After the Crisis Initiative: Healing from Trauma after Disasters

White Paper
Addressing the Traumatic Impact of Disasters on Individuals, Families, and Communities

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This paper represents an overview of four resource papers that were presented at the After the Crisis: Healing from Trauma after Disasters Expert Panel Meeting (April 24 – 25, 2006, Bethesda, MD) and additional research.

The After the Crisis Initiative is Co-Sponsored by:
The National GAINS Center for Systemic Change for Justice-Involved Persons and the Center on Women, Violence and Trauma, through the Center for Mental Health Services, SAMHSA.

Acknowledgement and Disclaimer: *The development of this publication was funded under Request for Proposal No. 280-04-0106, entitled: "Center for Evidence Based Programs for Persons in the Justice System" from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration's Center for Mental Health Services (CMHS), awarded to Policy Research Associates, Inc. (PRA). The views and opinions expressed in this publication are those of the author, and do not necessarily represent the official position or policies of PRA's National GAINS Center or the Center for Mental Health Services (CMHS).*

Trauma and Disaster

Understanding the Impact of Trauma

All disasters, both natural and man-made, carry with them destruction, devastation, stress, and trauma. The long-term legacy for individuals, families, and communities is dire. While the immediate focus on survival shifts to rebuilding life, the experienced trauma can linger for months, years, or even a lifetime. Understanding the impact that trauma may have on an individual following disaster and how it may be affecting health and wellbeing is important in the healing process.

Post-traumatic stress disorder (PTSD) and acute stress disorder (ASD) are two conditions that can be caused by experiencing or witnessing almost any kind of deep emotional trauma, especially one that is unexpected. For many, PTSD and ASD are the body's natural response to trauma—a normal reaction to an abnormal situation. There are two important distinctions between ASD and PTSD. One is that ASD is considered a more immediate, short-term response to trauma that lasts between two days and four weeks. If ASD symptoms persist for more than a month, then PTSD may be diagnosed. The other notable difference is that ASD is more associated with dissociative symptoms, which may include extreme emotional disconnection, difficulty experiencing pleasure, temporary amnesia (or "dissociative amnesia," if the loss of memory centers more around the traumatic event itself), depersonalization (feeling detached from the traumatic experience), and de-realization (world seems strange, unfamiliar, and not "real").

Symptoms of PTSD include emotional numbness, restlessness, anxiety, uncharacteristic irritability or even violent behavior, problems focusing or concentrating, flashbacks (which can be triggered by people, places, things, sounds, smells, etc.), and sleep disturbance. People experiencing PTSD often feel isolated, disconnected, and "different" from others, and they may see the trauma affecting the most routine activities of everyday life. Symptoms typically surface within three months following a traumatic event and may dissipate within a few months (West, 2005).

It is important to note the distinctions between the two responses because during and after disasters, ASD is fairly common. And while many recover and see the trauma symptoms dissipate, others will develop PTSD. Environmental and demographic factors, personality and psychiatric history, dissociation, cognitive and biological systems, and genetic or familial risk all play a role in an individual's risk for PTSD (Yehuda, 1999).

Individuals with mental health concerns are at a much higher risk of suffering trauma after a disaster. Individuals with prior trauma histories (e.g., violence, abuse, disaster, war) have a much greater risk of becoming re-traumatized by the experience. Re-traumatization takes place when a survivor experiences another traumatic event and is affected by that experience. This phenomenon is "personal" – while it may happen for some, it may not happen to all survivors, and what is re-traumatizing for one survivor, may not be for another. According to Kammerer and Mazelis (2006), "the impact of trauma is **cumulative** – the more times a traumatic event is experienced, the greater the impact; **additive** – exposure to *different* types of trauma is correlated

with greater impact; and **summative** – the combination of event(s) plus impact is what individuals carry forward through time, inscribed in memory, the sense of self, and behavior."

Trauma, when left unaddressed, is increasingly recognized as a significant factor in a wide range of health, behavioral health, and social problems (Felitti, 2003; Felitti et al., 1998). Trauma has been linked to hallucinations and delusions, depression, suicidal tendencies, chronic anxiety, hostility, chronic fatigue syndrome, eating disorders, and dissociation (Mueser et al., 2002). Trauma victims are also at a much higher risk for co-occurring mental health and substance use disorders, violent victimization and perpetration, self-injury, risky sexual behavior, and many other means of coping which themselves have devastating human, social, and economic costs (Anda et al., 1998). They are also prone to social, emotional, and cognitive impairments, disease, disability, serious social problems, and premature death (Anda et al.).

Recognizing the importance of the role that trauma plays in the lives of disaster survivors is essential in developing adequate emergency preparedness and response protocols. While crisis intervention and emergency assistance in the short-term are very helpful, adequate intermediate and long-term support must be in place for those who experience trauma and PTSD so that they, their families, and their communities can heal, live, and be well again.

For more information, please refer to the "Trauma and Retraumatization" resource paper at:

http://www.gainscenter.samhsa.gov/atc/pdfs/papers/trauma.pdf

Healing from Disaster-Induced Trauma

Although trauma may affect different people in different ways and to varying degrees, to mitigate the effects of trauma in the aftermath of disaster, two key steps toward healing should be taken in virtually all affected populations. First, an attempt should be made to regain a sense of normalcy as soon as possible, and, second, peer support should be offered to all victims. Focusing on these two steps is almost universally beneficial to those who have experienced trauma. Later in this paper we will delve more specifically into the challenges disaster-induced trauma presents to communities at large and to the criminal justice system, in particular, and discuss ways to deal with those challenges.

Regaining Normalcy

One of the most helpful steps in the healing process is to re-establish a normal routine after the traumatic experience (National Center for Post-Traumatic Stress Disorder, 2006). Going to work or school, participating in social gatherings, getting together with friends, and eating dinner with family are activities that can help to lessen the stress of trauma and keep important connections of support in place.

The added difficulty that survivors of disaster face is that many of the things that help to establish a sense of routine and normalcy may be gone. In the wake of Hurricanes Katrina and Rita, the challenge was of incredible proportions. Not only did survivors lose their homes or

perhaps even family members, but they also became displaced and removed from everything they knew life to be before the storm. With loss of employment, disconnection from important friends, unfamiliar surroundings, lack of privacy, and economic hardship, the course of life itself became incredibly difficult to manage. Add to that the experience of psychological trauma and lack of support to address it, and the result is the current condition of increased substance abuse, depression, suicide attempts, domestic violence, and child physical and sexual abuse.

In monetary terms, the cost to society is staggering. The cost associated with acts of domestic violence against adult women alone is estimated to exceed $5.8 billion annually, nearly $4.1 billion of which is for direct medical and mental health care services (U.S. Department of Health and Human Services, 2003). The economic costs of untreated, trauma-related alcohol and drug abuse were estimated at $160.7 billion in 2000 (The Lewin Group). For survivors of child abuse, long-term psychiatric and medical health care costs are estimated at $100 billion per year (The Ross Institute, 2006). Additional trauma inflicted by experiencing disaster only increases the societal expense.

We are seeing survivors of Hurricanes Katrina and Rita cope in ways that are already negatively impacting individuals, families, and communities. Experienced depression and sleep disturbance, suicide attempts, overall fatigue and short-temperedness – while the trauma may play out differently for people, the impact has made post-Katrina/Rita life quite difficult and not very pleasant. Regaining or establishing routines can bring about a sense of control during times of chaos. But as a public health concern, support for survivors of trauma needs to be long-term, accessible, affordable, culturally competent, and sensitive to each individual's experience.

Offering Peer Support

The traumatic experience of disaster may be different for each individual, and differences in gender, age, culture, personality, and geographic location may impact the way in which we respond to and heal from the experience. Peer support, however, is one approach to addressing trauma that effectively works for groups of all types, and is particularly attuned to the needs of the local community and its people.

According to Mark Salzer (personal communication, July 2006), Assistant Professor in the Department of Psychiatry at the University of Pennsylvania School of Medicine, received and perceived support are understood in terms of five overlapping supportive functions:

- Emotional support (someone to confide in, which provides esteem, reassurance, attachment, and intimacy)
- Instrumental support (services, money, transportation)
- Informational support (advice/guidance, help with problem-solving, evaluation of behavior and alternative actions)
- Companionship support (belonging, socializing, feeling connected to others)
- Validation (feedback, social comparison)

All of these integrated benefits of peer support directly help to address some of the ASD and PTSD symptoms and conditions mentioned earlier. For a survivor of disaster, and especially for

individuals with previous trauma histories, peer support provides the safety, understanding, connection, and long-term support to explore healing. In addition, if the peer support model is marketed and hosted in a way that is not labeling and does not identify an experience (i.e., sexual assault) or response (i.e., addiction or self injury) of the participant, potential stigma barriers can be avoided and the healing process can be pursued more freely.

For more information, please refer to the "From Relief to Recovery—Peer Support by Consumers Relieves the Traumas of Disasters and Recovery from Mental Illness" resource paper at:

http://www.gainscenter.samhsa.gov/atc/pdfs/papers/peer_support.pdf

Community Challenges after Disaster

Security and Governance Concerns

Many times in post-disaster history we have seen a lack of security and unclear leadership or direction on how to respond. Some actually refer to Hurricane Katrina as a man-made disaster because of the poorly constructed levees and lack of government responsiveness (USA Today, 2006). Sen. David Vitter (R-LA) remarked, "…this disaster was not out of the blue or unforeseeable. It was not only predictable, it was actually predicted. That's what made the failures in response — at the local, state and federal level — all the more outrageous" (Vitter, 2006). The expectation is that we should be able to predict, prepare, protect, respond, and provide assistance if needed in the aftermath of a disaster.

When looking at the aftermath of 9-11, although leadership was strong, looting and violence still occurred. In the aftermath of Hurricane Katrina, there was also confusion, lack of response, and mass chaos and violence to contend with. From a preventive standpoint, it is important to prepare communities so that they will know who should do what and can take appropriate and effective action if a disaster should occur (Walters & Kettl, 2005). This not only means addressing channels of communication and leadership, but also determining how to prepare the community to respond to anticipated trauma caused by disaster.

Following are some related community-focused recommendations:

- Include intermediate and long-term trauma support programs in emergency preparedness plans.
- Create a coordinated community response plan that addresses communication, resources, management, and long-term support.
- When conducting community drills and exercises, consider what parts various response partners might play in addressing the experienced trauma.
- Create a clear and well-known community-driven action plan that can be put into place post-disaster.
- Communicate often and listen well.

Destroyed or Depleted Resources

It is quite common for communities devastated by disaster to have lost (temporarily or permanently) much needed resources. Basic transportation needs may be blocked by damaged roads. Receiving adequate medical attention may be challenging when many physicians may have evacuated or relocated. Stores sit without needed groceries, gas pumps without fuel, and homes without families. The lack of resources makes it difficult to resume life, although we know that getting back to a sense of normalcy is essential to the healing process. The challenge to communities is significant. Swift mobilization, utilization of outside resources, recognition of essential needs, and continued attention and support to rebuild is exhausting, even in the best of circumstances.

Overburdened Neighboring Communities

In the aftermath of many disasters, as in the aftermath of Hurricanes Katrina and Rita, evacuees need to settle elsewhere, at least for a short period of time. Since communities are designed to accommodate their own residents, an influx of unexpected guests can quickly overburden a host community. In Houston, TX, for instance, where many of the Hurricane Katrina evacuees were initially welcomed, there is recognition that city services are strained. Law enforcement and managing the additional traffic are the most notable problems (Berger, 2006), but over-crowded schools, high unemployment rates, and overburdened social service systems are also significant. Unfortunately, host cities often do not receive the kind of attention, support, and resources that communities directly affected will receive, leaving them without the necessary tools to manage the strain on their infrastructure.

Host communities must also deal with the traumatic impact experienced by evacuees. Reports of increased depression, suicide, eating disorders, aggression and violence, domestic violence, and divorce typically surface in the first year following a disaster. All of these implications are experienced residually by hosting communities. Therein lies the challenge to address the needs and emotional trauma of evacuees so that individuals, families, and communities throughout the United States will be well following a disaster.

Destroyed Sense of Community

When evacuation happens as the result of disaster, what we often experience on some level is the destruction of neighborhoods and the sense of "community." Individuals and families are often displaced. The comforts of home—friends and family—seem far away.

Although trailer parks were created to house Katrina evacuees, very little consideration was given to the design of these temporary neighborhoods. For instance, trying to keep neighbors together in a trailer park could be very helpful in the quest to find a new "normal." This does take time and energy, but considering the emotional benefits to individuals who have lost so much, keeping friends and neighbors together could be instrumental in the healing process.

The same is true for individuals in controlled environments like jails, prisons, or psychiatric facilities. There is a level of comfort and familiarity with those we are around every day, and

disrupting that environment can create new problems and setbacks. In times of disaster, inmates from jails or prisons and individuals living in state psychiatric facilities are often sent to the nearest safe locations that have space to accommodate them. A little thoughtful planning to determine how to minimize disruptions would be helpful in lessening the impact of the traumatic experience on these individuals and would aid in the healing process.

Impact on Children and Families

The impact of disaster-induced trauma on children is directly related to how the disaster affected the family. Physical injury or death of a family member, lost home or possessions, displacement requiring attendance at a different school, lost employment and related economic struggles, and the way in which the parents cope in the aftermath all play a role in a child's ability to cope. Responses to a disaster may also be different for boys (who generally take longer to recover and display more antisocial and aggressive behavior) and girls (who are more distressed, talk more about their experience, and think more frequently about the disaster). Following a disaster, children who experience the disruption to "normal" life often exhibit somatic symptoms (headaches, abdominal pain, diarrhea, chest pain, etc.), aggressive, deviant, and defiant behavior, repetitious behavior (reenactment of details of disaster as a means of coping), regressive behavior (bed-wetting, thumb-sucking, fear of darkness, etc.), anxiety, depression, guilt, and PTSD (Saylor et al., 1994). While children are often thought of as resilient, the impact of disaster can create life-long challenges for the child survivor.

The Adverse Childhood Experiences (ACE) study (www.acestudy.org), which examined the health and social effects of traumatic childhood experiences over the lifespan of 18,000 participants, has demonstrated that trauma is far more prevalent than previously recognized, that the impacts of trauma are cumulative, and that unaddressed trauma underlies a wide range of health problems (e.g., heart disease, cancer, chronic lung disease, liver disease, skeletal fractures, HIV-AIDS) and social problems (e.g., homelessness, prostitution, delinquency and criminal behavior, inability to hold a job) (Felitti, 2003; Felitti et al., 1998).

As stated previously, adults who have difficulties dealing with their experienced trauma in the aftermath of disaster start showing signs of this stress (e.g., substance abuse, self injury, depression, suicidal tendencies, divorce, aggression, child abuse, domestic violence, etc.) about six months after the incident. Children of these parents also suffer, as the family connection is lessened and parental involvement is less reliable.

Following are some recommendations as they relate to children and families after disasters:

- Provide long-term support (at least two years) for children and families to address the experienced trauma.
- Offer children in communities affected by disaster special assistance in schools, healing art programs, and other therapies that will provide support and avenues for healing.
- Give parents resources and information on what they can do to be helpful with the trauma experienced by the child(ren) and exercises that can help the family to remain connected and understanding.

Impact on Those Labeled and Diagnosed with Psychiatric Disabilities

The risk and impact of trauma is significant for individuals who have been labeled and diagnosed with psychiatric disabilities. Yet, very little attention is given to emergency preparedness and response for this population.

During Hurricane Katrina, not only were the needs of individuals labeled and diagnosed with psychiatric disabilities not addressed, they "were segregated from the general population in some shelters, while other shelters simply refused to let them enter" (National Council on Disability, 2006). According to Levin (2006): "Some ended up in state parks or other refuges that were not set up to meet the needs of persons with psychiatric diagnoses. Still others were inappropriately institutionalized because they were stereotyped with the stigma of mental illness." The National Council on Disability (NCD) report goes on to cite discrimination, mismanaged evacuations, exclusion from disaster planning, lack of responsibility assigned and accountability to manage this aspect of the evacuation, and inadequate and prematurely discontinued relief services as some of the major findings. The goal of NCD's report is to set the stage for healthy dialogue, but clearly much more than discussion needs to take place.

Between 50 to 70 percent of all individuals diagnosed with a mental illness are estimated to have histories of physical and/or sexual trauma (Briere and Runtz, 1991). Since we know that a vulnerability to re-traumatization exists among these individuals, it is important to note the special conditions that affect people with psychiatric disabilities and to address the needs and supports that will honor the individual while providing both physical and psychological/emotional safety.

Following are some recommended areas to consider as they relate disaster preparedness and response to people labeled and diagnosed with psychiatric disabilities:

- Include individuals labeled and diagnosed with psychiatric disabilities as a distinct population in disaster preparation discussions so as to address concerns, needs, and supports that will impact health and wellbeing.
- Encourage state hospitals to consider important evacuation and displacement issues as they relate to individuals with mental health concerns (i.e., understanding how separating the community of patients may disrupt key relationships, ensuring that a move to another facility will include a healthy level of support through the transition and beyond, acknowledging that disasters can be re-traumatizing for many in this population, recognizing heightened concern that patients may have for the safety of those they love and depend on such as family members and friends, ensure patients are kept informed about on-going developments that affect them, etc.).
- Inform state hospitals, group homes, foster care homes, secure residential facilities, board and care homes, and other facilities of common responses to disaster that residents may experience and how to address re-traumatization through approaches that are sensitive to trauma (e.g., peer support).
- Provide mental health and social work professionals with information about the special needs that people with mental health concerns may have following a disaster.

- Support the preparation of a "personal guide" to disaster preparedness for individuals with psychiatric disabilities. This guide would include a communication plan (to stay connected with essential family and friends and with work), an evacuation plan, ways to help others affected by the disaster, and plans to establish and maintain personal safety, to acquire adequate supplies, and to document medical issues (including history, treatment, and current medications), as well as emergency contact information, and more. It should also incorporate information about common reactions to disaster for trauma survivors and people with psychiatric diagnoses to help normalize reactions that arise from being in extreme circumstances.
- Continue long-term support for all trauma survivors following a disaster.

Criminal Justice System Challenges after Disaster

Crime in the Aftermath

In the aftermath of Hurricane Katrina, like with other disasters in American history like the eruption of Mt. Saint Helens volcano (Amboy, WA), Hurricane Andrew (that impacted the Bahamas, Southern Florida, and Louisiana), or the bombing in Oklahoma City (Oklahoma City, OK), streamlined communications and services were not established to evacuate quickly, maintain law and order, and provide immediate post-crisis support to those who needed it. Safety, security, and a process by which to report crimes was not established for shelters, so when victims of violence arrived, they were left with little support and information related to their violent experience. Overcrowding, lawlessness, the breakdown of social and health service systems, and lack of law enforcement post-Katrina exacerbated this problem. For survivors displaced from the Gulf Coast, reporting crimes in a host community proved to be impossible because of jurisdictional issues, which left many without victim compensation and assistance.

In addition to pre-storm crime victims and those who fell victim to violence during and immediately following Hurricane Katrina, others fell victim to crime in the months following the disaster. Sexual violence against women and children who become displaced is historically documented, with the collapse of societal supports, overall increased vulnerability, a lack of companion support, feelings of powerlessness and anger, and unsafe shelter being cited as contributing factors (New York City Alliance Against Sexual Assault, 2005). During the chaos that accompanies destructive natural or human-induced disasters, some see the opportunity to prey on those who are affected and vulnerable, perpetrating violent crime.

What we know from examining the longer-term impact of disasters and times of emergency is that reported crime rates generally drop in every category except domestic violence, which can increase dramatically (Tucker, 2001). In fact, some communities have seen as much as a 50 percent increase in police reports of domestic violence after disaster (Norris, 2005). Many who have researched this phenomenon suggest that some survivors of natural disasters or other unexpected tragedies feel that life is so volatile and unpredictable that they inflict violence on family members in order to regain some sense of control. Others note that the increased strain on everyday life creates a breeding ground for family violence, which can be fueled by common unhealthy coping mechanisms like alcohol and substance use, self-injury, and aggression. According to Pat Breaux, past head of the Orleans Parish Medical Society, since Katrina "on a

per capita basis, we've seen an increase in suicides, depression, substance abuse, and domestic violence (Booth-Thomas, 2006)." Unaddressed trauma continues to impact individuals and families and the need for long-term support in healing from the experience continues.

For more information, please refer to the "Victims of Violence in Times of Disaster or Emergency" resource paper at:

http://www.gainscenter.samhsa.gov/atc/pdfs/papers/victims.pdf

Criminal Justice System Interruption

Protecting the criminal justice system during times of disaster is as important as establishing safety and security protocols. Not only does disruption impede investigations and arrests, but it also impacts the ability to uphold basic Miranda rights for those who are presumed innocent and have the right to a speedy trial. With defense attorneys evacuated or laid off, and a damaged criminal justice system (e.g. destroyed buildings, understaffed offices, difficulty locating documents, evidence, witnesses, and jurors, etc.), individuals may remain in a "holding" pattern for some time, which can affect mental, emotional, and physical wellbeing.

In the situation of Hurricane Katrina, New Orleans "District Attorney Eddie Jordan and several defense lawyers say 2,100 of those awaiting trial are in jails, many without adequate legal representation (Parker, 2006)." Without public defenders to assist in the process, thousands of individuals will have to be released. While Louisiana struggles to find resources to fund many different programs and services that are badly needed, not doing so will amount to even more substantial loss in terms of resources (e.g., time expended to investigate prior to Hurricane Katrina, the expense of keeping individuals imprisoned for an extended period of time when they may otherwise be released, re-traumatization for crime victims, etc.) if the state fails to adequately fund the criminal justice system. Such a substantial disruption adds significant stress, anxiety, and uncertainty for those working within and affected by the system.

From the very practical aspect of running a court, especially when so many employees are displaced and resources are depleted, it is hard to bring an entire system and process back to working order. Add to that lost records, documents, and evidence, and it is a daunting task. Being proactive about disaster preparation and determining interim modalities to keep the criminal justice system functioning during disaster-affected times will help to prevent similar problems in the future.

Impact on Justice-Involved People

Individuals with mental health or substance abuse problems and severe trauma histories are as likely to end up in jail or prison as in the mental health system. In fact, rates of prior trauma are as high or higher for individuals in the criminal justice system as for individuals in the mental health system (Jennings, 2005). Some research has shown the rate of serious mental illness is two to four times higher among prisoners than among those in the general population (Hammet et al., 2001).

When a disaster strikes, individuals with prior traumatic experiences and mental health concerns who are involved in the justice system face added stresses, including a lack of information, disconnection, and interrupted or unavailable services. While mental health professionals agree that establishing a sense of normalcy helps traumatized individuals, this is much more difficult to achieve with people in jail and prison. The lack of behavioral health protocols to address the psychological impact of disaster creates a tenuous situation for inmates and staff alike. A number of key areas in emergency preparedness need to be addressed to ensure adequate attention to the stress and trauma experienced by those involved in the justice system.

For more information, please refer to the "Criminal Justice Systems Issues and Response in Times of Disaster" resource paper at:

http://www.gainscenter.samhsa.gov/atc/pdfs/papers/criminal_justice.pdf

Communication Challenges

Most disasters have a way of illustrating where our communication challenges lie. Even in this tech-centric time, we see how vulnerable channels of communication are when disaster strikes. Cell phone lines become jammed, landlines do not work, evacuations lead to breaks in calling circles, and questions regarding authority and leadership make the reliability of information questionable. The news media report what they hear, see, and experience, but we have also seen numerous news reports recanted due to unreliable or unsubstantiated claims. Even with significant planning and preparation, disasters can and will make communicating challenging.

One area of communication that seldom receives recognition and action is disaster response for immigrants. There is very little attention given to culturally competent approaches for disaster planning, evacuation, and response. Understanding that immigrant communities include individuals who may not understand English and may not be literate (even in their mother tongue) is a very basic first step in this process. Yet very few communities in the United States have multi-lingual messages and outreach approaches to address immigrant communities to keep people safe and to help them recover in the aftermath of a disaster.

The lack of integrated communication at the federal, inter-state, and community and faith-based organizational levels meant great inefficiency and ineffectiveness before, during, and after Hurricane Katrina. Clearly, a centralized, streamlined process to open and ease channels of communication would greatly help in mobilizing to address the needs of the community. For instance, an online self-managing portal through which organizations and agencies of all types could update information, provide an overview of their role in response and services available, and recruit meaningful and talented volunteers could greatly aid in disaster response.

Communication is the cornerstone through which all things happen. Without addressing communication gaps, we risk facing disaster at greater magnitude and with harsher implications for the affected areas. Establishing effective disaster communication protocols should be one of the highest priorities.

Conclusion

History has shown us time and time again that we have not learned the important lessons that will help us to help one another from becoming traumatized by disaster. Effective communication protocols will help to establish more effective lines of response and support. Disaster preparedness for distinct high-risk populations including individuals with trauma histories, crime victims, veterans, individuals with psychiatric labels and diagnoses, hospitalized individuals, and people in jail and prison need to be carefully considered and established. Culturally competent outreach and intervention approaches should also be implemented for immigrant populations. Understanding trauma, re-traumatization, unhealthy means of coping, cultural needs, effective interventions, personal and family approaches to coping with trauma, re-traumatization, and peer support enable us to respond appropriately to disasters and their traumatized survivors.

Recommendations contained in this paper were developed in a series of four resource papers created by the After the Crisis Initiative.

About the After the Crisis Initiative

The After the Crisis (ATC) Initiative was convened following Hurricanes Katrina and Rita in 2005 as a means of addressing the mental health concerns of disaster survivors. In April 2006, the ATC Initiative brought together leading experts and organizations from throughout the United States to Bethesda, Maryland, in an attempt to begin to develop strategic solutions. The participants at that meeting have remained actively involved in the ATC Initiative to create recommendations and implement positive change that will better prepare communities for future disasters. The ATC Initiative currently has three special committees that focus on advancing strategies for peer support, community mobilization, and addressing the needs of the criminal justice system.

Key Partners

The ATC Initiative is a co-sponsored initiative of the The National GAINS Center for Systemic Change for Justice-Involved Persons and the Center on Women, Violence and Trauma, through the Center for Mental Health Services, SAMHSA.

Mission Statement

- To educate and organize constituents committed to developing national, state, and local readiness and capacity to begin to integrate the principles and practices of emerging, peer-run disaster response programs for people with mental health, criminal justice and/or previous abuse histories into mainstream disaster response efforts.
- To address what we know about how individuals respond to traumatic experiences, setting the stage for planning and organizing a more effective collective response to future disasters.
- To develop practical recommendations, strategies and program concepts for providing technical assistance to states, communities and individuals following disaster.

Core Recommendations and Key Activities

- Development of a peer support and response model to be used in communities affected by disaster
- Promotion of an appropriate service response for crime victims, persons with trauma histories, and justice involved persons with mental illness
- Improvement of communication among federal, state and local government agencies, non-profit service providers, faith-based communities, and first responders
- Improvement of service coordination and integration between the mental health and criminal justice systems

Contact Information

For more information about the After the Crisis Initiative, please visit the ATC Initiative Web site at: **www.gainscenter.samhsa.gov/atc**

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