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BRIEF REPORT

Federal Disaster Mental Health Response and Compliance with Best Practices

Jody McIntyre · Briana S. Nelson Goff

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Abstract This study investigated the comprehensiveness of disaster mental health state plans and their adherence to published best practices in three states that experienced post-9/11 federally-declared disasters. There were 59 disaster mental health best practices used in this study to assess each state disaster mental plan's compliance with best practices; the states demonstrated a range of adherence to the best practices. This research may serve as a guide for those developing disaster mental health plans and encourage further considerations in disaster mental health response.

Keywords Disaster mental health · Response · Planning · Best practices · Training

Disaster mental health is an evolving field of practice that involves interventions and practices that are designed to address specific stress reactions in contrast to developmental mental health needs (Jackson and Cook 1999). Disaster mental health differs in several ways from traditional psychotherapy models. Traditional mental health services are aimed at treating pathology via group and individual interventions, whereas disaster mental health is a proactive attempt to prevent acute stress pathology and normalize reactions to the disaster events (DeWolfe 2000). In disaster mental health, services occur across all phases of the disaster, with targeted programs beginning during or immediately after the incident (Mitchell 2003).

Since the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988, three disaster mental health models have become popular post-disaster interventions: Critical Incident Stress Management (CISM; Mitchell 2003); Psychological First Aid (PFA; National Child Traumatic Stress Network [NCTSN] and National Center for PTSD [NCPTSD] 2006); and the Federal Emergency Management Agency (FEMA)/Substance Abuse and Mental Health Services Administration (SAMHSA) Crisis Counseling Programs (CCP; FEMA 2010). While CISM, PFA, and CCPs may regularly occur in post-disaster mental health responses, each response model appears to have strengths to offer a community.

CCPs, which are implemented only for federally-declared disasters, are delivered primarily by non-mental health professionals and strongly encourage those in the affected communities to participate in post-disaster mental health responses. With the goals of educating the community on normal responses to disaster and offering guidance, CCPs strive to serve all affected by the disaster through such services as outreach, education, brief supportive counseling, and professional referrals. CCPs are often in place for several months past the immediate phase, when PFA and CISM are most appropriate.

Elrod et al. (2006) conducted research with 36 state agency directors who managed the SAMHSA CCP emergency response grant funds to evaluate the challenges in executing crisis counseling programs in their areas. Many states that did not regularly experience disasters did not have a disaster mental health plan in place and many of the plans that did exist were vague and immature in content. In addition, many disaster plans only minimally addressed the

J. McIntyre
Southwest Mississippi Mental Health Complex, Summit, MS 39666, USA

B. S. Nelson Goff (✉)
School of Family Studies and Human Services, College of Human Ecology, Kansas State University, 119 Justin Hall, Manhattan, KS 66506-1401, USA
e-mail: bnelson@ksu.edu

mental health concerns of the community they were to serve (Elrod et al. 2006). The investigators further concluded the need for training for state directors in a disaster mental health response, with guidance on how to complete the grant request and manage the community demands against administrative necessity.

Hobfoll et al. (2007) reported on the absence of evidence-based consensus supporting immediate and mid-term post-disaster mental health response. They recommended that the following five elements of psychological response be promoted when responding to victims involved in a disaster: (1) a sense of safety, (2) calming, (3) a sense of self and community efficacy, (4) connectedness, and (5) hope. However, the National Institute of Mental Health (NIMH) convened a workshop, which included the most well-known researchers and clinicians in the field of disaster mental health, trauma, and resiliency. The result was a publication that guides mental health responders and state officials in the most efficient way to respond to a disaster (*Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence. A Workshop to Reach Consensus on Best Practices* [NIMH 2002]). With the NIMH best practice guidelines that shape disaster mental health response and plans nationwide, there is a need to evaluate adherence to these best practices to determine whether they are in place to provide optimal response efficiency and outcomes in their disaster mental health response.

The current study evaluated the comprehensiveness of state plans and their adherence to published best practices in three post 9/11 federally-declared disasters: 2005 Hurricane Katrina response in a Southern state (State 1); a 2007 tornado in a Midwestern state (State 2); and 2008 flooding in a Midwestern state (State 3). Each of these states applied for and received FEMA/SAMHSA Crisis Counseling Program (CCP) grants for their state disaster mental health response following these disasters. With the frequency of disasters striking the United States and around the world today, there is a need to ensure that the NIMH best practices are being followed, both in written state disaster mental health plans and in the field.

Research Methods

This study utilized a mixed methods research design to gather significant and relevant themes in disaster mental health response as displayed in written disaster mental health state plans. The current study results were part of a larger study that included both qualitative interviews with key disaster mental health personnel in each state, as well as the evaluation of the written state disaster plans (reported here). The research enriches the understanding of disaster mental health response by comparing the state plans to identified best practices.

Research Participants

The primary data in the current study consisted of three existing state disaster mental health plans. These states (1 Southern and 2 Midwestern states) were selected for their involvement in diverse disaster mental health responses and because of the authors' previous experience with disaster mental health response personnel in the identified states. University IRB approval was received for this study.

All the states involved in this study have responded to nationally declared disasters and were granted funding to implement a FEMA/SAMHSA Crisis Counseling Program in their affected areas. By selecting these states, the study gathered information from state disaster mental health plans that involved hurricanes, flooding, and tornados. This diverse experience allowed the researchers to evaluate a variety of disaster experiences. We also believed that it was important for states to have experienced a nationally declared disaster, which served as an opportunity to directly evaluate their originally developed state plans.

Data Analysis

The best practices for this study were identified from the NIMH (2002) published guidelines in the field of disaster mental health response and from two additional disaster mental health response publications (Elrod et al. 2006; Hobfoll et al. 2007), for a total of 59 specific evaluation criteria used in this study. These criteria can be summarized in the following general topic areas: Mental Health Screening (2 items); Needs Assessment (4 items); Follow Up Contact (6 items); Disaster Mental Health Training and Response (28 items); Research and Data Collection (7 items); External Organizations (5 items); and Communication/Information Dissemination (7 items). (The authors may be contacted for a complete list of the evaluation and scoring criteria.)

Using a scoring rubric, the researchers evaluated the plans for adherence to the identified best practices. Each state plan was evaluated and each best practice procedure was identified as either being compliant (included) or non-compliant (excluded) with each best practice, providing a quantitative "score" for each state plan on the best practices evaluation form. Notes provided additional information that was gained during the review process. The findings were reviewed several times over the course of the data analysis. By reviewing and evaluating the three disaster mental health state plans, more insight about the state response and planning was gained and used to further explore how each state encompasses best practices in the field of disaster mental health.

Results

In the assessment of the state plans, the following primary areas were identified, based on the 59 best practices: disaster mental health training and response, mental health screening, needs assessment, disaster response communication/information dissemination, follow-up contact, research and data collection, and coordination with other response organizations. In the results, both the quantitative state plan scores and specific qualitative data from the written plans are reported, to provide a broad description of the study results.

Common Areas Identified in All Three State Plans

Each state plan varied in its inclusion of the 59 best practice areas. All three state plans included the following: training and response, needs assessment, communication/information dissemination, and coordination with other response organizations.

Training and response refers to the specific training or requirements that are in place for individuals to be considered appropriately prepared for disaster mental health response. These requirements included both clinical and administrative training and also addressed possible limitations for responders. In addition, all three state plans addressed training and response with special populations. Each plan addressed special populations with increased priority and recognized that their needs may be somewhat different than other affected individuals.

Needs assessment was based on the acknowledgement of completing a needs assessment for both individual and community needs. This consists of an evaluation to plan an organized response to a disaster affected area and gathering information, such as the population(s) and number of people affected; description of the area affected; description of mental health needs; and type of response and agencies that are needed. All three state plans outlined the process of completing a needs assessment, identifying that it was the responsibility of the local affected community to first recognize the need for external support or resources.

Communication/information dissemination identifies how each state distributes information to the public. This includes utilizing current technology for the community to access information, selection of hard copy materials that will be provided to the affected community, and identifying personnel who will be in charge of general information dissemination throughout the disaster mental health response. With survivors grasping for news from media and responders, each state plan recognized that it is essential to communicate accurate and timely information during a disaster mental health response.

The final common theme identified by all three state plans relates to coordination with other disaster response organizations. No organizations can respond effectively to a disaster without the support and relationship with others in the community and state. Without the constant collaboration with other organizations in the disaster response, disaster preparedness cannot fully occur. Best practices were identified that address the need for states to become involved with other organizations for consultation, collaboration, training, and mutual assistance.

Although these four areas were identified in all three state response plans, there were a few common best practice areas that were not included in any of the state plans. For example, none of the plans described the state organizational structure for disaster mental health (e.g., staff positions, funding base). In addition, while training was emphasized in all three plans, disaster preparedness experiential trainings (e.g., tabletop exercises) and program manuals for field guidance were not described. Finally, none of the state plans outlined any type of screening tool to identify individuals or groups considered high risk for PTSD or other formal clinical assessments, nor did the states identify any data collection tools that could be used for local disasters or disasters that lack the severity of a federal declaration. While the Crisis Counseling Program addresses the research and evaluation components of disaster mental health response, none of the three states involved in this study reported plans for conducting disaster mental health research.

Evaluations of Individual State Plans

The previous section described areas that were identified as present or absent in all three plans. The following descriptions detail the strengths and weaknesses of each plan related to the 59 best practices to provide a more comprehensive review of the unique aspects of each state plan.

State 1: Hurricane Katrina

The State 1 plan had the most inclusive evacuation plans for state-operated facilities of any of the three plans. This plan included such fore-thought as using a Public Information Officer and the use of diverse technology to inform the families of individuals in state-operated facilities. The plan outlined most specifically the evacuation and placement procedure of clients to special needs shelters in their state, including staffing requirements and responsibilities. The plan identified several agencies with which they have maintained interagency planning and communication,

including Native American groups, state and federal military facilities, law enforcement agencies and others. Overall, this plan scored a 12% ($n = 7$) on compliance with the 59 best practices. This plan included some information for the following best practice areas: Needs Assessment (3 items), External Organizations (1 item), and Communication/Information Dissemination (3 items).

The State 1 plan neglected state mental health responder training and lacked clinical input. The plan did not address any clinical training for community responders. The plan mentioned several times that Community Mental Health Centers are responsible for disaster mental health response in their jurisdiction, but there was no reference to any agreement between the state agency responsible for disaster mental health response and local Community Mental Health Centers. The plan requires all Community Mental Health Centers to have an active disaster mental health plan in their facilities. The plan did not outline any community-based information dissemination. However, the plan indicated the use of phone, radio, and internet sources to relay information. While this plan had extensive evacuation plans and a focus on state-operated facilities, many of the best practices were not included in the state plan.

State 2: Tornado

The State 2 plan was clinically inclusive and involved examples and training on all clinical best practices, with the added component of family intervention. Overall, this plan scored a 42% ($n = 25$) on compliance with the 59 best practices. The state agency that is administratively responsible for disaster mental health in the state and its subcontracting organization (responsible for the actual response program) are tasked with dissemination of information to the public, to ensure that consistent and accurate information is released. This plan showed further insight outlining that the distribution of information should be dispersed in non-traditional ways, such as through outreach services, disaster shelters, meal sites, churches, and community centers. Overall, this plan included information for the following best practice areas: Needs Assessment (2 items); Disaster Mental Health Training and Response (14 items); Research and Data Collection (1 item); External Organizations (2 items); and Communication/Information Dissemination (6 items).

The primary limitation of the State 2 plan was that the state agency responsible for disaster mental health response does not require the Community Mental Health Centers in the state to respond to a disaster, to be involved in any response training or preparation, or to have a disaster mental health plan for their agencies. With local responses not being mandated, much of the plan did not cover all local and state responses and was evaluated as being deficient in these areas.

State 3: Flooding

The State 3 plan was a very complex plan that encompassed a multi-layer approach to disaster mental health response. Overall, this plan scored a 71% ($n = 42$) on compliance with the 59 best practices. This plan clearly outlined the duties of each level of response throughout the disaster timeline. This plan exhibited a thorough training program and strengths were seen in logistic planning, training, and state-wide involvement and coordination. This was the only state plan that required any type of crisis counseling training and established minimum training standards for their disaster responders. The requirement of Psychological First Aid (NCTSN and NCPTSD 2006) accounts for meeting all the clinical requirements in the outlined best practices. This plan included information for the following best practice areas: Needs Assessment (4 items); Follow Up Contact (6 items); Disaster Mental Health Training and Response (24 items); Research and Data Collection (1 item); External Organizations (4 items); and Communication/Information Dissemination (3 items).

In terms of local disaster response, the plan detailed contracts with 92 counties to provided mental health response in their local areas. The plan indicated that a library of materials is maintained at the state agency charged with disaster mental health response, which can be utilized during a disaster mental health response. The plan detailed that the state disaster mental health agency will coordinate with other organizations that may provide disaster mental health response, identifying 18 supporting agencies within the state disaster mental health response plan.

Discussion

The purpose of this study was to examine adherence to best practices in disaster mental health response plans. The study investigated the comprehensiveness of state plans and their adherence to published best practices in three states that experienced post-9/11 federally-declared disasters: a 2005 Hurricane Katrina response in a Southern state; a 2007 tornado in a Midwestern state; and 2008 flooding in a Midwestern state.

Review of the Findings

Professional literature (Elrod et al. 2006; Hobfoll et al. 2007; NIMH 2002) has focused on what practices need to occur during all phases of a disaster mental health

response. There were 59 disaster mental health best practices used in this study to assess each state disaster mental plan's compliance with best practices. State 3 scored 71% on compliance with best practices. This state was strong clinically in its responders, with a longer history of disaster planning and preparation, and the plan catered to the mandated training, roles, duties, and incident command of a response. State 2 scored a 42% on compliance with best practices. State 2, with less support from surrounding Community Mental Health Centers and no mandated training for their responders, put more importance on the clinical aspects of their plan. Finally, State 1 scored a 12% on compliance with best practices. State 1 had responded to Hurricane Katrina where many facilities were not evacuated; consequently, they did not want to repeat this experience and made evacuation preparation the main part of their state disaster mental health plan.

The scores for each state do not represent the success of the actual disaster mental health response in the field. The scores are simply a numerical representation of the compliance with the identified best practices of the disaster mental health state plans evaluated in this study. There are several reasons that scores may not reflect each state response accurately, including the time lapse between the development of the plan and the actual disaster response and inconsistencies between the state plans (which are static documents) and actual disaster response (which is a continuously changing process).

Disaster mental health is an ever changing field with fluid demands and lack of predictability of the responses necessary for a successful deployment; thus, all elements of the state's response would not be included in their written disaster mental health plan. For these reasons, the state plans may not reflect what actually occurs during a disaster mental health response. However, the state disaster mental health plans are critical because they are the foundation on which disaster mental health response should be based, providing a common "roadmap" for planning, preparedness, and response to disaster events. Elrod et al. (2006) emphasized the importance for states to have a disaster mental health response plan, indicating that a written plan ensures better consistency across disaster responses. Upon reviewing each state's disaster mental health plan in the current study, it was evident that each state places a priority in different areas and varying severities of the disasters impact how the plan may be implemented during a response.

Training is an essential component to prepare states for disaster response, and all three states at least addressed some aspects of training in their state plans. Training ensures a consistent and higher quality response with responders who are prepared and know what to do to best help survivors. The lack of such training puts responders at risk of unintended harm towards survivors (NIMH 2002). States should engage in preparedness activities to improve and refresh skills needed to respond successfully and to improve collaboration and interagency relationships.

It is critical to build relationships with other response organizations prior to working together with them in a disaster setting (Elrod et al. 2006). By increasing interactions and developing effective working relationships between disaster response agencies prior to disasters and being part of other state agencies' disaster planning and response, mental health teams will gain respect and increase the strength of collaborative relationships in the process. While all three states evaluated in the current study included external organizations in their state plans, it is necessary for state disaster mental health programs establish new relationships and strengthen current relationships with local and state response organizations.

In each state, there was a heavy reliance on local resources to respond to disaster mental health needs during the initial phases of a response. Without a select group of individuals who have been identified and trained as responders, who have a formal agreement to respond in their area, and who have been adequately trained, an effective response is not guaranteed. The lack of response can decrease the sense of safety within victims and leave basic needs unmet as survivors struggle with the disaster (Gard and Ruzek 2006). Local response for any size disaster should be a priority, and although the necessity of a local disaster mental health plan has not been established, the need for having a guaranteed local disaster mental health response is clear.

During this research, all three states identified a person within the response who would be responsible for information dissemination, which is essential in disaster mental health response. In the past, the lack of consistent communication has been a very stressful and hindering part of disaster mental health response (Elrod et al. 2006). Best practices clearly identify the benefits of having control over information dissemination post disaster. Increasing the likelihood that correct information is provided in a timely manner will increase one's ability to remain calm and reduce feelings of fear and powerlessness (Hobfoll et al. 2007; NIMH 2002).

Limitations of the Study and Future Research Implications

Because in qualitative research, the researcher plays an important role in data collection and interpretation, potential bias must be recognized. The researchers attempted to control bias by utilizing a written evaluation of best practices from NIMH (2002) and other literature (Elrod et al. 2006; Hobfoll et al. 2007) for the state plan

reviews. The participants in this study were selected for two reasons. First, these states did represent a purposeful sample of diverse federally-declared disaster events that would be beneficial to the study. Second, the states were chosen to participate in this study due to their accessibility to the researchers. Although purposeful sampling was utilized, this exploratory study would have been more generalizable with increased numbers of participants.

As noted by NIMH (2002), more research needs to be completed in the area of disaster mental health response. Further investigation exploring best practices in disaster mental health response needs to occur to ensure responders are providing the best quality response possible. In addition, the effectiveness of disaster mental health programs needs to be further explored. Larger studies involving more states would allow disaster mental health responders to identify what is working in other states and possibly add components to their own plans. In addition, utilizing the best practice evaluation tool to evaluate disaster mental health response programs that occur after a disaster also would provide evidence of the effectiveness and adherence to the best practices in the field. Finally, it is necessary to recognize that all of the best practices may not be equally important or should be equally weighted in evaluating disaster mental health plans and responses. While the best practices need to be evaluated across states and disaster response programs, each state should determine how to set priorities in meeting these best practice parameters.

Each state brings unique attributes and experience to their disaster mental health response, which helps to mold the response to the state needs. As increased knowledge is gained from other state disaster mental health responses, more knowledge and expertise will contribute to disaster mental health preparedness across the county. Researchers and responders are encouraged to examine the findings in this study and continue to utilize the core best practices in their disaster mental health preparedness and response. This knowledge will add to the quality and effectiveness of services provided during disaster mental health responses.

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