CENTER FOR MENTAL HEALTH
EMERGENCY SERVICES AND DISASTER RELIEF BRANCH

# RESPONDING TO THE NEEDS OF PEOPLE WITH SERIOUS AND PERSISTENT MENTAL ILLNESS IN TIMES OF MAJOR DISASTER

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

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## PREFACE

Since the mid-1970's, the Federal Government has provided grant support to deal with the psychological consequences of major disasters. Funds for these grants are provided by the Federal Emergency Management Agency (FEMA).

The crisis counseling program managed first by the National Institute of Mental Health (NIMH) and now by the Center for Mental Health Services (CMHS) provides counseling and training to all who live and or work in areas declared disasters by the President. Within these general guidelines, CMHS and FEMA recognize that there are groups of people who are at greater risk for disaster-related stress, whose needs may require special attention by service providers, or who may have more difficulty using the variety of government services that become available following disasters.

In that spirit, the CMHS Emergency Services and Disaster Relief Branch has produced this technical assistance document to address the needs of people with serious and persistent mental illness following major disasters. Several people with direct experience in disaster services to this population were asked to develop chapters for the publication. Drafts of the document were shared with colleagues, CMHS staff, and an even broader audience for review and comment.

The task was more complex than anticipated. The writers struggled with how to address the needs of people with mental illness while not stigmatizing them further. They explored how, or even whether their needs differ from those who are impacted by largeBscale disasters but do not have a mental illness. And they struggled with the realization that when people with a serious mental illness experience the same disaster-related stress as anybody else, they often are inappropriately and unjustly labeled as experiencing an acute exacerbation of their illness.

This process has yielded two significant results:

First, we identified the need for this document, which is the first guide to use narrative and illustration, from providers, program planners and designers, and administrators of disaster response and recovery programs.

Second, we learned that the needs and desires of people with serious mental illness are closer to the needs desires of the general population following a disaster than previously thought. People with mental illness have the same need for housing, stability, and support as their neighbors in the days following a disaster. They are as capable as anybody else in behaving heroically during and after the disaster event. They have the same difficulties maneuvering through the complexities of the recovery process. And they share the desire to see their lives and communities restored.

In this attempt to identify how to best meet the needs of people with serious mental illness following major disasters, the developers of this document hope that the principles noted here might be generalized to other groups of people who, for a variety of reasons, find it more difficult to access the resources available following disasters.

The most gratifying part of my many years in disaster mental health work has been the privilege of witnessing firsthand the strength and resiliency of the human spirit following major trauma. I have been reminded of how much more the mental health field needs to learn about mental *health* as compared with mental *illness*. This project serves as a dramatic reminder that the presence of a mental illness does not preclude an individual from having the resources and strength to physically and psychologically survive a major disaster, and from assisting in the rebuilding of their lives and community following disaster. Indeed, people with mental illness do share the same pain and fear as everybody else.

Ironically, disasters provide a unique opportunity for individuals and communities to focus on the commonality of the human condition when the walls that separate us are both literally and figuratively knocked down. All those who participated in the writing of this document were reminded that the commonality of our needs and desires overshadows our differences.

Brian W. Flynn, Ed.D.
Chief, Emergency Services and Disaster Relief Branch

Center for Mental Health Services

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CHAPTER ONE

# Introduction to Crisis Counseling Programs and Services to Persons With Serious and Persistent Mental Illness

Tony Speier, Ph.D.

This document provides a brief guide for State and local mental health agency administrators and five detailed chapters for program planners and providers of direct services. The intent is not to suggest that persons with serious and persistent mental illness require separate disaster recovery programs, but that within the scope of such programs people with mental illness may require specialized strategies for accessing the services they need on the journey to recovery. Our goals are:

- to educate State and local mental health administrators, planners, and providers about the needs of individuals with serious and persistent mental illness who experience a disaster;
- to present practical suggestions for disaster preparedness, for structuring disaster response and programs that mobilize the strengths of survivors; and
- to summarize some of the broader issues regarding disaster mental health service delivery to people with mental illness.

This chapter produces an overview of the basic principles that underscore disaster recovery programs and the core principle of community support systems that form the basis for services to people with serious and persistent mental illness. A brief summary of the major points found in each chapter, includes a quick reference for the most likely audience for each of the chapters.

## Principles for Human Service Workers in Major Disasters

The foundation for much of the Federal and State response to disaster relief can be found in *The NIMH Training Manual for Human Service Workers in Major Disasters* (1978). This document acknowledges the presence of high risk groups who may require specialized crisis counseling services. Before discussing what distinguishes high-risk groups from the majority of disaster survivors, it is important to recognize the common needs expressed by almost all people who experience a disaster and the personal destruction it leaves behind.

## Common Needs and Reactions

1. Concern for basic survival.

2. Grief over loss of loved ones or loss of prized possessions.

3. Separation anxiety centered on self and also expressed as fear for safety of significant others.

4. Regressive behaviors, e.g., reappearance of thumbsucking among children.

5. Relocation and isolation anxieties.

6. Need to express feelings about experiences during the disaster.

7. Need to feel one is a part of the community and its rehabilitation efforts.

8. Altruism and desire to help others.

Crisis counseling programs are designed to respond to these needs and reactions. Survivors are assisted through services that are typically developed around four key concepts: (1) the target population is primarily normal; (2) mental health labels must be avoided; (3) help must be offered in innovative ways; and (4) the program must be appropriate for the community. The most successful crisis programs address the common needs of survivors, use indigenous outreach workers and volunteers, and respond to the socio-demographic and cultural diversity of affected communities. These kinds of programs help those with special needs or increased vulnerability to environmental stressors maintain their pre-disaster level of social and functional well being.

With respect to people with serious and persistent mental illness, the underlying philosophy of most treatment and program intervention in the 1990's emphasizes wellness and similarities between people with psychiatric disabilities and the general population. The background for this approach is the Community Support Program (CSP), which was established by the National Institute of Mental Health in 1978. Simply stated, the CSP philosophy and subsequent program initiatives emphasize the concepts of inclusion, wellness, and natural supports while deemphasizing segregated service systems, illness, and artificial social support systems. Anyone familiar with disaster counseling and CSP programs will recognize the similarities in philosophy and services emphasized both programs emphasize.

Consistent with this philosophy is the belief that people with serious and persistent mental illness are viewed as "people first", whose needs and responses are typical of all human beings. In the unnatural situation brought on by a disaster, these people will have the same basic feelings and will react in much like the rest of the population. Some will experience despair and shock; others will respond by performing heroic deeds. An individual's mental illness does not preclude mentally healthy responses and adaptive coping skills. However, in some instances the impact of one's mental illness or its related symptoms may present a special challenge.

An example from the Louisiana Hurricane Andrew Regular Services Program (Speier and Balson, 1994) illustrates the special challenge to some individuals. From a sample of 1,005

persons with severe and persistent mental illness, 47 percent required assistance after the storm. A total of 45 percent of these people still needed assistance 9 months later. In relationship to their expressed needs, only 19 percent, or 191 of the 1,005, had actually received assistance from FEMA and 8.5 percent, or 88 persons, had received assistance from the American Red Cross. From the perspective of the Louisiana program, the types of requests and assistance provided were not necessarily different from those received or provided by outreach workers from the estimated 5,000 non-mental health clients who sought assistance. The unique aspect of this experience was the large number of people with mental illness who had legitimate storm-related needs that were not identified during the recovery phase.

People with long-term mental illnesses often are psychologically vulnerable to rapid, unplanned changes in their environment and have difficulty assimilating new environmental contingencies into their life space. As a result, these individuals may be reluctant to seek help or do not have the organizational skills necessary to access services from FEMA or other Federal agencies.

The unique quality of providing disaster relief services to persons with *psychiatric disabilities* is often simply a matter of determining how outreach programs can be successful in engaging these individuals. While the crucial feature is often to help disaster victims access services, it also becomes the responsibility of outreach teams to recognize the perceptual set, value system, and lifestyle of each individual they are trying to engage in services.

People with mental illness have the same basic needs as the general population. However, the stress associated with the impact of the disaster and its aftermath may result in stress reactions that should not automatically be attributed to an exacerbation of mental illness. The unique features of addressing the disaster-related needs of mental health consumers have to do with the service engagement process. They include a competent understanding and awareness of how these individuals perceive the services being offered, and how aspects of one's mental illness may make some individuals reluctant to seek help. The programs and activities discussed in the sections that follow illustrate how helping systems can be mobilized and how people, including those with serious mental illness, recover from stressful disaster related experiences. Emphasis is placed on preplanning activities for organizing and mobilizing resources, and recognizing the strengths people with psychiatric disabilities need in the disaster recovery process.

## Chapter Summaries

These summaries offer a quick reference to the information in chapters that follow.

## Chapter 2: State Mental Health Authority (SMHA)

***Disaster Principles***

*This chapter gives State mental health program directors an overview of the role of the public mental health system in disaster response operations, with special emphasis on preplanning activities essential to mobilizing agency resources.*

State and local mental health program agencies typically function along parallel lines of authority and responsibility. Emergency situations require rapid and integrated agency responses.

SMHAs must plan and organize their disaster response operations before the disaster. Administrative policy development occurring concurrently with direct service responses are ill-advised and often confuseCrather than simplifyCthe response effort.

Disaster response planning requires the SMHA to understand the structure of State government, the mission and function of social and human agencies, and the responsibilities of local governments.

State emergency operations plans and the mental health response should be organizationally integrated, and direct responses must be well coordinated. The SMHA must assist responders and survivors during all phases of the disaster event and its aftermath.

The rapidly evolving nature of disaster events require a flexible mental health response. Quick implementation of preplanned administrative procedures assures availability of crisis counselors and crisis counseling services.

## Chapter 3: Local Mental Health Authorities

*Local mental health authorities, whose missions include providing services and resources to people with serious and persistent mental illnesses and providing mental health assistance to survivors and disaster, will find this chapter useful in assuring that the special needs of those with mental illness are met after a major disaster.*

People with mental illness have the same basic needs as the general population following a major disasterCsafety, shelter, food, social supportCbut they may have other special needs.

Programs designed to meet these special needs should not be anymore stigmatized than programs for other special populations, such as children, the frail elderly, or people with special language or cultural needs.

People with mental illness have the same capacity to "rise to the occasion" and perform heroically in the aftermath of a disaster as the general population. Many demonstrate an increased ability to handle this stress without decompensation from their primary illness.

Though the local mental health authority is responsible for reestablishing general mental health services to this population, it is also important to provide special disaster services and interventions for those with special needs, either through crisis counseling services for the general population or those specifically provided at mental health service sites.

Disaster mental health training should be provided to therapists, case managers, and care coordinators as well as to consumers, families, board-and-care home operators, single-room-occupancy hotel managers and consumers who operate satellite housing programs. Preparedness training should be provided to consumers.

Recognition should be given to staff members who continue to provide routine clinical services to people with mental illness as well as to those staff who provide disaster response services.

## Chapter 4: Community Mental Health Centers

*This chapter will help CMHC managers, program directors, clinical staff, and consumers prepare for, and recover from, a disaster experience*.

Making disaster planning as a part of an ongoing psychiatric rehabilitation program is a way to educate staff and consumers about preparedness, response, and recovery. Consumers can develop the curriculum and train their peers.

Staff must address disaster-related needs of consumers, provide opportunities for group work to share experiences and resolve the painful aspects of the experience, and provide opportunities for consumers to serve the larger community in its recovery.

## Chapter 5: Crisis Counseling Program

*This chapter is written for those who design, administer, or work in crisis counseling programs. It describes the crisis counseling programs funded by FEMA and monitored by CMHS. It also addresses how these programs may, within the scope of their intent, respond to the needs of this population*.

Establish predisaster plans, agreements, and relationships among State Mental Health Authority, local mental health provider agencies, State emergency management agencies, and FEMA will help ensure rapid, effective disaster mental health response and timely implementation of the Crisis Counseling Program.

***Disaster Principles***

CMHS staff may be contacted for help with developing the Crisis Counseling Program and negotiating the bureaucratic maze of State and Federal agencies. States that have recently implemented successful Crisis Counseling Program also can be consulted.

The disaster mental health needs of people with mental illness will be similar to those of the general population; it must be assumed that these needs cannot be met by traditional mental health and psychiatric programs.

The service concepts of "the three A's"Cavailability, accessibility, and acceptabilityCshould be incorporated into all crisis counseling services. Adjustments may need to be made for survivors with mental illness.

The Crisis Counseling Program function should be broadly applied. It must provide direct services for survivors; training and consultation for disaster workers, CMHC staff, and other providers of services; and crisis counseling and support with CMHC and other staff who are also disaster survivors.

## Chapter 6: Psychosocial Rehabilitation Programs and Consumer Empowerment

*This chapter is for providers of mental health services, consumers of those services, and their family members. It outlines the experiences of members of Fellowship House, a clubhouse program that experienced Hurricane Andrew.*

Developing and maintaining a community support network is vital to the ability to access needed resources during a disaster. Using social group work as a methodology prepares consumers and staff for the teamwork needed to weather an emergency. The sense of community and ownership of the clubhouse by consumers and staff plays a major role in recovery from a disaster.

Involving consumers in preparing for and recovering from a disaster provides needed human resources and makes good rehabilitative sense. Principles of psychiatric rehabilitation are as effective in a disaster as in normal times.

# CHAPTER 2

## The State Mental Health Authority's Role in Disaster Response Operations

**Tony Speier, Ph.D.**

The State Mental Health Authority (SMHA) plays a pivotal role in the State disaster relief operations. Successful disaster response activities require comprehensive knowledge of the State's administrative infrastructure and emergency operations plan. The mental health emergency operations plan should identify the necessary administrative and clinical activities and resources that can be mobilized rapidly in the face of a disaster. Emphasis is placed on establishing formal and informal communication networks between the various State agencies and providers who will be involved in disaster response activities. The SMHAS's experience in Louisiana ia an example of one State's response.

Disaster response presents a unique and seemingly overwhelming challenge for State bureaucracies. State systems are highly structured and function through many agencies working in parallel relationships. The logic or tradition that supports this way of functioning is directly related to State budgeting procedures and the need for unambiguous lines of authority and responsibility. As a result, agencies function within the scope of their legislative mandate and are very careful not to intrude into the "bureaucratic space" of their sister agencies. This method of functioning is appropriate in the routine and deliberate role of government and the majority of the population is usually well served.

Disasters, however, are not routine or deliberate. They are exceptional, chaotic, unpredictable, and immediate. The necessary response by State systems must focus on the nature of the event rather than the nature of the State system. Indeed, emergency services require rapid, integrated, flexible, collegial, and collaborative responses.

Obviously, there is potential for the State response to be a disaster itself. This can be avoided through some simple pre-disaster planning steps that are both deliberate and routine. The trick is to use what government does bestCbeing routine and deliberateCto provide the framework for the organizational response before the disaster. That way, the observable response during the various phases of the disaster is immediate, flexible, and spontaneous.

To be successful at disaster response planning, one must become familiar with (1) the existing structure of State government, (2) the mission and function of social and health-related human service agencies, and (3) local government emergency operation responsibilities. By reviewing both the organizational structure and service functions, one can gain a perspective of the relationships among government agencies and their integrated functional capacity of government

that will result in the comprehensive response crucial to all stages of disaster planning, response, and recovery.

## Pre-Disaster Planning: Understanding the Interorganizational Landscape

As with any endeavor, it is important to become familiar with the terms, acronyms, and roles of various agencies charged with disaster response duties. At the Federal level, the organizations with which SMHAs most often interface are the Emergency Services and Disaster Relief Branch, Center for Mental Health Services (ESDRB/CMHS), and the Federal Emergency Management Agency (FEMA). Except in the awarding of Regular Services Crisis Counseling grants, CMHS provides programmatic consultation and technical guidance to the SMHAs in all aspects of disaster planning, response, and service delivery. FEMA is the funding agency for crisis counseling services through its Individual Assistance Program (IAP). In addition to FEMA, at least 16 other Federal agencies have supportive roles in the Federal response to disaster recovery. Fortunately, the SMHAs role only requires routine interface with FEMA and CMHS. (Contact ESDRB/CMHS agency staff for up-to-date reporting relationships.)

While it is essential for the SMHA to understand the State/Federal interface, it also is important to understand the State's Emergency Operations Plans (EOP) and the roles of the various State agencies as designated in the EOP. The EOP should be considered a primary reference document in pre-disaster planning activities. This document identifies the statutory authority for emergency operations and the primary and support responsibilities of the various agencies. The responsibilities of all agencies involved are spelled out in this document. The EOP usually is designated by the Governor as binding on local governments, which are authorized to conduct emergency management operations, and on all State departments and agencies. Most likely, this is the document that identifies the primary and support role of the SMHA in any State emergency or disaster operation. It is within the context of the activities identified within the EOP that the integrated roles of agencies necessary for emergency response to a disaster can be ascertained. Activities routinely addressed in EOPs include:

- communications and warning
- emergency direction and control
- energy
- information management
- mass feeding
- public information
- search and rescue
- traffic control and evacuation routes
- damage assessment
- donated goods

- fire fighting
- law enforcement

- medical sanitation
- public works and engineering
- shelter operations control
- transportation

Whenever a state of emergency is declared, either as a true event or as a training exercise, the State's director of emergency preparedness may require State agency participation at the Emergency Operations Center (EOC). The EOC operates 24 hours a day and is equipped and staffed to provide support in coordinating and guiding emergency disaster operations. The SMHA plays two vital roles in EOC: (1) as support staff assigned to the EOC, and (2) as a primary service delivery agency or as support to other primary agencies responding to the emergency.

All formal and informal agency networking and coordination is initiated in the EOC during the early response stages of an emergency. This early involvement by the SMHA establishes crucial relationships that are invaluable during the later response stages as programming for the Immediate and Regular Services Crisis Counseling grants is developed.

Beyond SMHA participation at the EOC, the mental health authority should have established a mental health agency disaster response plan that identifies its 24-hour response capability. This mental health plan should be integrated with the broader State emergency response. The SMHA should test its plan by participating in exercises of the State's Emergency Operations Plan and by conducting training of local and State agency staff essential to implementation of the mental health emergency response.

Through participation in the State's emergency training operations, SMHA personnel can establish a communication network that involves a conceptual understanding of "official" roles and a personal appreciation of each individual who carries the various organizational responsibilities. These personal relationships are likely to allow the staff of the SMHA to successfully move the wheels of the bureaucracy at a rapid pace when the real emergency demands such a response.

With relationships between agencies established and "on maintenance," SMHAs need to focus on how to mobilize direct service providers quickly into organized and effective emergency response teams.

## Service Implementation: Planning for Organizational Support

***Disaster Principles***

Responding to a major disaster immediately places additional responsibilities on the SMHA. The SMHA must attempt to respond to the needs of the public and the responders as well as its own damage and loss. It must restore routine operations and services for its consumers as rapidly as possible while initiating services to the larger community. Consequently, the SMHA must also redirect the necessary counseling resources to respond to the emergency needs of its own staff and system as well as the needs of disaster survivors. This may even involve providing equipment and supplies for general public relief activities, which often are useful in improving the agency's public image and reducing stigma associated with mental illness. However, to address these various responsibilities, the SMHA's disaster response plan should identify and train immediate emergency response workforce teams that can be immediately deployed to the affected areas of the State. These teams should provide immediate services to survivors and responders at the disaster site(s) as well as any evacuation sits and shelters. Beyond this response, immediate response teams should be able to maintain disaster mental health operations and services until the Immediate Services Crisis Counseling program can begin. Typically, this requires 14 to 30 days of emergency response.

How can SMHA staff identify and administer an emergency workforce? For some States, this is not a difficult issue because the SMHA can mobilize a civil service workforce. This simplifies the organizational issues of who provides administrative line authority and who provides the financing and cash flow for the emergency personnel services as well as for resources such as rental cars, hotels, and car phones.

In States where the mental health workforce is largely comprised of nonprofit vendor or agency staff, the situation can be more complex. For States to avoid developing emergency procedures in the middle of a disaster event, planning and development of emergency agreementsCbetween nonprofit agencies and the SMHA and between the SMHA and the fiscal and executive branches of State governmentCcan address most issues before the disaster occurs. Through simple memoranda of agreement, the SMHA can make the necessary provisions to rapidly mobilize trained workers and necessary support resources. The internal agreements with the contracting and fiscal authorities in the State can assure that the necessary legal agreements are perfected so that financial resources can be deployed rapidly as well. By removing the organizational, administrative, and financial stress from the mental health service responder, the SMHA can concentrate on implementing emergency services that are responsive to the needs of those impacted by the disaster. Agreements between local mental health providers are often called mutual aid agreements.

While this seems like common sense, remember the first commandment of bureaucracies: "Never take anything for granted." Agreements worked out 6 months or a year in advance often become nonfunctional as personnel in the various agencies change. It is essential to participate as an agency in the State's emergency operations planning and training exercises, and it is equally important to practice the implementation of SMHAs emergency memoranda of

agreement with participating nonprofit agencies and the governmental agencies crucial to the contracting and financing of these emergency services. The keys to successful rapid service delivery at the onset of a major disaster or emergency are careful and deliberate bureaucratic planning and the routine exercise of these relationships and plans prior to a disaster event.

## The Louisiana Experience

Hurricane Andrew ravaged 39 of 64 Louisiana parishes (counties) on August 25, 1992. The State and the Louisiana Office of Mental Health were fortunate to benefit from early warning and preparation by the State of Florida. The massive devastation in Florida's Dade County removed any complacency about responding to storm warnings and evacuation orders.

The State's EOP was implemented well before the storm made landfall. People in the target areas were evacuated, and the resulting loss of life was minimal. Most fatalities were related to small tornadoes or isolated storm-related accidents. The SMHA responded by evacuating people with mental illness who were in residential facilities or hospitals in target areas. SMHA staff identified shelter locations, secured their own facilities, and contacted shelter sites before the hurricane hit land. Once the storm passed, State personnel responded through an existing 24-hour crisis response system for active CMHC clients. In addition, staff visited shelter sites and assisted American Red Cross (ARC) staff with routine response tasks and provided counseling and support to survivors as needed.

After the initial response and assessment of need, the OMH initiated a series of organizational responses. Within 24 hours of Hurricane Andrew making landfall, OMH field staff in the affected parishes had assessed site damages to CMHCs and other treatment locations and determined the need for immediate assistance to people located at shelter sites. Local staff and volunteers from surrounding communities comprised the cadre of crisis counselors during the first 72 hours of the post-hurricane response phase. Administrative statewide responses were limited for 4 to 6 days after the storm due to the complete shutdown of administrative offices impacted by power outages and storm damage. Within 14 days of the storm, SMHA had initiated full administrative support to the disaster relief effort. This administrative response included:

- identification of trained, assertive outreach case managers from unaffected areas of the State;

- administrative coordination of nonprofit social service agencies and SMHA field staff to administrative support to the newly established crisis outreach units;

- provision of training by FEMA, ARC, and SMHA regarding crisis counseling techniques, administrative relationships, and responsibilities of local, State, and Federal responding agencies;

- development of a culturally sensitive Immediate Services program and administrative distribution of funds within 7 working days of program implementation to private nonprofit agencies for counseling and outreach services;

- specialized outreach services to vulnerable population groups such as children, elderly, and people with psychiatric disabilities; and

- establishment of an interagency project oversight council with administrative authority to resolve administrative or programmatic barriers inhibiting the crisis counseling response.

Much of the success of the Louisiana crisis counseling response to Hurricane Andrew resulted from the willing spirit of administrative agencies and staff to cooperate and remain focused on solving the tasks at hand. Thanks to our collective experience with a disaster of this magnitude, Louisiana's public agencies, most notably the Office of Mental Health, have committed to emergency response planning and the maintenance of strong interagency relationships and agreements. The essence of disaster response services depends on the immediacy of the services that are implemented and their quality. The successful early-stage response following a disaster is highly predictive of the quality and success of the SMHA's long-term crisis counseling response to the event.

## Summary

- State program agencies typically function along parallel lines of authority and responsibility. Emergency situations require rapid and integrated agency response.

- State Mental Health Authorities must plan and organize their disaster response operations before the disaster. Administrative policy development occurring concurrently with direct service responses are ill-advised and often confuseCrather than simplifyCthe response effort.

- Disaster response planning requires the SMHA to have a working knowledge of the structure of State government, the mission and function of social and human service agencies, and the responsibilities of local governments.

***Disaster Principles***

- State emergency operations plans and the mental health response should be organizationally integrated and direct responses should be well coordinated. The SMHA must assist responders and survivors during and after the disaster.

- The rapidly evolving nature of disasters requires a flexible mental health response. Quick implementation of preplanned administrative procedures assures availability of crisis counselors and crisis counseling services.

# CHAPTER 3

## Local Mental Health Authority's Role in Disaster Services for People With Psychiatric Disabilities

### Competing Missions? or Have We Missed the Boat?

**Marye Thomas, M.D.**

Local mental health authorities (LMHAs) play a significant role in the provision of disaster mental health services to people with serious and persistent mental illness. Usually, they are the target population in the public mental health system for receipt of regular services. However, following major disasters where the system's focus is on survivors in the general population, special needs of other target populations must be clearly identified.

The task would seem relatively simple. Most local governments have primary responsibility for regularly providing services to people with mental illness and for providing mental health assistance to the general community in times of disaster. However, local governments do not always have responsibility for providing services to people with mental illness during disasters. The reasons have to do with:

- The seemingly competing missions of local government in the provision of mental health services to two different populations (one narrowly defined by diagnosis and disability, and the other broadly defined by virtue of having experienced the effects of a disaster);
- A misinterpretation of Federal guidelines regarding who is eligible for disaster mental health services;
- The failure to recognize and identify the unique needs of people with psychiatric disabilities in a disaster situation.

## Role of Local Mental Health Authorities: Competing Missions

Traditionally, the provision of mental health servicesCespecially services to people with psychiatric disabilities resulting from serious and persistent mental illnessChas been the responsibility of the State. How this responsibility is managed varies from State to State.

Some States continue to exercise that responsibility very directly through the provision of State-run clinical treatment programs. Others have opted out of direct service delivery in varying degrees and delegated this function to local government entities, such as counties, though in some instances cities have taken on this role. For example, in the State of California, the Department of Mental Health (DMH), part of the larger Department of Health Services, has overall responsibility for general policy, planning, and direction for mental health services. But its service delivery function is limited to operating a shrinking state hospital system. Most service delivery is designated, controlled, and delivered at the local level.

The responsibility for the organization and delivery of disaster response and recovery services generally parallels the organizational responsibility for nondisaster mental health services. Authority and responsibility for management of disaster-related services rests with the State and its Governor, who typically designates a lead agency and person with responsibility for coordinating and requesting Federal assistance. California has a Mental Health Disaster Coordinator at the State level within the Department of Mental Health. Her responsibility is to provide technical assistance and support to LMHAs before, during, and after a disaster. And although all applications for Immediate Response and Recovery grants are processed through her office, the actual provision of services is at the local level.

Disaster survivors are eligible for crisis counseling services if they are residents of the designated major disaster area or were located in the area at the time of the disaster. In addition, they must (1) have a mental health problem which was caused or aggravated by the disaster or its aftermath, or (2) they may benefit from preventive care techniques.

Instructions from FEMA/CMHS in providing crisis counseling and recovery services are quite specific: "The task is not to treat people with severe persistent mental illness directly, but to identify them, assess their needs, and help them receive professional or community support services through more regular channels."

While no one would suggest that schizophrenia or another major mental illness could be caused by an earthquake or other disaster, or that any amount of pre-disaster preparedness could prevent the onset of such illness, their instructions have led mental health systems to provide less than optimal post-disaster recovery services for people with mental illness.

## Failure to Recognize and Identify Special Needs of People with Mental Illness

In developing requests for federal funding assistance, LMHAs are told to focus on "high-risk" groups, such as children, the frail elderly, and the disadvantaged. They are cautioned about the inappropriateness of prolonged psychotherapy in this program. In an attempt to not further stigmatize our regular target population and fearing their ineligibility for services under Federal guidelines, many providers have failed to respond.

## One County's Experience with Disaster Response and Recovery

Alameda[1] is a county of 1.5 million people, 8 miles across the bay from San Francisco. The county encompasses many hundreds of square miles, 15 cities (including Berkeley and Oakland), sprawling suburbs, and sparsely populated agricultural areas. The wet season, which promotes lush vegetation growth, is followed by the dry season. This leads to extreme fire danger. It sits in "Earthquake County," at the intersection of many seismic faults, including the mighty San Andreas. The less well known Hayward Fault runs the length of Alameda County and bisects its most populous areas. It has been estimated that a major earthquakeCone of the magnitude of the Loma Prieta quake on the Hayward Fault, for example Cwould result in 80,000 people requiring hospital treatment. All 12 hospitals within the county are close to the Hayward Fault.

By virtue of topography and climate, Alameda County is subject to earthquakes and devastating fires. Both have occurred in the last 5 years: the Loma Prieta earthquake in 1989 and the East Bay Hills firestorm in 1991, which devastated almost 4,000 homes.

The mental health system in Alameda County regularly provides services, either directly with county employees or through contracts with other agencies, to more than 15,000 individuals annually. Declining funding in the past 15 years has forced the definition of who we serve to become narrowly focused. The county is able to firmly commit a range of essential services to a priority target population of people with serious and persistent mental illness who are most disabled by their illness.

The "system culture" of providing services to a targeted population (and denying them to others) is universally known by staff and the general community. The county mental health system provided immediate crisis response services and recovery programs for both the Loma Prieta earthquake and the East Bay Hills firestorm. Reaching out to embrace the larger community in both disasters presented challenges and opportunities for the system in performing our secondary mission, but also created "professional dissonance" (especially in the East Bay Hills Firestorm Recovery Program) for staff as they performed the primary mission.

Similarities and differences between the two disasters and the mental health responses to them are noteworthy. They have allowed the inference of certain principles with general applicability to local governments in the conduct of the two missions.

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[1]Alameda County is located in California where primary responsibility for the delivery of mental health services rests with the county. Though written from a county perspective, the issues are generic and applicable to any local public mental health authority.

## Preparedness or Pre-Disaster Planning

Both the Loma Prieta earthquake and East Bay Hills firestorm occurred without warning; the impacts were immediate and devastating. Because of the nature of the disasters that impact Alameda County, people tend to live on the edge of panic or exercise a sense of denial that verges on the bravado; neither attitude is helpful in pre-disaster planning. Much has been written about physical preparedness, from securing buildings and their contents to clearing brush in a predefined area to creating an emergency pack with essentials such as food, water, clothing, first-aid supplies, and regular medications, planning for reunification of families separated during a disaster; and determining alternate treatment sites for providing mental health services.

It is assumed that these physical preparations will be maintained in the future. Psychological preparedness is less concrete but its importance cannot be overstated. The psychological relief individuals experience from preparing physically for a disaster is palpable. People with psychiatric disabilities are no different in this respect. Alameda County experienced this immediately following the Loma Prieta earthquake.

The community was expecting aftershocks, and the media insisted that this was not the big oneCthat a bigger one was coming. Attempts to discuss recovery efforts and issues under these circumstances were almost impossible. Everyone (the general population and the mental health consumers and providers alike) preferred talking about preparedness, which:

1. helped relieve their immediate stress and anxiety;
2. prepared them emotionally for the aftershocks or possibly the "next one;"
3. helped them prepare physically for the next one; and
4. helped them experience a sense of control.

Any emotional or physical preparedness that occurred then may have fizzled over the next 4 years, replaced by the more immediate preoccupations of daily living.

In other disasters where warnings of any length are possible, the warning itself can be of major psychological benefit and allow for focused preparation. For instance, prior warning allows people to salvage important personal items, such as photo albums or a family heirloom.

The actual mechanics of preparedness and responding to warnings may be different for people with mental illness than for the general population. People with mental illness may need different levels of assistance, and special training for friends, family, and staff who know or live with our clients should be devised. The role of county mental health services through our disaster plan is to provide preparedness training for service providers who work most closely

with consumers of our services, such as operators of board-and-care homes, staff in halfway houses, SRO hotel managers, consumer-run programs, satellite houses, and consumers themselves.

## Impact or Response

In the Loma Prieta earthquake, the local population most impacted were poor, undereducated and ethnically diverse (often monolingual). Many resided in downtown single-room-occupancy hotels, which were destroyed; and many were our traditional target population of people with serious mental illness. Staff were impacted as was the general population, but personal losses by staff were relatively small. The East Bay Hills firestorm, on the other hand, impacted an upper-medium-income to upper-income population of suburban dwellers who were relatively well educated, often professional. There were relatively few people with preexisting serious mental illness. Many mental health staff were personally impacted by the loss of homes and personal possessions.

Most of the LMHA response services were directed toward disaster survivors in the general population. We did not specifically tailor disaster response or recovery services to people with serious mental illness, but rather, attempted to identify them and connect or reconnect them to the regular mental health delivery system. In retrospect, focused services would have been helpful. A number of consumers have said that their regular therapists wanted to continue "business as usual," focusing on their illness and not acknowledging the consumers' normal and understandable response to disaster. Some consumers attempted to join survivors groups, were said to be "disruptive and inappropriate" and were referred back to regular mental health services. Others experienced the earthquake as a "normalized community-shared trauma" and responded in much the same way to the disaster as the general population. In fact, many consumers offered to be part of disaster assistance teams.

The following examples of consumer involvement in disaster recovery illustrate that the resilient and self-reliant qualities of the human spirit are not necessarily diminished by mental illness.

- A 30-year-old man with manic-depressive illness came for his regular clinic appointment several days after the earthquake but seemed unusually disheveled and tired. When the therapist asked about his demeanor, the consumer indicated he had been managing one of the largest shelters in San Francisco. This individual was honored by the city and county of San Francisco along with other "heroes, and his self-esteem and sense of self-worth increased accordingly.

- A woman who received ongoing treatment for her serious mental illness volunteered at a shelter in Oakland and was made the manager on the second day.

> When the disaster coordinator met her at the shelter, she was somewhat in an agitated, overwhelmed state. She offered immediate debriefing services and was provided with additional support. When emotional decompensation seemed to pose a threat, she was provided counseling regarding setting limits for herself.

These experiences suggest that mental health disaster response and recovery services, while distinct from regular mental health treatment, could be focused at service sites where consumers receive ongoing services.

Although therapists are trained to work with people with serious mental illness, it should not be assumed that they are adept at providing disaster services. Training should be provided to assist them in distinguishing what are "normal disaster-related responses to what are manifestations of exacerbations of the preexisting illness.

Some consumers experience greater comfort if these special disaster recovery services are conducted by their "regular" therapist, case manager, or case coordinator. Others may prefer receiving these services outside the "regular" service milieu, recognizing that their emotional responses are quite normal in an abnormal situation.

## Other Lessons Learned

Staff viewed the addition of disaster-related services in both positive and negative ways. They experience "professional shock" or "dissonance" because resources and time are devoted to people who are not part of the usual priority target population. They see the work done in disasters as "glamorous," highly valued, high profile, and rewarded by the community and the system. In contrast, they feel that little recognition is given to those who continue the regular work of the mental health system while the disaster recovery work is proceeding.

A strategy for addressing these competing feelings is to provide training for staff members in how to focus on the disaster needs of people with serious mental illness as well as the survivor needs of the larger community. In addition, awards and recognition for exemplary service should be given to regular staff as well as to those who do disaster intervention.

## Summary

- People with mental illness have the same basic needs as the general population following a major disaster regarding safety, shelter, food, and social supports, although they may have special needs as well.

- Recognition of the special needs of this population and tailoring programs to meet these needs should not be any more stigmatized than meeting the unique needs of

other special populations, such as children, the frail elderly, or people with special language or cultural needs.

- People with mental illness have the same capacity to "rise to the occasion" and perform heroically in the aftermath of disaster as the general population. Many demonstrate an increased ability to handle this stress without decompensation from their primary illness.

- Though a mental health system has as its primary responsibility the reestablishment of regular mental health services to this population, it is important to offer and provide special disaster services and interventions for them as well as the general population.

- Disaster recovery training should be provided to therapists, case managers, and care coordinators to (1) provide disaster counseling services to people with mental illness, and (2) assist staff in distinguishing normal disaster responses in people with preexisting illness and exacerbations of their mental illness. Disaster recovery training should also be provided to others who give support to clients such as family members, board-and-care home operators, single-room-occupancy hotel managers, consumers who run programs, staff of satellite housing programs; and to consumers regarding preparation for what to do during impact, response, recovery, and peer counseling and support.

# CHAPTER 4

## Mental Health Disaster Services for Psychiatrically Disabled Individuals from the CMHC Perspective

**Nancy Carter, M.S.W.**

This chapter explores ways to educate staff and consumers about preparedness, response, and recovery from a disaster experience. Mental health consumers have the same needs as the larger community in coping with disaster. They can be the core group to develop training and plans for staff and consumers within a broad range of Community Mental Health Center (CMHC) programs. Consumers can assist with outreach and with other community recovery efforts. It is important to recognize the disaster-related needs of consumers as distinct from their ongoing mental health treatment needs to address their disaster-related needs appropriately.

## Introduction

A variety of structural and organizational relationships involve the delivery of community mental health services on the local level. These recommendations are intended for management and staff concerned with service delivery within the appropriate organizational units as defined by State and local authorities.

The initial challenge for any local provider of mental health services is to educate the staff and clientele about disaster preparedness. Preparedness includes:

- Vigilance about having essential supplies on hand in anticipation of a disaster;
- Knowledge about where to obtain food, water, and shelter and how to take self-protecting action during the warning, impact, and post-impact phases of disaster; and
- Information about where to go for necessities, services, and financial assistance.

Psychiatric rehabilitation and other mental health programs offer opportunities to educate staff and consumers about preparation, survival, and post-disaster services.

The assumption that people with mental illness are more vulnerable to the shock of a disaster is a common perception that must be challenged. People with serious and persistent mental illness

have the same range of needs and responses as the general population. They experience shock and emotional disequilibrium, and they perform heroic acts, as do other survivors and responders. Staff and consumers need the same crisis counseling services as the general population. Providers need to be able to recognize and treat the emotional responses of consumers to the disaster event as distinct from issues related to their mental illness.

A curriculum developed in collaboration with consumers that educates consumers and staff about emergency preparedness is needed. Topics discussed should include actions consumers and staff can take, what they are likely to experience during and immediately after different types of disasters, and resources available during recovery. Training can be adapted to different programs, depending on the consumers and the time available to cover the material, and this training can be conducted by consumers. Developing the curriculum is empowering and educates the consumers and staff, who often then become valuable contributors to response and recovery in an actual disaster.

## Program Definitions

The discussion of emergency preparedness planning and response that follows focuses on five primary mental health programs through which most of these individuals are served: (1) medication clinics; (2) clubhouse or other psychiatric rehabilitation programs; (3) supportive housing programs; (4) regular case management; and (5) Assertive Community Treatment (ACT) teams or Intensive Case Management (ICM) teams. Mental health disaster services encompass three phases: preparation, response, and recovery.

Below is a brief description of each of these mental health programs.

*Medication clinics*: Consumers are scheduled to be reviewed for the adjustment to medications at regular intervals (that is, every 30, 60, or 90 days). Scheduling and screening might be done in groups or individually. The program might include a combination of group and individual appointments. Opportunities to deliver disaster services arise when groups are scheduled or when consumers are waiting to see the provider.

*Clubhouse or other psychiatric rehabilitation programs*: Clubhouse and other rehabilitation services may be day, evening, or weekend programs. Club members usually come for 4 to 8 hours a day. In clubhouses, the program is organized into work units, and consumers operate those units, taking responsibility for the operation of the overall program with staff supporting and facilitating. Non-clubhouse programs vary in design from day treatment to consumer-run drop-in centers. Professional staff may have a more traditional and directive role or may function as consultants to consumer staff. The focus in all such programs is typically personal recovery and skill development, which include daily living skills, independent living skills, and employment.

*Residential programs*: Generally, these are for types of residential programsCgroup homes, group transitional housing, individual transitional housing, and supported independent living.

*Regular case management services*: The assignment of a group of consumers is delegated to a staff person who is responsible for assessing the consumers' needs for a range of services in the community, and assisting and advocating for consumers accessing these services. This brokering model is different from the assertive model.

*Assertive Community Treatment (ACT) teams or Intensive Case Management (ICM)teams*: These programs often have one case manager for a small group of consumers (10 to 15). Or, a team of case managers may work in tandem to address the needs of a shared group of consumers, with an average of 10 to 15 consumers per case manager. The ACT teams serve people who have a history of rejecting traditional treatment programs as well as those who are at high risk for psychiatric relapse.

Services in these programs are based on the principles of intensive engagement and respecting consumer preference for services being delivered in their natural environment. Most services are delivered in the consumer's residence, which may be a homeless shelter, a jail, or a spot under a bridge. If the consumer fails to keep an appointment, the case manager looks for him or her. Most staff time is spent working with people on issues such as money management, housing, family relationships, employment, medication compliance, and substance abuse treatment.

## Emergency Preparedness Curriculum Development

The most important CMHC disaster planning function is to educate staff and consumers who utilize the above services about emergency preparedness. Emergency preparedness curriculum development could be a project that clubhouse or rehabilitation program members could develop. This curriculum may be adapted to the types of programs defined earlier. Whether it is taught in units at medication clinics, as part of the activity/rehabilitation services provided at group care facilities or clubhouse/psychiatric programs, or delivered individually through regular case management or assertive community treatment/intensive case management programs, the curriculum would support restoration of consumer equilibrium and CMHC operations more quickly.

## Planning From the Consumer's Perspective

**Preparedness phase**: Planning for this phase might include teaching the differences between a forecast, a warning, and an alert, how these are issues, and what to do if any are issued. It would

include talking about the kind of food and water to have on hand, how to rotate food and water so that it is fresh, and where and how to store it. Information about survival supplies would include use-and proper storage of candles, matches, flashlights, batteries, simple cook stoves and firstaid kits. Planning might include locating area shelters for both consumers and staff, who might shelter at the same sites. Management of medications, including obtaining advance supplies and how to store medications if refrigeration is required, also would be appropriate. Information about what consumers could expect from staff and each other, and how to help one another prepare, could also be available.

**Impact phase**: Material on the impact phase would outline protective measures, which depend on the type of disaster. Instructions are different for earthquakes, tornadoes, floods, chemical spills, hurricanes, nuclear accidents, and fires. Which shelter to go to, depending on the type of disaster, may be an issue as well.

**Response phase**: The response phase would emphasize the chaos and lack of organization likely to be experienced during the first few days after the disaster. Possible reactions also might be discussed. Where consumers could go for food, water, shelter, and financial help would be reviewed, as well as how to locate program sites, fellow consumers, and staff. How consumers could help locate one another through outreach and help the community should be included, too.

**Recovery phase**: Material about the recovery phase would encompass the kind of assistance available through FEMA, Red Cross, Salvation Army, and other groups, and how to ask for or apply for this assistance. Knowing how to cope with the bureaucracy, the amount of time it might take for repairs, new housing, or financial assistance can help reduce later frustration by adjusting expectations.

## Planning From a Staff Perspective

**Preparedness phase**: Preparedness must include opportunities for staff to take care of themselves and their families in an impending disaster. This should be part of the consumer curriculum so consumers do not interpret staff actions as abandonment. Planning would include how staff scheduling would be managed to permit this kind of preparation. Staff proximity to specify emergency shelters should be assessed and consumer assignment to shelters should coincide with staff assignments, if at all possible. Joint assignment can foster continuity of care and a sense of community for everyone. While the education program that is recommended could tell consumers about the location of their area shelter, staff assignment would be administrative. Owners, operators, and staff of group residential facilities should be familiar with preparedness actions and shelter locations.

Planning could encompass a priority-based notification system for consumers, residential sites, and program components. Consumers with the greatest need for support or the largest residential and program components should be notified, visited, and moved to shelters first.

**Response phase**: Chaos and confusion are significant issues immediately following a disaster. During this time, the SMHA may be mobilizing crisis response teams to assist local providers. Local staff generally need to check on their homes and places of employment. The plan should include an expectation of when staff should try to report for work and where staff is needed most post-impact. A priority list could be based on successive work sites depending on work site damage.

Working from a plan of priority consumer contact based on need and vulnerability, nonlocal SMHA counselors could be paired with local staff to begin visiting group and transitional living sites. ACT and ICM team members could be assigned with local and nonlocal teams to locate their clientele.

The response phase should probably include some planning guidelines about when staff should move consumers to safer quarters. If consumers are coping well, they could be told where to go for mental health services and general assistance. Treatment team meetings should include assessment of how consumers are coping and a judgement of frequency and type of contact individuals may need.

Clubhouse or psychiatric program participants should be encouraged to report to regular program locations. Rehabilitation efforts might include assigning consumers to community-wide relief and recovery operations. Opportunities for debriefing, crisis counseling, and group discussion of experiences, needs, problems, and feelings should be a part of the response for consumers and staff. While joint consumer and staff groups can help disaster workers deal with some aspects of their experience, staff in their dual role of survivors and caregivers will need crisis counseling and debriefing services specifically directed to their needs. Medication clinics and group residential and psychiatric programs can also include group debriefing opportunities for staff and consumers as these programs return to operation.

Outreach for rural consumers and clients who have not reported for program servicing should begin within a week of the disaster event. Consumers who have reengaged in services could be helpful in locating peers and offering support and assistance to them.

Depending on the number of consumers and their family members, it could be feasible for FEMA to process applications at mental health service sites. If this is not practical, staff and consumers could be teamed as groups to make application to area Disaster Application Centers. With some advance planning, they could be given advance orientation about the process before reporting. It is assumed that staff also will be applicantsCa therapeutic normalizing process!

**Recovery phase:** Crisis counseling grantees are encouraged to develop a capacity to provide disaster-related crisis counseling services to consumers. Services can occur within the existing structure of the CMHC programs, through discussion groups during medication clinics, during clubhouse/psychiatric programs, and at residential sites. ACT and ICM consumers will be more difficult to reach because they tend not to participate in organized programs. Training mental health workers to counsel these consumers about their disaster experience is one approach; assigning crisis counselors to work with this target population is another.

In times of disaster, consumers share the primary concerns of the general populationChousing, replacing personal possessions, obtaining financial assistance, and processing the experience emotionally. Opportunities to address these as a part of disaster recovery, and not merely as an expression of their mental illness, is vital.

**Summary**

- Disaster planning as part of psychiatric rehabilitation programs, is a way to educate staff and consumers about preparedness, response, and recovery.

- Consumers can develop the curriculum and train their peers, affording the opportunity for staff and consumers to plan together for shelter and reunion after the event.

- Staff must address disaster-related needs of consumers as distinct from their mental health treatment needs. They must also provide opportunities for consumers to share their experiences and resolve their pain. Also, consumers need the chance to serve the larger community in its recovery.

# CHAPTER 5

## Crisis Counseling Services for Disaster Survivors With Mental Illness

Deborah J. DeWolf, Ph.D., M.S.P.H.

Crisis Counseling Programs are funded by the Federal Emergency Management Agency (FEMA). These programs provide disaster-related mental health services for survivors, including persons with serious and persistent mental illness, following declared disasters.

These kinds of programs are most successful when pre-disaster mental health planning has already taken place. Effective programs are culturally appropriate, and they incorporate innovative community outreach strategies, training and consultation for service providers, and specialized activities for at-risk populations. The needs of survivors with mental illness are best met through active coordination among disaster counselors and community mental health providers.

When the President declares a disaster, the affected State may apply to FEMA for funds to implement a Crisis Counseling Program for disaster survivors, Survivors with serious and persistent mental illness constitute one group that may need special attention. The purposes of the Crisis Counseling Program are:

- To provide short-term support services, including counseling, to disaster survivors and their families to relieve mental health problems caused or aggravated by a disaster or its aftermath;

- To address the special mental health needs of at-risk groups, including survivors with serious and persistent mental illness, in a culturally sensitive manner;

- To offer training to disaster workers, mental health professionals, and health care workers to help them provide mental health services to disaster survivors or to identify survivors who need mental health referrals; and

- To refer survivors to disaster relief agencies and assist them with accessing resources to help with recovery.

The Crisis Counseling Program has been developed in cooperation with FEMA and the Center for Mental Health Services (CMHS). The Crisis Counseling Program has two phases: immediate services (a 14- to 90-day program after disaster declaration) and regular services (a 9-

month program starting 3 to 5 months after declaration). A State may be awarded funds for approximately 1 year of services following the disaster declaration. (For more information, contact the Emergency Services and Disaster Relief Branch, CMHS, at 301-443-4735.)

The Crisis Counseling Program is meant to augment a State's existing mental health services. In States where services are comprehensive, adequately funded, and widely accepted, the Crisis Counseling Program is an adjunct. However, many State mental health systems are underfunded and over subscribed, and statewide disaster response plans for mental health have not been developed or have not yet been evaluated in many years.

Clinical field experience has shown that disaster survivors with mental illness function fairly well following a disaster if most essential services have not been interrupted. Both Austin (1992) and Black (1992) reported that following Hurricane Hugo, many people with significant mental illness were able to put aside their pre-disaster symptoms temporarily and function at a higher level. According to anecdotal reports from California following the Loma Prieta earthquake (1989) and from Florida following Hurricane Andrew (1992), survivors with mental illness became disaster relief volunteers and helped with food and water distribution and community cleanup. These experiences of successful coping and being a part of the helping team had far-reaching benefits, strengthening these survivors' sense of competence and capability.

Some survivors with mental illness may have achieved only a tenuous balance before the disaster. The added stress of the disaster disrupts this balance; for some, additional mental health support services, medications, or hospitalization may be necessary to regain stability. For others, psychological reactions and needs may parallel the extended physical and community recovery process. They may experience intense anxiety or depression in conjunction with seasonal events, such as the return of hurricane or flood seasons, or with triggering events such as moving back into a repaired residence or stormy weather. McFarlane (1986) found that following a natural disaster, some people with past psychiatric histories had recurrences of their previous conditions and were predisposed to post-traumatic stress disorders (PTSD).

People with mental illness who have disaster-related mental health needs can be loosely categorized. The following list describes common situations and mental health needs encountered by disaster field workers. The first two groups also pertain to the general population. The needs of the majority of survivors with mental illness will be the same as the large community's. These descriptions reflect the problems found in a minority of survivors with mental illness.

- Survivors for whom disaster-related stressors create a burden that exceeds their ability to cope. These stressors may include loss of a home or valued possessions, death or injury of a loved one, interruption of treatment or medications, disruption of daily routines or services, lack of housing, or

loss of a support system. (See case examples of "Mike" on p. 39 and "John" on p. 40.)

Survivors for whom the experience on nondisaster-related stressors accentuate disaster effects. These non-disaster-related stressors may include the death of a loved one, living in poverty, being assaulted or victimized, having health problems, or being homeless. (See case example of "Joan" on p. 40.)

- Survivors previously diagnosed with PTSD who suffer an exacerbation of their condition because the disaster triggered a reaction associated to prior psychological or physical trauma;

- Survivors with previously undiagnosed mental illnesses who are identified through disaster outreach (see case example of "Mary" on p. 39); and

- Survivors who cannot care for a family member with mental illness any longer because of the physical and emotional demands that the disaster imposes (see case example of "Mary" on p.39).

**Immediate Services Phase**

The amount of Crisis Counseling Program involvement for people with mental illness immediately after the disaster depends on four factors: the disaster's impact on mental health facilities and personnel; the State mental health system's level of disaster preparedness and ability to respond quickly to citizens; the State mental health department's ability to rapidly activate linkages with FEMA, CMHS, and State Emergency Management to obtain immediate services funding; and the availability of qualified mental health professionals and paraprofessionals to implement the Crisis Counseling Program.

The following questions should be addressed to assist with post-disaster mental health planning:

1. Where are disaster-affected individuals with mental illness located (for example, Red Cross shelters, homeless shelters, disaster-damaged structures or communities, or remote rural areas)?

2. Do they have access to necessary services, including psychiatric assessment and medications?

3. What services or resources are critical?

4. How has the disaster affected existing mental health facilities, psychiatric rehabilitation residential facilities, and personnel? And, if these facilities have been damaged, what is the projected length of time for repairs?

During the early disaster response, two types of services are most relevant: direct services for survivors with mental illness and their families, and training and consultation for disaster workers and other service providers to enhance sensitivity to the needs of people with mental illnesses. Disaster mental health planning should assure that mental health professionals are present, or at least available, at sites where disaster survivors, including those who have a mental illness, are likely to seek or receive services. These sites include disaster shelters, Red Cross Service Centers, and FEMA Disaster Application Centers (DACs).

## Shelters

Disaster response always involves coordination and communication among agencies with complementary and conflicting goals. Gaining access to a shelter where mental health services can be provided requires clear roles and responsibilities on the part of the agency overseeing the shelter and the agencies providing mental health services. Open and frequent communication must occur among the agency operating the shelter, the local community mental health system, and the mental health responders within the shelter (if they are separate). When a significant number of people with mental illness and substance dependence are living in a shelter, detox areas and onsite psychiatric quiet areas may be established. following the Loma Prieta earthquake in California, CMHC workers and detox Center staff were onsite soon after the shelter opened at the Moscone Center in San Francisco. The shelter "clinic" was staffed by appropriate mental health personnel with on-call capability. In disasters affecting urban areas, homeless people with mental illness who were not directly affected by the disaster often come to disaster shelters and remain until alternate housing is made available or until they are forced to leave. Myers (1994) provides an excellent overview of mental health issues in disaster shelters.

Mental health providers in a shelter should:

- Wear clear identification;
- Begin and maintain contact with individuals with mental illness in the shelter, and help them connect or reconnect with known mental health services, providers, and resources;
- Identify any individuals with mental illness who cannot manage the chaos of the shelter or who are disruptive to other residents, and find other places for them to stay;

- Set up a charting and reporting system for people receiving psychiatric evaluations, medications, or intensive interventions; and

- Provide training and consultation to shelter staff about working with people with mental illness who live in the shelter.

Mental health workers in shelters will get the best sense of how people are coping by circulating around the shelter and informally touching base with residents. Typically, residents will not seek counseling at a table labeled "Mental Health," but they are receptive to informal supportive contact initiated by workers. Mental health workers often assist with organizing the shelter, making sure there are areas for children's activities and quiet areas for those who want to rest.

## Red Cross Service Centers and FEMA Disaster Application Centers

Red Cross Service Centers and FEMA Disaster Application Centers may be located together. Questionnaires and procedures for applying for disaster assistance may seem threatening or overwhelming to survivors with mental illness. Those with limited reading and writing skills may need help understanding and completing forms. Some may be unwilling or unable to provide the necessary information to get relief assistance. Others may have experience getting government aid and may be aggressively demanding, hostile, or intimidating to disaster workers. Mental health professionals can help by explaining procedures and services and intervening in difficult situations. When Hurricane Andrew ravaged Louisiana, for example, Red Cross mental health volunteers initially staffed the service centers and DACs. As the Louisiana Immediate Services Program (ISP) got underway, the ISP staff initiated and maintained contact with the Red Cross mental health team for an effective handoff of information and clients as the Red Cross operations closed down.

Myers (1994) suggests coordinating with the DAC registrar, who has contact with each individual as they come into the DAC. Disaster relief programs typically require a home visit to verify disaster damage and losses, so people with mental illness in need of psychiatric assistance may be identified through these home visits. It is essential that mental health providers coordinate and communicate with the agencies operating the centers as well as with the local community mental health system. They should establish an efficient system for referral.

## Training/Consultation

When a large number of people with mental illness are affected by a disaster, training for different provider groups can help make service delivery more effective. Examples of provider groups are emergency responders, Red Cross workers, FEMA workers, church volunteers, nonpsychiatrically trained health care providers, and community mental health providers. Training should be pragmatic, concrete, and immediately relevant to the group being trained and

to the nature of their contact with disaster survivors with mental illness. For example, FEMA DAC workers might receive training and a simple one-page handout on the signs and symptoms of disaster stress, what questions to ask, and resource and referral information.

Training also should be considered for health care providers and community mental health center personnel, because they often are unfamiliar with the psychological effects of major community disasters and the systems, procedures, and agencies involved in disaster recovery. Training might include an overview of psychiatric and community responses to disaster, phases of disaster recovery, common presenting problems of disaster victims, and resource and referral information for disaster relief programs.

In disasters that cause widespread damage or loss of life, staff of CMHCs and residential facilities also may have suffered losses and be engaged in their own psychological and physical recovery. Crisis Counseling Program staff may consult with administrators and encourage time off for employees to address personal recovery. They also may provide debriefing and supportive counseling for those workers. In South Carolina following Hurricane Hugo and in Florida following Hurricane Andrew, CMHC workers suffered considerable disaster damage to their homes and communities. Mutual aid agreements were reached to import mental health staff from other parts of the States.

**Post-Emergency Response**

When community disruption is extensive and recovery is prolonged, some survivors' psychiatric symptoms may worsen. Crisis counselors should anticipate and educate those who may receive requests for help from these survivors with mental illness or their families. In a rural area, survivors may seek services at a local health clinic or from a general practice physician. In Louisiana following Hurricane Andrew, crisis counselors who were on hand in each of the public health clinics in areas hardest hit by the hurricane received numerous referrals.

After the initial disaster response phase, when temporary living quarters are no longer available, disaster survivors will contact organizations that assist with housing. Isolated individuals with mental illness may be unaware of available disaster relief resources. Others who have received money for repair may be taken advantage of by unethical contractors.

**Regular Services**

At the outset of the Regular Services Program, it is useful to step back and review experiences and findings. This information will provide the basis for regrouping and modifying programs. The Regular Services Program is designed to address the disaster-related mental health needs identified through the Immediate Services Program. Typically, the Regular Services Program further develops and formalizes the structure established during the Immediate Services

Program. Additional mental health needs may emerge as the adrenalized activity of the early response phase gives way to the prolonged work of recovery.

The following questions are useful in assessing the needs of disaster survivors with mental illness:

1. What impact has the disaster had on individuals with mental illness?

2. What contact points or avenues have been most or least successful in reaching disaster survivors with mental illness?

3. Are there sectors of the population that have been missed by outreach activities thus far?

4. What critical milestones or events are anticipated that might impact survivors with mental illness (for example, financial determinations, trailers being recalled, or shelters being relocated)?

5. What related factors are relevant for program planning (for example, cultural or community needs or issues, substance abuse and dependence issues, or lack of housing)?

6. Which agencies, organizations, provider or consumer groups need to coordinate to best assist disaster survivors with mental illness?

Additional staff are hired and trained to implement the Regular Services Program. Successful programs involve diverse staff compositions that match the communities they are serving in terms of demographic characteristics and ethnic, racial, and cultural backgrounds. Bilingual disaster counselors serve survivors who do not speak English. Staff should be outgoing and respectful of differences, because much of the work involves initiating contact with survivors who may not view themselves as needing help. Also, staff need to function independently and responsibly, because outreach work usually is away from the central office.

A referral system between the Crisis Counseling Program and the community mental health centers must be established. When the Crisis Counseling Program is implemented as part of the community mental health system, guidelines for referring disaster victims who have a mental illness into the CMHC system must be clarified. Procedures should assure that services are provided efficiently. A mechanism for responding to an increase in referrals to CMHCs should be established.

***Disaster Principles***

When the Crisis Counseling Program is implemented through an agency that is not affiliated with the CMHC, communication between the CMHC and the Crisis Counseling Program must be established so referrals can be made easily. In some instances, it may be necessary to overcome a history of competition for mental health dollars or territorial conflicts to achieve a good working relationship.

Determining which needs are disaster-related and which needs reflect pre-disaster social problems is a challenge often encountered by Crisis Counseling Programs. Outreach workers attempting to get resources for disaster survivors often are faced with a lack of housing which may be made worse by the disaster. Individual incomes often fall short of covering the most basic living expenses. Even when housing is found, often there is no money for household items or furniture. It can be difficult to focus on "disaster counseling" when a person lives in a dangerous or unsafe neighborhood in a structure that poses a public health hazard. Under these circumstances, crisis counselors may be frustrated by the pervasive social problems faced by the disaster survivors and the limited services that are covered by FEMA funding guidelines. Some Crisis Counseling Programs have incorporated community organizing to increase community awareness of and responsiveness to local social problems as a way to address these issues.

The Crisis Counseling Program must respond specifically and sensitively to the various cultural groups affected by the disaster. Crisis counselors must appreciate the cultural differences that exist regarding mental illness and asking for help, the role of healers, the role and responsibility of family members, rituals surrounding death, grief regarding the loss of home and possessions, and the cultural meaning associated with disaster. It is important to involve trusted cultural community leaders and mental health care and medical health care providers who are members of the community being served. For example, farm families were significantly affect by the great Midwest floods of 1993. Crisis Counseling Programs worked closely with Extension Services and Farm Advocacy Programs to better reach and help farmers and their families. These collaborative efforts can be invaluable in gaining acceptance and providing relevant services.

Crisis Counseling Programs provide a range of problem-focused services to disaster survivors. In addition, each survivor needs to tell his or her story, often many times. Crisis counselors aid the healing process by spending much of their time listening compassionately. Because of the high numbers of people affected by a disaster, contacts are typically brief. Often, disaster survivors do not directly seek crisis counseling services, so crisis counselors must rely on innovative outreach strategies. The following section focuses on four types of crisis counseling services: (1) community outreach and casefinding; (2) crisis intervention and problem-solving; (3) brief supportive counseling; and (4) liaison or case management and advocacy.

**Community Outreach and Casefinding**

***Disaster Principles***

Aggressive outreach in the disaster-affected community usually is a primary component of Crisis Counseling Programs. Crisis counselors may attend community gatherings, set up booths at county fairs, or give presentations at church events in an effort to reach disaster survivors with mental health needs. Frequently, paraprofessional workers are involved in door-to-door outreach activities. These "peer counselors" need adequate training to identify disaster survivors who need psychiatric assessment. Meeting with disaster survivors in their homes gives outreach workers an opportunity to also meet with homebound family members. Occasionally, people with undiagnosed mental illness are identified this way.

**Case Example:** An outreach worker contacted a family consisting of a mother, her 23-year-old daughter Mary, and Mary's four children. The mother's home had been seriously damaged 4 months earlier in a tornado. The mother told the worker that Mary had returned home after the tornado because her boyfriend had beaten her and thrown her out. She expressed concern that Mary would occasionally disappear for days at a time. She didn't wash or groom herself, she heard voices, and she made inappropriate sexual comments that "got her in trouble with men". When the outreach worker took Mary out for a sandwich, Mary tore apart her sandwich and ate through the center of the bread, taking the remainder home to feed her children. The outreach worker referred Mary to the local inpatient psychiatric hospital. She was admitted the following day and remained for 3 weeks. She was diagnosed with schizophrenia and became stable with treatment and medication. This was the first time she had received mental health services. The outreach worker maintained contact with the family, helped them find resources for repairing and replacing destroyed household items, and located a supportive summer camp program for the children. Mary trusted the outreach worker and responded well to her encouragement to stick with treatment. The outreach worker worked closely with Mary's case manager.

**Crisis Intervention and Problem-Solving**

Suicidal ideation or attempts, problem drinking, drug abuse, domestic disputes, and violence may occur in the aftermath of a disaster, especially when people are vulnerable due to preexisting psychiatric illness or stressful life experiences. Crisis Counseling Programs must be able to respond to these acute needs and usually work closely with the local CMHC Emergency Services Program. During the recovery process form an acute episode, crisis counselors may be involved in disaster-related case management activities.

**Case Example:** Mike had been diagnosed with depression with psychotic features and had a history of attempting suicide and using alcohol when depressed. During a flood, 5 feet of water flooded his home, ruining all his possessions. During the 2 months that he lived in a motel following the flood, he became increasingly depressed and began to drink heavily. He began to act out when intoxicated and was involuntarily committed. He agreed to go into detox. Shortly after arriving at the detox facility, Mike suffered a grand mal seizure. He fell, striking his head on some cement stairs so forcefully that he was hospitalized and unable to speak for several days. The crisis counselor/case manager arranged for Mike to go to residential alcoholism

treatment, and later arranged for him to rent a permanent bed at the crisis respite house in his community. His mental illness stabilized, and he maintained abstinence from alcohol so that he could successfully participate in the residential program. His crisis counselor/case manager met with him weekly for support

**Brief Supportive Counseling**

Crisis counselors must be prepared to deal with disaster survivors who are feeling overwhelmed by physical recovery demands. Survivors also may have recurrent anxiety associated with reminders of the disaster or experience pervasive depression due to loss of home or cherished possessions. In many cases, several focused sessions that address specific problems may help the survivors. In some cases, the supportive contact fostered by visits regarding resources to meet physical need indirectly provides emotional support.

**Case Example:** John, who was a longtime consumer at the local community mental health center, had been diagnosed with chronic paranoid schizophrenia. When his family evacuated prior to the hurricane, his anxiety and paranoia prevented him from leaving his home. He was afraid to abandon his home and be with a lot of people. Alone in his home during the hurricane, he spent the next 5 days isolated in the house without electricity, water, or contact with his family. Downed powerlines and trees prevented his family from returning home.

His CMHC counselor referred him to the Crisis Counseling Program 10 months after the hurricane because he continued to have nightmares, was extremely anxious during storms, and would panic and turn off the television when there were reports from any disasters in other parts of the country. He would not leave his home if there was a chance of bad weather. The crisis counselor initially focused on "debriefing" John's disaster experience and then gradually worked to desensitize him to weather conditions. The counselor assisted the family in developing a workable disaster evacuation plan.

**Liaison, Case Management, and Advocacy**

Crisis counselors educate consumers about accessing services and then empower them to make the necessary contacts. Along with outreach workers, crisis counselors often help disaster survivors get assistance from many resources. With persistent and conscientious resource finding, clients can be connected with a range of necessary community services, such as applying for additional assistance from the Red Cross, writing an appeal to FEMA, seeking specific help from a local religious organization, and getting meals from a Meals on Wheels program. They may also need help accessing health care services, obtaining help for rebuilding, getting transportation, and obtaining clothing from community organizations.

**Case Example:** Joan, a 32-year-old women with recurrent major depression with psychotic features and episodic substance abuse, was hospitalized several days after an earthquake. Her

husband had died 4 months earlier, and her apartment was destroyed by the disaster. Joan's case manager contacted the Crisis Counseling Program for help in finding housing for Joan so she could be discharged from the hospital. She could not afford most rents on her income. The crisis counselor finally found an apartment, but Joan relapsed in the hospital and the apartment was lost. Finally, after 8 months in the hospital, Joan was discharged and moved into an empty apartment that she could afford. The crisis counselor helped Joan connect with numerous resources to help her furnish and establish herself in her new home. The counselor worked closely with Joan's case manager and helped her deal with the loss of her home, the death of her husband, and her fears about future earthquakes.

## Conclusion

Most disaster survivors with serious and persistent mental illness cope fairly well during the immediate aftermath of a disaster. If necessary services have not been interrupted, adjustment problems parallel those in the general population. Crisis Counseling Programs must address the needs of survivors with mental illness and develop effective, culturally appropriate ways to provide services. When a disaster occurs in an area with inadequate health care, inadequate housing, and poor public safety enforcement, crisis counselors are challenged to focus on disaster-related needs while not taking on the community's pre-disaster conditions. Crisis Counseling Programs may become a part of "Unmet Needs Committees" or "Disaster Assistance Councils," where representatives from a range of community resources agencies come together to address individual and community needs. A collaborative and cooperative working relationship is essential between the Crisis Counseling Program and the community mental health service providers for survivors with mental illness.

## Summary

- Establish pre-disaster plans, agreements, and relationships among State Mental Health Authorities, local mental health provider agencies, State emergency management agencies, and FEMA for rapid, effective disaster mental health response and timely implementation of the Crisis Counseling Program.

- Assume the disaster mental health needs of people with mental illness will be similar to those of the general population and that these needs will not be met by existing CMHC and residential services.

- Incorporate the service concepts of "the three A's"Cavailability, accessibility, and acceptabilityCfor all crisis counseling services and make adjustments, when necessary, for survivors with mental illness.

***Disaster Principles***

- Consider the Crisis Counseling Program function as a broad one: direct services for survivors; training and consultation for disaster workers, CMHC staff, and other providers of services; and crisis counseling and support for CMHC and other staff who also are disaster survivors.

# CHAPTER 6

## Disaster Response in a Psychosocial Rehabilitation Program©
## A Hurricane Tolerance Test of Structure, Philosophy, and Methodology

**Marshall Rubin, A.C.S.W., C.I.S.W.**

This chapter examines how the consumers and staff of a psychosocial rehabilitation (PSR) program, specifically one operating from a clubhouse philosophy, can prepare for and cope with the aftermath of a disaster. The chapter is organized around the principles and guidelines of psychosocial rehabilitation and based on the experience of Fellowship House and Hurricane Andrew in Miami, Florida.

Psychosocial rehabilitation programs for persons with mental illness provide experiences which improve ability to function in the community. The philosophy emphasizes common sense, practical needs, and usually includes vocational and personal adjustment services geared toward the prevention of unnecessary hospitalization. The psychosocial rehabilitation setting is purposefully informal to reduce the psychological distance between staff and members as active participants in program planning. Consumers are continually encouraged to assume productive citizenship roles both within the psychosocial rehabilitation facilities and in the broader community which is viewed as an integral part of the total psychosocial rehabilitation setting.[2]

The staff role, in its broadest sense, is to help consumers attain individual goals primarily in the context of and through membership and role assumption in a variety of groups. The groups range from the large, communal "town meeting' to the smaller work units, committees, and activity groups. These expectations also apply in group homes or apartments where consumers live. The staff role is to help the group focus on the affective domain, that is, how group members relate and the quality of the experience for each, and the task domain, which is the accomplishment of some kind of group purpose. Community integration is a critical element as well, in which staff and members are encouraged to participate actively in civic clubs and community businesses and organizations. These community groups can be instrumental in the recovery of staff and members.

Disaster planning is required by regulating agencies that are facility based, and requires safety and disaster plans only for each facility the agency controls. This facility-based focus of required disaster plans minimizes agency attention to those who do not live in agency-controlled

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[2]The definition of the International Association of Psychosocial Rehabilitation Services (IAPSRS).

residences. PSR agencies must realize that they could provide a large portion of both the structural and emotional support available to consumers and their families in times of disaster. A common response from families whose homes were damaged in Hurricane Andrew was, " I couldn't take care of rebuilding and caring for my son at the same time." This held true for those living in agency residences and those who just come for the vocational and social program. Families needed a respite.

Several points relate to disaster response by PSR agencies and providers:

**Common sense and practicality:** During a disaster, members have the same hierarchy of needs to be met as other people: the basicsCsafety, food, shelter; their emotional needs; and the care and repair of personal property.

**Prevention of unnecessary hospitalization:** The decision to hospitalize during a disaster must be based on how decompensated a person is and the principle of least restrictive settings. PSR providers must be very careful to allow members the opportunity to cope successfully with disasters. They should not react to overprotect prematurely based on perceptions of heightened community stress or projections of their own fears.

**Role assumption:** The dearth of relationships, social withdrawal, anhedonia, and resulting vulnerability to stress are negative or residual symptoms of schizophrenia that medication cannot control but PSR can alleviate. The nonclinical nature of the agency reduces the distance between staff and member; during a disaster, this allows for role assumption based on need, ability, and availability. A clubhouse is purposefully "understaffed" so that staff have to rely on members to get their work done. In working together to run the clubhouse, members develop relationships with staff, fellow members, and the agency. A sense of belonging results. This type of relationship building is the essence of the support system necessary during normal times as well as in disasters.

**Reliance upon support systems:** The focus on social, vocational, and residential servicesCthe nonclinical program offering of a clubhouseCencourages the development of the roles of friend, worker, and roommate as the outcomes of relationship building. Theses roles are the foundation of a support system that each of us relies on to carry us through difficult times and are normal and functional during a disaster. In addition, the broader community can relate to them and become involved in them as part of a support system.

**Agency Methodology**

According to a recent paper by Hans Falck, a professor of social work at Virginia Commonwealth University, "Social group work is a methodology of social work that is widely applicable for all those clients who wish to obtain help in improving the

qualities of their membership with others in their communities." Social group work methodology is used extensively by PSR agencies.

Improved quality of membership is the focus of work with members and the thrust of relationship building with the community. Staff should be encouraged and subsidized to join and participate with members in Kiwanis, Rotary, chambers of commerce, and other civic clubs. The board of directors should be chosen carefully to expand the network of relationships in the community. Business and civic leaders should be included on the board with social service health care workers who already are involved with the agency and committed to help through everyday work as colleagues. Business and civic leaders bring new or previously inaccessible resources and supports for members and the agency. A membership focus makes it natural for community groups to come to an agency's aid after a disaster.

Seven operating methods, fundamental to the psychosocial rehabilitation philosophy, are also essential in coping with disasters.

1. **Develop and maintain relationships:** The strong working relationship that develops between consumer and staff in the normal operation of a psychosocial rehabilitation program is crucial in disaster recovery. That same relationship with community groups also supports recovery. The common knowledge that exists among consumers, their families, and staff about each person's personal circumstances strengthens the mutual support that is needed in recovery. Excerpts from an interview with one consumer whose family moved north after Hurricane Andrew illustrate the importance of these relationships. When asked why he did not relocate with his family, the consumer said,

   I've been a member for 10 years....I went outside about 7:30 a.m. after trying to call Fellowship House. I then went to five other Fellowship House apartments to check on my friends....I finally got Fellowship House on the phone about 1:00 p.m. and then caught a ride on the van in...I helped take water and food to all the apartments...I got an award for my work...I felt it was important for me to help out here...I needed to be here to help...This place is like a second family. You don't walk out on family. If I'd go to live with my family, I'd be in their way. I can do the most good here. I work with friends, not associates or employees. If I survived Andrew, I could survive Emily. I'm needed here.

2. **Work from strengths:** The principle of focusing or building on strengths in the daily operation of a psychosocial program becomes even more valuable in disaster recovery. Success becomes a great motivator. Candace, a 35-year-old woman, is a good example. She preferred to live with her parents when she was not in the hospital during 20 years of recurrent mental illness. She entered our most highly structured residence when it became impossible for her to remain at home, about 2 years prior to Hurricane Andrew. Candace was prone to emotional outbursts, crying, and paranoid thinking. She also was fearful of others. She had good homemaking skills, however, and was gradually

encouraged to use those skill to gain attention. Hurricane Andrew hit her parents' home hard. She was very worried about them, but had been unable to contact them for 4 days; her case manager was also unable to locate them. On the day after the hurricane, food supplies included 90 hard-boiled eggs that had been prepared for a Sunday outing, which had been canceled. "Well, there is no sense in just worrying about my family", Candace said. "I know how to make egg salad." She proceeded to make egg salad sandwiches, which were delivered to other members in our apartment program. When her parents did come to visit her, she was involved in cooking and taking major responsibility for keeping up the clubhouse residence for the additional 30 members and staff who moved in.

For months after the hurricane, when Candace began to get emotionally upset, staff and members reminded her how she had risen to the occasion during the disaster. A smile would come across her face and she would beam and acknowledge her ability. She had new status as a capable person who had functioned as a true hero for her friends.

3. **Utilize and foster interdependence:** Interdependence, the relationship that bonds society together and upon which healthy relationships develop, is essential in the success of psychosocial rehabilitation programs. It becomes pivotal in disaster recovery. Rotary and IAPSRS provided financial aid to staff and members to assist with their recovery. At the same time, staff members helped distributed food through the Red Cross, volunteered at the mental health association, and held a blood drive at the clubhouse.

4. **Support people's attempts at growth:** Trying is most important and recognizing success, however small, and celebrating it is a basic philosophical tenet. In a disaster, this recognition is directed at people's efforts to survive, cope, and recover. Recognizing these efforts, whether they be simply showing up at the facility or involve heroic deeds, is very important.

   After Hurricane Andrew, many members could not get through to Fellowship House by telephone. But they were able to come to the agency within several days. Ted, for example, was known to Fellowship House for many years, but his involvement in the program was inconsistent and limited. From time to time, he helped out by reviewing the *Federal Register*. Ted showed up 3 days after the storm to ask if he could help with some *Federal Registers*. He was given public recognition at the town meeting for this, and he began to attend Fellowship House programs regularly. He then began to participate regularly in the clerical unit. When asked why he came in so soon after the storm and whether the storm had any effect on his improved attendance, he said, "I stayed home with my parents the first few days and began looking forward to company and someone else to talk to. I realized I had to get off my ass after nearly being killed."

Staff need to be recognized as well. Some may have suffered significant losses, yet feel the need to help. Others may feel guilty at not having suffered losses and want to compensate. Their needs for support, relief, time to deal with personal issues, and recognition for their contributions to recovery are critical.

5. **Normalize:** Psychosocial rehabilitation programs mirror normal expectations and requirements for living that exist in the larger community. Work, social activities, friendships, and daily living skills are all elements replicated in the program. Involvement through civic activities increases members' integration into the larger community and educates the community about the talents and abilities of members and the contributions they can make. Disasters are normalizing experiences! Everyone suffers losses, emotional and concrete. Staff support of members' involvement in their personal recovery, rehabilitation program, and community civic activities increases members' integration into large community and recovery. The clubhouse members, in turn, can help staff cover operations so staff have opportunities to address their personal recovery.

6. **Provide spectrum of opportunities for involvement:** An important element in the operation of psychosocial rehabilitation programs is the blurring of roles between staff and members. Both work in partnership to achieve mutually defined goals and assure the essential operations are carried out. This is accentuated in disaster. Roles become situational and staff and members take on new roles as they apply their talents and skills to unusual situation. After the hurricane, it was necessary to deliver food to members confined to their apartments. Van drivers were busy elsewhere so a social program staff person drive the van and a member pointed out where other members were living in the apartment complex. Members also delivered meals using their own cars. One member's apartment became a storage area for emergency supplies and he and his roommates took charge of distributing these in their apartment complex. They also cooked meals for members in that complex who could not cook.

7. **Interact with the larger community:** This key concept allows a PSR agency to receive from a give back to the community. It is an extension of the concept of interdependence, and its application allows rehabilitation to occur beyond the four walls of the agency. The day-to-day building of a sense of community, among those at the clubhouse and between the clubhouse and the wider community, occurs over time. Resources from the wider community are vital in the aftermath of a disaster. Some will be needed to support staff so they can regain effectiveness; other will be used solely by members; and still other will be used by both. Some of the social services and health resources are listed below.

   Outside mental health staff can provide counseling to members and staff as well as coverage in agency residential facilities. These mental health workers can run groups for

staff and process the trauma of the disaster and teach staff techniques to help members through the same process. While staff support of members' involvement in their personal recovery, rehabilitation program, and community through civic activities increases members' integration.

- Medical services are available for members and staff unable to reach their own physicians.

- Psychiatrists are on hand to evaluate members and prescribe medications as needed for those whose regular psychiatrists are unavailable.

- Employee Assistance Programs are just one of the outside resources that may be used to provide individual counseling for staff on a confidential basis.

- Agreements can be made with psychiatric hospitals and crisis centers to expedite care for members who need hospitalization.

Business and civic groups may also provide support in times of disaster. Members and staff may need emergency grants to cover expenses not covered by insurance. Such monies my be donated by business or civic groups with long standing relationships with the clubhouse or by professional associations. Fellowship House received such support from both Rotary International and IAPSRS. Staff had belonged to Rotary for years. Fellowship House members regularly attend lunch at a nearby Rotary Club and support Rotary fundraising projects. After the hurricane, Rotary International collected more than $500,000 to help hurricane victims with $1,000 donations to help cover expenses for uninsured persons. Because of our close relationship, approximately 50 members, families and staff were able to apply quickly through our Rotarian members and receive relief. IAPSRS also gathered monies from member agencies across the nation. Representatives of local mental health agencies formed a committee with consumers to decide who would receive these funds.

- Staff who do not have reserves to cover out-of-pocket expenses until insurance funds become available need emergency loans.

- Insurance counseling for and education about claims processing is useful to disaster survivors. At Fellowship House, a founding board member provided this help.

- It is important to arrange access to a pharmacy where members can get prescriptions filled quicklyCideally, during the warning period (if any) prior to a disaster. At Fellowship House, case managers worked with a local pharmacist to provide a 1 week supply of medications for members.

## What Would We Change?

What have we learned from experience that would better prepare members of our clubhouse for the future? What would be do differently? Perhaps it is still too early in the recovery process for objective reflection. Still, some suggestions may help in the future.

(1) Make specific plans with each member about where to go in case of a disaster and how to get there. Add this information to their Emergency Information Form along with their medication information and who to contact in an emergency.

(2) Assess all agency structures, including apartments, for how may additional members they could house temporarily during a disaster. Add folding cots and sleeper sofas, as appropriate, to accommodate additional temporary residents. Case managers should advocate for specific nonresidents and prioritize who wants and should get emergency spots.

(3) Inquire about plans for dealing with disasters when visiting boarding homes and members' apartments. If a plan does not exist, advocate for it.

(4) Help all members obtain a week's supply of medications. Make sure they have emergency basics, such as a flashlight, water, and access to a battery-powered radio.

(5) Involve members and families in reviewing and updating the agency disaster plan. Agencies should encourage their local Alliance for the Mentally Ill (AMI) affiliate to plan and present training sessions for families of members.

(6) Staff should evaluate and plan how to respond in a disaster. Have we prepared our homes adequately to maximize our energies for the members, or will we be running around at the last minute neglecting one or both? Survey staff to plan precisely who can be where in the event of a disaster. Take into consideration who has child care responsibilities and who can be available. Where and what will they be assigned? For those with child care responsibilities, can they plan effectively to maximize their availability?

(7) There should be a mental health system that recognizes that poverty and natural disaster are bedfellows. Those who do the worst in a disasterCpeople with mental illness and those withoutCare people who live in poverty conditions. People who have severe and persistent mental illness often live in a state of near disaster.

What can an agency do to change this? We can focus our resources on creating more housing opportunities and involving more people in our programs. The members who live in our

residences are further away from disaster than many other members. We also can expand our preparation efforts to those who live beyond our facilities.

**What Would We Change?**

Members who lived in residences operated by the program were better prepared than those living in boarding homes, their own apartments, or with family. Now case managers and group workers are responsible for making specific disaster plans with each member. This information is part of the member's Emergency Information Form and includes medication information and who to contact in an emergency.

Assessment of all agency structures, including apartments, has been done to determine how many people they could accommodate as emergency housing. Folding cots and sleeper sofas will become extra sleeping space in emergencies. Inquiring about and strongly encouraging emergency planning at group homes and with members in independent apartments has also begun.

Pre-disaster plans include helping members obtain a week's supply of medication and making sure they have emergency supplies like flashlights, water, access to battery-powered radios, etc. Also, reviewing and updating the agency's disaster plan includes staff, members', and families' participation. The Alliance for the Mentally Ill can help educate family members about planning needs.

We now recognize that staff and members respond to disasters with the adrenaline driven potential. The mutual trust and respect that characterized day-to-day operations becomes the foundation of shared recovery. As one member who lived in a boarding home in South Dade during the hurricane said, "I am so proud of myself now that I think about it. The water was coming in and windows blew in. I didn't lose my cool, but led my roommates into the closet with pillows that we all stood there holding over our heads through the storm....It was my idea."