with serious mental illness and also to look at mental health as a public health problem rather than as an isolated problem. Public opinion is changing to some degree. People want mental health services; they demand mental health services. So, it is a time for change.

In that context, with a somewhat dysfunctional system as a backdrop, how was I going to talk to you about terrorism? I had a fascinating notion of turning the lights out at The Carter Center, creating total darkness.

I would say to you, "I want you to get back to downtown Atlanta. There is a national emergency. We do not know what has happened. There won't be any available transportation. We know the roads are closed, so we cannot tell you how to get to Atlanta. You have two hours before curfew. You have to figure out who is going to lead you. And, by the way, your performance will be critiqued by the media and by politicians.

They'll have the opportunity and advantage of looking at it in a day or two and will tell you what you should have done."

What I presume would have happened in that scenario represents what happens in most disasters. First, we are reactive and not proactive. Second, whatever planning takes place is spontaneous, and because the situation was not thought out ahead of time, the responses would be fragmented.

In detail, each of you would have chosen a different alternative to get to Atlanta. Some of you would have decided on someone as a leader to trust. Most likely the people with successful results would be the people who collaborated with the locals, because the residents know the lay of the land better than the out-of-towners, which should tell you something about disaster planning and terrorism. It is a local issue. When we start thinking about what we need to change in how we function as a mental health system, these are all things we need to pay attention to.

Terrorism's purpose is to disrupt. Loss of life may be less significant to terrorists than disrupting the way that we live and function on a day-to-day basis. In that context the role of government, the role of providers, the role of professionals becomes even more important to ensure that there is minimum disruption. Continuity of delivery systems is paramount.

Who is government and who are providers? The largest obstacle in formulating a response plan is that our system is multilayered. It is both vertically and horizontally layered. The federal government with each of its departments, the state government with each of its departments, and the local government with each of its divisions all are telling providers what to do. The people who are receiving services have no idea who is making the decisions. Horizontal layers also create chaos in a disaster or in a terrorist situation. Law enforcement is involved, social services are involved, health is involved, mental health is involved, environmental protection is involved, and public works is involved. In reality, none of those programs or people coordinates very well. So how should we respond?

Response planning begins with preparedness. It includes getting to know the people who will be sitting at your table. If I told you now that you

would be required to formulate a plan to go to downtown Atlanta under emergency conditions and then gave you a couple of days to work on it, chances are you would all do a good job. But if I were to turn out the lights right now, you probably would not. You have to know now what it is and whom it is you are going to be dealing with.

The SAMHSA-sponsored summit meeting in New York on terrorism on the heels of 9/11 was the first step in doing just that—introducing people to each other who normally do not have a reason to talk to each other. Some of my best, most relevant new partners are sheriffs. People ask, “Why law enforcement?” The issues of homelessness and of criminal justice involvement with mental health make the partnership viable and indispensable. In the event of disasters or terrorism, law enforcement personnel are out there as first responders. If I know them and they know me, it makes my job a lot easier when mental health steps up to the plate.

That is not to say that having one meeting to develop relationships and shake hands makes a difference. People change and government changes. There may be a different cast of characters at any given time, so you must have regular meetings to develop a partnership system. You need a memorandum of understanding to be clear on how to work together, who is in charge, how to notify people, how to communicate, what is the chain of command. You need to learn new technology and new terminology, such as vector control and incident command. You learn where you fit into the solution while other people learn what you have to offer.

I thought California had a fairly sophisticated disaster response system; in fact we routinely respond to disasters. But now I know that California did not have a carefully thought out plan of disaster or, more specifically, terrorism response. On 9/11 most of the hijacked planes were headed to California. When the planes were crashed and with the assumption there were affected families in California, we immediately mobilized to provide support services to the families. We called the airlines and asked for the passenger manifests in order to begin our outreach to support the families and loved ones.

The answer to our request for the manifests was, “Absolutely not.”

We asked, “How can we help the people who have lost loved ones? Why won’t you release the names?”

“Because the hijackers’ names are on the manifest. We cannot release that information because it is an active investigation.”

Suddenly we learned that the world was different, that we would have to figure out a new way of doing business.

Planning is essential. I cannot emphasize enough how many times you need to plan and replan and to plan continually for different circumstances. Brian Flynn talked about weapons of mass destruction and biological warfare. His remarks serve to underscore the necessity to plan differently for explosions or snipers or biological weapons, and that exacerbates the problems of training.

We were trying to develop a plan for biological warfare. I started meeting with all the constituents and, once again, realized that we were ill prepared. Questions were raised. How do you know when a biological event happens? How do you get primary care providers and hospitals to recognize that an incident may be occurring, and then to notify the state health department and CDC, and then have the loop from state and federal agencies returned to start notifying every other entity that may be involved in interventions? We do not have a communication system in place all the time. Telephone communications can be disrupted. Roads can be blocked. People may not be able to get where they want to go.

How do you deal with the anxiety of the first responders who might say, “I am not going to go in an ambulance and pick up somebody if they have the plague or smallpox. I do not want to be exposed to that”? How do you deliver the necessary medications? How do you staff the emergency rooms? People have to make personal choices. They may not be altruistic and come to work if they feel they or their families are in danger. Most of us have families and a potential moral dilemma. Do you stay home with your family and make sure they are safe, or do you leave to try and help somebody else, worrying about who is going to take care of your family? It is a very difficult choice, and I do not think that there is a right answer—but it is something that must be addressed.

When the commission started to look at all these issues, we realized that we had no answers. The only way to have answers is to model disasters, to run drills, to practice. Mental health must impose itself into that paradigm.

One California community with a state mental hospital was doing a biological warfare drill. I asked, “Why don’t you have the state hospital involved?”

They said, “We just have mentally ill people there. Why would they be involved?”

I said, “Because we are a hospital. Because we have doctors. Because we have nurses. Because we have medical facilities. Because we have expertise other than mental health, and, I can guarantee you, you will have mental health problems when a disaster occurs.”

During that bioterrorism drill, the question was asked, “Do you tell people to stay at home?”—

The only way to have answers is to model disasters, to run drills, to practice. Mental health must impose itself into that paradigm.

and consequently commerce stops, so you cannot get anyplace or get anything done. Or do you tell people about the potential illness, and then everybody floods the emergency rooms and primary care providers because they have a cold or the flu? Those are decisions that must be worked out in your community. You need to coordinate not only at the local level, but also at the state level and federal level.

Another problem that we encountered in our New Freedom Commission work is that we do not have the mental health work force to be able to provide all the services we need to provide today. If we add the demand to deal with terrorism and crisis and trauma, how are we going to deal with that, even if a complete response plan is in place? Not all mental health professionals are necessarily trained to do mental health work with trauma victims, terror situations, or disasters. In our professional schools we need to start training how to deal with these specific responses. Furthermore, training in disaster response needs to be part of ongoing education.

When disaster strikes, primary care providers will have first contact with the ensuing public health toll. The community will go to where

treatment and outreach are available, whether it is community-based organizations, faith-based organizations, or community leaders. Mental health cannot do it all. We need to work with our consumers, our family members, our community-based organizations, and our faith-based organizations. We need to learn how best to support those entities.

We also need to work with the media. We can further the healing through communication. Community leaders must be engaged to help in the grieving process, both as communicators and models. The media can inflame—but the media also can soothe. We need to make sure that accurate information is disseminated to media people in our own communities to ensure that the media is helpful, not harmful. Not only can they critique you, they can empower you.

I am most interested now in the issue of sustainability. We are very good at being reactive. We push ourselves in the crisis phase. But we know from the Oklahoma City and Columbine tragedies that some mental health problems occur after the event, much later—12 months, 18 months, even six years later. The problems can occur on anniversaries or when something reminds people of a catastrophic event. Unfortunately mental health professionals return to their regular jobs shortly after the crisis, leaving an anemic resource system for people who experience difficulties after the crisis or immediate phase. It is incumbent upon us to begin doing outreach, using the schools, teachers, paraprofessionals, and primary care providers to plan for delivering services to those individuals at risk for posttraumatic difficulties. Looking ahead in this way is a different way of doing business, being proactive rather than reactive, anticipating rather than waiting.

It comes down to a paradigm shift: to move away from a system that is rule-driven, that responds with multiple bureaucracies, to a system that looks at the whole individual, at solving problems, at doing whatever it takes to move to the next level by being flexible, adaptive, and creative. We will not know all the things we need to do until we begin that paradigm shift. We must move away from turf issues and our silos and start looking at the fact that we are dealing with people. People are not defined by pieces of their lives. I am not a mental health person. I am



a person who does mental health, has a family, and has a variety of other interests and complexities. Making that shift is going to be difficult, because change is difficult amid strong-willed forces for homeostasis.

What does it all boil down to? I am ambivalent. I am very optimistic about this country. We have the energy, the will, and the resilience to deal with just about anything. I am very proud of the mental health community and its remarkable resourcefulness. It pushes itself. It challenges itself. It raises the bar. And I know that it can succeed.

But I am also afraid, because we do live in that world of denial. I think that we underestimate the impact in ways that we never expect that

terrorist-caused disasters can have on us. Until we start working with our other systems and leaders in other fields, we are not going to be able to deal effectively with this very large problem.

But what we do in working together to anticipate a disaster or a terrorist attack is the very thing that we need to do to make our mental health system work for everybody in this country. Whether it is about terrorism or about a good mental health system, proactivity, integration, cooperation, collaboration, creativity, flexibility, and acknowledgement of the complexity and resiliency of people are all part of the value system we must adopt.

PANEL III: INTEGRATION OF MENTAL HEALTH INTO PUBLIC HEALTH

Carl C. Bell, M.D.

In this panel we focus on what most of us do when we need help and where most of us get services. Surgeon General David Satcher reminded us that probably there will never be enough mental health professionals. It is just not going to happen. The fact that it is not going to happen will inhibit our ability to deliver mental health and mental wellness.

Even if there were enough mental health professionals, the reality is that most of us have

How do we cultivate resistance?

How do we cultivate resiliency?

enough sense not to go and see them! We go to our natural support systems. We go to family and friends and business support systems, primary care physicians, and pediatricians. We go to church. If we are children, we go to our teachers. If there is a disaster, we get contact from first responders.

The conversation here is: How do we cultivate resistance? How do we cultivate resiliency? How do we cultivate skills of resourcefulness and problem solving, curiosity, compassion with detachment? How do we convince people of their right to survive? How do we help people to retain and remember good, warm, and loving images? How can people be in touch with their emotions? Mayor Giuliani talked about being in touch with his affect, but not being overwhelmed by it. How do we give people a goal to live for? How do we give people a vision and desire to restore moral order? How do we get people to conceptualize the need and ability to help others? How can we be altruistic? How do you turn learned helplessness into

learned helpfulness, because those are the resistance skills that get us through these sorts of tragedies.

I hope we take some lessons from other cultures. Other cultures cultivate resistance skills and strategies. East Indians talk about the development of the *Atman*, the true self, that core inside rock. It is an anchor in times of difficulty and trouble. Martial artists talk about *kokoro*, or heart, or indomitable fighting spirit, and how people cultivate it. We know that in sports, some people have an indomitable fighting will—and other people wimp out. Native Americans talk about totems and identify with animal spirits. Those things help. Chinese people talk about *chi*, cultivating life force in their techniques and strategies. And in the black church, we talk about spirituality and we cultivate that.

I just finished an Institute of Medicine report on suicide. One finding was that African-American women have the lowest suicide rates of everybody in the country. But sisters catch hell! They catch hell from black men. They catch hell from society. They catch hell from racists—yet we have these low rates of suicide. What is that?

We have to study and cultivate this whole issue of resistance and resiliency.



WORLD TRADE CENTER: FDNY MEDICAL RESPONSE

Kerry Kelly, M.D.

I would like to share with you our response to the World Trade Center event from the perspective of the Medical Department, Bureau of Health Services, of the New York Fire Department (FDNY).

On September 11th, with the initial assault on the North Tower of the World Trade Center, the first responders of New York City—the firefighters, fire officers, EMTs, and paramedics, as well as police officers—turned out to meet the challenge with no regard for their own safety. They ran in to help others. When the second tower was struck, more responders arrived to continue these efforts. This was a total job-wide response. Members from every rank, every bureau, responded to the call. The first responders focused on evacuation of civilians, rescuing more than 25,000 civilians.

With the collapse of the towers, all first responders became victims, but their efforts continued with the additional outpouring of more firefighters, EMTs, and police to help find friends, family, and strangers buried in the rubble. The losses were great, with 2,280 civilians and 343 firefighters and paramedics and 60 New York City police and Port Authority police perishing that day.

As chief medical officer of the New York City Fire Department, I have been actively involved in the events of that day as well as the aftermath. The members of our department were exposed both physically and mentally that day, and in the days and weeks and months that followed, as they continued their mission to bring home their fellow firefighters, police officers, and perished civilians. Both physically and emotionally, the entire New York City Fire Department was affected.

The Bureau of Health Services existed prior to 9/11. We dealt with three to five line-of-duty deaths a year. The Bureau of Health Services also is responsible for injuries and illness in the field and candidate evaluations. We are responsible for

following up on people after they have had problems. We have a pre-existing counseling service, which has worked to support families and help people after line-of-duty deaths, as well as to deal with substance abuse and posttraumatic stress issues in the past. With the magnitude of the 9/11 losses, coupled with the intense exposure of our entire work force, a concerted effort was required to meet this challenge.

I would like to present to you how we integrated mental health care with primary care medicine in our response to the events of 9/11. In the initial days after this event, the most traumatic injuries were seen at the Bureau of Health Services. Mayor Giuliani well expressed that the ability to tell your story about the events of that day was very important. As firefighters, officers, and paramedics came in to tell us about their orthopedic injury or how they hurt themselves, they

were given the opportunity, in one-to-one interactions with physicians, to tell their story of the day. These riveting stories allowed

us to hear what these individuals had gone through. The members were able to give us a sense of their feelings, their reactions. It was clear that many people were having immediate stress reactions—not only to their own near-death experiences, but also to the losses of the people with whom they were most intimately involved. Physicians could discuss sleep changes, nightmares, intensive images, feeling numb, flashbacks, and other symptoms. Members were referred to the Counseling Services Unit for individual as well as group sessions.

The losses to this department were incredible. About 20 percent of the first responders present that day were victims. Our special operation

As firefighters, officers, and paramedics came in to tell us about their orthopedic injury or how they hurt themselves, they were given the opportunity, in one-to-one interactions with physicians, to tell their story of the day.



units—the squads and the rescue companies—sustained the heaviest losses, with entire firehouses completely lost. Many of our most senior officers, the most respected and most seasoned officers, were killed. And the recovery of the bodies was an extraordinarily slow process.

The site, with the continued rescue and recovery efforts, became an area where people continued to work for months following this event, which added to the delayed response of people dealing with many of their feelings and reactions. At the site, there were continued concerns about exposure to toxins that members experienced while they were doing this duty—although no one would ever have given up that duty, if they felt that this was an important mission. We were coping with both the physical and emotional aftermath of this event.

We were able to partner with institutions that were helpful to us. The Bureau of Health Services partnered with the Centers for Disease Control and the National Institute of Occupational Safety and Health to study the health effects on our members. Our Counseling Services Unit worked with the New York City and New York State Departments of Mental Health to secure funding through FEMA to get a Project Liberty designation. This critical Project

Liberty designation allowed us to develop unique programs that met the needs of our members. The FDNY Counseling Services Unit was designated its own Project Liberty site. All our members were seen as tier 1 victims because of the incredible exposure of our members and their families. We also received funding and support from the International Association of Firefighters for counseling efforts.

Because of concern over the particulate matter and the respiratory and eye symptoms people were having and since our Bureau of Health Services was the entry point for physical complaints, we developed a World Trade Center medical. The World Trade Center medical was an examination of our members that took place

between October and February. During that time, we saw more than 10,000 people. Our staff worked three shifts a day, seven days a week, to get this medical done. As part of the medical, we had the advantage of pre-existing data; all our members had been seen in annual medical exams prior to this event. We had the advantage of pre-existing pulmonary function tests, EKGs, and blood work, so we were able to do a legitimate comparison to their prior testing. This was helpful from the viewpoint of knowing whether there had been changes, but also recognizing that people's concern about their physical well-being was an important part of their emotional well-being. During this exam we did EKGs and blood work, including some toxins.

During the medical we administered a computer survey that allowed members to identify their complaints and problems. At the conclusion of the medical, a physician talked to small groups of members. During these PowerPoint presentations, we addressed some of the issues and concerns that people were having. It allowed us to discuss such things as cognitive or behavioral changes they might be having in response to stress, how these were normal reactions to stress, and how people could access

help when they needed it. It also was an acknowledgement that their symptoms were not unique, but that many other people shared them and that it was perfectly normal and acceptable to have these symptoms. We were dealing with a population that does not believe in flaws in mental health.

In the first of our questions, we asked people if they had used counseling services. It was clear that this is not a group that is plugged into using counseling services. Eighty percent said they did not use counseling services. The ones who did use the satellite centers we had set up in the communities. They used our central places. They used clergy. They used the people who were important to their lives before. It was important that we had a pre-existing unit with a reputation for taking care of people. We were partnering with the local communities and developing satellites in the communities where members live. People might work in Manhattan, but their families were on Staten Island and Queens and Long Island and Brooklyn. It was important to get those services to those areas.

Members were asked if they thought that they would develop health problems. An overwhelming number of people did believe that they would develop problems in the future, if they did not already have problems. Another part of this questionnaire asked about whether the member's family had concerns. Sixty-one percent said that their families had concerns about their health problems. Addressing their problems—even if they were just concerns, rather than actual health problems—became an important part of our mission. That is why the World Trade Center medicals were important and why our concern about following the members becomes very important. There has been concern that people put themselves at increased risk by being at the World Trade Center. People can accept the risks they took on that day in removing people or doing what they needed to do, but they do have concerns about the long-term consequences.

Our goal has been to continue to develop communications. A newsletter goes out as a follow-up to our members from the Bureau of Health Services and our counseling unit that addresses some of the issues and concerns that people have been having.

Members were asked in the first six months post-World Trade Center, "Have you received emotional support?" Their answers reflected how vitally important the support network of family and friends is to our members. This is a close-knit group of survivors who turned toward the emotional strengths of their spouses, their families, and their fire department friends for assistance. In shaping our mental health response to the members, we targeted these areas to tap into this network.

We developed programs such as the couples connections, family liaison weekend, and a program called The Other Side of the Firehouse. These were designed to reinforce relationships, for couples to improve communication skills, and to increase support for spouses. The Peer Team Program also sought to improve communication in the individual firehouses in recognition of how important fellow firefighters and fellow officers are in this recovery. With help from the International Association of Firefighters and with labor/management support, we brought clinicians and peers to the firehouses in recognition that the kitchen is the hub of activity for the firehouse. That is the area where most problems are solved, whether it is tax problems, parenting problems, or mental health issues. This is the area where people sit and talk and turn to each other.

A question about the depth of losses showed that the dead and missing were people who were very close and intimate family or friends. Eight percent of our department lost a family member who was on the fire department. Most members lost one or more friends. In addition, the losses were felt across our entire city. Mayor Giuliani stressed that in the boroughs and the little towns that all make up the New York metropolitan area, each community felt the loss of people who died, whether they were firefighters, police, or civilians, because these people were part of the fabric of life.

We asked a series of questions about symptoms that people were having, about changes, and how people were feeling in terms of distancing, feeling numb, trouble concentrating, and difficulty remembering. Thirty-seven percent said they had no problems, but in a chance to give multiple responses, more than 63 percent identified symptoms consistent with posttraumatic stress

disorder—although it should be noted that people were working at the same time that they took this medical. More than 90 percent of the people who took this medical were on full duty when they answered these questions, so this is a group that is coping despite having symptoms.

We asked questions about people's patterns of sleep. A third said they had no problems. The remaining two-thirds had at least one or more symptoms consistent with either depression or posttraumatic stress disorder.

We asked questions about people's ability to function and changes in their appetite. People had more difficulties at home than they had at work. Work is often a haven for these individuals, who are used to being active, used to having a goal or mission of helping people.

We had to develop programs that drew people in and encouraged them to get help when they needed it. The programs had to be specific for the individual group we were dealing with, whether it was firefighters or the paramedics. We encouraged people to get help so they could be helpful to their families. We encouraged people

to talk to other people and to go back to the associations that in the past have given them so much help and relief.

People continued to work. They continued to function during these times. Many of the activities that they were doing were not the activities they had been hired to do. The site remained open from September through the end of May, and during that time, people would go down to the site for tours of duty lasting about 30 days at a time. They were actively involved in looking for and recovering body parts—certainly a task that most people were not trained to do in the fire service or in the EMT/paramedic service. We had to address those issues.

We hoped that by asking about spousal counseling we might get them interested, but 75 percent said their spouses did not need any counseling—and do not bother to call. But when it was clear that people were not going to allow us in without some work, we sent a letter to every home, so the letter could bypass the members and go directly to the spouses to let them know what counseling services were



available. We recognized that many of our members might never tell their spouses that counseling was available. We published a newsletter to help people know what was going on.

We looked to address behaviors that could have been affected by World Trade Center events, such as tobacco cessation. Although most of our people are health-conscious, to the small percentage who did smoke, we tried to suggest a smoking cessation program run through the Bureau of Health Services. In a series of four meetings, people come in for small group and individual sessions. We have partnered with Pharmacia, which has been helpful in giving us nicotine products.

Most of our members denied that they have a problem with alcohol. But we called our prior clients who had been seen at the Counseling Services Unit and asked them to come back into day programs or weekly programs to help them address the issue.

Exercise was affected by the World Trade Center. We tried to develop programs to let people know how important it was to continue to exercise and wellness programs that would address the issues of how people were feeling. Programs were set up to help people see alternative ways to get better and that there was no one way that people could achieve wellness. We tried to develop programs that meet the needs of members in a department that feels very strongly about physical well-being. Programs in the community satellite units also became helpful in offering people alternative methods toward wellness.

A book called *The New Normal*, which stresses the resilience of our members, is being distributed by peer counselors, stressing the coping mechanisms that have been useful to our members, including humor and being together as a group. A workbook was developed for our families so children and spouses and the member could sit and talk about what had happened in their world. Many children of firefighters never realized what their dads or moms did until 9/11. But when they saw them dressed every day to go to funerals, it reinforced that this could happen to their own mom or dad. This workbook gave the families a chance to sit and talk as a group. We also produced a series of videos to help people with the educational component of learning how to cope with tragedy, learning how to reinforce the skills of coping with stress.

It is a year later. We are still dealing with the aftermath of this event. Our work goes on as we continue to face the challenge of providing care in the context that the bioterrorism threat still exists.

We feel that the presence of our pre-existing occupational medicine program and pre-existing counseling unit were key to providing integrated services that acknowledge the unique qualities of our work force. We partnered with many federal, state, and city agencies, using FEMA funds to provide services to recognize the unique needs of our members.

We cannot go back in time to prevent the attack. We cannot bring back the nearly 3,000 lost, including 343 firefighters. And we cannot prevent exposures that already have occurred. But we can work to restore the health of those who did survive.

TOGETHER TO MAKE A DIFFERENCE: FAITH COMMUNITY-MENTAL HEALTH PARTNERSHIPS IN RESPONSE TO COMMUNITY-BASED EMERGENCIES AND DISASTERS

Harriet McCombs, Ph.D.

We have learned some lessons in dealing with and alleviating human suffering of the mind, the body, and the spirit. The events of September 11th made us more sensitive. The events made us more sensitive to trauma, but they also pointed to the need to develop plans to respond to trauma and brought out the important role that the faith community can play in alleviating trauma. I will discuss what we can do together to make a difference in responding to what I term community-based emergencies and disasters.

I would like to share a vision of local communities possessing the capacity to respond quickly, safely, and effectively to the mental health needs of victims of community-based emergencies and disasters. I hold that out to you as a vision. We have the opportunity to transform lives, and if we would take leadership to transform the capacities of our communities, we would see a difference.

I ask you to embrace the vision in three ways: Adopt the use of the terms “community-based emergency and disasters” and “community-based trauma”; enlarge the concept of primary care provider to include providers within the faith community; and promote the development of partnerships between the faith community and the mental health community. Trauma is defined in terms of injury and emotional wounds. But we also should think of the spiritual wounds. We talk of trauma in terms of an event that creates disruption in the lives of people in their daily routine and their sleep. But it also creates direct disruptions in their relationships with others, particularly in their belief and faith in God—whether it is shaken or disrupted—creating turmoil in individual lives. Who is there to address that? I suggest that the faith community is there.

In looking at community-based disasters, a group of people from around the country came together in Baltimore, Maryland, in June 2002.

There was broad representation. Marlene Wong of the Los Angeles Unified School District was there, as were police chaplains and fire chaplains and clergy who had been called to respond to various emergencies around the country. Medical examiners, who often do a lot of counseling and it is not necessarily their role, attended.

In a disaster localized within a community where everyone is affected, a number of unrecognized groups are out there. These affected people are tied together by a common bond, whether by geography, profession, or other ties. For example, flight attendants experienced trauma after 9/11. Planes were ready to fly, but some staff and crew would not fly. We have overlooked them in our response to trauma.

Community-based trauma and community-based disaster are present in our lives throughout this country. Tragedy strikes all the time. We hear about it in the news, and we understand that people go on with their daily lives. But we are seeing free-floating trauma that results from undiagnosed and untreated distress. In small, localized community-based disasters, the scope of the disasters often far exceeds communities' capacities to respond. Because of their size, however, some disasters do not qualify for federal designation. Communities are forced to come together—in a good way, because they begin to share resources and help their communities—to overcome. In these situations we find that traditional sources of care can increase their effectiveness. The mental health community can become more effective if we partner with the faith community.

Community-based disasters happen all the time throughout the country—fires, sniper attacks, airplane crashes, traffic accidents, church burnings. Sometimes the community is local, sometimes it is regional. I am fortunate to be involved in providing mental health services to clergy affected by church arson.

There is church arson and also other forms of community arson. Recently in Baltimore a family that had protested drug use in the community was burned out. The mother, the five children, and later the father died. The entire community is affected by these events. Floods, even those too small to qualify for federal funding, affect the entire community. Chemical spills in a community, a train that derails with chemical spills, fire, plane crashes, shootings, gang wars—they occur all the time. Marlene Wong helped me understand that following gang wars at night, children often come to their school grounds the next morning and find bodies on their playground. Communities are experiencing trauma all the time.

Local communities sometimes are devastated if they sustain damage to their single economic base. If farm communities lose their silos or grain elevators where they store everything, the entire community is affected. It is rural. It is urban. It is everywhere.

I want to stress that individuals find ways of coping. With all of this going on, people still go to work every day. They still perform their duties, often experiencing symptoms, but still they continue. National survey data on means of coping show that in these incidents, people turn to family and friends—but also, they turn to clergy. Ninety percent turn to religion, an important concept to embrace.

I suggest that we enlarge our concept of primary care. The defining characteristics of primary care are: It is the first point of contact; it is a place where we can begin with early identification of symptoms and coordination of care; and it is a place where individuals and family members receive care. Primary care providers are close to home and close to work, and usually they are more affordable than specialty care.

Are these not the same characteristics of clergy and chaplains? I would like to seriously consider enlarging our definition of primary care to include the faith community. We forget that



in New York there were prayer stations. There were all kinds of expressions of the faith community to respond to that tragedy, and it translated throughout the entire country. The means of coping are diverse. The various faith communities need to be recognized for the role they play in keeping a community healthy, keeping a community on the road to wellness.

I present an opportunity. We can begin to use all the information we have gathered from

The mental health and faith communities need to be proactive in developing our relationships.

national planning and apply it to the local setting, not only lessons from national emergencies and disasters, but also from international events—for example, lessons we learned from the U.S.

Embassy bombing in Nairobi, Kenya. We look at the Oklahoma City bombing, but we should not forget Nairobi, particularly in thinking about how communities frame events. To illustrate, in Nairobi, Kenya, the community framed the event and the anticipated impact in interesting ways. If the impact was thought to be psychological, people wanted mental health treatment. If it was considered more spiritual, folks who were hurt by the bombing sought counseling. Within the counseling there was a strong demarcation between secular counseling and faith-based counseling. There were opportunities for Christian counseling, Muslim counseling, and Hindu counseling, all of which had to be established for that community to accept care. We need to learn from these kinds of lessons as we continue to prepare.

The mental health and faith communities cannot wait for each other to find each other. We need to be proactive in developing our relationships, because it has been shown that our combined efforts increase the effectiveness of all the care that is provided. There are benefits to partnerships. They create a holistic approach to care giving. We become more efficient and more effective. Sometimes we forget about the research in primary care that shows the impact of one's faith on recovery and healing. We need to draw from that literature. In addition, the literature on refugee stress and distress adds to our understanding of recovery. Torture is a topic of interest in the refugee trauma literature. Torture means that you, as an individual, are personally

identified for a specific traumatic event. In some community-based disasters, communities are specifically identified for certain types of violence.

Partnerships with the faith community ensure a sense of security and comfort. People want to go where they are understood. People want to go where they feel comfortable, and the faith community offers that. In addition, partnerships offer the possibility of controlling rumors after an event. Information during a traumatic event is often exaggerated. The faith community has to be informed about how to communicate with the public. For example, when we explain 9/11 in the context of religion or faith, what do we do with the concept of evil? That suddenly moves the faith community into explaining whether this is evil and whether God intended it or not, and who are those people, and are we doing "God's work," and how do we do that. It is important that we get involved not only in controlling rumors, but also in communicating effectively with the public.

Faith communities offer opportunities for providing translation and interpretation. Faith-based organizations are situated in and include multiple layers of culture. Sometimes those cultures are non-English-speaking. Faith communities often have deaf ministries that use sign language. Persons who may not have access to information through the airwaves might appreciate receiving it from a source they rely upon.

Barriers to effective partnerships include lack of multicultural participation, assuming that one faith community has the market on care and not including all faith communities. Turf wars among federal, private, and various faith-based organizations are another barrier. Lack of volunteers is still another. Moreover, we have not communicated well the methods of organized disaster response. Faith communities do not understand incident command structure; as a result, they sometimes offer unsolicited and inappropriate "help." Many faith communities were in distress when they found that they could not participate in the 9/11 recovery, primarily because they did not understand incident command structure and because they needed to have had an existing relationship with emergency response agencies prior to the disaster.

The faith community was instrumental when Hurricane George went through the Florida Keys. The Counseling Ministry of South Florida, a faith-based organization, was able to fax information on how to respond to a disaster to churches in the Keys, and they were able to carry out the recovery effort. We need to understand the collaborative role the mental health and faith communities can play in such situations.

Other problems we must avoid include using professional jargon—especially by helping folks to understand the language of FEMA, CMHS, SAMHSA, Red Cross. We need to help the faith community understand that they have a role, and we can find the language to include them. For example, the faith community/mental health coalition in Baltimore was given the task to find language for treating depression. It took a full day for the two communities to come up with the same language: “healing the brokenhearted.” There are ways to build consensus, and we need to think about a way we define trauma that is not too narrow.



Baltimore has been engaged in faith community/mental health dialogues. It usually takes about four dialogues for a community to come together, understand, and work together.

Another barrier is the absence of care for caregivers. Who will help those who are helping others? With the faith community hearing so many of these stories, it is important that mental health services be available to them in a way that they can accept them.

Finally, we need to take action. Action is the antidote to despair. We need to take action by improving our communication between these two communities, defining the leadership role, recognizing the leadership in faith communities, providing training to communicate with each other, and providing guidelines on the use of facilities. We have discussed what we will do for children in schools, but have we considered what happens when disaster strikes when school is out? There are faith-based organizations in communities where kids go in the summer for recreation, and the kids are familiar with those persons.

The final action step is to apply our dollars to make collaborations work, so both communities have the responsibility for relieving suffering. An aspect of recovery can be enhanced when we recognize and respect the roles that we play in each other's lives. Every community has different dynamics, but within all communities, a glue tends to hold it together—faith in the future and faith in tomorrow. When that faith is shattered, where do people turn? We find that they seek the vision that there can be peace in their lives from their faith community.

We need to take action. The right action at the wrong time is a mistake. The wrong action at the right time is a disaster. The wrong action at the wrong time is tragedy. But the right action at the right time is success. I wish us success in our collaborations.

BEHAVIORAL HEALTH, PRIMARY CARE, AND BIOTERRORISM

Harold A. Pincus, M.D.

My presentation covers three major areas; the first is barriers to the integration of behavioral health and primary care under any circumstances, not specifically with regard to terrorism or bioterrorism. Importantly, if we can improve our systems of care on a regular, everyday basis, we also can improve our systems of care in the context of a bioterrorist or terrorist event. The second focus of my talk is on the implications of caring for the mental health aspects of bioterrorism on preparedness, and the third focus consists of steps we can take to improve primary care providers' capacity to meet some of these needs.

My major theme is captured in the November 1, 2001, Washington Post headline: "At ERs, Main Diagnosis is Anxiety, Not Infection." This

**November 1, 2001,
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"At ERs, Main Diagnosis is
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quote nicely demonstrates the inability to separate the mind and body. The assumptions people make about the effects of a terrorist or bioterrorist attack do not necessarily take into

account the fact that the mind and the body are inextricably linked. Notably, an important source of care for any type of mental disorder is the primary care system, especially for the most common mental disorders (such as anxiety and depression) and especially in a terrorist or bioterrorist event. We must think about the interplay of mind and body as we prepare for the future and understand the relationship between primary care and behavioral health as it relates to bioterrorism preparedness.

As we look to the past, we need to recognize important historical and other barriers at many different levels with regard to the relationship between primary care and behavioral health.

Going back to the 1600s, Descartes formally introduced the concept of the mind/body duality. Even before that, there were centuries of stigma with regard to mental illness that exist through today, exemplified by the lack of parity in insurance benefits between physical and mental problems. Additionally, important conceptual

barriers exist, as well as barriers at the patient level, provider level, practice or delivery system or agency level, health-plan level, among public or private purchasers of those health plans, and at the population or community or policy level. We need to think systematically about each of them.

Conceptually, when you consider how primary care providers address mental health problems, very different perspectives are involved. The majority of the literature about mental health problems does not necessarily speak to the issues in primary care. The literature usually comes from specialty settings, often tertiary or quaternary academic psychiatric settings. The diagnostic system that is used so commonly in mental and behavioral health settings, DSM-IV, is not well-accepted or well-understood in primary care settings. Primary care perspectives are very different—less about diagnosis per se and more about specific problems or symptom causes from which one derives different treatment. Primary care providers tend to be narrowly focused in time, content, and context. They deal with their patients' specific health problems. In the mental health system, we need to be aware of interfaces with multiple systems, such as substance abuse, social services, criminal justice, education, and consumer systems.

At the patient level, the very symptoms of a mental disorder (e.g., for depression: pessimism, lack of energy) may inhibit an individual from seeking out effective care. Also, stigma and lack of a modern understanding of mental health problems and their treatments are important barriers.

At the provider level, major barriers include limited time to deal with each patient. Providers see patients in nine- to 13-minute increments. They do not necessarily have a strong interest in the behavioral aspects of health care; after all, they chose not to be psychiatrists. In many cases, they do not have the tools available to help them rapidly assess and implement appropriate treatments. Many assessment tools

are geared toward specialty, not primary care, settings. Finally, primary care providers have limited training in mental health.

At the practice or delivery systems level, the relationship between the primary care sector and the mental health specialty sector is not well-delineated. There is limited understanding of who is responsible for care. There is a lack of clarity about the roles and responsibilities between primary care and behavioral health. There is limited communication and teamwork between the specialties on key issues, including: How should care be provided? What is the nature of the interaction and the linkage? Do things need to be totally integrated? Is a consultative role needed? Is there a longitudinal, as compared to cross-sectional (i.e., “one-shot deal”), focus in terms of when care is provided?

Thinking about the responsibility of care, where along the continuum of primary care and behavioral health services do we cut things? Is it delineated in any specific way? What kind of relationship do we have between primary care and behavioral health? Are things well-integrated or collaborative, or are people working along parallel-play tracks with little interaction? By and large, the primary care and mental health systems of care are totally autonomous. We need to figure out ways to move toward collaboration and integration.

Looking across the longitudinal continuum of an individual's health care, much of what goes on now in primary care settings is focused on the diagnosis/assessment and short-term management phase. That may be so in a bioterrorist event as well. But we also need to think about risk factor identification and prevention on one end of the spectrum and on continuing and consultative care on the other end.

Multiple organizational, economic, and policy barriers present themselves, including the separation by managed behavioral health organizations that “carve out” financing responsibilities of mental health care from general health. The organization of health care financing creates affiliation and communication problems between primary care doctors and mental health specialists. The system's financial incentives encourage people not to communicate across these barriers. Purchasers of health plans have little interest in changing these perverse

incentives. They do not see mental health issues on their radar screen as much as we would like. As a result, there is a lack of parity in benefits. Problems of confidentiality create other barriers to communication, particularly with the new Health

Insurance Portability and Accountability Act (HIPAA) requirements. While these barriers at the policy and organizational level are not specific to bioterrorism, they create a framework that in the event of a bioterrorist attack will need to be addressed in any response plan.

Bioterrorism has special implications for primary care practitioners. They will be “first responders” as patients present to emergency rooms, community clinics, and private medical offices. The nature of symptom development in bioterrorism will encourage that. Symptoms may be delayed between exposure and illness, and the symptoms may look like other common illnesses.

A recent survey found that primary care doctors felt woefully unprepared for any kind of bioterrorist event, especially with regard to its psychological aspects. And when you think about it, the psychological effects are likely to be much greater than the specific effects of direct exposure in the population. Some have posited that the psychological casualties will outnumber the physical by as much as 10 to one.

Bioterrorism impacts a number of distinct populations that must be dealt with: those who have been exposed, those

A recent survey found that primary care doctors felt woefully unprepared for any kind of bioterrorist event, especially with regard to its psychological aspects.



who have been infected, those who think they have been infected, and those who have significant psychological/behavioral reactions. Each of these populations presents distinct challenges to primary care providers who will be faced with multiple complex tasks—all of which must be completed with great speed. Primary care providers need to be prepared for assessment and diagnosis. They need algorithms for rapid triage and assessment of people's particular problems and difficulties and also for figuring out who has real symptoms of the biological agent and who does not. They need to be prepared for short-term interventions that can be done in the context of primary care, such as the availability of anti-anxiety medications and cognitive behavioral techniques. They must be prepared to be a resource for medical information. Primary care providers have to be educated about communication issues, because they will be the source of information for a large portion of the



public. They also have to be prepared for the potential psychological impact of isolation and quarantine, a particular issue in the context of bioterrorism response. One major issue is clarification of the roles and responsibilities with regard to each of these tasks. Who is responsible for what?

Importantly, primary care providers also need to be prepared for their own behavioral responses. What do people think about when terrorism occurs? Family, family, family. All of us need to be encouraged to develop individual and family disaster and emergency plans, so we have a sense of what is happening in this context and are clear about how to activate the plans.

The strategies that need to be in place to improve clinical response capacity must recognize a primary care provider's needs within a guiding framework. First, they need to be agent-specific; the response to anthrax is different from the response to smallpox, based upon the nature of the agent and the kind of infection pattern and treatment response that occurs. Second, strategies need to be problem-focused and adaptable to the primary care perspective. Third, they need to be specific to the particular population that is exposed. Fourth, they need to be time/phase-dependent. Fifth, they need to be sector- or role-relevant. In other words, primary care providers and the primary care sector as a whole are good at some things and not good at others. The mental health specialty sector is good at some things and ought to be doing them. Finally, strategies have to be developmentally appropriate. We need to think about how to target these kinds of interventions to children and adolescent populations, which are different from interventions for people in midlife or the elderly, who may have more mobility problems.

From a clinical perspective, we need to think about the specific clinical presentation and symptoms that result from an exposure to an agent. Infections can cause direct central nervous system symptoms, psychiatric symptoms, and behavioral symptoms. We also need to think about somatization. People will focus on their somatic processes. There will be varying tendencies to magnify those perceptions and to seek care in relation to their sensations about their body. In a bioterrorism event, there will be a great deal of anxiety symptoms—avoidance and arousal symptoms. Acute and persistent traumatic stress symptoms can occur. Numbing and dissociative symptoms may occur in patterns different from preoccupying, intrusive thinking. Sleep problems will likely be among the most prevalent problems.

We also need to think about traumatic grief. People will die suddenly and horribly, and close relatives will have reactions. We also need to think about depressive symptoms, not only in terms of major depression and bipolar disorder, but also subthreshold depressive reactions.

Implications for substance abuse are important. Think of the problem of the recovering alcoholic who has been stable, but following an event

suddenly has problems sleeping. To get to sleep, maybe he took a drink again. We need to be prepared to deal with these kinds of issues as well as the exacerbation of pre-existing mental health conditions across the board (e.g., PTSD).

Regarding population-centered responses, we need to think about people directly exposed, people indirectly exposed, relatives and friends and other people, and subgroups of the general public that are generally vulnerable. Strategies need to be developed with regard to each of these populations.

We need to be time/phase sensitive. We need to think about interventions using a longitudinal perspective that not only postdates the event, going out years, but also predates the event. As Mayor Giuliani said, ruthless preparation is necessary—preparation for evaluation, triage, treatment, and prevention.

Finally, our approaches must have relevance for the particular health care delivery structure and the particular sector (i.e., primary care, mental health specialty care) where people are treated for the types of problems they present with. We need to begin to develop rationality to this process. We need to think about where people go under certain circumstances, or ought to go for care under certain circumstances, as compared to other circumstances. We need to expand the presence of behavioral health specialists in primary care settings to avoid huge cracks that people can fall into if they are referred out of the primary care context.

To summarize, we need to understand the complexity of the interrelationships and barriers between primary care and mental/behavioral health and also between the health care system and the overall terrorism/emergency response system. We need to develop strategies that are agent-specific, problem-focused, population-centered, time/phase-sensitive, sector- and role-relevant, and developmentally appropriate.

We need to consider the psychological effects on health care workers themselves and how that impacts in a number of different ways, including the availability of people to do the work and our ability to respond appropriately. What are the implications for a terrorist or bioterrorist event for people who need “usual care” and for people with serious illnesses unrelated to the terrorist event, but who need significant health care at a time when the system is overwhelmed as it provided acute care in response to an attack? We need to engage primary care providers, behavioral health specialists, and the public in a partnership for effective risk communications, so that we might mitigate or reduce potential harmful psychological impact.

We need to develop innovative ways to study and evaluate the effectiveness of some of these methods and strategies and to study new models for integrating primary care and mental/behavioral health.

My final message is that we need to get away from the notion of separation of physical health and mental/behavioral health, of mind and body. It was best expressed by Frank Degruy, a primary care practitioner, in the 1996 Institute of Medicine report:

Systems of care that force the separation of “mental” from “physical” problems consign the clinicians in each area of this dichotomy to a misconceived and incomplete clinical reality that produces duplication of effort, undermines the comprehensiveness of care, hamstring clinicians with incomplete data, and ensures that the patient cannot be completely understood.

We need to do away with the thinking that separates these two systems.

Note: This presentation is derived from Dr. Pincus' work with the Robert Wood Johnson Foundation's program on Depression and Primary Care: Linking Clinical and Systems Strategies and with the RAND Center on Domestic and International Health.

TERRORISM AND MENTAL HEALTH: PUBLIC HEALTH AND PRIMARY CARE

Robert Ursano, M.D.

As the last panelist, I have the opportunity to summarize previous presentations. What are the issues we need to grapple with to bring together mental health, public health, and primary care? Most pointedly and importantly, we also need to bring them to communities that have resources as well as needs. By linking the communities together, we hope to solve some of the difficult problems we face in confronting the issues of terrorism.

This issue is highlighted by language problems in discussing this issue. We have lost the word “evil” in the issue of medical care. Terrorism brings it back to us. Torture is feeling targeted to create pain. That is perhaps what was done in New York City, where a particular community was targeted to create pain. Words such as

leadership, communication, and distress are not words of the medical care system. In the medical care system, we speak of illness, disease, health, diagnosis, and treatment. In the public health system, if we think of malaria, we speak of a host who is getting a disease. We speak of an agent, the vector that is transmitting the disease. We speak of primary, secondary, tertiary care, prevent, postevent, and mitigation. This language barrier is tremendous. We ignore it at great risk to our ability to accomplish our task. It takes time to cross these language barriers.

We have heard many times that the goal of terrorism is to induce terror in the nation. It is not just to create death. It is to infect an entire population, 300 million people in the United States, far beyond the individuals who experience



the direct impact. The goals of terrorism are to alter our sense of national security, to disrupt the continuity of our society, and to destroy its social capital, its morale, its cohesion, and its shared values. In doing that, terrorism opens the fault lines of our society and has the potential to identify cracks present in our society about which we have known for years and have ignored or been unable to repair. Those fault lines include racial and ethnic divisiveness, economic differences, and religious differences. These have the potential to destroy communities, an unanticipated result of the terrorist attacks.

Our nation's security traditionally has been built on military power, economic power, and perhaps our information systems. Given the target of terrorism, health must also now be a part of our national security plan and the security of our communities—in particular, mental health, because our mental health is the target of terrorist events. Terrorism tries to undermine our sense of morale, our cohesion, our ability to look to the future with hope and to sustain our communities and our families.

Traumatic events come in many forms. Individuals and populations are exposed to traumatic events. When we speak of individuals and traumatic events, we think of intentional events such as assaults and robberies and unintentional events such as accidents, motor vehicle collisions, injuries. When we think of communities, we have a similar dichotomy—human-made disasters, including industrial accidents, plane crashes, toxic exposures, and terrorist events, and natural disasters such as hurricanes and earthquakes.

Terrorism's particular characteristics can inform us on how we can begin to think about the provision of medical care after a terrorist event, as well as about the needs of primary care settings. Terrorism is a type of human-made disaster. It generally strikes large populations because of its terror impact, not necessarily because of the number of deaths. The October 2002 sniper attacks in Washington, D.C., were a terrorist event. Eleven people died—but more people than that died in motor vehicle accidents in Washington, D.C., during that period of time.

When we think of terrorism and plan for our primary care and public health systems, we must also remember that terror comes in different

forms. Each type has different implications for how we mobilize our health care and community support systems. We have had examples of several different types of terrorism. The Oklahoma City bombing was a single attack; the World Trade Center/Pentagon attack, multiple attacks—which could have been much more complex if you imagine attacks happening in other parts of the country simultaneously; the anthrax attacks, multisite but also continuous. Continuous threat is a characteristic of terrorism. The D.C. metro sniper attacks were continuous and repeated. Each of these patterns has different implications for our communities and their response needs, as well as for the provision of resources.

In many ways, we are more concerned with “the public's health” than we are with “public health” after a terrorist event. Public health is one component of our approach to the public's health. Terrorism brings that home to us. The “public's health” includes (1) the medical care system, (2) the emergency response system, and (3) the public health system. Traditionally the public health system has engaged in being aware of protection, prevention, and promotion. Our medical “system” includes the public and private care system, but it is much more a patchwork quilt than a system. It includes outpatient and hospital care—and at times has more holes than threads.

The emergency response system is a key component of our public's health. Often we do not think about its needs when we plan for the mental health issues in terrorism. Police, fire, and emergency responders deal with core needs of our communities—water, electricity, and communication issues.

So why is mental health of such great importance? First, mental health addresses human behavior in high-stress environments, including evacuation and warning systems. Second, we understand and can respond to individuals' distress responses, changes in morale, changes in concern and fear, even when these do not reach levels of disease and disorder. Third, we have the skills and knowledge of mental health for addressing new, emergent diseases, disorder, and, most importantly, resiliency.

Our mental health is the target of terrorist events.

Resiliency, we should recall, is the finding in nearly all studies of terrorism. We must both hope for and plan for the resiliency of our communities, as well as the dangers they face.

Addressing mental health needs after disasters and terrorism requires addressing all three of these areas: behavior in high-stress environments, distress responses, and mental illnesses/resiliency. We need programs that address all of these. Distress responses, which include changes in safety and the ongoing experience of change in threat, can result in changes in whether or not we choose to travel, fly in a plane, or, in Washington, D.C.'s sniper environment, whether we get gasoline inside the city, outside the city, or in another state. Human behaviors in high-stress environments also change. Examples in fire departments include alterations in smoking and alcohol consumption, as well as more subtle alterations such as overdedication, which can occur in response teams and lead them to increasingly risky behaviors. For example, a number of studies have identified that overdedication in toxic environments leads to



damage to protective suits, because people do not take time out to avoid fatigue. In the area of mental health and illness, PTSD and depression are well-known examples.

Who is affected? People who are directly impacted, injured, and bereaved; first responders; those who were vulnerable before; and those who lose the social systems that may have enabled them to get care and maintain themselves as functioning in the community.

Then there is the rest of the nation or community who experience the threat, the fear, and the altered sense of safety.

We know that the greater the threat, the higher the number of psychiatric disorders we will see. That has been found in every study that has ever been done. "Did Oklahoma City have more psychiatric casualties than Indianapolis at the time of the bombing?" No one ever asked that question, because it was obviously true. In World War II, the higher the degree of combat, the higher the degree of psychiatric casualties. The greater the impact, the higher the psychiatric casualties we can expect.

The issue of those who were injured is of particular concern to those of us who work in hospitals. If you were to go into the emergency room in a hospital and tell the hospital manager that 35 percent of the people coming in have tuberculosis, you would get an immediate response for a proactive intervention to identify the problems and set up treatment. If you say that 30 percent of those suffering a serious orthopedic injury coming into the hospital also have significant psychiatric problems warranting intervention, you may get yawns. Our systems are not set up to respond to this need. We have not educated people to understand, and we have not developed systemic ways of intervening. Yet we know that this injured population, whether it is from a disaster or from motor vehicle accidents, suffers from significant rates of psychiatric distress and disorder.

Disaster behaviors are an important topic to be addressed in mental health planning. Management of disaster behaviors can prevent the development of subsequent diseases and disorder. At the first World Trade Center explosion in 1993, a small-sample study had important findings. The study reported on the two towers, each with a community of 13,000. As you will recall, the blast created a crater seven stories deep. About 76 percent of people thought something serious had happened. Why is that number important? Twenty-four percent of people did not. What is 24 percent of 13,000? Around 3,000 people. Thirty-two percent had not begun to evacuate after an hour. Thirty percent decided not to evacuate at all.

Importantly, 50 percent of people evacuated in groups larger than 20. Why is that important? One of the key findings in this study was that large groups—groups greater than 20—took more than six and a half minutes longer to initiate evacuation. Six and a half minutes. In the most recent World Trade Center disaster, six and a half minutes may have meant death rather than survival.

How do we educate people about how to evacuate and how to respond to alarms? How can community support systems and community support groups keep active their knowledge about how to evacuate?

This last piece of information may not be surprising to people who work in large groups or bureaucracies. To make a decision in a committee is very difficult. But that is what happens in these large groups—committee decisions are made on whether to evacuate. If you knew more people in the group, you also evacuated more slowly. For good or ill, crowds of people known to each other inhibit individualistic solutions in favor of a shared norm. We might think of this as an autoimmune disorder. In many settings we want to foster social cohesion and attachment. But social cohesion and attachment in this setting may be dangerous.

Other disaster behaviors are similar. Lars Weisaeth has spoken about disaster behaviors following a paint factory explosion. People ran from the paint factory towards their friends, who happened to be in the same direction as the smoke was blowing, increasing their risk. If they had turned left and run 50 yards, they would have been safe. Similarly, in the evacuation of oil rig disasters in the North Sea, Dr. Weisaeth reported that when individuals jump into the sea, in which they have a bit more than a minute to live, they will swim towards the boat with their countrymen—even if another boat is closer.

These behaviors increase risk. We need group strategies, plans, and policies for families as well as organizations and information about appropriate behaviors that protect against exposure and decrease injury. Practice is needed.

Posttraumatic disorders are not uncommon after many traumatic events. But it may not be the most important mental disorder or outcome. Nearly all of us have had the acute form of

posttraumatic stress disorder (PTSD) at some time in our lives. Many of you have been in a serious motor vehicle accident. If for the following month or two you experienced difficulty sleeping, you did not want to go back to where the motor vehicle accident took place, you took several days off from work, you noticed that you jumped when someone hit the brakes, then you had PTSD. You also probably recovered from it.

This illustrates how terrorism may also bring an opportunity to reach out to decrease stigma in psychiatric illnesses and diseases. There are bumps, bruises, and sprained wrists of psychiatric illnesses and disorders, as well as cancers and pneumonias. PTSD may come in both a chronic, severe form and as an acute disorder, which many of us have and for which we need guidance, counseling, evaluation in the primary care system, tincture of time, and re-evaluation at another time to ensure that it has not become pneumonia and return to our community with the appropriate support, guidance, and relief of pain. These early interventions call for a tight-knit collaboration among primary care, mental health, and community support elements.

There are a number of other trauma-related disorders. Traumatic grief is of substantial concern after a terrorist event, because intervention and treatment for traumatic grief are different from that for exposure to threat to life that we see primarily with PTSD.

MIPS or MUPS are terms used to indicate multiple idiopathic physical symptoms or multiple unexplained physical symptoms—shorthand for preoccupation with somatic concerns. Why is that important? In the face of a bioterrorist event, somatic symptoms may be the most common presentation of distress in the primary care setting, in families, and in schools. Our ability to understand why people have somatic concerns and how to respond to somatic concerns will be an important part of our responding to a bioterrorist event. Depression is a well-known issue following disasters, as well as sleep disturbances, increased alcohol and cigarette use, and family violence and conflict.

Terrorism may also bring opportunity to reach out to decrease stigma in psychiatric illness and disease.

It is also important to recognize that the events both prior to and following a trauma or disaster influence the risk for subsequent disease, disorder, and illness. If you have lost your job, if you have gone through a divorce or separation, if you have had a death in the family, your risk for depression and PTSD is higher. Events that have occurred before or after a terrorist attack affect mental health outcomes. These contribute to the risk of disease and illness and offer opportunities for community intervention.

We have good studies to indicate that everyone is at risk following exposure to trauma and disasters: Carol North's work in Oklahoma City, our own group's (Ursano et al.) work on prisoners of war and their exposure, and True and Goldberg's studies on Vietnam combat exposure in twins. These studies all indicate that even without previous psychiatric risk factors, people are at risk of disease after exposure to severe trauma and disaster.

In Oklahoma City, 40 percent of the individuals developing PTSD had no previous history of psychiatric illness. Why is that important? First, it offers us opportunities to deal with the issue of stigma. Everyone is at risk. Second, it highlights important differences in the training of primary care providers. When you work with an algorithm of how to provide treatment, it often makes assumptions about the people who are coming into your office. The assumptions may include the fact that a person has had a previous disease or illness, or, for example, that a person does not have a support system or has a history of disorder. These assumptions will not be true in populations after a terrorist attack. The algorithms must be different to address the patients who come in. These studies also provide an opportunity to talk to communities about how they are all at risk and therefore how their communities can operate to aid in protection as well as resiliency following terrorist events.



Questions & Answers

Q Frequently primary care practitioners guide people away from treatment and toward religious help or psychiatric help or other kinds of help. The tragedies of the traumas and the terrors rally the troops to collaborate and cooperate, but then people go back to the old system of not working together. How can the primary care community become part of the total resolution of the problem?

A Dr. Kelly - Our pre-existing presence has helped. Our Bureau of Health Services and the Counseling Services Unit have partnered for years. We faced disaster on June 17, 2001, when we lost three firefighters and dealt with the losses and bereaved family issues. We had near-death experiences of other firefighters who were brought to local hospitals. We had to address both their physical and emotional well-being and the concerns of their families. In those cases several firehouses were affected. We sent counseling services to each of those firehouses, and we provided follow-up for members who were injured. We had a single point of entry through the Bureau of Health Services for everyone out with an injury and illness to be cleared by our physicians to go back to full duty. Those encounters may take a minute or two or they may be more lengthy, depending on the situation.

Are primary care physicians perfect in picking up on behavioral changes? No, but it helps when you know the members and you have a sense of what the people are like.

I wear another hat. I am a primary care physician with a private practice. My community is Staten Island, which was much affected by the World Trade Center attacks. Many of the people who worked in Manhattan came from that borough. Many people came into my office with complaints related to cough and congestion and eye irritation. That became the avenue for, "Let us talk about what is going on." Many times those one or two or three encounters are enough to let people acknowledge what is going on. They do not need more complicated care than that.

As a family physician, I feel very comfortable talking about the spirituality of healing and utilizing the resources that are available from a

faith-based community and from the mental health community and from traditional medicine. The problem with mental health from a primary care perspective is that we have a division of care. Psychiatrists are seen as people who hand out pills, and others are clinicians who talk to people. Insurance issues create barriers for people trying to get help to get better.

Speaking as a primary care physician, we are very concerned about the behavioral issues of our patients. We see patients when they are well and not well, and we are able to address those issues.

A Dr. Pincus - I agree that huge barriers exist, but it is a two-way street. Problems on the specialist side create some of these barriers as well. The strategies are educational, organizational, and financial to overcome them. Educational: If you test for it, they will come. Expectations for knowledge and training in behavioral health must be built into the testing certification of primary care providers and accreditation of training programs early on. Organizational: Place more behavioral health specialists in primary care settings. Financial: Change the financing incentives.

Q How do you forward people coming in to the counseling realm for clinical care if they need it?

A Rev. McCombs - With regards to forwarding persons to counseling, pastoral counselors are dually trained. They are trained within their faith and also in the mental health tradition. Sometimes it is not necessary to forward persons, but in those cases where it is, a couple of things take place.

One thing to consider is the medicalization of suffering. Often in community-based disasters, communities experience suffering and pain, loss and grief, on a daily basis. At certain times it becomes medicalized. We have to help the faith community understand when it exceeds their capacity to respond. This is a learning and training issue. Sometimes it is appropriate to provide care within the faith community, and sometimes it is appropriate to refer people to the

Questions & Answers

mental health community. It becomes our job to explain how the two communities work and what they have to offer with regard to people.

People know when they are hurting. They have an idea when they need to see someone and whom they need to see. They have an idea of what they should receive when they go to see them. We should not minimize persons' internal knowledge of their condition.

Q Dr. Satcher and others early on identified the possibility that this might be the first time that PTSD was transmitted via the media; you could be exposed through a television set with repeated exposure. Has there been any further identification of whether that hypothesis is true?

A Dr. Ursano - On our Web site, www.uhuhs.mil, at the bottom of the page is a button, "Disaster/Terrorism Care Resources." We address some of these problems. Dr. Pfefferbaum noted that the relationship between TV and outcomes is complex. It may well be that people who have more symptoms watch more TV. Studies of spouses of soldiers deployed to the Persian Gulf War showed that TV both decreased symptoms by relieving fears of what spouses were facing and increased symptoms of those who were waiting for their spouses to go overseas.

Another type of autoimmune disorder may be a result of identification with the victims of a terrorist attack. This may be the primary issue

involved, whether by TV or other mechanisms. We foster identification with the victims, which may increase our own distress and the distress in large populations.

Q I was at the World Trade Center on September 11th as part of the mental health response team. I would like to put the events into perspective. September 11th was primary day in New York City, the end of one of the most divisive primary elections I had seen. The city was ethnically divided. The multiethnic and cultural fabric of the city was falling apart. On the morning of 9/11, when perhaps Mayor Giuliani was listening to opera, I was listening to African drums and Spanish guitar. But we had a common goal.

With every crisis, there is opportunity. If we are going to be leaders in this effort, we need to develop criteria not only for response to the emergency as it is, but response to the emergency as an opportunity for us to be able to work together in the future.

A Dr. Ursano - Emergency responses offer the opportunity for communities and groups to come together and bridge gaps that were there before the crisis. Responses change available social relationships, and we need to take advantage of that where it may be helpful to our communities to build new partnerships.

CHARGE TO THE WORK GROUPS

Given what we have learned about the responses undertaken in attempting to meet the mental health needs of Americans in the wake of September 11, 2001, what strategies should the federal and state governments and local communities adopt in their planning and preparedness activities to ensure the future mental health of citizens in future traumatic events?

KEY FINDINGS FROM THE WORK GROUPS

Mental Health in Disaster Planning, Preparedness, Response, and Recovery

- Develop clear command and control structures from planning through recovery by which decisions are made during a crisis by integrating all resources
- Integrate the mental health plan into the broader public health planning by working across organizational lines
- Develop a local template for action
- Develop mental health guidelines for specific terror events and different groups affected

Leadership

- Engage leadership at the federal, state, and local levels regarding the importance of mental health
- In advance of a crisis, build relationships with stakeholders and organizations with designated responsibilities during a disaster across all disciplines
- Ensure funding for mental health services
- Integrate mental health as a full partner in planning, preparedness, response, and recovery
- Encourage citizens who need services to seek them

Tools

- Identify and utilize existing materials concerning mental health in disasters and learn from the best practices of other states and jurisdictions
- Develop information packet on psychological first aid:
 - How to manage fear
 - How to foster resilience
 - How to cope with tragedy
- Develop a workbook for families

- Disseminate guidance materials for the media:
 - How to report disasters in a helpful way
 - How to sensitively interview survivors
- Develop and disseminate guidance materials for public health officials
- Develop programs that draw people in and encourage them to get mental health services

Communication

- Communicate credible, consistent, and clear messages to the public about what to expect to prevent panic among the affected population
- Develop communications targeting hard-to-reach and/or vulnerable populations including first responders, children, those with pre-existing mental illness, etc.
- Communicate clear messages to the public and health care providers on how to recognize signs of symptoms and problems
- Communicate the existence of a mental health component in the preparedness plan
- Communicate clearly a leadership structure

Education

- Educate/inform government officials at the federal, state, and local levels of the importance of addressing the short- and long-term mental health consequences of terrorism threats and events as well as the effectiveness of interventions
- Educate/inform key governmental and private funders about the mental health and financial consequences of failing to include mental health as a key component of terrorism planning and preparedness
- Educate teachers, school officials, and parent groups about the special roles schools might play in the mental health of school-aged

children in a variety of crisis situations and assist them in identifying or developing appropriate materials

- Educate parents about how best to prepare their children for a terrorist threat or event and about the short- and long-term responses children might exhibit

Central Command Center

- Develop at federal, state, and local level
- Provide evaluation of mental health situation in the long and short term

- Develop a database on best practices and case studies to assist federal, state, and local leaders
- Provide information to the public on preparing/responding to mental health emergencies
- Provide technical assistance to response team in the event of a catastrophe
- Provide information on where citizens can get proper mental health treatment
- Provide mental health services in aid stations, disaster centers, and other field locations

CONVERSATIONS AT THE CARTER CENTER: IN THE WAKE OF SEPTEMBER 11TH

On the morning of September 11th, I went to the World Trade Center site as soon as I learned that the first plane hit the North Tower, where I met up with Mayor Giuliani. I had gone there in anticipation of accessing the emergency operations center, which was located at 7 World Trade Center. Some people had put the name “bunker” to that facility; a great deal of money was spent to create a very elaborate, well-developed telecommunications system. But we could not get into the building, because there were concerns about its structural integrity. And later in the day, that building actually did collapse.

We were, therefore, in need of a site where we could communicate with Washington and seek air cover for New York City. We went into a nearby building on Barclay Street, where the mayor did reach the White House, learned that the Pentagon had been under attack, and was able to secure air cover. We were positioned there when the first tower collapsed.

From there we attempted to relocate the seat of government, to find a location to convene governmental leadership and coordinate a response. Within a few hours we settled into the Police Academy, about two miles north of the World Trade Center site. A few days later, we relocated the emergency operations center to Pier 92 overlooking the Hudson River.

At the Health Department we activated an emergency response protocol within minutes of the second plane hitting the South Tower. Seven emergency preparedness committees were activated immediately, including surveillance, medical/clinical, sheltering, environmental, laboratories, operations, and management information systems. We previously had practiced and drilled in anticipation of a possible Y2K crisis. Although that crisis never materialized, it



gave us the opportunity to anticipate what we needed to do when we faced an “all hands” disaster of any type.

One of the first lessons we learned is the importance of drilling, practicing, and expecting the unexpected—creating an incident command structure with designated titles, jobs, responsibilities, and a plan of action, including communications, to get information across the various sectors of our own agency, as well as to communicate with other governmental sectors at the level of the city, state, and federal government. It is very important that you do not meet your governmental counterparts for the first time in the midst of a disaster.

The CDC has had a close and historical relationship with the New York City Health Department. Within hours we had activation of the national pharmaceutical stockpile, which arrived in New York that evening, providing us with several tons of medical supplies if we were to need it.

Epidemiological Intelligence Service officers from the CDC joined the effort within a few days. They manned, on a 24/7 basis, 15 hospital emergency departments, because we decided that we needed to carry out active surveillance for the potential release of a biological agent. To do that, we would look for any unusual clinical manifestations or clusters of symptoms that might signal a bioterror event. To do that, we needed to have staff in the emergency rooms. As weeks went on, we were able to substitute electronic transmission of clinical data, but we could not have made the transition without the support of the CDC.

Our most immediate concern was monitoring the ability of the hospital system to respond to what we anticipated would be large numbers of casualties and injured individuals—whether we had enough hospital beds and whether emergency departments would be able to care for all the sick. And as you know, tragically, we did not get to test that. The surge capacity of the system was not challenged. But we did learn that approximately 10,000 people had injuries, even if relatively minor, that led to their going to the emergency department. About 100 hospitals in the greater metropolitan area saw people who



were injured at the 9/11 site with about 450 admissions. The lesson I take away is that terrorism is not going to have a local health impact. It is likely that health impacts are going to be seen very widely beyond the boundaries of a specific terrorist focus. If possible, people are going to go to their homes, their neighborhoods, and their communities to seek care. All planning will need to be regional in scope.

We also were challenged with the need to have rescue workers use the necessary personal protective equipment for their own health and safety. That is exceedingly difficult to do in the midst of a rescue operation. People tend to subordinate their own health in moments like that. They are concerned with the urgency of rescuing their buddies.

The fires that burned at the World Trade Center for many, many weeks also challenged us. Particulate matter was spewing out in lower Manhattan; depending upon wind currents, it would leave an odor miles away. That was particularly noxious to people with sensitivity to chemicals and to those with asthma. We needed to reassure people that the best possible monitoring was being done to ensure their health and safety. Of course we also anticipated a looming mental health crisis. We immediately did a quick review of the literature on the impact of the Oklahoma City bombing.

It is very important that you do not meet your governmental counterparts for the first time in the midst of a disaster.



L to R: Dr. Robert Ursano; Dr. Neal Cohen; Mrs. Rosalynn Carter; Dr. Julie Gerberding; Dr. John Hardman, executive director, The Carter Center; Dr. Thomas Bornemann

With the World Trade Center tragedy, we expected a tremendous mental health impact in New York.

New York felt very different to those of us like myself who are native New Yorkers. It felt like a much smaller town and community. Normally in

Health impacts are going to be seen very widely beyond the boundaries of a specific terrorist focus.

numbers and await your turn to get off. But in those weeks after 9/11, we chatted with each other. We felt a need for communal support.

We then put together a public education campaign. Project Liberty focused on recognizing the health and mental health impacts on New Yorkers—those who would never think that they would be in need of mental health services. We needed to do that in a manner that would be destigmatizing. The slogan for the campaign was

All planning will need to be regional in scope.

“New York Needs Us Strong”—since we are all in this together. We wanted New Yorkers to know that if their emotional pain and stress are not getting better, they might benefit from accessing a mental health professional’s care and services.

The good news at this point is the evidence derived from surveys done in New York four to six weeks after 9/11 and follow-up surveys six and

New York City people do not speak to each other in an elevator; you look up at the

nine months later and one year as well. Telephone surveys recorded significant distress and posttraumatic stress disorder-like symptoms. Over time we have seen a diminution in the incidence of significant levels of distress. We also are seeing more people who are phoning the 24/7-day-a-week hotline, 1-800-LIFE-NET. While we are receiving more calls for help, we do not have a sense that we are seeing new cases, but people who are now accepting that this is time for them to get the help that they need. We would like to think that the public education campaign is contributing to that awareness and opportunity to take action.

I am a psychiatrist who was asked to serve as health commissioner with a vision of unifying the two public health agencies, the Department of Mental Health and the Department of Health, to create a more integrated vision of public health that would place mental health issues into the mainstream of the public health agenda. Surgeon General David Satcher had advocated strongly for an integrated public health model, and the aftermath of the 9/11 tragedy speaks to the value of this approach.

Dr. Bornemann

Dr. Ursano, you have spent a career as both a clinician and a scholar in the area of trauma, with soldiers and civilians alike. Perhaps you could give us an idea of what we might expect in terms of reactions from both individuals and communities?

Dr. Ursano

The challenging question, following on where Dr. Cohen left off, is the question of why is mental health prominent at the table following terrorist events. Those wiser than I have said that the nation’s security is composed of its military might, its economic might, and—in these days, perhaps—its information capabilities. But given that the target of terrorism is truly to undermine the social fabric of the nation, to attack its values, its ability to persist and to maintain a picture of its future, we are talking of the home of mental health. In that setting, therefore,

mental health becomes an important part of the nation's security. The maintenance of the mental health of the nation becomes an important target for our public health system.

We make an error not to remember that the goal of terrorism is not the tragedy of 3,000 people dying in New York; it really is the induction of terror in the nation. It is the impact on 300 million people that is the goal of terrorism. The task of mental health interventions is to counter this with countermeasures, with interventions, that allow people to regain a sense of their future, to establish it if they have lost it, or to hold onto it if they fear that it may slip away.

In the face of terrorism, we usually think about at least three vulnerable populations. There are those who are directly impacted, certainly those who have lost loved ones, and first responders, who are exposed to the death and the dying and the grotesqueness of a disaster; the leaders, who must deal with tremendous stress in those environments, having to make some rapid decisions with small amounts of information; and the rest of the nation. There are those who experience the disaster through exposure to the media. So we have the vulnerable, the directly impacted, and the rest of the nation. We must consider broadly what are the mental health needs of all three of those populations and those in each group who are at greatest risk.

Terrorism is a particular type of disaster—a disaster that stirs terror that spreads rapidly through communities. If you think of terror as the agent, this agent can spread rapidly around a nation, particularly if we have terrorist attacks in multiple sites and the terrorism comes in multiple forms.

Our communities, of course, have experienced terror as an endemic aspect of life. Recently in Baltimore, Angela Dawson died. She had protested the drug abuse going on on her block. Subsequently her house was firebombed. She and her five children died. Her husband survived. The house was firebombed by the drug abusers—not primarily to kill Angela Dawson and her family, but in fact to intimidate the rest of the neighborhood.

So terrorism comes in many forms and has been present in our nation for a long time. It can come in single events. It can come in multiple-site events. It can come in continuous events over time. Each form has different mental health implications that we need to think through.

Bioterrorism carries particular concerns and worries. We know that the impact of being exposed to a threat to life, for those who experienced that impact at the World Trade Center or in motor vehicle accidents, can be responses such as posttraumatic stress disorder. From the acute form, most people will recover; in the chronic form, it can be intractable and disabling.

In studies from New York City, as Dr. Cohen has alluded, we know that PTSD occurred in somewhere between 15 and 20 percent.

I believe the studies, which were from south of 110th Street, looked at both PTSD and depression. PTSD is perhaps one of the most widely talked about of the trauma-related disorders, but perhaps not the most important. Depression occurs, altered smoking, altered drinking, perhaps family violence (for which there is some good literature), and, perhaps even more importantly, altered behaviors.

We wanted New Yorkers to know that if their emotional pain and stress are not getting better, they might benefit from accessing a mental health professional's care and services.

Mental health becomes an important part of the nation's security.



In one study we looked at the Pentagon in terms of alternate experiences of safety and altered confidence in government. Both of those are outcomes of terrorist events that can tremendously strain communities, strain the experiences of families as they relate to each other, as well as how communities build themselves and confront the future.

How to counter the experience of altered safety and how to restore a sense of confidence in government can become critical aspects of the mental health task, particularly to sustain the continuity of government. Many people outside Washington, D.C., may not appreciate the threat to the continuity of government experienced with the terrorist events of September 11th. Vice President Cheney talks about the Secret Service grabbing him and literally pulling him to a safe site. When the government considers moving to a safe site and when at one o'clock in the morning, two o'clock in the morning, three o'clock in the morning, NATO planes are flying overhead to protect the capital, the threat to the continuity of our society and to our way of life has become high.

Mental health interventions and consultation offer the opportunity to restore those functions through public health interventions, as well as through medical treatment facilities that can provide care to the targeted populations, as well as education to facilitate recovery.

Dr. Bornemann

Dr. Gerberding, you were called into the events surrounding 9/11 both as a technical expert and for your leadership within CDC. Your agency is

at the forefront of our nation's response and preparedness activities associated with terrorism. What do you think the public needs to know, at both the community and personal levels, to prepare us for such events?

Dr. Gerberding

For a period of time CDC was believed to be a target of a terrorist attack and it was believed that there was an unaccounted-for plane in the air. We evacuated our Clifton Road campus. Despite all the planning we had been doing for the two or three years prior to this event, I think none of us actually believed that we would be a target. Our planning had not gone far enough to include that in our minds, let alone in our actual plan. That set the stage for a new reality. That lesson learned is the first that we tried to integrate and go forward with as we prepared for what is likely to be a future scenario.

One way of thinking about our mission or our responsibilities now is to continue to look back on past experiences and learn from them. We certainly learned that we were missing some capacities at CDC. We are a scientific organization. We pride ourselves on being able to get all of the data before we make a decision or offer guidance. But in the context of any kind of public health emergency, particularly terrorism, you just simply do not have the luxury to get all of the information before you make a decision. We had to learn as we went, and we had to acknowledge that we could not know everything. Therefore, we needed to be able to tell people what we knew today, but also to prepare them for the expectation that tomorrow we may know more and to be able to change our minds as we went forward.

We also had no experience with what we are now calling forensic epidemiology, the ability to conduct our public health work side by side with criminal investigators. We have very different cultures at CDC and the FBI. We do investigations from very different perspectives, in learning how to share information, and share even our interviewing skills, and certainly sharing our hierarchies and the communications that go out of our trenches into the higher echelons of government. It was a new experience for us. We practiced a lot in the fall and have



now developed an excellent network. I am confident that that alliance will be successful in the future. Some competencies have improved.

We also have learned a great deal about the need to think about broader capacities and the sorts of things that you do not need on an everyday basis but you might need during a crisis. For a simple example, we had a real class anthrax laboratory at CDC that handled about 30 specimens a year of suspected cases of anthrax associated with veterinary care. Suddenly in the fall we had to process 2,500 samples of potential anthrax from the various exposure sites and also to support the laboratories around the country that were receiving all the white powders from Dunkin' Donuts and other materials suspicious for anthrax. Our preparedness now is oriented not just toward the baseline, but much more on what we need to do to scale up to meet any number of different scenarios. We are trying to ensure that we have the capacity across the board to do that, whether it is chemical or biological or radiological terrorism.

We also learned how important coordination is. CDC has been working with the Department of Health and Human Services and other federal agencies to provide to state and local governments more than a billion dollars for planning. The states received their money in late spring, early summer. They obviously are involved in a lot of planning. A major focus of the planning effort is coordination. People need to know who is in charge, and it needs to be very clear. We need to understand what we mean when we talk about incident command, which is a very different way of doing business from what we typically see in the health care environment. This is the hierarchical and orderly system by which decisions are made during a crisis or a disaster, with a clear understanding of who is responsible for what. A lot of the planning resources will help people at the local level do that successfully and integrate all the partners that need to be involved.

We also learned a great deal about communication. As you know, the press criticized CDC for not having a proactive communication strategy for the general public. Part of that issue was that we were operating under the Federal Emergency Management Act, and CDC was not supposed to be communicating with the public under the

authorities of that response plan. But as events unfolded and the anthrax crisis arose, it suddenly was important for us to be communicating. We actually did a very good job, I think, of communicating with state and local health officials who were dealing with matters at the local level. But we were not prepared for the demand of communicating with the general public or the media. Often we would be sitting in our conferences looking at data as it became available, watching our data go across the CNN ticker tape. We would be a little worried about how that data was getting out of the lab and onto the television before we even had had a chance to interpret it.

The need for effective, regular, and trustworthy communication during a public health emergency cannot be overestimated. At CDC and in state and local health departments, we are sponsoring a great deal of training and support around communication for all of the various groups, including clinicians, the general public, the media, public health workers, and so on and so forth. Practice is absolutely essential.

The public needs to understand that we are not going to know everything at the beginning—but we can commit to saying what we do know, saying what we do not know, and letting you know that we will tell you more when we know more. The mayor of New York, so incredibly beautifully during the whole tragedy in New York City, had consistent and regular communication—revealing information as it became known, rather than waiting to tie it up in a nice package.

We have learned a number of lessons. And we now have some investments in homeland security that will allow us to scale up what we are doing and package the essential components of preparedness. One is planning. I have described some of the things that are going on in terms of planning. Another is products, things such as smallpox vaccine or the antitoxin to botulism or the chemical that we need in the stockpile to

We had to learn as we went, and we had to acknowledge that we could not know everything.

CDC has been working with other federal agencies to provide to state and local governments more than a billion dollars for planning.



protect people in a chemical attack. A third thing, people trained at all levels of the response system who know what their job is during a crisis and who are truly prepared to deal with their responsibilities. And finally, the very most important thing of all is practice. We must practice all of these plans if we expect to do the very best we can.

This summer, CDC used the system of public health preparedness to deal with West Nile virus outbreaks, because we wanted to practice our system. We learned lessons from that experience also.

You will begin to see throughout the entire public health system, when there is a crisis or a problem, we are going to use this emergency response system model to exercise the people in the capacities that we have. Each time we do it, we will get better and better and better. We certainly are more prepared now than we were in the fall, and I think our preparedness will continue to increase exponentially as some of these investments come to fruition.

I feel really optimistic, but what frightens us most is complacency. In the context of terrorism, part of the mental health issue is to try to deny that it will happen again. But as soon as we forget or we resist the knowledge that it is not over yet, our preparedness can drop way down.

I am sure that there is probably a psychological term for it—"forgetfulness" would be one

This summer, CDC used the system of public health preparedness to deal with West Nile virus outbreaks.

word. We all are concerned that we need to sustain the vigilance and the interest and the investment, no

matter how tempting it is to pretend that it will not happen again. The reality is that it probably will, and we need to be prepared.

Dr. Bornemann

You have all challenged us to think the unthinkable. Each of you in your own way has done it in your domains. What advice might you give the public about how they may prepare themselves and their own families? We

understand how agencies have done it through better communication, better preparedness activities. Is there a parallel for families?

Dr. Cohen

When I was growing up we were told to go under our desks in school as preparedness for nuclear attack. I think we generally thought that that was going to do us some good, because authorities told us that.

But today there is a lot more sophistication about real threats and appropriate actions to be taken. We are living with cable TV, with 24/7 news coverage, and access to new information constantly. People are going to hear about potential threats from any distance. So our reality is that we live in a society where vast amounts of information are out there, with the need to digest it and to find guidance from leadership that will help us understand what to do with that information. The communication among government, public health, and health care leaders with local stakeholders who care about the quality of life in their community is needed to create partnerships that will allow people to sit at the same preparedness table.

There is a literature that demonstrated, in the response to the Oklahoma City attack as well as to the 9/11 attack, that greater watching of the events on television was associated with greater stress levels and symptoms. This doesn't establish causality, but it is evidence that television is a powerful force to influence the way people absorb and mediate the information that is given to them externally and what they do with it internally. This suggests to me that we need other options to digest information, such as this forum, providing a dialogue between community stakeholders and the governmental leadership, public health, and health care communities.

Dr. Gerberding

I would take a different spin on that, which is to think about preparedness in the home from a more practical standpoint. At CDC we discovered that many people did not have plans for what they would do with their children if they suddenly had to stay all night in the laboratory or where the focus would be for telephone communication if they wanted to account for all the members of their family.

Family preparedness means having a family emergency plan. The plan spells out who is the common point of contact, where you can tell your children to go if they or you cannot get home, how you make sure that should you have to stay in your workplace that you have what you need to do that comfortably—an extra change of clothes, for example—and you have a back-up communication system, so if the telephone goes down, you have another communications mechanism or safe haven for the people in your family who are dependent on you.

A number of checklist elements go into family preparedness; we are working with the Red Cross on that. If, for example, we should have a smallpox attack, one important issue would be home sheltering. If people can be in their homes, they would not be at risk for exposure to other people with smallpox, and they would be safe. But we have to communicate—as you do in a hurricane—that the procedure is to go home, stay home, and make sure you have what you need to do that comfortably for some period of time.

Dr. Ursano

The issue of locating loved ones is a huge issue in times of disaster, as was true in New York and other disasters. The questions one first feels are: Where are your loved ones? Can you find them? Can you communicate with them? This has a tremendous effect on the immediate stress in families. Therefore, having a plan for how you would be in touch, if something happens, can be very important for relieving initial distress. We have good data that active coping in many forms relieves stress in families.

Dr. Cohen suggested that the media can serve as a vector, both for knowledge and potentially for distress. When you watch troublesome things on television, one of the most important actions one can do, often very difficult, is to turn it off. You do

not have to watch, particularly not continuously. That means not watching the four-thousandth time that the World Trade Center has collapsed and the second or third time you have seen people jump out, fall out, or be blown out of a building.

Those images are very distressing and increase the distress in populations. And it can be hard to turn off the television.

Greater watching of the events on television was associated with greater stress levels and symptoms.



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Q I am interested in how to cope with the difficulties in getting treatment. Maybe mental illness has been destigmatized and the insane asylums are gone, but people I know who have had mental health problems still have trouble getting treatment.

A Dr. Ursano - When we talk about the public health system and mental health, we traditionally have meant mental hospitals, particularly prior to the 1960s. In the 1960s and early 1970s, the public mental health system was the community mental health center. In no place, however, have we developed a systematic approach to the provision of public medical care for mental health problems across the entire range of needs, from the outpatient client to the inpatient clinic to the primary care setting, where most mental health problems currently are dealt with. Terrorism challenges that system tremendously, because we have to deal not only with those who need direct care, but also with populations that may need assistance, guidance, and knowledge.

What you are pointing out is the absence of a public health system directed toward mental health care across all of its needs. I believe it is a very important missing element of our health care system.

Q I was struck by the comment about a sense of community that developed after the tragedy. Does that sense of community still go on or did it go back to the way things were before, when people looked up in the elevator and did not talk?

A Dr. Cohen - My sense is that while that sense of community has not shut, the window is closing. To some degree, there is the need to heal and move away from the pain, so that will lead people naturally to try to restore their pre-9/11 level of functioning, feeling, and their sets of relationships with their peers, their families, and their community. At the same time, we also continue to learn of new threats on a daily basis. A majority of people in the New York area expect that something will happen again that will be very traumatizing. So there is still a shared feeling about vulnerability that we carry with us on a daily basis that has to

be addressed and transformed into some constructive opportunity for communities to relate to these threats in ways that are compatible with their values and vision.

Dr. Ursano - It also highlights the fact that we know that certain phases follow disasters. There is the experience of cohesion of communities after nearly all disasters. It also is an opportunity, as Dr. Cohen suggested, to mobilize communities and natural support groups to contribute to the recovery of the community. We also have to remember, however, that a phase of anger often occurs after a disaster. You can predict that after a certain period of time, a community becomes angry about why were things not stopped, why did they have to happen, couldn't things have been done better. So we need to plan for those elements.

You highlight a very important issue, that terrorism also strikes at the fault lines of our society. It increases the chances of the rupture of society across issues of ethnicity, religion, race, and socioeconomic background. Terrorism highlights those divisions in our communities. We need to plan for those, because they will occur—as they did in Washington during and after the anthrax exposures in the post office. There is a fault line around race. The decision to provide Cipro to people on Capitol Hill and dicloxacillin to those in the post office was interpreted as discriminatory (in fact, people at the Supreme Court also got dicloxacillin). Both were appropriate medications, but that was not how they were experienced at that time.

Q As we become more a global village, in our country we are seeing more diverse groups coming in—the Latino community, the Asian community—with their own sets of values. How do we reach out and spread communications through these different groups?

A Dr. Cohen - Your reference to ethnic communities is relevant to the need not to create a “one size fits all” approach, but, instead, to find relevance in the values and vision that derive from many communities. There are a great many public health problems

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that defy progress because we have not adopted these approaches. Terrorism and bioterrorism preparedness will require strong community participation and “buy-in.”

Q Fear is a powerful motivator. We have heard how fear can motivate for a positive effect in a community setting and also encourage preparedness. You talked about the anger that comes with fear, and we are on the brink of war as a result of that fear.

What can we do to better channel the positive energy that occurs following a fearful terrorist event to improve community cohesion and make that sustainable, and yet decrease the anger that brings us to the point that we are at now? What research needs to be done to make sure that we can do that effectively as public health practitioners?

A Dr. Ursano - Mobilizing communities becomes very important—town meetings prior to events, so communities can develop issues like Neighborhood Watch, neighborhood assistance programs, so a structure exists around which community cohesion can happen. In this way fear has a channel in which it can flow. It does not become chaotic. It has a mode to be active that may be productive, that can include planning for who will watch the children on the block if they come home from school and mom or dad is not home yet. What will happen if some child needs to be picked up at school? Is there a way that that can be planned for, both in the school system and in the Neighborhood Watch program? Communities can make many decisions on the small scale, block-size, but that happens only when communities begin to see this as their task, begin to see it as something they can do and something they want to do.

Dr. Gerberding - It was interesting to read what was predicted we would see in this kind of environment. Many people write about public panic. If you read the literature or study disasters, the public usually does not panic. In many cases, they rise to the occasion. There were great examples of altruism in the World Trade Center and at the Pentagon and over Pennsylvania. When people are armed with leadership and a course of action that allows

them to take charge and to participate in the management of the situation, we do not anticipate the problems of panic that occupy so much attention from the abstract perspective.

Q In Colorado one of our difficulties in dealing with the aftereffects of the Columbine shooting was preparing for the likelihood that peak demand for mental health services would not occur until about a year after the event. That is what the Oklahoma City bombing people told us, and that is what we experienced. The greatest demand did not emerge until between 12 and 18 months after the Columbine event. Was that your experience? If so, how did you handle that?

A Dr. Cohen - We are at 13 and a half months. I think it is very likely that we also are going to see a rise in service demand, because we do have a very significant increase in the number of calls that are being made to the mental health hotline.

There had been a report that substance abuse agencies were seeing 10 or 15 percent greater demand for services earlier on, which was not the case for mental health agencies. I am hearing that waiting lists are beginning to get longer once again. I think good research has to be done to ascertain the meaning of that phenomenon and its relationship to September 11th.

Clearly what is different about what we have been living with and what occurred in Oklahoma City is that after the bombing in Oklahoma City, most citizens would have agreed that they were not at further risk of attack, that it was a one-time event. And we cannot say that. So we have this continuing experience of terror, threat, and vulnerability. There is no prior experience that would allow us in a credible way to project the impact of the experience going forward.

Dr. Ursano - The principle that mental health problems show up later is a good one to hold on to. When you begin to tease that apart, we need to begin to think about what types of mental health issues we are talking about. If we are talking about bereavement, the chart by which bereavement decays begins high initially and

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goes down afterwards. If we talk about posttraumatic responses, such as hypervigilance, difficulty sleeping, those start high at the beginning, decay much more slowly, and, for some people, continue beyond six months. That is when it becomes a much greater concern. If we talk about increased smoking, we know that increased smoking occurs in the high-stress environment. We do not know if that decays or not. We know that increased alcohol use occurs during the high-stress period. We do not know if it decays afterwards. There is also the issue of what types of interventions may be most useful at which period of time.

There's another whole set of behavioral issues, pre-event behavioral issues. We know from studies of the first World Trade Center disaster, the bombing in 1993, that people who evacuated the World Trade Center in groups greater than 20 took an additional six minutes to decide to evacuate—six minutes. Six minutes in the recent World Trade Center disaster would have meant life or death. So behavioral decisions about evacuation alerting and alarm, which are pre-event aspects, represent a different focus and intervention strategy than traditional mental health disorders that are postevent.

Many of us worry about the immediate future in terms of terrorism and war, poverty, the impacts that our own country will have on other countries—and hence the future of international relations. We know that mental health symptoms will occur as a result of future terrorist events. Embarking on mass smallpox vaccination campaigns or preparing for war or sending troops abroad or perhaps instituting a draft tend to reinforce our vulnerability.

One society that is most like ours is Israel, which is in a constant state of terror. Could you speak to the relative frequency of mental illness symptoms in Israel, what that country does to cope with it, and whether they have had any success in doing that?

Dr. Ursano - There are important issues in how we look to other countries for models of how we can intervene, as well as what we might anticipate will happen. Israel is a good example and Ireland is another.

The Israel example has been posed many times. A number of superb colleagues in Israel have done marvelous studies, but they will be the first to remind you that their country is built differently from ours. It is possible there to mobilize everyone to use a gas mask and not have anyone say, "I do not want that to happen" (or at least very few). Israel experiences different cultural constraints and opportunities, and Israelis have different ways of responding.

If we were to use Israel as a model, active coping is a tremendous activity in Israel. Gas masks have been issued to everyone; consideration for vaccination has been given to everyone; and special consideration for how to deal with children exposed to toxic elements has been provided in education programs throughout the nation.

Those areas that are hit by bombs, by suicide bombers, show high rates of psychiatric disorder. There is no immunity there. But you find when you ask them how they deal with chronic terrorism, they respond, "We just keep going. We just keep going." That attitude involves maintaining hope. There is also a part about their sense of sadness.

On the one hand, one's alerting system has changed, and on the other, your picture of the future and how you will plan is changed.

Dr. Cohen - I was reminded that in the Surgeon General's Report there is the statement that we know a good deal about mental illness but very little about mental health. That has always been a challenge to a public mental health science. We make advances in psychobiology and have better understanding of the organic underpinnings of mental illness, but we still are not very clear about the field of mental health promotion. We know about cholesterol levels, nutrition and diet, sedentary life style, and their impacts on health and public health—but we cannot give guidance on preventing mental distress and illness.

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Now we are coping with life in the post-9/11 era with the new reality of terrorism that is impacting us all. The challenge to our health and mental health in this environment is very strongly felt, and it underscores consideration of mental health issues as a major component of our public health agenda. We will also need to rethink the public health research agenda in relation to this reality.

Q We talked about the capacities we will need to develop, capacities that we may already have, and some that need to be furthered. I am concerned about the stigma issue. We know a lot about how to treat some of the major mental disorders likely to be outcomes of the next attack, just as they have been for previous ones—PTSD, depression, substance abuse. But even when we have the treatments available and the people and community infrastructure in place, often people do not come for treatment. The biggest challenge may be getting those people who need and who would benefit from treatment to engage in it. What might be done around destigmatizing both the syndromes and the treatments, so we can match those two things together for better health outcomes?

A Dr. Ursano - A couple of thoughts. I will come back to the point that you are making, but terrorism also raises stigma in other forms. That is, we begin to see threats where they are not present. Following 9/11 a component of our community was stigmatized. Many people reported that when they sat next to an Arab male on an airplane, they were frightened. If in fact an Arab lived in your community, I'd bet that people talked to him less often. So stigmatization following mass violence of all kinds and terrorism in particular, needs to be a target for mental health intervention, even beyond our patients.

Going back to your other question, destigmatization of individuals with a mental illness can benefit greatly from leadership by community leaders. It is an aspect of a leader's willingness to talk about what is in fact unspeakable that allows the rest of the community to talk about it.

A good friend of mine coined the term "grief leadership." He was trying to capture the process of how different leaders lead a community through a mourning process. Mayor Giuliani is a wonderful example of that. A major part of the skill of a leader is the leader's sensitivity to what is going on in the community and the ability to speak the right phrase at the right time—because then a community can speak that as well.

A leader who says out loud, "We need help," allows others to say, "I need help." If leaders do not say that, they essentially prohibit other people in the community from being able to say that.

In the mental health arena, I think we have done ourselves harm. We have done ourselves harm by treating all mental disease as if it were cancer. And in the medical realm, cancer has great stigma attached to it. All psychiatric illness, all mental disorders are not cancer. People recover from them. In particular, there are what we like to call "event-related disorders," such as PTSD, which have been in some way caused by a life event. Good treatments are available, and people can recover from it.

We also need to change our way of approaching mental disease and to recognize that there are event-related disorders and there are noncancers. There are the "sore throats of mental disease," some of which may become pneumonia, but from most of which people may recover with no intervention at all. Yes, they had a mental disease, and they got better. And they got better because of the normal healing processes of our bodies.

Dr. Gerberding - Another aspect of stigma relates to the response community. We saw how heroic the firefighters and the police officers were in New York City. At CDC, our EAS officers, the people who worked 24/7 for so many weeks in a row, also were heroes and heroines of the attack. When you see yourself or your peers personified as heroic, it is difficult to acknowledge that maybe you do not feel so heroic or that you are having mental health issues. Seeking health care under those circumstances creates concerns about being stigmatized for not being heroic and for not

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being on a par with the peers with whom you work side by side. Some special mental health issues exist around the response community at large, in how we portray them, and in how we allow them to be human and to acknowledge the special needs they might have in this environment.

Dr. Cohen - We used a model in New York of pairing a peer with a mental health professional when we approached uniformed services agencies to offer counseling services. Those uniformed services have a tradition of being very insular and not readily accepting outsiders. We saw value in peer support and making sure that

what you are offering to people is targeted to their needs at any given time. We have a very well-developed mental health services community in New York, but in developing a public mental health response, we needed to be concerned with the skills of mental health professionals who would be volunteering their services. With many psychoanalysts, biological psychiatrists, and therapists without training in crisis intervention or grief counseling, the larger mental health community will need to address the training issues that will be needed to strengthen its ability to be "first responders" and to connect with people at moments of terror and crisis in this post-9/11 world.



CLOSING REMARKS

Rosalynn Carter

Chair, The Carter Center Mental Health Task Force

September 11th served as a warning signal, and across the country, efforts are underway to ensure that we'll not be caught off guard again. From the federal government to neighborhood watch groups, Americans are creating crisis management plans to deal with any future violent or terrorist acts. Those of us in the mental health community have a tremendous opportunity – and obligation – to make sure that the designers of such plans recognize the importance of including psychological and emotional supports in any preparedness activities. Rudy Giuliani immediately saw the value of incorporating an understanding of mental health into New York City's response to the World Trade Center attacks in something as basic as communicating shock, grief, sympathy, and strength to our nation. Judging by the reactions he received from the world, his approach was successful and serves as one very simple example of how crucial a mental health component is in effectively dealing with disaster.

From this symposium we take away two messages. One is that we must be ready for another national trauma, and the other is that mental health must be an integral part of all crisis response preparations. Our work here has generated many new ideas, and we have compiled an outstanding set of resources and expert contacts. Our job now is to get this information to our country's leadership at all levels – federal, state, city, community – to impress upon them that no plan can be complete without considering the mental health consequences and to urge them to take appropriate steps now to protect the physical and *mental* well-being of all the citizens in their care.

Rosalynn Carter

Biographies



William R. Beardslee, M.D., is psychiatrist-in-chief and chair of the Department of Psychiatry at Children's Hospital in Boston, and Gardner Monks Professor of Child Psychiatry at Harvard Medical School. He received his bachelor's degree from Haverford College and his M.D. from Case Western Reserve University. Currently Dr. Beardslee directs the Preventive Intervention Project, an NIMH-funded study to explore the effects of a clinician-facilitated, family-based preventive intervention designed to enhance resiliency and family understanding for children of parents with affective disorder. He also serves on the advisory board of the Center for Mental Health Services of SAMHSA and

on The Carter Center Mental Health Task Force. He is the author of more than 100 articles and chapters and two books: *The Way Out Must Lead In: Life Histories in the Civil Rights Movement*, a story of what enables civil rights workers to endure; and *Out of the Darkened Room: Protecting the Children and Strengthening the Family When a Parent Is Depressed*, a book about how parents and caregivers can help families overcome depression.



Carl C. Bell, M.D., serves as president and CEO of the Community Mental Health Council & Foundation, Inc. He also serves as director of public and community psychiatry and as clinical professor of psychiatry and public health, University of Illinois. He is principal investigator of the NIMH-sponsored study Using CHAMP to Prevent Youth HIV Risk in a South African Township and a co-investigator of the Community Partnership to Prevent Urban Youth HIV Risk with Columbia University's School of Social Work, Social Intervention Groups, and a co-principal investigator of the Chicago African-American Youth Health Behavior Project. He also is a collaborator with the Chicago HIV

Prevention and Adolescent Mental Health Project (CHAMP) at the University of Illinois.

Dr. Bell served on the Violence Against Women Advisory Council and the White House's Strategy Session on Children, Violence, and Responsibility. He was appointed to the planning boards for the Surgeon General's Reports on Mental Health: Culture, Race, and Ethnicity and on Youth Violence. He is a member of The Carter Center Mental Health Task Force.



Neal Cohen, M.D., served as the Commissioner of Health of New York City from 1998-2002 and oversaw the public health responses to the West Nile virus outbreak, World Trade Center tragedy, and anthrax bioterrorism outbreaks. Subsequent to the events of September 11, Dr. Cohen established the Project Liberty initiative to ensure that New Yorkers receive support services, counseling, and treatments to address the impact of the trauma. Prior to serving as the Health Commissioner, Dr. Cohen served as the Commissioner of the Department of Mental Health, Mental Retardation and Alcoholism Services.

A native New Yorker, Dr. Cohen received a B.A. from Columbia University and M.D. from New York University School of Medicine. He is currently the Executive Director of the newly created Center on Bioterrorism.



Charles Curie, M.A., A.C.S.W., serves as administrator of the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services. Mr. Curie has more than 20 years of professional experience in the mental health and substance abuse arena. Before joining SAMHSA, he served as deputy secretary for mental health and substance abuse services in the Pennsylvania Department of Public Welfare. Mr. Curie is a graduate of the Huntington College in Indiana and holds a master's degree from the University of Chicago's School of Social Service Administration.



Brian W. Flynn, Ed.D., currently serves as associate director of the Center for the Study of Traumatic Stress, Department of Psychiatry, Uniformed Services University of the Health Sciences, and has an independent consulting practice. He is a former rear admiral/assistant surgeon general in the U.S. Public Health Service, where he served as director of the Division of Program Development, Special Populations and Projects in SAMHSA's Center for Mental Health Services. Dr. Flynn received his M.A. in clinical psychology from East Carolina University and his Ed.D. in mental health administration and human systems design from the University of Massachusetts at Amherst.



Julie Louise Gerberding, M.D., M.P.H. is the director of the Centers for Disease Control and Prevention (CDC) and administrator of the Agency for Toxic Substances and Disease Registry (ATSDR). Prior to assuming the position of CDC director, Dr. Gerberding served as acting deputy director of National Center for Infectious Diseases (NCID) and director of the Division of Healthcare Quality Promotion, NCID. Previously, Dr. Gerberding worked at the University of California at San Francisco (UCSF) where she was director of the Prevention Epicenter, a multidisciplinary service, teaching, and research program that focused on preventing infections in patients and their healthcare providers.

Dr. Gerberding earned a B.A. magna cum laude in chemistry and biology and an M.D. at Case Western Reserve University. In 1990, she earned an M.P.H. at the University of California–Berkeley. She is an associate clinical professor of medicine (Infectious Diseases) at Emory University and an associate professor of medicine at UCSF.



Brooklyn-born **Rudolph W. Giuliani** graduated from Manhattan College and from New York University Law School, where he graduated magna cum laude. In 1970 he joined the office of the U.S. Attorney, where he eventually rose to serve as executive U.S. attorney. Then he was recruited to Washington, D.C., where he was named associate deputy attorney general and chief of staff to the deputy attorney general. He served there a number of years before returning to private practice in New York. In 1981 he was named associate attorney general, the third highest position in the Department of Justice, where he served until being appointed U.S. attorney for the Southern District of New York. He was elected and re-elected mayor of New York City.

On September 11th, Mayor Giuliani narrowly missed being crushed when the towers fell. He immediately began leading the recovery of the city as it faced its darkest hour. He worked tirelessly to restore the city and the morale of its residents.

In January 2002, the mayor founded Giuliani Partners, a professional services firm that specializes in public safety, financial management, leadership during crisis, and emergency preparedness.



Kerry Kelly, M.D., serves as chief medical officer for the New York City Fire Department. She is responsible for the Counseling Services Unit of the FDNY. As a board certified family physician, Dr. Kelly is a graduate of Vassar College and Brown University School of Medicine. She received her residency training at Downstate University Medical Center, Kings County Hospital, Brooklyn, New York.



Martha Knisley serves as the first director of the new Department of Mental Health of the District of Columbia. She led the system from federal court receivership in the first year following her appointment. She has spent her entire 32-year professional career in public mental health, serving earlier as director of Ohio's Department of Mental Health and deputy secretary for mental health in Pennsylvania's Department of Public Welfare.



Stephen W. Mayberg, Ph.D., has served as director of the California Department of Mental Health since February 1993. Since then he has embarked on an ambitious agenda that includes major initiatives to reform the mental health system. These reforms reflect changes based on programmatic research and program outcomes and accountability. Dr. Mayberg received his undergraduate degree from Yale University and his doctorate in clinical psychology from the University of Minnesota. He completed his internship at the University of California–Davis, and he has worked for the California mental health system since that time. During his public service career, he has been an advocate for interagency programming and planning. His primary interest has always been as a clinician, and throughout his career, he has continued to provide clinical services. Dr. Mayberg serves on the President's New Freedom Commission on Mental Health.



Reverend Harriet McCombs is associate minister of Payne Memorial African Methodist Episcopal (AME) Church, Baltimore, Maryland. She received a doctorate degree in psychology from the University of Nebraska at Lincoln and attended the Lutheran Southern Seminary in Columbia, South Carolina. She has served on the faculties of Wayne State University, Yale University, and the University of South Carolina. Rev. McCombs has served as a pastor in the AME Church, drafted legislation on mental health for the AME Church, designed training for mental health promotion for the faith community, and promoted local mental health and faith community dialogues. Rev. McCombs has led national efforts to provide mental health services to clergy affected by church arson. She is the recipient of numerous

professional and service awards, including an award for her work with the U.S. Agency for International Development in Nairobi, Kenya, where she provided on-site technical assistance for implementing a trauma mental health program for people affected by the bombing of the United States Embassy.



Betty Pfefferbaum, M.D., J.D., is a general and child psychiatrist, as well as professor and chair of the Department of Psychiatry and Behavioral Sciences at the University of Oklahoma College of Medicine, where she holds the Paul and Ruth Jonas Chair. She has treated many victims and family members and is actively engaged in research related to the bombing. Dr. Pfefferbaum assisted in mental health clinical and research efforts related to the 1998 United States Embassy bombings in East Africa. She has provided consultation regarding clinical and research efforts associated with the terrorist attacks of September 11, 2001. She has been selected to direct the Terrorism and Disaster Branch of the National Child Traumatic Stress Network, a federal initiative to improve treatment and services for traumatized children.



Harold Alan Pincus, M.D., serves as professor and executive vice chairman of the Department of Psychiatry at the University of Pittsburgh School of Medicine. He also is a senior scientist at RAND and directs the RAND Health Institute in Pittsburgh. Dr. Pincus directs the Robert Wood Johnson Foundation's National Program on Depression in Primary Care: Linking Clinical and Systems Strategies. Dr. Pincus graduated from the University of Pennsylvania and received his medical degree from Albert Einstein College of Medicine in New York. Following completion of residency at George Washington University Medical Center, Dr. Pincus was named a clinical scholar of the Robert Wood Johnson Foundation clinical scholars program.



Robert Pynoos, M.D., M.P.H., is professor in the UCLA Department of Psychiatry and Biobehavioral Sciences. He also serves as co-director of the National Center for Child Traumatic Stress funded by SAMHSA, director of the UCLA Trauma Psychiatry Service, and executive director of the UCLA Anxiety Disorders Section. A graduate of Harvard University and Columbia University Schools of Medicine and Public Health, he has edited several widely respected books on posttraumatic stress in children and adolescents and has authored numerous published articles in professional journals. He has written extensively on child development and the impact of disaster, violence, and loss on families and school communities.



Steven Shon, M.D., serves as medical director of the Texas Department of Mental Health and Mental Retardation. He received his undergraduate degree from the University of Southern California and his medical degree from the University of California–San Francisco. He completed his residency in psychiatry at the Langley-Porter Neuropsychiatric Institute of UCSF. He is a clinical assistant professor, University of Texas Health Science Center, San Antonio, and clinical associate professor, University of Texas School of Pharmacy, Austin. Dr. Shon is co-director of the Texas Medical Algorithm Project (TMAP). Dr. Shon has served on the National Advisory Council to the Center for Mental Health Services and is board chair of the National Asian American/Pacific Islander Mental Health Association (NAAPIMHA) and consultant to several local, state, and national organizations.



Bradley Stein, M.D., Ph.D., is a natural scientist at RAND and an assistant professor of child psychiatry at the Keck School of Medicine, University of Southern California. He also serves as a psychiatric expert with the Los Angeles Unified School District Mental Health Services Unit and is director of the School Consultation Program for the USC Division of Child Psychiatry. Dr. Stein has extensive experience in crisis response following violence and disasters. He has been involved in responding to a variety of traumatic events, providing crisis services to direct victims through multiple organizations, including the American Red Cross, the National Organization of Victims Assistance, and the University of Pittsburgh Critical Incident Stress Debriefing team, and spent 1994 working as a humanitarian aid worker in Croatia

and Bosnia. In addition to research on the mental health effects of terrorism, Dr. Stein's current research involves efforts to improve the quality of mental health services delivered to children in schools, including the evaluation of a program providing school-based mental health services to traumatized children in the Los Angeles Unified School District.



Farris Tuma, Sc.D., is a health scientist administrator with the National Institute of Mental Health in the Division of Mental Disorders, Behavioral Research, and AIDS. He completed his formal training in public health at Johns Hopkins University. He also holds a master's degree in health policy and management.

Dr. Tuma manages two extramural programs of research, one on disruptive behavior disorders in children and adolescents and another on traumatic stress and victimization. The Traumatic Stress Program supports research on the mental health sequelae of interpersonal violence as well as the institute's portfolio on major traumatic events, such as combat and war, terrorism, natural and technological disasters, and refugee trauma and relocation. This includes research on psychobiological and behavioral reactions to trauma; behavioral and biobehavioral risk factors and markers for developing mental disorders and adverse functional outcomes; service delivery and treatment for victims; and effectiveness of programs designed to reduce, delay, or prevent trauma-related mental health problems in children, adolescents, and adults.



Robert Ursano, M.D., is professor of psychiatry and neuroscience and chairman of the Department of Psychiatry at the Uniformed Services University of the Health Sciences in Bethesda, Maryland, where he also is director of the Center for the Study of Traumatic Stress. Dr. Ursano was educated at the University of Notre Dame and Yale University School of Medicine and received his psychiatric training at Wilford Hall United States Air Force Medical Center and Yale University. He was a national consultant for planning clinical care responses and research programs following the September 11th terrorist attacks.

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