MHA OF NYC

THE CENTER FOR POLICY, ADVOCACY AND EDUCATION
OF THE MENTAL HEALTH ASSOCIATION OF NEW YORK CITY

Terrorism in New York City: The Mental Health Impact of 9/11

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Terrorism Struck

I appreciate the interest that The Canadian Mental Health Association is taking in an event that had such great impact on the people of the United States--especially on New Yorkers. It is good to know that we have such good friends.

One of the most striking features of this terrible event was the compassion and unity that it inspired. People came to New York to help not only from all over the United States but also from Canada and many other nations. All of us in New York are grateful for the solidarity between our nations.

For this reason I am pleased to be here tonight to share with you what the experience of 9/11 and its aftermath has been and what we have learned.

Memories are Painful

But I must confess that it is not easy to talk about the events of 9/11. The memories speaking tonight arouses are painful--even though in the long run this is a story of overcoming adversity rather than being overwhelmed by it.

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I was just 20 blocks away from the World Trade Center when the planes hit it. My staff and I didn't realize at first what had happened, didn't realize its significance. Was it an accident? Was it terrorism?

We could see the flames shooting from the tops of the towers, see the smoke, which hung in the air for days, smell the fumes of fire that permeated the City.

Then we saw thousands of people running up Broadway, covered with ashes and soot, tears running down their faces.

No Words to Describe What We Saw

The reality began to penetrate. "Oh my God. Oh my God," was all that we kept saying. We had no words for what we were seeing.

Or for what we were hearing--sirens loud enough to drown out all the sounds of the City--sirens coming from every direction--like an air raid of the kind I was constantly drilled to prepare for as a child.

Even now when I hear a siren in New York City, my heart stops.

On television we saw people leaping to their deaths; we saw the towers collapse; we saw huge balls of dust and debris chasing people who were running for their lives.

Later we heard them talk about being enveloped in total darkness, sure that they were going to die.

We heard speculations that perhaps 50,000 people had been in the Towers at the time of the attack, that perhaps 10,000 or more had died.

Out our windows, we saw lines of dust-covered people with shocked expressions begin to form at pay phones. Cell phones were down. People were desperate to reach their loved ones to tell them they had survived and to be sure that they had also survived.

Our Phones Were Silent

Then we realized that our phones were dead silent. Even LifeNet--our 24 hour a day, 7 day a week information, referral, and telephone crisis center--which ordinarily is busy in the morning-- was dead silent.

We knew that LifeNet would be a critical resource in a disaster of this magnitude, but we couldn't reach the New York City Department of Mental Health. The phone system for most of New York City's government was down and so were their cell phones.

Fortunately, we have local backup lines for our 1-800 numbers, so we were able to receive calls, though there were no calls during the first few hours.

The first call in fact was from the National Mental Health Association offering to help. It gave us a very welcome sense of support.

Finally we heard from the New York City Department of Mental Health and the New York State Office of Mental Health--which could not communicate with each other directly. And for a while, MHA became the link between the city and the state.

MHA's offices are located in the "frozen zone"--an area of New York City that was virtually shut down after the terrorist attack. We were quite worried whether our workers could come in around the clock to staff LifeNet. But they did, even if they had to walk to work; and, because they provided a vital service, they were allowed to cross the police lines.

In addition MHA Board members called to offer to cover the phones or just to come in to help out by making coffee and doing clerical work. There was a tremendous sense of not being alone.

Monumental Coordination Effort

Over the next couple of days vast relief efforts were mounted. The City, the State, the Federal Emergency Management Agency, The American Red Cross, NYC's uniformed services, its hospitals, its voluntary mental health agencies, its social service organizations worked together to set up emergency relief sites and to get people who could help to the sites where they were needed.

It was a monumental job of coordination in which United Way of New York City played a major role.

- In fact on 9/11 at 2 PM--5 hours after the first plane hit--Ralph Dickerson, head of United Way, convened a conference call to begin to coordinate the human service system response. MHA was there, of course.
- At 9AM the next morning, a series of meetings began at United Way headquarters co- chaired by United Way and NY Community Trust. Each meeting brought together leaders from the different sectors of the non-profit and public human service systems, including mental health, health, day care, education, senior services, youth services, child welfare services, etc. Each sector met during a different time block, and many of us attended several meetings because we serve multiple populations.
- The mental health meeting included the Federal Emergency Management Agency (FEMA), the American Red Cross, Salvation Army, NYC's victims services agency, LifeNet, the primary hospitals, major voluntary mental health agencies, the Jewish Federation, Catholic Charities, the Protestant Federation, as well as the leadership of the NYC Department of Mental Health, and the NYS Office of Mental Health.

I'll say it again. It was a monumental job of coordination.

And I'm proud that, for mental health, LifeNet became the central point of communication and coordination.

Emergency sites set up by the City, the State, FEMA, and the Red Cross needed mental health professionals. LifeNet took their calls, contacted mental health providers throughout the City, and directed personnel to the sites where they were needed.

We also got calls from workplaces, schools, day care centers, community centers, houses of worship, senior citizen centers, etc. Hundreds of organizations called LifeNet seeking help for their traumatized clients and for their own staffs, who were making heroic efforts to help even while they themselves were suffering and needed support.

Over and over again we heard helping organizations say, "We don't know what to do to help people with their grief and their emotional trauma. We need help to help them. And we need help ourselves."

We arranged for mental health professionals to be "stationed" in many of these settings. They conducted talks, did mental health screenings, and provided direct crisis counseling.

Thus MHA's Crisis Resource Center was established. It arose to fill a void in a crisis, but continues to play a vital role in the process of recovery in the New York City area.

MHA, of course, was not alone in rising to the occasion. It was inspiring to see how people and organizations extended themselves. Hero after hero emerged ready to do whatever needed to be done.

Police, fire, and emergency medical personnel put their lives on the line; many sacrificed their lives. It is not possible to give them all the recognition and gratitude they deserve.

But there were less visible heroes as well--from all walks of life, including mental health.

And somehow, out of the initial chaos, some order began to emerge. The crisis was being managed.

Over the next couple of months, there were more and more calls to LifeNet from individuals having terrible emotional experiences.

Stories from LifeNet

Here are some of their stories.

- A 50-year-old man called LifeNet a month after the disaster to report that he had been in his office near the Twin Towers when he heard an explosion. He looked out his window and saw a gaping hole in one of the buildings and thought a bomb caused it. He saw what he thought were "shadows coming down the building" and then realized that they were "people falling to their deaths." When he heard a second explosion and a rumble, he looked out to see the second tower crumbling. The lights went out in his building, and he began to feel "very nervous" as people began evacuating the site. He "saw a lot of smoke and smelled the dust." Since the tragedy, he had been crying almost every day, was constantly waking up in the middle of the night, and felt so distraught and afraid that he wanted to get out of the Wall Street area. He feared that something else would happen, and he was becoming increasingly angry and impatient. He had been "snapping at people," even though he realized that he had to "take it easy and not take it out on others."

- A woman called two weeks after the catastrophe, saying she was an airline flight attendant and needed counseling because she could not handle her job now. She

barely made her scheduled flight to New York shortly after September 11, staying in the plane's restroom for most of the time. The morning she was about to board her flight home, she felt her body shake, experienced severe stomach pains and was too frightened to board. She had been having nightmares about her plane being hijacked and her wrists and throat being slit.

- A 35-year-old man called two months after 9/11, saying he was "deeply depressed" as a result of various tragedies occurring within three months. In August his grandmother died. Shortly after that he ended a three-year relationship with his girlfriend. Then his sister died at the World Trade Center. Then he lost his job as a result of the attack. The sister who died was his only sibling and his only relative in New York. He reported that neither he nor his family ever sought help in the past, but the incidents over the past three months were too overwhelming for him. The night before his call he had contemplated suicide. He said he no longer felt suicidal, but recognized a need for professional help.

- A woman called saying that she worked for a travel agency that had previously been located in the World Trade Center. The agency had suffered a terrible loss of life. Only ten of thirty employees survived. The survivors returned to work after the disaster, but there was a continuing sense of "devastating loss and sadness." According to the caller, work was no longer "enjoyable" for the staff, and they were finding it increasingly harder to go to their jobs every day.

- A 55-year-old woman called in mid-December, saying that she still could not get over her experience of 9/11. She had seen one of the planes heading for the Tower and had the sensation of wanting to "reach out the window to grab the tail before it hit." She had not been able to sleep because she kept "seeing the plane." Her appetite and personal relationships were also suffering as a result. She said that she felt "stupid and emotional."

- A 48-year-old woman called saying that she was under a lot of stress and that the World Trade Center tragedy had affected her life in several ways. The day before she called she had lost her job as a result of her company's downsizing in the aftermath of the disaster. Her husband's livelihood as a limousine driver had been adversely affected by the fall off in travel, and the couple and their two children were experiencing serious financial hardship. She added that she was tired of "being everyone else's rock." Many of her neighbors had lost family members in the attack, and she had spent much of her time visiting and consoling them. Now she regretted having done so because she was frequently called for help, including doing small errands. The experiences had left her "severely depressed," she said. Her husband, whose best friend was killed on 9/11, was a Muslim Arab who had been experiencing discrimination. He had become bitter and had withdrawn into his religion. Their marriage was suffering, adding to her stress and depression.

I find just these few stories of calls to LifeNet almost too much to bear, but they are just the tip of the iceberg. LifeNet has received thousands of calls like these.

And, keep in mind that most people affected by the disaster did not seek help with their mental health. They had other things on their minds--dealing with death, taking care of their children, finding new sources of income, etc., etc., etc. Far more people need emotional help than have reached LifeNet or other mental health resources.

I hope I've managed to give you a feel for what we experienced in NYC after the terrorist acts of 9/11.

What We Have Learned - Psychological Reactions to Terrorism

Now I want to become a bit more reflective and to talk about what we have learned. I will do this in three parts:

- Psychological Reactions to Terrorism
- Mental Health Services Needed and Provided
- Problems Encountered and Ways to Improve Readiness for Future Terrorist Acts

First, I will talk about psychological reactions to terrorism.

Second, I will talk about the kinds of services that are needed to respond to psychological trauma and about the services that have been organized in NY. P>And finally I will talk about some of the problems that emerged in the efforts to respond on 9/11 and about what needs to be done to be prepared to handle terrorism better the next time.

Psychological Reactions to Terrorism

It is not surprising that terrorism has awful psychological consequences. That is its fundamental purpose--to arouse terror, to create a sense of vulnerability, to undermine the unity and will of a nation, to disrupt the economy, to create social schisms.

To some extent the terrorist acts achieved their purpose.

- First, in the weeks after 9/11 the American economy, which was already weak, was weakened further by panic in the stock market and by the decline of business.
- Second, people previously committed to civil liberties began to clamor for security measures without regard to fundamental rights, and almost everyone in a position of political power seemed afraid to speak out.
- Third, anti-Muslim sentiment surged.

Fortunately economic panic proved temporary, even though the economic consequences of terror continue.

In addition, the willingness to speak out for a balance of security and liberty has emerged to some extent.

And, perhaps most remarkably, anti-Muslim sentiment has been largely brought under control through a determined display of religious tolerance and unity in diversity in both New York City and Washington, DC.

Terrorism failed to cripple the United States. If anything it created a new unity and determination.

Extent of Impact Still Unknown

But terrorism did take a large psychological toll on individuals and families. No one knows quite how great the impact has been.

We know that calls to LifeNet have nearly tripled. (From March 2001 to March 2002, they rose from 3000 to 8000 per month.)

LifeNet data also showed a significant rise in symptoms of Post-Traumatic Stress Disorder (PTSD). From March through August 2001, there were fewer than 50 calls a month from people with symptoms of PTSD. From September 2001 to March 2002, there was a steep rise from 300 in September to over 900 in March.

In addition a telephone survey by the New York Academy of Medicine showed that a significant number of people in New York City could be diagnosed with post-traumatic stress disorder and/or depression and/or substance abuse.

Through extrapolation, the researchers--David Vlahov and Sandro Galea of the New York Academy of Medicine --found that 7.5% of the residents of the southern 2/3 of Manhattan had post-traumatic stress and 9.7% had clinical depression. These rates are two to three times higher than in the general population.

In all likelihood all of us who live in or near New York City have experienced some degree of fear, sadness, sleeplessness, and loss of concentration. These reactions are entirely expectable. Terrible events arouse emotional distress.

Must Distinguish Between Normal Emotional Distress and Diagnosable Mental Disorder

But not all emotional reactions are "normal", and to understand the psychological reactions to 9/11, it is very important to distinguish between normal emotional distress in response to a terrible event and a diagnosable mental disorder.

(As an aside, it is important to note that it is initially very difficult to distinguish between normal and pathological responses. This makes it very difficult to accurately quantify each type of emotional distress until quite a while after a terrorist event.)

Normal reactions to terrorism include:

- Anxiety
- Sadness
- A sense of despair about the future
- Sleeplessness
- Difficulty concentrating
- Loss of pleasure in what usually are pleasurable experiences
- Almost obsessive interest in the tragedy and its consequences
- Reluctance to return to the scene of the disaster
- Marginal increases in drinking and smoking, etc.

But some people have more severe and/or longer lasting emotional reactions. They develop diagnosable mental disorders.

Disaster Related Mental Disorders

- Post-traumatic Stress Disorder (PTSD)
- Other Anxiety Disorders
- Clinical Depression
- Substance Abuse
- Combinations

Of diagnosable disorders the most common is Post-Traumatic Stress Disorder (PTSD), which is characterized by:

- Severe, often disabling, anxiety
- Nightmares
- Flashbacks
- A virtual phobia about return to the site of the trauma
- Irritability and outbursts of anger
- Guilt about survival

Some people who develop PTSD also develop depression and/or substance abuse problems.

Some people do not develop PTSD but do develop other anxiety disorders, depression, and/or substance abuse problems.

Although, as I've said, we have little idea how many people develop mental illnesses in the aftermath of terrorism, we do know from prior research and from the experience in NYC that psychological reactions to terrorism unfold in phases. The research literature conflicts about exactly how many phases there are and what they should be called. But basically it boils down to two phases--

Phases of Psychological Reactions

- Immediate reaction to the crisis
- Getting back to normal

While some people experience acute psychological reactions requiring immediate psychiatric intervention in the immediate aftermath of a disaster, people's primary concerns are not how they feel. They are far more concerned about being safe, dealing with death, preserving the family, and meeting concrete needs for food, shelter, and the money they need to live.

Later, psychological needs become more important to people, and they are far more likely to seek help from mental health providers.

There has been some debate about how long it takes for people to develop post-traumatic stress disorders and other mental illnesses. The experience of Oklahoma City has been that psychiatric problems emerged extensively after six months and continued to emerge for more than three years.

But some experts on post-traumatic stress maintain that it develops rather quickly--generally within two months.

Carol North, a research psychiatrist from Washington University Medical School, who has done the most extensive research on psychological reactions to terrorism in the

United States, maintains that diagnoses could have been made almost immediately after the bombing in Oklahoma City.

It seems to me that the apparent disagreement about when post-traumatic stress emerges arises because people are asking two very different questions.

- One question is--when does the illness develop?
- The other question is--when do people request help?

Whenever the illness develops, it often takes quite a long time for people to ask for help because the early phases of reaction focus on getting life back to normal. For many people it is only then that they can acknowledge their own psychological needs.

What We Have Learned - Mental Health Services Needed and Provided

Because psychological reactions to terrorism are complex, devising mental health services is also complex.

For purposes of this presentation I will oversimplify the needs and make a number of observations related to the kinds of services that are needed, the training that is needed to deliver these services well, and how the services need to be organized.

The most oversimplified statement I can make is this:

- A broad range of mental health services are needed
- Evidenced-based models of intervention need to be developed and/or disseminated
- Mental health providers need a great deal of training in these models
- Organizing services into a system which is responsive to people coping with crisis requires a huge administrative effort.

Service needs include:

- Outreach
- Crisis Intervention
- Public mental health education
- Treatment
- Self-help/peer support
- Disability management
- Social supports
- Training

And services need to be "culturally competent." Most importantly:

- People who provide help need to speak the languages of the people who need help
- It is critical to understand the different pathways cultural groups follow to get help
- It is critical to understand how differently different cultures interpret helping services

For example, an Asian woman called Asian LifeNet on 9/15 to get help for her daughter whose husband was missing in the World Trade Center explosion. She said her daughter was "very depressed", constantly crying while repeating her husband's name, and she was not sleeping or eating. The mother was especially concerned because her daughter was pregnant with the couple's third child. The caller herself was emotionally wrought, but felt that she had to stay strong for her daughter's sake. She agreed to get help for herself "for the sake of my daughter and the children."

It was very important that the person working at LifeNet spoke Chinese and understood that the mother would not have sought help for herself but that she would do what she could for the sake of her daughter and her grandchildren.

As I've said, service needs in response to terrorism are very complex. Tonight I will limit myself to a number of observations about what I think are the most important issues.

Major Observations

- Service needs vary by phase
- Crisis counseling and “emotional first aid" is essential
- Training is essential
- Outreach is essential: i.e. provide services where people go for help and in the context of the help they want
- Public mental health education is essential
- Provide non-medicalized "crisis counseling" for people experiencing "normal" emotional distress in response to terrorism
- Provide treatment for people with diagnosable mental disorders
- Provide other interventions including peer support, social support, and disability management
- Tailor services for different populations
- Especially for children and adolescents, who have special needs
- Provide support for those who provide help, including the uniformed services
- Organizing services requires major efforts of coordination and collaboration
- Use mental health insights to mitigate terror

Service Needs Vary by Phase

There are some differences between the service needs immediately after a terrorist event and service needs during the period when people are getting their lives back in order.

During the phase of immediate crisis the most important needs are:

- Getting out of danger
- Surviving immediate risks to life-- finding shelter, having enough to eat, getting medical care
- Coping with death and loss
- Getting a place to live, financial means, etc.
- Emotional support.

During this phase people generally don't think very much about their mental health needs. Therefore, mental health services need to be integrated with response to danger and concrete need.

For example, the New York City Department of Mental Health assigned skilled clinicians to carry out a variety of concrete tasks, such as helping people search through lists of names for missing loved ones, applying for emergency assistance, applying for death certificates, and the like.

After dealing with the immediate crisis, other mental health service needs become important. I will comment on them later.

Critical Incident Debriefing

Many people believe that the best approach to help persons exposed to a catastrophic event is a method commonly referred to as emotional or psychological "debriefing", which is performed early in the crisis phase. It is based on a belief that helping people to talk in detail about their experience as soon after the event as possible is necessary to help them process and integrate it, so they feel less overwhelmed. It is often done in groups, where the sharing of experiences is intended to invite group support and help normalize reactions to the catastrophic event. Some organizations go so far as to mandate "debriefing."

Research has typically shown that persons receiving psychological debriefings are not more protected from developing acute stress or PTSD. Interestingly, research shows that most of the people who have received it believe that it was instrumental in helping them get better, even though these same studies suggest that they likely would have gotten better without it. This suggests that for people who are likely to be more resilient, psychological debriefings are experienced as reassuring, supportive and helpful.

However, for persons more prone to PTSD, psychological debriefings may not only fail to be helpful but, in some cases, are harmful. Research has found that some people are simply not ready to talk about the experience so soon after the event, and being pushed to do so in group settings may make matters worse. For these reasons the National Center for Post Traumatic Stress Disorder in the United States does not support making participation in psychological debriefings mandatory.

The National Center does support “emotional first aid” or “crisis counseling”, which seeks to provide support at the level the individual expresses a need for it.

However, none of these terms is clear and all are used rather loosely. What is clear is that we need an evidence-based model to guide those who try to help during the crisis phase.

Need for Training

In addition to the lack of an evidence-based model of crisis intervention, the experience in New York City made it clear that there were many more people willing to help than there were people who were trained to help. In fact almost all of the mental health professionals who extended themselves heroically had no experience in this kind of crisis intervention.

For example, a psychologist I know--a very experienced clinician--told me that when he arrived to provide "debriefing" and asked for an orientation, he was told to use his common sense.

Although he had good common sense, many people do not. (I think it was Mark Twain who noted how uncommon common sense is.)

It is very important; therefore, to provide training in crisis intervention before crisis events occur.

It is equally important to know who is trained and to be able to reach them in a crisis.

Training is also very important in the kind of crisis counseling that needs to be provided even after the first phase of the crisis is over. This kind of work stresses relating to people in a way that does not assume that they are mentally ill. Most mental health professionals are trained in detecting and treating illness, with less understanding about how to identify and build on personal strengths that maintain health. Thus special training is important for crisis counseling.

Finally, training is also very important for responding to post-traumatic stress and related disorders. Research suggests that medication combined with cognitive-behavioral treatments – interventions that focus on thoughts and behaviors that either interfere with or promote healthy functioning – are the most effective approaches. However, few mental health professionals have been trained to do this.

Project Liberty

Before moving on to the next three observations--about the need for outreach, public education, and crisis counseling--I want to be sure that you are aware that in New York the federal government funded a major initiative called "Project Liberty." This is a massive undertaking, which provides outreach, mental health education, and crisis counseling to the entire NYC area, including Northern New Jersey and Southern Connecticut. Project Liberty is the largest mobilization of disaster-related mental health and crisis support resources in the history of the United States.

I will be referring to this project in what follows.

Outreach

Although a very large number of people experience emotional distress in reaction to terrorism, a relatively small percentage of them turn to the mental health system for help.

Both during the immediate crisis phase and subsequently, people go to crisis centers and helping places in the community such as schools and houses of worship. They also turn frequently to families and friends and to primary care physicians.

For example, a man phoned LifeNet, saying he was a retired construction worker who had been working for the past week at Ground Zero, cutting steel. He had been having trouble sleeping, waking up "about ten times a night," thinking about the body parts he saw and feeling overwhelmed by "the total devastation of it all." He had been talking about it to his bartender, but to no one else.

As we all know, talking to bartenders is a common way that people seek help--though fortunately not as common as talking with family and friends, with clergy, and with primary care physicians.

While over time the number of people who seek professional mental health assistance increases because people begin to get their lives under better control and have time to acknowledge that they need some help, still what most people have on their minds after a disaster are:

- Reestablishing homes
- Dealing with finances and jobs
- Getting kids back to school
- Getting past mourning

And they go for help to places that can help with these kinds of very fundamental, human needs.

For this reason, it is critical to provide mental health services in the places where people go for help and in the context of the help they want.

That is, it is critical to reach out to people.

Project Liberty is built on this assumption and reaches out to people where they work, where they go to school, where they go for emergency help, where they go to worship, etc.

Public Mental Health Education

Beyond concrete needs, one of the things that people want most is mental health education.

Most commonly they ask for help to learn how to talk with their children so as to help them with the difficult emotions they are experiencing.

They also want advice about how to cope with their own emotional distress.

And those who feel the need for professional help want to know where to go to find good professional intervention.

Thus, public mental health education is a vital mental health service for a very large number of people.

Public mental health education needs to be provided very rapidly and to continue for a considerable period of time after the event. It needs to provide information not just about where to go for help, but also about expectable emotional reactions and how to cope with them.

Through Project Liberty we have mounted a major, multi-media public education campaign designed to help people identify signs and symptoms of “normal” emotional distress in themselves and in their family members, as well as signs of emotional distress that may mean that they should seek help.

It directs people to ask for help by calling 1-800-LIFENET. Some examples of posters that were carried on subways, busses, bus shelters, bill boards, translated onto post cards, cups, were all in multiple languages.

Advertisements featuring celebrities are on TV and radio, in newspapers, on public transportation, etc. telling people that help is available and that asking for help is important to do when you need help.

We have found, no surprise, that TV is the most effective way to reach people.

As I've already noted, MHA's LifeNet has played a vital role in this public education campaign because it has served as the regional telephone communications hub.

And, as I've also noted, the campaign has been remarkably effective.

For example, a 25-year-old man called LifeNet after seeing the ad on television. He related how he had never sought counseling before, and until now he had relied on discussing his World Trade Center experiences with his wife. "But now she can no longer take it," he noted, adding that his emotional state and his reliance on his wife for support were affecting his marriage.

Note that this man had never sought help before and that he had relied on his wife. This is fairly typical. It is also not unusual for the family and friends to whom people tend to turn to burn out after a while. It is then that people need to connect with resources outside of their usual sources of help, and it is then that the public education campaign is vital because it gives them a number to call to get connected to help they otherwise would not know how to find.

Crisis Counseling

For the vast majority of people who can benefit from psychological help, it is very important not to "pathologize" their problems by providing diagnoses and medically oriented services.

Therefore, a major effort needs to be put into providing "crisis counseling" services, which are geared to providing emotional support to people who are having normal, distressed reactions to a terrible event.

Such services are designed to help people process their emotions and to draw on their substantial inner strengths to improve their ability to manage emotions which are both powerful and unusual because they are triggered by events which are powerful and unusual.

Project Liberty provides crisis counseling wherever people request it--in their workplaces, in their schools, in their houses of worship, in community centers, or in the privacy of their homes.

Working with people in the settings where people are most comfortable helps to convey the message that emotional distress is a normal consequence of terrorism and the many people can find ways to overcome it without extensive treatment.

Treatment

However, as noted earlier, not everyone experiencing emotional distress is having a normal and transient reaction to a terrible event. Some people do develop diagnosable mental disorders which are likely to persist and for which treatment is advisable.

For these people, it is critical to make treatment services available.

For those who have mental health insurance, treatment services should be available through the private sector. (The distinction between the private and the public sector is probably not applicable in Canada, but it is very important in the United States.)

That presupposes, of course, that there are mental health professionals in the private sector trained to respond to post-traumatic stress and related disorders.

But at least 40% of Americans do not have private coverage and need to get mental health treatment through the public mental health system.

This may become a problem in the United States because the federal regulations which govern Project Liberty preclude providing treatment to people with diagnosable mental disorders. It is limited to providing crisis counseling to people having normal emotional reactions to disasters.

The failure of the Federal government to fund these services could become a serious problem because New York State's public mental health system is stretched to its limits and is oriented primarily to people with serious and persistent mental illnesses.

Without doubt more treatment capacity needs to be developed in New York State for people with post traumatic-stress and related disorders.

I would expect that the same would be true in Canada if there were a major terrorist event.

And I would suggest that the Canadian Mental Health Association should research sources of funding for expanded treatment services, if you have not done so already.

Other Interventions

There are a number of additional interventions that could be very helpful to people who develop mental disorders in reaction to terrorism but which are rarely considered. They include:

- Self-help and Peer Support
- Community Building
- Rehabilitation and Disability Management

It is well documented that self-help and peer support can be very helpful for people with mental illnesses and many other problems. Experience in Oklahoma City suggests that people with mental illnesses can be of great assistance to people who develop mental disorders in the aftermath of terrorism. It only makes sense to include this sort of service as part of the range of services put in place after terrorist events. It has been included to some extent in Project Liberty.

It is also well documented that one of the most significant risk factors for developing mental illness in the aftermath of terrorism is lack of social support. Therefore, community-building initiatives could be very helpful.

In addition, people who develop mental disorders frequently experience some vocational dysfunction as a consequence. In general those who work in disaster psychiatry seem to believe that vocational dysfunction will disappear once the disorder is successfully treated. However, we know both from the corporate sector and from experience with people with long term mental illnesses, that vocational dysfunction can be successfully addressed with a variety of rehabilitative and disability management techniques. These kinds of services make it possible for people to stay on the job or to return to work quickly even though they have not fully recovered from mental illness. These kinds of techniques, I believe, should be adapted to the context of responding to disaster.

Needs of Different Populations

Different populations have different needs and mental health services needed to be tailored accordingly. Populations which need special consideration include:

- Children and adolescents
- Children and adolescents in foster care
- Bereaved people
- People who lose homes
- Working people
- People who lose jobs
- People with serious mental illnesses and other disabilities
- Elderly people

Children and Adolescents

Although there are many populations with special needs in the aftermath of terrorism, I have been asked to make a few comments on children and adolescents particularly.

This is not easy because, in truth, there has not been enough research to make definitive recommendations.

Research from Oklahoma City does make it clear that children who were not direct victims of terrorism as well as those who were have strong psychological reactions to the experience. Exposure to the events through the media--especially television--affects kids virtually as powerfully as direct experience.

Despite the lack of formal research findings, I believe that there are some lessons to be learned about children and adolescents from the experience in New York City.

Perhaps most important is the fact that children and adolescents react differently. The reactions of young children tend to be more apparent, and they tend to look more to their parents for help. Adolescents, true to form, tend to deny distress and not to ask parents for help.

Young children tend to regress and to want more contact with their parents. Some want more time together. Some want more hugs and kisses. Some become more "clingy."

Young children also tend to be very concrete in their interpretation of events. For example, one little boy I know became very upset when he heard his parents, and the news commentators, say right after the event, "Nothing will ever be the same." He began to cry because he thought he wouldn't go to school again, wouldn't play soccer again, wouldn't see his friends anymore, etc. Sorting out reality from adult metaphors can be very important for children. Young children are particularly affected by the repetition of events in the media. For many of them, each time they see or hear about the terrible event, the trauma is repeated.

This creates a great dilemma in efforts to help children deal with events. It is important for them to know that adults are available to help, but if we constantly repeat the story of the event as part of our effort to reach out to children, we risk adding to the trauma.

This need for an exquisite and elusive balance creates a challenge for school-based programs. Yes, schools offer a great opportunity to reach children who need help, and schools and mental health providers should work together to use this opportunity. But programs need to recognize the risks of reinforced trauma.

We should all keep in mind that the first programs developed in schools to prevent adolescent suicide actually increased the risks of suicide.

I make this observation not to discourage intervention with kids, but to encourage cautious intervention and careful monitoring of outcomes.

For adolescents, providing support at home and at school is as tricky as it always is to help adolescents who are struggling not to need adults. They need adults but they don't want to need adults. We need to be available. We need to be sure they know we're available. But we need to avoid forcing ourselves on them unless they clearly cannot cope.

I know that doesn't give very clear direction. Hopefully, further research about the many efforts that are now being made to reach and support children and adolescents will eventually provide the direction we need.

Support for Those Who Provide Help

The other population I want to devote a little special attention to is the help-givers.

The people who help during the aftermath of disaster go through terrible emotional turmoil themselves. It is not uncommon for them to work 12 or more hours per day, for them to be emotionally drained, for them not to be able to sleep, for them not to be able to get the stories they've heard out of their heads. They need help so that they can continue to help, and support for them needs to be a priority.

This includes people who are providing mental health services as well as teachers, day care workers, clergy, and many others to whom people turn for help.

And it includes police, fire, and emergency medical personnel, who work under tremendous emotional stress. In Oklahoma City, 25% of those who sought mental health services 2-3 years after the bombing were members of the uniformed services. By the end of 1997 six members of the uniformed services committed suicide, and there were 30 known interventions that prevented suicide among the uniformed service members and

their families. In New York 343 firefighters and 23 police officers lost their lives to the World Trade Center tragedy. An additional 18,500 Uniformed Services Personnel were exposed to it. The potential for developing serious and life threatening mental disorders is great. As a result, many efforts have been underway since 9/11 to address their mental health needs early on.

Here is an example of one call from a fire fighter that we received at LifeNet.

- He was reluctant to talk. He said he was calling from the basement of his home. His unit was sent to the WTC and as he retold his experiences there, he began to weep, at times uncontrollably. As the Referral Specialist worked to comfort him, he began to reveal the nightmares he was having of bodies with the faces of his children. He was devastated to lose so many friends and colleagues in the Fire Department. He was overwhelmed with the scope of the loss of life and cringed when others addressed him as a "hero". The feelings of guilt for not being able to rescue other fire fighters were significantly affecting his ability to concentrate on his work. He also found himself losing his temper with his family. He worked long hours and the children were feeling neglected. He attempted to shield his family from his traumatic stress but had avoided contact with them in the process.
- Fairly clearly this man is suffering from post-traumatic stress disorder, and just as clearly he feels ashamed and unable to reveal his pain to anyone--not to his family and not to fellow firefighters.
- And he is probably not a person who is going to turn to the mental health system for help because he feels he has so much to hide.

In New York City, the fire and police departments have mounted significant efforts to provide mental health services to their personnel within their departments, and many people, who would not go outside the close circle of their departments, have found help there.

MHA has been actively involved in these efforts. We formed the Uniformed Services Work group consisting of the NYC Police Foundation, the counseling services unit of the FDNY, the regional Emergency Services Council, and other providers of support services to uniformed personnel. This work group was created to enhance cooperation and sharing of outreach and educational approaches between services and to link them to community based treatment providers who could be of assistance.

Additionally, the NYPD has mandated group counseling sessions for all of its members to identify problems and to create group support. By mandating all officers to participate, these groups decrease the stigma that the police culture attaches to seeking help. Evidence from Oklahoma City demonstrates that, if untreated, stress produces increased incidence of domestic violence, suicides, and excessive use of force. As of March, 1685 police employees have participated in the program.

The FDNY has obtained over 2.5 million dollars in support from the federal government. These monies will be used to expand outreach, provide counseling services within FDNY counseling centers to all members and their families in need, and place counselors in all of the firehouses. Since 9-11, over 2,000 FDNY personnel have utilized mental health services. Prior to 9-11, there were less than 500 open cases at the FDNY counseling center.

MHA of NYC is in the planning stage for a conference for the Uniformed Services to enhance the awareness of potential issues, risks, and concerns within the uniformed services community and to address why they should seek help. Because we know that many individuals will not ask for assistance, strategies on how to overcome the stigma and prompt their members to seek help will be discussed.

Organizational Effort of Coordination and Collaboration

Managing services in the aftermath of a disaster takes a huge organizational effort.

It requires:

- Establishing crisis centers
- Setting up an array of services in them
- Finding, assigning, and supervising qualified staff
- Coordinating service providers from a large number of systems that don't ordinarily work together

All of these require monumental effort.

Even now planning coordinated services of various kinds continues in New York City through a task force of human service organizations that has been established, and it is not an easy process.

Because a telephonic communications system is a core element of a coordinated system of disaster response services, MHA's LifeNet has been a vital resource as part of New York State's effort to develop a collaborative service system.

In order to participate in disaster response effectively, MHA had to go through a rapid process of planning and internal reorganization.

Early in the crisis, the director of LifeNet and I felt like chickens running around with our heads cut off. With the help of our Board President, we engaged in a strategic planning process through which we were able to identify our strengths and how we could make the greatest contribution.

We decided to focus on our communication system (LifeNet) and on our ability to serve as a community catalyst and organizer. We are able to do this because we are respected as neutral in the competition for funding for services and because we have relationships with providers in all service systems, which enable us to rapidly bring together constituencies, which are sometimes in tension with each other.

We cast a plan focused on a limited, but essential, role; and that has made all the difference.

Mitigating Terror

Perhaps the most fundamental mental health need in the aftermath of terrorism is avoiding the psychological terror it is meant to instill in people.

Both public officials and the media have very important roles to play in this regard.

In their public communications, public officials can help to calm people or can stir up their fears. It is particularly important for public officials to speak about events in ways that do not fuel terror.

Mayor Guiliani was remarkably good at this, and one of the reasons he was so good was that he listened to his mental health commissioner who helped him to understand the nature of people's emotional reactions.

It is remarkable to me how well public officials in New York City and in Washington used public ceremonies to facilitate a healing process as well as to build unity. Inclusion of Muslims in these ceremonies, for example, helped enormously in the effort to avoid an outbreak of violence against Arabs, which seemed inevitable in the first few days.

In general the mental health community needs to try to be helpful to public officials, a task which the Federal Substance Abuse and Mental Health Administration is taking on by developing guidelines for public communication.

The media in the United States, I believe, did not do as well as The President and the Mayor. They have become accustomed to creating alarming headlines and repeating them over and over again as a way to attract viewers or listeners. They showed bad news repeatedly. Whatever threat could be imagined, they reported as a current danger. They had no difficulty scaring the Hell out of everyone about bombings, anthrax, small pox, etc.

In the aftermath of terrorism, the media need to learn to be factual without being alarming.

And the mental health community should work at developing guidelines for the media.

What We Have Learned - Improved Readiness for Terror

Now I want to turn to the final section of my presentation: improved readiness for terrorism.

I have great admiration for the heroic efforts that were made by the City, the State, voluntary providers, hospitals, the American Red Cross, and thousands of individuals in response to the terrorist acts of September 11. It is almost unbelievable how effectively the response was mobilized under such terribly adverse conditions.

But, of course, there were problems, and it is always possible to do things better.

There are lessons to be learned from the experience, which can be used to be better prepared for future terrorism.

What were the problems?

- Lack of readiness to use the disaster plan
- Lack of clarity of authority
- Lack of coordination

- Lack of a shared model of intervention
- Shortage of trained personnel
- Lack of a database of trained personnel
- No mechanisms to pay for services
- Regulatory barriers to treatment

Despite the existence of a disaster plan, neither the public nor the private sector was adequately prepared. The plan itself needed improvement, and there had been no drills. Many people really didn't know what to do.

Issues of authority emerged because there were so many governmental and quasi-governmental agencies involved--each of which had its own sphere of authority and its own command center.

Coordination of so many groups was difficult--to say the least.

There was no shared, evidence-based model of crisis intervention.

There weren't nearly enough people trained to provide crisis intervention or treatment for post- traumatic stress disorder.

There was no database to identify trained personnel, except the Red Cross's, which was too limited.

There were no mechanisms in place to pay for services.

The scope of Project Liberty was limited because of federal regulations.

Therefore, new treatment capacity has not been developed.

Finally, it was difficult for the public mental health authority to extend its role and provide leadership for the private as well as the public sector.

What Needs to be Done to be Better Prepared?

It is striking to us that there is already intense activity to be better prepared for bio-terrorism, but so far as we know little has been done for prepare for the psychological impact of terrorism.

Mental health services are always at the bottom of the list of people's needs. Apparently it is no different in times of terror, even though nothing could be clearer than that disruption of mental health is the primary goal of terrorism.

We believe that a planning process should be set in motion immediately in the areas of the United States which are targets of terrorism to assure an adequate mental health response to future acts of terrorism. This is probably needed in Canada as well. And these plans cannot be only national or even statewide (provincial in Canada). Each locality needs to have its own plan--a plan tailored to fit local circumstances. We know that most localities have disaster plans, but we believe that all of these plans should be reviewed, and revised as needed, to provide more attention to the mental health needs of people in the aftermath of a disaster.

Community Mental Health Disaster Readiness Checklist

All Localities should have the following:

- A Local Mental Health Disaster Plan
- A Local Mental Health Disaster Response Entity
- Clarity Regarding Authority--Both in the Public and in the Private Sectors
- Established Linkages and Plans for Coordination
- Telephonic Communications Center
- Plan for Outreach
- Plan for Public Mental Health Education
- Readiness to Provide Public Communication to Mitigate Terror
- Shared, Evidence-Based, Models of Intervention and Treatment
- Cadres of Trained Personnel
- Support and Training for People Providing Help Including Uniformed Services Personnel
- Emergency Funding and Payment Mechanisms
- Review of Regulatory and Funding Structures
- Contingency Plans
- Routine Drills
- Plan for Evaluation

While local plans must vary, they all need to include a number of critical elements.

- Each locality should establish a disaster response entity to develop the mental health disaster plan and organize and manage mental health services in a disaster.
- Issues of authority should be addressed. Who is in charge in "command centers" and who is in charge in the field? Should the authority and responsibility of public mental health authorities expand during "public mental health emergencies?"
- Issues of coordination should be addressed. How will governmental agencies interact? How will Red Cross interact with the governmental agencies? How will private organizations that provide mental health services in the public mental health system be linked into the overall response? How will the private mental health sector--employers, employee assistance programs, and behavioral managed care organizations be linked to the mental health response? How will mental health service capacities in schools, child welfare organizations, police and fire departments, the VA, etc. be linked into the overall mental health response?
- Local mental health providers should be required to have plans regarding disaster response linked to the overall plan.
- Each locality needs a telephonic communications center, like LifeNet. To operate a hotline and information center 24 hours a day, 7 days a week, we recommend the development of regional communications hubs which could handle communications for multi-county areas.
- Local mental health disaster plans should anticipate the need to reach out to people in the places where they are most likely to go for help. This will include emergency assistance centers, schools, workplaces, houses or worship, other community organizations, etc.
- Readiness to provide public mental health education is a key element of local mental health disaster plans. There should be public service announcements, programs in schools, houses of worship, and other community organizations.
- The plans need to take into account the impact of public communications on the mental state of the general population. Terrorism is designed to create terror.

Statements by public officials and media accounts can help to relieve fear or they can arouse even greater fear. Public spokespeople should be prepared for their roles, and media should develop policies about how to handle the reporting of events so as to give full and accurate information but to do so in the way that is least alarming.

- It is important to formulate a shared--evidenced-based--model of intervention, which will be implemented after a disaster or act of terrorism.
- Cadres of trained mental health personnel should be developed and a database and communications system created to mobilize them immediately after a disaster.
- A mental health "reserve corps" should be created. In addition to cadres of mental health personnel who can respond immediately after a disaster, there is a need for mental health professionals to provide ongoing mental health services after the acute crisis phase. Hiring new personnel is problematic because there is a shortage of mental health professionals even to meet current needs. It is also problematic because additional personnel will, hopefully, be needed for a limited period of time, phasing down over a period of about three years. Therefore, the local disaster plan should provide for the creation of a "mental health reserve corps" of mental health professionals who are retired or who have part-time practices and who are willing and able to work in the public mental health system on a time-limited emergency basis.
- Local disaster plans should anticipate the need for support and training for people providing help to people in crisis--including police, fire, and emergency medical personnel.
- Emergency funds and payment mechanisms should be in place. A payment model, such as that developed for Project Liberty, should be in place and ready to use immediately rather than having to develop such a model after a disaster has taken place.
- A review of state (in Canada, provincial) and federal regulatory and funding structures should take place during the planning process, and recommendations should be sent to state or provincial and federal governments.
- Contingency plans should be in place. In times of disaster or crisis, almost anything can happen. For example NYC's emergency service center was in the World Trade Center and was destroyed, leading the city to scramble to create a new center. Other contingencies include loss of power or phone service and transportation problems.
- Routine Drills should be held: Plans frequently do nothing but gather dust on shelves and become relatively useless in times of crisis because no one is prepared to lead the crisis response and those who are supposed to implement the plan do not know what they are supposed to do. For this reason we recommend that there be disaster drills involving mental health personnel. Since in most communities drills are held from time to time for nuclear, bio-chemical and other disasters, we further recommend that mental health drills should be linked to these processes rather than to be pursued separately.
- Finally the plan should include provisions to evaluate the effectiveness of the mental health disaster response.

This may seem like a lot to do to prepare for events we all hope will remain rare. The alternative, however, is to be unprepared and to rely on spontaneous heroism to muddle through. At MHA of NYC, we believe it would be better to be ready.

Conclusion

I was asked to speak a very long time tonight, and despite my better judgment I have done that. As also requested, I have tried not to get too technical. But I have provided what may be an over-abundance of information.

I hope that I have not become the evening's soporific.

Let me end with one overriding suggestion.

Each community needs to be prepared for the awful possibility of terrorism.

I, therefore, recommend that each of you go back to your community and assess whether it is prepared to provide a response to the mental health needs created by terrorism and determine as well what role you can play in helping the community be prepared.

Again I want to thank the Canadian Mental Health Association for its interest in an American mental health problem. You are wise, I think, to anticipate that at some point it may be a Canadian problem as well, though I hope for your sake that that prophecy proves false.