

Mental Health Issues Related to Hurricane Katrina
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Behavioral health issues are involved in virtually all aspects of preparedness, response, and recovery. These issues are coming more and more to the forefront with our recent disasters, but it's something that's important, and something that CDC is beginning to focus more attention and resources on.

While no one who experiences a disaster is untouched by it, resilience in our responders is the norm. Rarely do we have individuals who are deployed who are experiencing a mission altering or behavioral endangering stress. We want to remind people that we see in the field, both among victims and among responders, normal reactions to abnormal situations. Mission success is directly tied to responder knowledge, skills, training, and resilience.

Preparedness improves recovery. Preparedness improves the probability of mission success, it decreases the cost of stress to staff members, and it also can facilitate an effective reintegration back to our day job on our personal life, which is part of what CDC is focusing on right now. It also minimizes the loss of productivity.

Our official reports as of yesterday indicated that 99 people were deployed to the field in response to Hurricane Katrina yesterday, 42 people are in the field relative to Hurricane Rita. These individuals are public health nurses, occupational health specialists, laboratorians, physicians, epidemiologists, sanitarians, environmental health professionals, individuals conducting disease surveillance, public information officers, and health risk communicators.

Recent Observations - *This is very preliminary information. It is not considered data at this point.*

Various mental health issues - Our teams in various locations are observing numerous mental health issues. We're seeing people who have had chronic mental health conditions that have been exacerbated by the storm, by the relocation, and by the separation from family members, familiar surroundings, control those kinds of things, as well as individuals who have had some mental health conditions that seem to be exacerbated by their current circumstances.

Unaccompanied Minors - You can imagine the traumatic impact that that has on parents who are unaware of where their children are, and, of course, those poor children, many of course are confused and unclear as to where their parents are, and even though I understand there are a lot of organizations trying to bring those family members back together, that is a challenge that is a significant source of stress.

Persons with Disabilities - There are individuals who need dialysis who have been separated from their pharmaceutical sources and supplies. Individuals with mobility problems, vision problems, hearing problems, even individuals who are non-native English speakers are encountering some problems, which can exacerbate the already stressful nature of being in a camp.

Socioeconomic Status - We also have preliminary reports of an over-representation of lower socioeconomic status and poorly educated individuals in the shelters that we have some information about so far. We are beginning to see some evidence of individuals coming out of Louisiana where there's a very strong culture, very strong communities, and quite a unique way of doing things, and we're

seeing children from these communities being absorbed in the new schools. That creates a challenge for them as they try and learn new behavior patterns, new social patterns, and for some maybe even some new vocabulary. But there are also some issues for the indigenous population as these new students come in and participate in athletic endeavors, try and become integrated in academics, and fit into the social hierarchies, that's not just stressful to the displaced persons, to the evacuees, but that's stressful to the individuals who are the new home base.

Communities - Certain communities may have a tendency to focus a little bit on the victim, as opposed to the host, and have not quite gotten the hang of taking an integrated community view at the school level. So the focus is still on these poor individuals, and they're not seeing it from a higher level, kind of a bigger picture. Many evacuees are kind of living on the edge, no surprise to anybody, they're on the margin, and they have huge concerns about where they're going to go, what's going to happen next, what happens when the vouchers run out. There are time limits on these things, there are dollar limits to aid that's being applied.

Indigent Issues - There may be a shift from schools and communities being primary points of concern, primary points of contact. As time goes on, we may see more indigent issues arising in these communities, which is a different approach from integrating into schools, and there is a possibility of an increased presence of police and judiciary intervention, public mental health concerns are likely to increase somewhat, and primary care providers may very well see an increase in individuals, not only with the physiological issues, but with psycho, social, and behavioral concerns as well. So the healthcare systems in these communities are likely to be impacted as well.

Evacuees and Abandonment - Some evacuees reported feeling unheard, feeling frustrated with the processes that can seem cumbersome or potentially sterile to them. Some feel abandoned. Technically some have been abandoned; certainly many have been separated from not only the individuals that they know, and have established relationships over the years, but also with familiar sites, sounds, processes, and systems that they've mastered in previous communities, previous neighborhoods, and their families of origin. Other individuals, of course, are viewing that differently, and they're viewing this as an opportunity to kind of have a new start.

Observations from San Antonio and Special Needs Populations - This population includes individuals with mental health concerns, medical problems, handicapped individuals, etc. In some of the larger evacuee facilities they could actually be triaged into special needs shelters. So that was something that we found very beneficial, saves time, reduced some anxieties. In some of the larger centers general medical service providers were the individuals who were diagnosing mental health issues, and were able to do referrals to crisis counselors, or mental health counselors. Of course, many families, as we mentioned previously, seem to be disrupted, and what some of our deployees are telling us is that frequently one parent would take the children prior to the storm's arrival, and would say, "I'm going to X location," but X location also wound up being affected, and the parent who stayed home looked after the home or the property isn't sure now where to look. So that lack of contact is generating some concerns.

Acute Stress - Acute stress can be due to the storm, due to the evacuation, bereavement issues, ambiguity, the uncertainty with which these individuals are faced on in not just a day to day, but in hour to hour basis. So symptoms of depression, anxiety, frustration, and confusion are not at all unusual, and are something that people in that area are dealing with. Some persons are also experiencing additional symptoms of acute stress of having flashbacks, or nightmares, having sleeping issues, still feeling quite a bit traumatized by their experience while they're in the process to trying to reestablish themselves in a new environment.

Psychological First Aid - ABC's of Psychological First Aid –

A - Arousal

- Reduce arousal for individuals who have been exposed to noise and chaotic events, and potential violence, or noxious fumes, etc.

- Provide a safe environment, we want to make them as comfortable as we can, we want to console them and do some normalizing of behaviors as opposed to pathologizing to help them experience a greater sense of calm.

B - Behavior

- Individuals should have the opportunity to function as effectively as they can, realizing that if they've been pulled away from their home, they are no longer in control of themselves. When they eat, where they eat, what they eat, what they wear, if they're wearing somebody else's clothes, eating somebody else's food, that can be very disempowering, and can increase a sense of helplessness, which in some people can be co-morbid with a sense of hopelessness.
- Give people a choice in what they're doing, help them be making decisions, what they're wearing, where they're going, access to phones so that they can try and make some contact so that they can begin to assume some control, begin to be responsible for their behavior as much as possible has a beneficial effect.

C - Cognitive processes

- Provide reality testing as best we can
- Provide clear information, it doesn't help to sugarcoat or minimize. It doesn't help to be vague. They need to have accurate information. We need to treat them with respect and courtesy, but treat them as adults.

This approach to treatment focusing on psycho-social and behavioral issues is very different than standard psychotherapy. So relative to disaster mental health a lot of us who are clinical practitioners have to significantly change our approach. I don't have a 50-minute session in my nice comfortable quiet office. So as I'm going around to shelters I'm involved in reaching people at a center, and I might only have a few minutes. My best way to help them might be to give them a cup of coffee and let them use my cell phone, and it might be to comfort them. Avoid platitudes, but give them some accurate information, console them, and once again normalized behavior. I'm going to have to have a microscopic therapeutic alliance established in a nanosecond, but it's very different, and that's a difficult adjustment for a lot of clinicians.

Interdisciplinary Approach to Evacuees - This isn't just a problem for acute care folks, it's not just a problem for emergency care folks, or for mental healthcare practitioners, but primary care physicians, PA's, RN's, emergency care folks, need to work together. In fact we even received an e-mail at CDC from some physical therapists and occupational therapists emphasizing the importance of the role that they could play. So I want to emphasize that multi-disciplinary, interdisciplinary approach to dealing with individuals, to treat them from a bio-psychosocial model acknowledging that they've got assets as well as liabilities, and they've got strengths as well as deficiencies or deficits.

Preparedness Empowers Response - Certainly now we're looking downstream, and I think each of us can do our own little lessons learned, do our own individual or unit, or facility-wide after action report, and see what kinds of things we can do on the front end, how can we provide information on the front end to give people the opportunity to prepare themselves, to develop disaster plans and communication plans, and those kinds of things.

Unfortunately, we often find that disaster mental health sometimes is poorly integrated, and poorly resourced into hospital emergency operations plans. We have the opportunity now to look ahead to next time to see what we can do in terms of access to proper medications for folks, having that stockpiled or pre-deployed.

Fostering Resilience in Individuals and Communities - By resilience there are multiple definitions out there, one of the easier ones is the ability to prepare for, withstand, and bounce back from a traumatic event. It's more than just being able to absorb, and certainly each of us knows individuals professionally, and personally. Some people are better at dealing with setbacks. But everybody can become better at it.

That is part of what we want to do, that's part of what the resilience and mental health teams focus is, is focusing on preparedness, and focusing on preparation.

Questions and Answers

My question has to do with your observations of children in the shelters, particularly how people are responding to children if they were using toys and puppets to engage them, or just what you observed there in the shelters with regard to children's interventions?

L. McKnight

Regarding the use of interventions, are you speaking of therapeutic interventions in the shelters, engaging them with toys?

The whole gamut of even the Psychological First Aid for children, all the way up through any type of therapeutic interventions. Like for example when I was in Louisiana in Appaloosas, in our shelters we were using toys and puppets, but I was hearing reports from other places that that was not being done, and that basically the children were just given coloring books, and that was the extent of it. So I'm concerned that we try to get some more interventions for the children, and I just wanted to hear your observations or thoughts on that.

L. McKnight

Again, I must give the caveat that I was only in San Antonio and in a few of the shelters there. Based upon my personal observations a lot of the services that had to do with children had to do with integrating them more towards the normal aspect of their life, like making sure that they were in school, there was a huge emphasis on making sure that they were in school, the school buses were there to pick them up promptly, making sure that they had all of the materials that they needed for school: book bags, pencils, different clothing items. Additional resources for the parents involved having day care there if the parents needed to go out and look for jobs, etc., having a place where the kids could go and be safe, and be entertained. There were other options for entertainment for the children.

I feel like a lot of the emphasis was placed on basic needs, and getting the parents reestablished themselves so that they therefore could take care of their children, and that they could process with the children what was going on, and help them, and let them know that they were safe, and that things were okay. A lot of the kids, in all honesty, appear to be dealing very well. They were having a good time running around, and they had a good time when they were in school.

Given the controversy over debriefing, could you update us as to this procedure, and if you're using it? If so, how?

R. Klomp

We certainly aren't trying to be prescriptive, or tell anybody else what they should do, but those concerns about critical incidents stress debriefing, or the larger critical stress management has been weighing heavily on our minds.

Our focus, as we work with deployees, and are trying to help them reintegrate back into their previous work experience, and their family life, is that they benefit more from an operational debriefing. So we have contact via e-mail to kind of give them a heads up, preferably a couple of days after they return from the field, saying that we will contact them by phone to set up either a face to face or a person to person phone interview, and we ask a series of general questions that

we have clarified are confidential, and designed to help us improve our deployment processes in the future. We're asking about what worked well while they were in the field? What could have worked better? How did their team function? How could they have been supported better professionally? How could they have been supported better personally? So it really is an operational debrief, it's 100% voluntary, it's not mandatory. If individuals choose not to participate in that one on one operational debrief, and I'm not just using semantics here, it's not a psychosocial or behavioral debrief, it's an operational debrief. We give them the opportunity to participate in a written anonymous survey that's done electronically so that confidentiality is maintained.

We also provide group operational debriefings. Once again, I'm not playing semantic games, it's not a critical incident stress debriefing, but we will hold a group operational debriefing so that the focus is on improving our processes. You realize however that certain individuals might be having some distress that may be manifesting itself in cognitive or physiological or emotional symptomatology. So we are working in concert with our employee assistance plan, and so if we encounter somebody when we're doing our operational debriefings that is demonstrating some type of distress, our protocol and the way that we operationalize that is that we actually refer them to the employee assistance plan. So it's kind of a bit of a tightrope for us. I'm a licensed professional counselor, but as someone's peer, as someone's colleague, we felt it was improper for us to be engaging in any type of psychotherapy, and we're keeping that very separate so that we're trying not to blur that line at all.

There also will be regularly scheduled group meetings by the employee assistance program that will have more of an emotional focus. Those are voluntary and not mandatory, they will not be held for heterogeneous groups, and we will try and aggregate as best we can. Homogenous groups who had similar assignments in similar locations, and they will not be following a standard CISD kind of a model.

We also run into the problem that so many of the individuals with whom we work have been trained in CISD and enjoy it, and are not aware of some of the ambiguity or ambivalence in the literature. Our understanding is that there are no conclusive data to demonstrate that it has an efficacious effect.

I have a follow up. Do you have any impression of what's happening though with the evacuees? We're getting some on our message board at the medical reserve corp we're getting some questions about debriefing the evacuees. Do you have any feedback, or feeling about what's happening at shelters now, or what you're seeing?

R. Klomp

I do not have information about that at this point. It's tough because when you're in the field you're seeing everything that's going on, but if you interface or you bump up against something that's beyond your scope of your mission, or beyond the scope of your resources, or your mandate, it's difficult to know how to handle that. We do not have any information on what's being done for the evacuees themselves.

We know that in some of the larger facilities crisis counseling is available, I'm not sure if that's on a group or an individual level, I assume primarily individual?

Yes. Primarily on an individual level, and some of the facilities were located like in the center of the shelter, and persons who were having

issues were quickly recommended to be able to speak with crisis counselor and could do so on an individual basis as needed.

R. Klomp

CDC is not making any formal recommendations in that direction. We feel like there still is much data to collect there. It's something we would like to be able to do to make a recommendation, but I think that the jury is still out, and we're looking at different alternatives, and different options. I know a lot of people swear by CISD.

I was wondering what information specific to mental health issues you would like to see us get out to the public? Are there signs or symptoms, or things we could be referring people to do?

R. Klomp

We actually have pulled together some very preliminary information that we share with our folks on a pre-deployment briefing basis. That includes some guiding principles relative to disaster mental health. We talk about behavioral and cognitive and physiological symptoms of stress, and of trauma. I think it's helpful for people to know that, and a lot of what we do is normalized behavior, and you ask somebody, "If your house had just been washed away or blown away, would it be abnormal or unreasonable if you were irritable, or were experiencing some grief, or if you had a hard time concentrating. So we think it's important to normalize behavior.

Survivor needs and reactions are important to get out there. As I've mentioned earlier, we're all about preparedness. So everything that we can do to help families come up with a communication plan, with an evacuation plan, to general family preparedness, a lot of the FEMA materials are just excellent on that as you well know.

So we look at some of the ... materials. Of course, we emphasize self-care when we're talking to our responders and our deployees. So everybody that I'm able to address in a pre-deployment briefing I emphasize the importance of maintaining balance physically, emotionally, cognitively, behaviorally, and spiritually, and encourage them to take one or two things with them that will help them to disengage from the chaotic environment which they find themselves.

So that's kind of a general response to your very specific question. We have a disaster mental health page that has some general information, but SAMSA and FEMA, and other agencies of the National Mental Health Association, the APA have some wonderful materials.

One other thing that might be of some value is something that we use in our training. It is from the APA and it's called, "*The Road to Resilience*." It has ten different ways that individuals can build resilience. I would think that that would be something that would be very helpful to share with evacuees. It's simply stuff, about making connections, building relationships, reestablish your support structure, avoiding seeing the crisis as insurmountable, accepting that change is a part of living, move towards your goals, take decisive actions, look for opportunities for self discovery in this situation, nurture a positive view of yourself, keep things in perspective, maintain a hopeful outlook, and take care of yourself.

Once again, that's called the road to resilience, and it's at helping.ata.org. So there's a wealth of information out there, and I appreciate your willingness to get that word out. I'm sure we've got a lot of people's attention right now, and a lot of families who were not impacted can benefit from this, and can have some

vicarious strengthening of their family, and the preparedness effort can get a huge boost. So I think you're right on target.

I have a question concerning the psychologically fragile individuals in the shelters who may be identified as suicidal as far as what services are offered to them?

R. Klomp

I'm afraid that we don't have enough of a cross section of responses from our employees spread out through three different states to be able to give a generalized answer about that, whether that's being handled admirably, or inadequately. Obviously, it's a gigantic issue, as you're removing social support, as you're increasing the uncertainty of your environment, maybe restricting their access to the meds that were keeping them kind of in balance.

I'm not aware of accurate data at this time to either quantify or address the specific needs of that very, very important special population. I wish I had a specific answer for you. Is that your primary patient population?

I am a psychology nurse. I have worked in an acute care setting. I am concerned about the clients that might be out in the midst in shelters, and who are being missed and not monitored.

R. Klomp

I assume at some point we'll have some data on that, unfortunately, it's going to be, I think, fairly far behind the curve in terms of giving you a heads up that you would like at this point, and legitimately so. I do have some information that these individuals are being identified by a lot of the primary care folks in the better run facilities, but I can't tell you what percentage that might be.

Could you again recap some of the materials that we could resource in terms of the ABC's of crisis counseling?

R. Klomp

I can give you some general information, let me give you a CDC mental health resource, and that is www.bt.cdc.gov/mentalhealth. That's a disaster mental health resources page that we pulled together, but there are phenomenal links from the National Mental Health Association, the American Psychiatric Association, the American Psychological Association, the American Counseling Association, SAMSA has a wonderful site, FEMA has a great site. Some of these organizations, by the way, also have sister sites for children.

There are some good sources there. Specific to the ten points, on the road to resilience that was from the APA site, and that was helping.APA.org. So as we try and juggle many priorities we're trying to pull together valid information. We're also trying to conserve resources and time by not recreating the wheel.

We did work with the American Red Cross several months ago, and coauthored with them five different documents to help people deal with stress in uncertain times. Those were geared specifically at middle school students, high school students, adults, senior, and caregivers. Those are available, and they're jointly branded CDC and the American Red Cross on the American Red Cross page, and I believe they have a sub page relative to disasters. But there's a wealth of information out there. The Federal sources have just some tremendous information; there are field guidebooks for mental health, and those kinds of things. WE don't have all of that on our Web site yet. We realize that, unfortunately, some people still don't have Internet access, so I realize that not everybody's going to be able to access Web sites.

You touched on it a little bit, but I was wondering if you have a feel for how much your folks are seeing, or the primary folks are seeing of people that have mental disorders that are being exacerbated by this particular stressful situation, and how they're typically being handled. Is it a lot of the business, is it a small bit of experience that you're having in this area? I know that the stress of being an evacuee is an incredible one for someone who normally has much of their life together. If you do have problems that are going to be exacerbated by some this stress, it could be much more difficult.

The other things are some typical things that one would look for as a disaster mental health person to show that the person that you're working with really needs a more in-depth referral, and maybe beyond some of the types of things we've talked about already.

L. McKnight

Again, I feel with each response that I give that I must give the caveat that I was in San Antonio shelters. So certainly my comments are limited in part. What I observed in the shelters were that many of the people who did have previous mental health issues for themselves self-identified and knew that they needed either medication or help. So they sought out those services themselves.

When I spoke to them, people who had had previous medication needs, or had been previously in therapy for a PGSE groups that already sought out, even in the community in which they were in, or in the shelter, to get those types of services. They did feel that their issues were exacerbated by some of the experience that they had been through, but they were themselves reaching out for services.

R. Klomp

The second part of your question about reactions that might signal a possible need for mental health referral is a great question. I'd like to just list a couple of things that we share with our deployees as they're going out in the field. As I mentioned earlier, we try and give them a sense of what common cognitive physiological and emotional symptoms are, and then we say, "Here is some things that would not be considered typical, and would not be considered customary."

Disorientation, if somebody's dazed, and they're experiencing memory loss, they're unable to give the date, time or recall recent events. If somebody is depressed, and I'm not talking about just feeling sad and sitting on a curb with your head in your hands because your house has been blown away once again, that would be expected, but by depression I'm talking about a pervasive feeling of hopelessness and despair, withdrawal from others, inability to focus, concentrate, completely without hope for the future.

Anxiety would be a third reaction that might signal a need for additional mental health referral. So constantly on edge, restless, obsessive fear of another disaster, maybe a hyperactive startle response. Acute psychosis, hearing voices, seeing visions, delusional thinking, obviously would jump out at a clinician. Inability to care for ones self, not eating, bathing, changing clothing, or handling daily life at all. Suicidal or homicidal thoughts or plans, problematic use of alcohol or drugs. Now we know that from previous disasters that alcohol and drug abuse, along with intimate partner violence, tend to increase post disaster. So that's also a possible indicator.

That's basically the list: disorientation, depression, anxiety, acute psychosis, inability to care for self, suicidal or homicidal thoughts, problematic use of alcohol or drugs, domestic violence, child abuse, or elder abuse.

Are there any special things you look for with children and adolescents in that area?

R. Klomp

The short answer is that that has been beyond the scope of my focus in working with the CDC deployees. So we would think there might be others who would be better positioned to answer that question for you.

I'm from the California Department of Health Services. We're working on a project to train primary care providers to intervene in a post disaster, either natural or bio-terrorism. We're particularly interested in looking at pre-event planning, practice management changes, and then certainly the acute short term and long term intervention. We're wondering if anybody on the call can tell us about a training curriculum that they may know of, or a resource agent that may know of a training curriculum that we could contact?

R. Klomp

I think actually that goes a little bit beyond the scope of what we would be prepared to do on this call in terms of endorsing specific programs in a public forum. I hate to hedge like that, but I know that there are some good programs out there by a variety of universities who've devoted resources to disaster mental health issues. I apologize for not being able to be more specific. I have to be careful relative to what might appear to be an endorsement of a particular program or service.

Is CDC assisting in any way with the schools, with all of those challenges? Are there any plans to do a conference call like this for the schools themselves?

L. McKnight

Regarding the children and their integration in the schools, what I saw in the shelters was that there was a concerted effort, first of all, to make sure that all the children were enrolled in the schools. There was an emphasis on that in terms of having them placed in a normal environment, and continuing their education was important to their own psychological well being.

So there was a tremendous emphasis in that regard, and making sure that the school bus was there to pick them up each day, and that they were able to get back on the bus and come back to the shelter. Maybe there was something on their clothing to indicate to the teacher where they needed to return back. So from my time in the San Antonio shelters that was what I saw as the emphasis with the children. I believe you asked an additional question regarding within the community?

My focus is the schools, and I'm particularly interested in how schools are bringing the kids in. I anticipate that there will be a honeymoon period where these kids are new, and kind of welcomed by the other kids, but with the different cultural differences, and that kind of thing, I see them being very vulnerable to being bullied, and that kind of thing somewhere down the line. I'm wondering whether schools are prepared for those kinds of eventualities?

R. Klomp

I think you're probably right on target relative to that honeymoon period. We get post-disaster, that whole heroic let's pull together kind of things, and then people start worrying about resource allocation and drains, and expenses, and those kinds of things. Historically that's tended to be the case. So I believe that you're right on target. Of course, we don't have any of that data yet. Most of our forward observers, most of our responders, were in the actual shelters, so they weren't seeing anything of what was going on in the schools. So I think we don't even quite have the tip of the iceberg there, but I think you're right on target that that will be a significant issue.

You'd also ask relative to CDC plans to follow up or contact the schools directly, and the fact is that as we've indicated this is very preliminary information, and the parts of CDC that are involved with supporting schools have not had access because there's nothing to access, this is so preliminary at this point. So that's outside of our interaction and our knowledge of what may happen in that venue.

I'm the employee health nurse at a large hospital in the Baton Rouge area. I just wanted an idea of maybe incorporating the staff that were getting out of the area, helping them feel wanted and appreciated here in our hospital. Probably 60% of our patients we're seeing here at the hospital at any given time right now is out of the New Orleans area. So our staff is at an emotional overload helping to protect the patients, and they're bringing in staff members, and they're also very emotionally needy.

R. Klomp

It sounds like you've got a real challenge there. Are you saying that you're actually bringing some of them on board?

We've hired probably 200 people since the hurricane. We're two facilities. I'm the employee health coordinator, so I'm looking at the emotional needs of my staff.

R. Klomp

I'm guessing you probably haven't had much time to sit down and to look at some of the resources that are available on line.

I've looked at some of that, and we do have an employee assistance program, and I am giving out brochures on that, and encouraging staff to use it because it allows them to go outside of our system to maintain their confidentiality.

R. Klomp

That sounds like you're taking a very sensible approach. Of course, some people like to do group processing and some people don't. Some people's primary coping mechanism is to deal with it in silence, or in solitude.

A lot of the staff right now we're finding is they're so emotionally vulnerable right now that they don't want to talk, and the new people coming on board are pretty much, "Don't ask me right now."

R. Klomp

Based on our previous discussion relative to approaches that would mandate, or set an expectation for a disclosure, that would be contraindicated for lots of folks.

That's why we're offering the assistance program and letting them know that you can get in touch with them on your own time, and whatever time you feel you're ready and you need some assistance.

R. Klomp

It sounds like you're taking a very sensible approach. Good luck in that integration and support process.