Gulf Coast Hurricanes: Addressing Survivors' Mental Health and Substance Abuse Treatment Needs

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November 29, 2006

Congressional Research Service
7-....
www.crs.gov
RL33738

Summary

Major disasters such as Hurricanes Katrina, Rita, and Wilma, which struck Gulf Coast states in 2005, have the potential not only to cause mental health problems for individuals, but also to weaken or disable the systems designed to address those individuals' needs. Striking an appropriate balance of responsiveness, fiscal responsibility, and accountability in the provision of federal assistance programs during and following a disaster remains a difficult goal.

Federal leadership for mental health and substance abuse programs resides in the Substance Abuse and Mental Health Services Administration (SAMHSA), in the Department of Health and Human Services (HHS). SAMHSA carries out numerous activities to address mental health and substance abuse problems following disasters, including the Crisis Counseling Assistance and Training Program (CCP), which is authorized in the Robert T. Stafford Disaster Relief and Emergency Assistance Act (the Stafford Act) and implemented jointly by SAMHSA and the Federal Emergency Management Agency (FEMA).

The response to the 2005 hurricanes has prompted a re-examination of CCP and other federal assistance programs that address disaster mental health. Concerns include the timeliness and effectiveness of services provided, the appropriate scope and duration of these services, and matters of cost and accountability. In particular, the respective roles and responsibilities of SAMHSA (which provides technical expertise for CCP programs), FEMA (which funds them), and states and their contractors (which implement them), are not always clear.

Following a news investigation, some Members of Congress have expressed concerns about Project H.O.P.E., the CCP program implemented in Florida in response to Hurricane Wilma. Others have sought to expand CCP to provide substance abuse services, and to require that SAMHSA, other federal agencies, and state and local governments conduct resource assessments and develop strategies to address mental health and substance abuse service needs following disasters. (See **S. 3721**, reported in the Senate.)

This report describes federal assistance programs in HHS that address mental health and substance abuse problems following disasters. In addition, relevant policy issues are presented in the context of the 2005 hurricanes, and several prior disasters. Three appendices provide information on CCP awards made to states in response to Hurricanes Katrina, Rita, and Wilma, and on the scope of services that constitute mental health treatment. This report will be updated as circumstances warrant.

Contents

Tables

Appendixes

Contacts

Introduction

Hurricane Katrina struck the Gulf Coast in late August 2005, causing catastrophic wind damage and flooding in several states, and a massive dislocation of victims across the country. According to government sources, the storm, one of the worst natural disasters in the nation's history, killed at least 1,464 people in Louisiana,[1] more than 200 in Mississippi, and about 20 more in Alabama, Florida, and Georgia.[2] Hurricane Rita made landfall along the Gulf Coast in late September 2005. While not as deadly, Rita re-flooded New Orleans and impacted other areas where Katrina evacuees were struggling to recover. (Rita was directly responsible for seven deaths and 55 "indirect" deaths, some during the pre-storm evacuation.) Hurricane Wilma made landfall in south Florida in late October 2005, killing five people and also causing extensive damage.[3] These three hurricanes, as well as hurricanes Dennis and Ophelia and Tropical Storm Cindy, each resulted in federal disaster declarations for affected areas in 2005.[4]

Previous research has shown that substance abuse and various manifestations of mental illness—including anxiety, depression, post-traumatic stress disorder (PTSD), and suicidality—often occur or worsen following disasters, and that some effects may persist for years.[5] Early studies suggest a similar trend in the aftermath of Hurricanes Katrina and Rita.[6] These disasters were especially challenging, given the extensive relocation of victims, the loss of the medical records of victims with pre-existing conditions, and the loss of infrastructure and healthcare workers to support the response. It is reported, for example, that New Orleans now has only about one-third of the 462 psychiatric beds it had before Hurricane Katrina, though the remaining population is at more than half of the city's pre-storm level, and, by some accounts, has an even greater need for the beds.[7]

In 1974, Congress enacted broad disaster assistance legislation, the Robert T. Stafford Disaster Relief and Emergency Assistance Act (the Stafford Act). Section 416 of the act provides authority, when there is a presidentially declared disaster, for federal assistance to state and local governments to address the mental health needs of victims.[8] Called the Crisis Counseling

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[1] Louisiana Department of Health and Hospitals, Hurricane Katrina Reports of Missing and Deceased, Aug. 2, 2006, at http://www.dhh.louisiana.gov/offices/page.asp?ID=192&FromSearch=1&Detail=5248.

[2] National Oceanic and Atmospheric Administration, National Weather Service, National Hurricane Center, "Tropical Cyclone Report: Hurricane Katrina, 23-30 August 2005," Dec. 20, 2005, at http://www.nhc.noaa.gov/pdf/TCR-AL122005_Katrina.pdf.

[3] Hurricane damage and casualty reports are available at the National Hurricane Center's archive of tropical cyclone reports, at http://www.nhc.noaa.gov/pastall.shtml.

[4] See Federal Emergency Management Agency, "2005 Federal Disaster Declarations," at http://www.fema.gov/news/disasters.fema?year=2005.

[5] See, for example, C. L. Katz et al., "Research on Psychiatric Outcomes and Interventions Subsequent to Disasters: a Review of Literature," *Psychiatry Research*, vol. 110, no. 3 (July 2002), pp. 201-217; and National Association of State Alcohol and Drug Abuse Directors, "Policy Brief: Trauma and Substance Use: Implications for the Response to Hurricane Katrina/Rita," September 2005, at http://www.nasadad.org/resource.php?doc_id=450.

[6] See R.H. Weisler et al., "Mental Health and Recovery in the Gulf Coast After Hurricanes Katrina and Rita," *JAMA*, vol. 296, no. 5 (Aug. 2006); and Kessler et al., "Mental Illness and Suicidality after Hurricane Katrina," *Bulletin of the World Health Organization*, vol. 84, no. 8 (August 2006), at http://www.who.int/bulletin/volumes/ 84/10/06-033019.pdf.

[7] Robin Rudowitz et al., "Health Care in New Orleans before and after Hurricane Katrina," Health Affairs, vol. 25, pp. w393-w406 (Aug. 29, 2006), Web exclusive. See also, Louisiana Healthcare Redesign Collaborative, "Region 1 Health Care Profile," Aug. 20, 2006, at http://www.dhh.louisiana.gov/offices/ news.asp?ID=288&Detail=925.

[8] 42 USC § 5183.

Assistance and Training Program (CCP), the program met its first major challenge with the bombing of the Murrah federal building in Oklahoma City in 1995. Funding for the program that was established by Oklahoma in response, named *Project Heartland*, was extended several times to accommodate the immediate needs of victims as well as the stress experienced by victims in the long term, such as during the trials of the accused bombers.[9] Following the terrorist attack of September 11, 2001, New York established a CCP program, called *Project Liberty*, to assist victims in the greater New York City area. Funding for Project Liberty was also extended several times.[10] CCP programs were established in 29 states in response to Hurricane Katrina, reflecting the widespread dislocation of the storm's victims. One year later, with many victims still facing problems with mental illness, 17 states have asked for program extensions. These include Alabama, Florida, Louisiana, and Mississippi, which were directly affected, and 13 states that hosted hurricane evacuees.

The objective of CCP is to help disaster victims understand the breadth of normal behavioral responses to stressful events, recognize which responses may warrant specific intervention (including professional treatment), and locate follow-up services when needed. CCP is not designed to provide or pay for medical, including psychiatric, treatment for those victims who may need it. Rather, victims needing treatment are to be referred to existing service systems. Given that many Americans lack health insurance, and that mental health and substance abuse services may not be adequately covered for those who are insured,[11] Congress and others remain concerned that, despite CCP and other federal assistance programs, the mental health and substance abuse treatment needs of many disaster victims may go unmet.

In October 2006, a local newspaper ran a story questioning a number of aspects of *Project H.O.P.E.*, the CCP program established by the state of Florida in response to Hurricane Wilma. The story, which raised questions about the effectiveness of the program in targeting victims and in addressing their mental health needs, prompted calls by some Members of Congress for investigations.[12]

This report describes CCP and other programs administered by the Substance Abuse and Mental Health Services Administration (SAMHSA, an agency within the Department of Health and Human Services, HHS) to provide federal assistance for the mental health and substance abuse treatment needs of disaster victims. (When a disaster is caused by terrorism or other forms of violence, a number of federal programs to assist victims of violence may be available through the Department of Justice or other agencies. Those assistance mechanisms are not discussed here.[13]) Several issues associated with CCP are discussed, including whether the services provided are

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[9] U.S. Department of Justice, Office of Justice Programs, "Responding to Terrorism Victims: Oklahoma City and Beyond," p. 19, October 2000, at http://www.ojp.usdoj.gov/ ovc/pdftxt/NCJ183949.pdf.

[10] See New York City Department of Education, Project Liberty home page, at http://www.projectliberty.state.ny.us/; and GAO, "Crisis Counseling Grants Awarded to the State of New York after the September 11 Terrorist Attacks," GAO-05-514, May 2005.

[11] See CRS Report RL31657, *Mental Health Parity: Federal and State Action and Economic Impact*, by (name redacted) and (name redacted).

[12] Sally Kestin, "FEMA-Funded Projects Blasted; Lawmakers Want to Investigate Puppet Shows, Bingo Intended for Storm Victims," *South Florida Sun-Sentinel*, Oct. 13, 2006.

[13] For an inventory of selected federal grant programs to address the mental health needs of children affected by disasters, see GAO, "Mental Health Services: Effectiveness of Insurance Coverage and Federal Programs for Children Who Have Experienced Trauma Largely Unknown," GAO-02-813, Table 16, p. 79 ff., Aug. 22, 2002. Many of the listed grant programs are not limited to children.

well matched to need, and whether the effectiveness of the program has been demonstrated. The report also analyzes the implementation, effectiveness and coordination of other SAMHSA disaster mental health programs, and discusses relevant policy issues in ensuring the provision of mental health and substance abuse treatment services following disasters. This report will be updated as circumstances warrant.

SAMHSA Disaster Assistance Programs

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the lead federal agency providing assistance to meet the mental health and substance abuse treatment needs of disaster victims.[14] In addition to its regular authorities to fund and support substance abuse and mental health treatment services, the agency has authority to provide emergency assistance through three additional mechanisms, discussed below: the Crisis Counseling Assistance and Training Program (CCP), SAMHSA Emergency Response Grants (SERG), and supplemental appropriations. For its response to Hurricanes Katrina, Rita and Wilma, SAMHSA received funding to administer CCP programs, and provided SERG grants through its regular appropriations, but did not receive a supplemental appropriation.

Crisis Counseling Assistance and Training Program (CCP)

The Stafford Act authorizes a variety of assistance programs for individuals, families, state and local governments and others affected by disasters.[15] Section 416 of the act authorizes CCP, a program to provide mental health counseling in presidentially declared disasters,[16] as follows:

> The President is authorized to provide professional counseling services, including financial assistance to State or local agencies or private mental health organizations to provide such services or training of disaster workers, to victims of major disasters in order to relieve mental health problems caused or aggravated by such major disaster or its aftermath.[17]

CCP does not provide mental health treatment or substance abuse services. (See the subsequent section on "Scope of Mental Health Services under CCP.") Congress has amended CCP authority only once since it was first enacted in 1974. In 1988, Congress removed a reference to the

[14] HHS, Substance Abuse and Mental Health Services Administration (SAMHSA), home page, at http://www.samhsa.gov/. See, also, SAMHSA disaster relief information, at http://www.mentalhealth.samhsa.gov/cmhs/katrina/; and "SAMHSA's One-Stop Shop for Katrina and Rita Resources," at http://www.samhsa.gov/hurricane/Parents.aspx?link4=true&.

[15] 42 USC § 5121, et seq. For more information, see CRS Report RL33053, *Federal Stafford Act Disaster Assistance: Presidential Declarations, Eligible Activities, and Funding*, by (name redacted).

[16] Section 401 of the Stafford Act authorizes the President to declare that a major disaster has occurred in affected areas, providing certain forms of assistance, including CCP. In addition to the authority to declare a major disaster, the President also has authority, pursuant to the Stafford Act, to declare an emergency, which authorizes a lower level of federal assistance than does a major disaster declaration. CCP authority is restricted to major disaster declarations.

[17] 42 USC § 5183. President George W. Bush declared major disasters in Florida, Louisiana, Mississippi and Alabama following Hurricane Katrina, and in Texas and Louisiana following Hurricane Rita. Florida also received a presidential disaster declaration following Hurricane Wilma in October 2005, and established a CCP program subsequently. FEMA provides information on Stafford major disaster declarations at http://www.fema.gov/news/disasters.fema.

National Institute of Mental Health (NIMH), the institute within the National Institutes of Health (NIH) that was originally responsible for administering CCP.[18]

Through executive orders, the President has delegated to the Federal Emergency Management Agency (FEMA), an agency within the Department of Homeland Security (DHS), responsibility for administering the major provisions of the Stafford Act. FEMA has published regulations that specify, among other things, the scope and duration of services provided under CCP.[19] The program is largely administered by SAMHSA through an interagency agreement with FEMA. SAMHSA has published program guidance that further describes the scope of services eligible for funding, and other matters.[20] Eligible awardees are state mental health agencies or other local or private mental health organizations designated by the governor of the affected state. Eligible services are reimbursed by FEMA through its Disaster Relief Fund (DRF), a no-year account in which appropriated funds remain available until expended. The DRF is typically replenished through supplemental appropriations, especially in the aftermath of catastrophic disasters.

States apply for funds by preparing a formula-based needs assessment within 10 days of the date of the disaster declaration, documenting the inadequacy of their available resources, and presenting a plan for service delivery. (The needs assessment takes into account the level of casualties and destruction of property that result from the disaster.) There is no matching requirement, and requested CCP funds must supplement, not supplant, existing local or state resources. CCP consists of two smaller programs: the Immediate Services Program (ISP) and the Regular Services Program. The ISP provides funds directly from FEMA to states for up to 60 days of services immediately following a disaster declaration. The RSP provides funds for up to nine months following a disaster declaration. (Regulations permit extensions in certain cases, as discussed in the subsequent section on "Duration of Mental Health Services under CCP.") RSP funds are provided to the states through SAMHSA, which is reimbursed by FEMA through the DRF.

CCP services may be provided to victims of presidentially declared disasters even if they have relocated.[21] Hence, HHS reported that in response to Hurricane Katrina, all 50 states as well as Puerto Rico and the District of Columbia would be eligible to apply for CCP grants, presumably because they all could potentially host evacuees from presidentially declared disaster areas.[22] Not all states applied, however. As of October 2006, 29 states had been awarded CCP funding for Hurricane Katrina, totaling $132 million. In addition, $6 million was awarded to Louisiana and Texas following Hurricane Rita, and $13 million to Florida following Hurricane Wilma. Awards by state are listed in **Appendix A**.

[18] P.L. 100-707, the Major Disaster Relief and Emergency Assistance Amendments of 1988. The act also renumbered certain sections of the Stafford Act, including CCP authority. FEMA's regulations for CCP, amended most recently in 2003, continue to refer to NIMH as the HHS liaison for program administration.

[19] 44 CFR § 206.171.

[20] SAMHSA, Center for Mental Health Services, "Crisis Counseling Training and Assistance Program Guidance," undated document, hereafter called CCP program guidance, at http://www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/progguide.asp.

[21] 44 CFR § 206.171(h)(1)(i).

[22] HHS, "Summary of Federal Payments Available for Providing Health Care Services to Hurricane Evacuees and Rebuilding Health Care Infrastructure," Jan. 25, 2006, at http://www.hhs.gov/katrina/fedpayment.html.

SAMHSA Emergency Response Grants (SERG)

In 2000, in its reauthorization of certain SAMHSA programs, Congress gave the agency new authority to redirect a portion of its fiscal year funds to make non-competitive grants to address emergency substance abuse or mental health needs in communities, via SAMHSA Emergency Response Grants (SERG).[23] SERG may be awarded whether or not there has been a Stafford Act declaration, based on a determination by the HHS Secretary of the existence of a substance abuse or mental health emergency.[24] Hence, SERG may be used to provide assistance when there has not been a major disaster declaration, or, when there has been, to fund substance abuse and mental health treatment services that are not permitted under CCP. SERG grants have been awarded following the 2002 Washington, DC -area sniper incidents and the 2003 Rhode Island nightclub fire. Following Hurricane Katrina, FY2005 SERG grants totaling $600,000 were made to Alabama ($100,000), Louisiana ($200,000), Mississippi ($150,000) and Texas ($150,000).[25] Mississippi received an additional $300,000 in FY2006.[26]

Supplemental Appropriations

If Congress provides SAMHSA with supplemental funds for disaster response, the funds, unless they are restricted, may be used to augment activities carried out under SAMHSA's standing authority to provide assistance to prevent or treat mental illness and substance abuse, in particular to meet those needs that may not be met with CCP or SERG funds. For example, substance abuse and mental health treatment services, psychotropic medication expenses, methadone treatment, suicide prevention programs, and major administrative expenses for mental health and substance abuse resulting from the disaster may be addressed through this mechanism. Congress provided funding for the response to Hurricanes Katrina and Rita through several supplemental appropriations, but SAMHSA did not receive any of this funding. The bulk of the supplemental funds went toward replenishing the DRF, with smaller amounts provided to other federal departments and agencies, including other agencies in HHS.[27]

Other Services

In response to Hurricanes Katrina and Rita, SAMHSA carried out a variety of activities through its standing authorities and with its existing funding, including coordination of services, suicide prevention, mental health services, public education, and substance abuse services. Some of these services were provided in the immediate aftermath of the hurricanes, while others were provided six to 12 months afterward.

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[23] 42 USC § 290aa(m). SAMHSA may redirect up to 2.5% of its appropriation for a given fiscal year, excluding amounts provided for a homeless assistance program.

[24] SAMHSA published an interim final rule laying out criteria for such a determination in 66 *Federal Register* 51873, Oct. 11, 2001, and finalized the rule with only technical corrections in 67 *Federal Register* 56930, Sept. 6, 2002.

[25] HHS, "HHS Awards $600,000 in Emergency Mental Health Grants to Four States Devastated by Hurricane Katrina," news release, Sept. 13, 2005.

[26] SAMHSA, Office of Policy, Planning and Budget, Sept. 5, 2006.

[27] For more information, see CRS Report RS22239, *Emergency Supplemental Appropriations for Hurricane Katrina Relief*, by (name redacted).

Coordination of Agencies: SAMHSA convened a national summit in New Orleans in May 2006 to provide a forum for lessons learned from the 2005 hurricanes. While SAMHSA was the primary federal agency that provided mental health and substance abuse services, key services were also provided by: the Health Resources and Services Administration (HRSA), which funded Federally Qualified Health Centers (FQHCs); the National Institute of Mental Health (NIMH), which funded deployments of mental health providers; and the Centers for Disease Control and Prevention (CDC), which conducted surveillance of mental health needs.[28]

Coordination of Services: SAMHSA established the SAMHSA Emergency Response Center (SERC) to provide on-the-ground coordination of its mental health services. The SERC, which was in operation until January 2006, was a point of contact to receive information and have access to resources, regarding staffing and resources to be deployed.[29] The SERC coordinated delivery of mental health services by managing the deployments of mental health providers to the affected area, and by organizing daily conference calls with representatives from all HHS agencies.

Suicide Prevention: SAMHSA administered a combination of grants and other programs for suicide prevention. In the immediate aftermath of the hurricanes, SAMHSA expanded its toll-free suicide prevention crisis hotline, and coordinated deployments of counselors to the affected areas.[30] In September 2006, SAMHSA awarded Louisiana and Mississippi $2.4 million over three years, through the Garrett Lee Smith Memorial Act, for youth suicide prevention activities.[31]

Mental Health Services: SAMHSA's National Child Traumatic Stress Network (NCTSN) made its resources available to help parents and service providers assist children, in both immediate crisis responses and long-term recovery settings. In addition, SAMHSA's critical incident stress management program addressed the mental health needs of first responders who were exposed to the aftermath of the hurricanes.[32]

Public Education: In December 2005, SAMHSA launched a public awareness campaign through Public Service Announcements and brochures. The campaign sought to enable victims to recognize the need for mental health treatment for themselves and their children in the aftermath of the hurricanes.[33] Coinciding with the one year anniversary of the hurricanes, SAMHSA launched a series of new national public service print and billboard ads, encouraging survivors who experienced continued psychological distress to seek mental health services. Some of these new ads targeted first responders as well as parents and caregivers who can assess their children's emotional well-being.[34]

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[28] HHS, "Activities at HHS Agencies, Disasters and Emergencies: 2005 Hurricane Season," Aug. 10, 2006, at http://www.hhs.gov/katrina/hhsagencies.html.

[29] SAMHSA, "From Hurricane Response to Long-Term Recovery," SAMHSA News, Nov./Dec. 2005, at http://www.samhsa.gov/SAMHSA_News/archive05.htm.

[30] SAMHSA, "SAMHSA's One-Stop Shop for Katrina and Rita Resources," at http://www.samhsa.gov/hurricane/help.aspx.

[31] SAMHSA, "Louisiana and Mississippi to Receive $2.4 Million for Youth Suicide Prevention, Early Intervention," SAMHSA News, Sept. 14, 2006, at http://www.samhsa.gov/news/newsreleases/060914_la.aspx.

[32] SAMHSA, "From Hurricane Response to Long-Term Recovery," SAMHSA News, Nov./Dec. 2005, at http://www.samhsa.gov/SAMHSA_News/archive05.htm.

[33] SAMHSA, "HHS Secretary Leavitt Unveils National PSA Campaign to Provide Mental Health Services to Hurricane Survivors," SAMHSA News, Dec. 7, 2005, at http://www.samhsa.gov/news/newsreleases/051207_hurricane.htm.

[34] SAMHSA, "SAMHSA and Ad Council Launch New Ads to Offer Mental Health Services to Hurricane Survivors," (continued...)

Substance Abuse Services: On August 31, 2005, SAMHSA issued a guidance for State Methadone Authorities and Opioid Treatment Programs in hurricane-affected states providing short and long-term emergency methadone and buprenorphine treatment services to heroin-addicted populations affected by the disaster.[35] In addition, SAMHSA has compiled baseline data on pre-hurricane substance use in states affected by Hurricanes Katrina and Rita.

Issues for Congress

This section discusses several policy issues, including federal leadership and coordination of mental health and substance abuse treatment and other services in the aftermath of a disaster; issues regarding CCP, including the scope and duration of CCP services, as well as matters of program administration and effectiveness; the availability of funds for SERG grants; and, the assessment of resources and needs for mental health and substances abuse services.

Disaster Mental Health in Federal Planning

Federal leadership for responding to the mental health consequences of disasters can be enhanced by clear delegations of authority, or may be compromised by ambiguous delegations of authority. In 2004, DHS published the National Response Plan (NRP), as mandated by Congress in **P.L. 107-296**, the Homeland Security Act of 2002. The NRP establishes a comprehensive framework for the coordination of federal resources in response to disasters.[36] In the current version of the NRP, leadership for the federal coordination of mental and behavioral health services following a disaster appears to be split. The NRP includes 15 *Emergency Support Functions*, or ESFs, which are specific plans for certain sectors, such as transportation. Emergency Support Function 6 (ESF-6), Mass Care, under the leadership of FEMA and the American Red Cross, lays out the coordination of emergency shelter, feeding, and related activities for affected populations. Emergency Support Function 8 (ESF-8), under the leadership of the Secretary of HHS, lays out the coordination of the public health and medical response to disasters.[37] "Crisis counseling" is among the responsibilities delegated in ESF-6, while federal coordination of "behavioral health care"—including assessing mental health and substance abuse needs, and providing disaster mental health training for workers—is delegated in ESF-8. Hence, federal leadership for disaster mental health in the NRP is delegated to both FEMA and to HHS. (When the disaster involves terrorism or other forms of violence, the Department of Justice may also become a key federal partner, as was seen with Project Heartland following the Oklahoma City bombing.[38])

(...continued)

SAMHSA News, Aug. 29, 2006, at http://www.samhsa.gov/news/newsreleases/060829_psa.htm.

[35] SAMHSA, "From Hurricane Response to Long-Term Recovery," SAMHSA News, Nov./Dec. 2005, at http://www.samhsa.gov/SAMHSA_News/archive05.htm.

[36] 6 USC § 312(6). See Department of Homeland Security, National Response Plan, December 2004, at http://www.dhs.gov/xprepresp/programs. The NRP superseded the Federal Response Plan that had been used since 1992. See also CRS Report RL32803, *The National Preparedness System: Issues in the 109th Congress*, by (name redacted).

[37] For more information, see CRS Report RL33579, *The Public Health and Medical Response to Disasters: Federal Authority and Funding*, by (name redacted).

[38] The Department of Justice shares leadership responsibilities with DHS for ESF-13, Public Safety and Security. ESF-13 does not explicitly mention mental health.

In the aftermath of a disaster, adequate communication and coordination between federal agencies and affected states can ensure that services are delivered in a timely and efficient manner. A recent news report questioned whether FEMA shared information with the state of Florida about the location of Hurricane Katrina evacuees, in order to help the state target its CCP program for these individuals as efficiently as possible.[39] While the news report said that FEMA "refuses" to provide this information to state officials, FEMA stated in a recent Federal Register notice that its regulations pursuant to the Privacy Act have long permitted such disclosures, and that it has the authority to provide such information "(t)o another Federal agency or State government agency charged with administering disaster relief programs to make available any additional Federal and State disaster assistance to individuals and households."[40]

Problems with coordination and cooperation are mentioned repeatedly by mental health professionals who have found themselves in the position of responding to major events in their communities.[41] Officials from the Louisiana Department of Health and Hospitals reported that there was no coordination of services provided by individuals who were not deployed through SAMHSA.[42] While the federal government plays an important role in addressing the mental health needs of survivors in the aftermath of a disaster, there may be value in engaging in joint disaster planning efforts with state and local governments and the private sector to prepare for future disasters.[43] Norris *et al.* conclude that coordination of delivery of mental health services through a public health or population-based approach, and continued coordination to provide services as the long term effects of the crisis unfold, are likely to be beneficial for the survivors' mental health. Responses are seen to be most useful, the authors conclude, when they are tailored to subgroups according to their unique combinations of risk and protective factors.[44]

Concerns Regarding CCP

Programmatic and Fiscal Accountability

With one party (FEMA) responsible for CCP funding, another (SAMHSA) responsible for approval and oversight of proposals and activities, and the third (the state) responsible for implementation, accountability for problems with the program may not always be clear. FEMA does not provide scientific, technical or medical expertise to support the delivery of mental health or substance abuse services. That expertise, at the federal level, clearly resides with HHS and SAMHSA. Establishing authority for CCP in the Stafford Act, which is administered by FEMA, is a means to provide funding for crisis counseling services quickly and as needed through the DRF, assuring that such services can be provided without regard to constraints that may be

[39] Sally Kestin, "FEMA Spends Millions on Puppet Shows, Bingo and Yoga," *South Florida Sun-Sentinel*, Oct. 8, 2006.

[40] 71 *Federal Register* 38408, July 6, 2006.

[41] F.H. Norris et al., "60,000 Disaster Victims Speak: Part II Summary and Implications of the Disaster Mental Health Research," *Psychiatry*, vol. 65, no. 3 (Fall 2002), pp. 240-260.

[42] I. Cannella, "Mission to the Gulf: Meeting the Crisis of Hurricanes Katrina and Rita," American Psychological Association Annual Convention, New Orleans, Aug. 11, 2006.

[43] Siegal et al., "Coping with Disasters: Estimation of Additional Capacity of the Mental Health Sector to Meet Extended Service Demands," *Journal of Mental Health Policy Economics*, vol. 7, no. 1 (March 2004), pp. 29-35.

[44] F.H. Norris et al., "60,000 Disaster Victims Speak: Part II Summary and Implications of the Disaster Mental Health Research," *Psychiatry*, vol. 65, no. 3 (Fall 2002), pp. 240-260.

imposed by HHS's or SAMHSA's annual appropriations. It has the effect, however, of placing FEMA in the position of fiscal responsibility for a program for which it lacks the requisite technical expertise.

Mechanisms for shared federal responsibility for CCP, and for disaster mental health and substance abuse services in general, may work well if federal agencies coordinate with each other and with the states. A recent news report has raised questions about how well recent CCP programs have been carried out in Florida in response to Hurricanes Katrina and Wilma.[45] One question raised in the news account is whether the program activities developed for Project H.O.P.E.—namely, puppet shows, bingo and yoga—are appropriate to address disaster mental health needs. Further, of the three responsible parties, FEMA, SAMHSA and the state of Florida, which is ultimately responsible for assuring that services are appropriate, or at fault if they are not? (This question depends in turn on an understanding of the effectiveness of disaster mental health services in general, a matter discussed in a subsequent section, "Evaluating the Effectiveness of CCP.")

A function of good leadership by a federal agency is to ensure that taxpayers' funds are put to effective use. The news report prompted considerable interest among Members of Congress, many of whom expressed concern both about the possible irresponsible use of taxpayers' funds, as well as a possible failure in meeting the legitimate needs of hurricane victims.[46] FEMA Director R. David Paulison responded to the original story, noting in a press release that FEMA had merely supported outreach programs that the state had requested.[47] The press release did not mention SAMHSA or its role.

In May 2005, GAO published its review of financial accounting for CCP services provided under Project Liberty, in response to the attack on the World Trade Center in 2001.[48] GAO reported that FEMA and SAMHSA did not require grantees to submit revised budgets as the services provided evolved, and that SAMHSA did not keep track of program expenditures as well as it tracked the program's delivery of services. GAO recommended that SAMHSA and FEMA develop mechanisms for improved budgetary oversight, as well as mechanisms to measure the effectiveness of the program. In its comments to GAO, SAMHSA disputed some of GAO's assertions, and commented on the difficulties associated with federal fiscal management of awards given to state and local governments, and then to sub-grantees.

Appendix A lists CCP awards to states for ISP and RSP programs in response to Hurricanes Katrina, Rita and Wilma, as reported by SAMHSA. **Appendix B** compares these amounts with CCP allocations for the three disasters as reported by FEMA in the agency's weekly reports to Congress.

[45] Sally Kestin, "FEMA Spends Millions on Puppet Shows, Bingo and Yoga," *South Florida Sun-Sentinel*, Oct. 8, 2006.

[46] Sally Kestin, "FEMA-Funded Projects Blasted; Lawmakers Want to Investigate Puppet Shows, Bingo Intended for Storm Victims," *South Florida Sun-Sentinel*, Oct. 13, 2006.

[47] FEMA, "FEMA Director Paulison Responds to Criticism of Crisis Counseling Program," press release, Oct. 13, 2006, at http://www.fema.gov/news/newsrelease.fema?id=30705.

[48] GAO, "Federal Emergency Management Agency: Crisis Counseling Grants Awarded to the State of New York after the September 11 Terrorist Attacks," GAO-05-514, May 2005.

Evaluating the Effectiveness of CCP

Congress authorized CCP "in order to relieve mental health problems caused or aggravated by [a] major disaster or its aftermath." Optimally, CCP services would prevent or minimize mental health problems in affected individuals or populations. But the actual effect of the program on health outcomes has not been demonstrated. In 2002, the GAO recommended that FEMA and SAMHSA collaborate in evaluating the effectiveness of CCP, noting that the FEMA Inspector General had made the same recommendation in 1995.[49] Neither FEMA nor SAMHSA has published results of outcomes evaluations for Project Heartland, Project Liberty, or any other CCP programs.[50] A recent news report has questioned whether the activities carried out in Project H.O.P.E., the CCP program established in Florida in response to Hurricane Wilma (See "Crisis Counseling Assistance and Training Program"), are likely to benefit the mental health of victims.[51]

The intrinsic merit of CCP, as currently implemented, is not the key question, many observers believe. Rather, they question whether the funds provided could be more effective in preventing or reducing the burdens of post-disaster mental illness if spent differently. Ongoing debate about the appropriate scope and duration of services provided under CCP—discussed later in this report (See "Scope of Mental Health Services under CCP" and "Duration of Mental Health Services under CCP")—reflect ongoing uncertainty about the "best" way to craft the program to meet statutory objectives. Unfortunately, these discussions are hobbled by a weak knowledge base. Research in this area is challenging for several reasons. First, there are technical challenges in mental health research in general, including a limited suite of standardized measurement tools, limited information on the baseline prevalence of mental illness in populations, and difficulty in comparing studies that use different measurement tools or follow-up times. Second, disasters are by their nature episodic, varying in type, severity and location, making comparisons difficult. Finally, different types of disasters may affect the mental health of victims in different ways. For example, some experts feel that victims' responses to war or terrorism are substantially different from their responses to natural disasters.

SAMHSA reports that it will be conducting an evaluation of CCP services delivered in the aftermath of Hurricanes Katrina and Rita, in collaboration with the National Center for Post-Traumatic Stress Disorder (NCPTSD), a center within the Department of Veterans Affairs (VA).[52] The NCPTSD supports a broad national network for PTSD research, including several federal departments, academic and private sector collaborators, making it well suited for the kind of complex outcomes research that is needed for a better understanding of CCP effectiveness. Whether the evaluation will encompass the full scope of mental health and substance abuse problems that have affected the hurricanes' victims, or whether it is more narrowly targeted to PTSD, remains to be seen.

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[49] GAO, "Mental Health Services: Effectiveness of Insurance Coverage and Federal Programs for Children Who Have Experienced Trauma Largely Unknown," GAO-02-813, August 2002. At the time of publication, the agency was called the General Accounting Office.

[50] FEMA provides funding, and SAMHSA provides guidance, for states to conduct CCP "process evaluations," which focus on the effectiveness of program implementation rather than on health outcomes. Process evaluations have reportedly been conducted for Projects Heartland and Liberty, but nothing has been made publicly available.

[51] Sally Kestin, "FEMA-Funded Projects Blasted; Lawmakers Want to Investigate Puppet Shows, Bingo Intended for Storm Victims," *South Florida Sun-Sentinel*, Oct. 13, 2006.

[52] SAMHSA, Office of Legislative Affairs, Aug. 16, 2006. For more information on the NCPTSD, see http://www.ncptsd.va.gov/.

Scope of Mental Health Services under CCP

Survivors of a disaster often need a range of mental health services that go beyond those provided for by CCP, which only provides referral to mental health services.

Neither the Stafford Act nor FEMA's regulations clearly articulate or restrict the scope of "professional counseling services" as stated in the act, or "individual and group treatment procedures" as stated in the regulations.[53] These terms do not clearly relate to specific services delivered in the field of mental health. However, SAMHSA makes matters more clear in its guidance, explaining that CCP is not intended to provide mental health treatment, which it describes in clinico-legal terms as involving a diagnosis and other activities that may only be carried out by state-licensed providers. According to SAMHSA:

> In contrast to the crisis counseling services provided through the CCP, mental health treatment ... implies the provision of assistance to individuals for an existing pathological condition or disorder. In this context, it involves providing a variety of interventions following the assignment of a diagnosis .... This diagnosis is made following an evaluation and/or psychological testing by a licensed mental health professional.... During treatment, the provider maintains a documented treatment plan and record. The mental health professional is licensed by the State and is protected by, and is subject to, a wide variety of legal matters including malpractice, informed consent to treatment, confidentiality, and patient/therapist privilege.[54]

SAMHSA notes that "the thrust of the (CCP) since its inception has been to serve people responding normally to an abnormal experience," and that the services funded focus on individual and group counseling, education and referral, and training of counselors.[55] CCP's scope of services do not, therefore, provide disaster victims with medications, office-based therapy, diagnostic services, psychiatric treatment, or inpatient and outpatient services for mental health conditions that are caused or aggravated by the disaster. CCP funds are not intended to support long-term or traditional mental health or substance abuse services.

As compared with several other federal programs, SAMHSA's definition of "individual and group treatment procedures" for CCP is narrow, and the types of mental health services available under CCP are limited. For example, in the context of reporting the number of people receiving mental health services, SAMHSA's Office of Applied Statistics' (OAS) definition of mental health treatment/counseling includes inpatient and outpatient care, as well as some prescription medication.[56] Medicare includes, in the mental health services that it covers, outpatient and in-hospital programs, as well as treatment for mental health problems.[57] The U.S. Courts include inpatient and outpatient counseling and medication in their definition of mental health treatment, in the context of services provided to individuals on probation, parole or awaiting sentencing

[53] 44 CFR § 260.171(b)(3).

[54] CCP program guidance.

[55] Ibid.

[56] SAMHSA, "Estimated Numbers (in Thousands) of Persons Aged 18 or Older Receiving Specific Types of Mental Health Treatment/Counseling in the Past Year, by Demographic Characteristics: 2000 and 2001," 2003, at http://www.oas.samhsa.gov/nhsda/2k1nhsda/ vol3/Sect8v1_PDF_W_35-40.pdf.

[57] Center for Medicare and Medicaid Services, "Medicare and Your Mental Health Benefits," CMS publication no. 10184, April 2002, at http://www.medicare.gov/ publications/pubs/pdf/mental.pdf.

period.[58] (For a more comprehensive description of the services and treatment venues included under the term "mental health treatment," see **Appendix C**.)

In a recent news story, a psychologist in Florida questioned whether CCP counselors who were not formally trained in diagnosis could accurately screen disaster victims, and whether their lack of professional expertise could at times jeopardize the welfare of those receiving services.[59] However, assuming that CCP services are potentially beneficial, limiting services to those provided by licensed professionals would likely make the program more costly, and be hampered by the limited numbers of these professionals.

In Project Liberty, CCP services were expanded to provide enhanced screening methods and a broader array of brief counseling approaches, for individuals who continued to experience trauma symptoms and functional impairment after initial crisis counseling.[60] In August 2006, the Senate Committee on Homeland Security and Governmental Affairs reported **S. 3721**, the Post Katrina Emergency Management Reform Act of 2006. Section 219 of the bill would amend Section 416 of the Stafford Act, expanding the scope of CCP to include substance abuse services. There has been no corresponding legislation introduced in the House. The possible costs of such an expansion are not known.[61]

Duration of Mental Health Services under CCP

While post-disaster mental health needs may persist for quite some time, CCP is designed as a "short-term" intervention.[62] Disasters may impose substantial long-term adverse mental health effects. Residents in affected areas are expected to develop high rates of mental health disorders, including post-traumatic stress disorder (PTSD), depression and anxiety. As defined by the VA's National Center for Post Traumatic Stress Disorder (NCPTSD), diagnosis of and treatment for chronic PTSD typically starts at three months, while delayed onset PTSD is known to set in more than six months after the disaster.[63] Weisler *et al*. have commented that due to limitations on CCP, mental health services in the states affected by Hurricane Katrina are lacking when they are most needed.[64] Some Louisiana mental health providers have commented that up to one-third of the people affected by the storm may have PTSD, but that most have not been able to receive treatment.[65]

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[58] Administrative Office of the U.S. Courts, "Commonly Used Terms," at http://www.uscourts.gov/library/glossary.html.

[59] Comments of Charles Figley in Sally Kestin, "FEMA Spends Millions on Puppet Shows, Bingo and Yoga," *South Florida Sun-Sentinel*, Oct. 8, 2006.

[60] Government Accountability Office, "Crisis Counseling Grants Awarded to the State of New York after the September 11 Terrorist Attacks," GAO-05-514, May 2005.

[61] The U.S. Congressional Budget Office (CBO), in its cost estimate for S. 3721, noted that it could not estimate the additional costs associated with amendments to the Stafford Act's assistance programs because it cannot predict the timing and severity of future disasters. See CBO, "S. 3721, Post-Katrina Emergency Management Reform Act of 2006," cost estimate for the bill as reported by the Senate Committee on Homeland Security and Governmental Affairs on Aug. 3, 2006, p. 6, Sept. 18, 2006.

[62] 44 CFR § 260.171(c)(1).

[63] Department of Veterans Affairs, NCPTSD, "What is Posttraumatic Stress Disorder?" July 20, 2006, at http://www.ncptsd.va.gov/facts/general/fs_what_is_ptsd.html.

[64] R.H. Weisler et al., "Mental Health and Recovery in the Gulf Coast After Hurricanes Katrina and Rita," *JAMA*, vol. 296, no. 5, August 2006.

[65] Kim Dixon, "Post-Katrina Stress Still Weighs on New Orleans," *Reuters Health E-Line*, Feb. 15, 2006.

CCP is intended to supplement, not replace, permanent state and local (public and private) mental health resources. The budgetary and related authority for CCP, and the limitations in the length of services provided, are laid out in FEMA's regulations. CCP RSP grants provide crisis counseling services for individuals affected by a disaster for a time period ranging from 60 days to nine months following the disaster. FEMA may grant an additional 90-day extension upon request. SAMHSA and FEMA expect that individuals with needs that extend beyond the duration of CCP will be referred to other agencies or services that provide the appropriate treatment.[66]

In March 2003, following its experiences with Projects Heartland and Liberty, FEMA amended its regulations to allow extensions of CCP Regular Services programs beyond the nine-month-plus-90-day limit, in limited circumstances (such as disasters of a catastrophic nature), upon the request of a state, when FEMA deems it to be in the public interest.[67] Extending the duration of RSP programs has fiscal implications for FEMA and the DRF.

Even before FEMA amended its regulations, on two previous occasions—for Project Heartland and Project Liberty—the duration of CCP services was extended beyond the nine-month-plus-90-day limit. Because Project Heartland was the first community mental health response to a large-scale terrorist event in the United States, there was no previous experience to establish and deliver services for psychological trauma caused by terrorism. Project Heartland found that traditional crisis counseling techniques were not sufficient, and new approaches were developed to reach survivors. FEMA extended funding for Project Heartland three times before it ended on February 28, 1998. Until Project Liberty, this was the longest Regular Services project FEMA had ever funded.[68] Project Liberty, which was created in 2001, received numerous extensions and is still in operation.[69]

The time extensions for Projects Heartland and Liberty, and the extensions now being considered for CCP programs in many states in response to Hurricane Katrina, reflect uncertainty about the appropriate duration of CCP services. Such uncertainty is likely to persist until the knowledge base regarding the long-term mental health effects of these programs improves.

Treatment for Co-occurring Disorders under CCP

It has been observed that many individuals who need mental health care are also in need of treatment for substance abuse. However, CCP funding does not support substance abuse treatment services, thus separating treatment for mental health and substance abuse problems. SAMHSA's guidance recommends referring people with substance abuse disorders to specialized providers, because the mental health system, of which crisis counseling is a part, may not be the most appropriate and qualified to provide these services. In 2000, Congress directed SAMHSA to report on prevention and treatment services for individuals who have co-occurring mental illness and substance abuse disorders, and to realign its block grant programs to better meet the needs of these individuals.[70] While the effort to coordinate routine services in the states could lead to better

[66] CCP program guidance.

[67] 44 CFR § 206.171(g)(4)(i).

[68] U.S. Department of Justice, "Responding to Terrorism Victims: Oklahoma City and Beyond," October 2000, in Chapter 3 of http://www.ojp.usdoj.gov/ovc/publications/infores/ respterrorism/.

[69] New York City Department of Education, Project Liberty home page, at http://www.projectliberty.state.ny.us/.

[70] P.L. 106-310, the Children's Health Act of 2002. See also, SAMHSA, "Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders," November 2002, at
(continued...)

coordination when states set up post-disaster CCP programs, as of 2005, only 14 states and the District of Columbia had received SAMHSA grants to address co-occurring disorders.[71]

Some have recommended that CCP outreach workers be trained to work with individuals with substance abuse disorders. Training CCP workers in substance abuse treatment would enable individuals with co-occurring disorders to receive both services simultaneously and in the same location. However, the substance abuse treatment services they receive from CCP workers, who are not specialists in the area, may not be optimal for their condition, and may lead to a delay in individuals receiving specialist services.

As discussed earlier (See "Scope of Mental Health Services under CCP"), **S. 3721**, reported in the Senate, would amend the Stafford Act, expanding the scope of CCP to include substance abuse services.

Fiscal Year Limits on Availability of SERG Funds

In creating authority for emergency mental health and substance abuse (SERG) grants in 2000, Congress authorized SAMHSA to reallocate up to 2.5% of its discretionary appropriations for this purpose in a given fiscal year. The agency may determine, based on its planned obligations for a fiscal year, that the actual amount it could make available may be less than the 2.5% permitted. Also, as a fiscal year progresses, the agency would have available to it fewer funds from which a reallocation could be made. Because Hurricanes Katrina and Rita occurred at the end of FY2005, SAMHSA had only $600,000 that it could make available for SERG grants.

As the timing of the emergencies for which the program is designed are often unpredictable, Congress may consider options to give SAMHSA more fiscal flexibility in making SERG grants. These include giving the agency the authority to fund in advance, up to the 2.5% ceiling, based on the total appropriation for the current fiscal year, and clarifying a mechanism by which SERG awards could be made when the agency was functioning under a continuing appropriations resolution. Each approach carries the risk that the awards made could erode the agency's budget for the subsequent fiscal year.

SAMHSA could also finance emergency response grants through the Public Health Emergency Fund, a no-year funding authority provided by Congress to the HHS Secretary upon his determination of a public health emergency.[72] The fund has not received a recent appropriation, however, and contains no monies. As a consequence, the fund was not available for any aspect of the responses to the 2005 hurricanes.

(...continued)

http://www.samhsa.gov/reports/congress2002/ index.html.

[71] SAMHSA, Co-occurring State Incentive Grants (COSIG) page, at http://www.coce.samhsa.gov/about/ index_right.aspx?obj=7.

[72] For more information, see CRS Report RL33579, *The Public Health and Medical Response to Disasters: Federal Authority and Funding*, by (name redacted).

Assessment of Resources and Long-term Needs

Some immediate needs assessments and resource assessments were carried out by states and federal agencies in the aftermath of the hurricanes. However, there have been no longer-term assessments and none are statutorily required.

An assessment of resources and needs in the initial stages of disaster response can improve cost-effective disaster response through prioritization, program planning and management. As individuals return to their homes and start rebuilding their lives in the months following a disaster, it would be helpful to reassess the mental health needs of the community and the state's resources to meet those needs. In other words, conducting a follow-up needs and resources assessment can provide a better understanding of the resources needed to meet the longer-term mental health needs of the community.

The transition from immediate to long-term disaster mental health services can be a complex and bureaucratic process, often involving multiple providers with varying levels of expertise and training. Experts believe that the field of disaster mental health should match the intensity of help with survivors' need.[73] A higher intensity of help may reach those at greatest need if initial and follow-up needs assessments are conducted.

Needs assessments are required by FEMA's regulations and SAMHSA's guidance, not by the Stafford Act. The Stafford Act does not assign responsibility for conducting an initial or a follow-up needs assessment. FEMA regulations assign the responsibility to state governors or their designees.[74] SAMHSA guidance provides greater detail about the initial needs assessment, along with the formula that the state must use. The requirement to conduct an initial assessment of resources is implicit in the application for CCP funds: states are required, in their ISP and RSP applications, to document that their capacity is inadequate to meet the needs created by the disaster. Also, for the RSP, the guidance requires that states incorporate FEMA damage assessments into their assessments of mental health and crisis counseling needs.[75]

Several initial needs assessments were conducted in the aftermath of the hurricanes. Following Hurricane Katrina, SAMHSA streamlined the needs-assessment requirement for states applying for CCP funding. As part of this streamlined process, states used only preliminary data to submit a needs and resources assessment for counseling services, as part of their CCP application. In two separate surveys in October 2005, SAMHSA projected the potential overall mental health needs of those impacted by the hurricanes, and the CDC conducted a survey of returning New Orleans residents. SAMHSA estimated that 500,000 residents may have needed mental health assistance, and CDC found that 83% percent of returning New Orleans residents indicated some need for mental health assistance.[76]

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[73] B.H. Young et al., "Disaster Mental Health: Current Status and Future Directions," *New Directions for Mental Health Services*, No. 82, Summer 1999, pp. 53-64.

[74] 44 CFR § 206.171(d).

[75] SAMHSA, Supplemental Instructions for the Regular Services Program, at http://download.ncadi.samhsa.gov/ken/msword/RSP%20Supplemental%20Instructions.doc.

[76] CDC, "Assessment of Health-Related Needs After Hurricanes Katrina and Rita—Orleans and Jefferson Parishes, New Orleans Area," *MMWR*, vol. 55, no. 2, Jan. 20, 2006.

No longer-term needs assessments have been conducted and none are statutorily required. A follow-up needs assessment could document the chronic mental health needs of the survivors and inform the development of a strategy to address these needs, using public and private resources. States are not required to submit any follow-up needs or resources assessments in the months following the disaster. However, states are required to submit a report on how CCP funds were used. While FEMA's regulations provide for a mechanism for extension of RSP, they do not explicitly require a follow-up needs assessment to accompany the application for extension. Rather, the regulations only require states, for "documented extraordinary circumstances," to justify their need for extension of RSP.

In August 2006, the Senate Committee on Homeland Security and Governmental Affairs reported **S. 3721**, the Post Katrina Emergency Management Reform Act of 2006. Section 219 of the bill would require that SAMHSA, other relevant federal agencies, and state and local governments, conduct resource assessments and develop strategies to address mental health and substance abuse service needs following disasters. There has been no corresponding legislation introduced in the House. (S. 3721 would also expand CCP to cover substance abuse services. See the prior section, "Scope of Mental Health Services under CCP.")

Conclusion

Hurricane Katrina was one of the most devastating natural disasters in the nation's history. One year later, Congress and others continue to study the adequacy of the response and approaches for future improvement. The field of disaster mental health continues to evolve with lessons learned from the 2005 hurricanes and their aftermath.

The 2005 hurricanes prompted, once again, a familiar set of questions. What types of mental health and substance abuse problems are victims likely to face after a disaster? How long might these problems last, and how might they change over time? Are there interventions that are likely to be of benefit? If so, when should they be delivered, and by whom? How can victims who would benefit from assistance be identified, and how should they be monitored? What can the federal government offer, through assistance to states, individuals, and others, that would be helpful to victims in enabling them to recover and move on with their lives? The federal programs set up to address mental health and substance abuse problems in those affected by the 2005 hurricanes offer opportunities for scrutiny. Careful study of these programs, and those established after the Oklahoma City bombing and the 2001 terrorist attacks, could lend clarity to, and improve the effectiveness of future federal responses.

Appendix A. State CCP Awards

Table A-1. State CCP Awards

(dollars in thousands)

State	Hurricane Katrina		Hurricane Rita		Hurricane Wilma	
	ISP	RSP	ISP	RSP	ISP	RSP
Alabama[a,b]	3,136	2,189	NA	NA	NA	NA
Arkansas[b]	349	532	NA	NA	NA	NA
Arizona	236	0	NA	NA	NA	NA
California	1,004	0	NA	NA	NA	NA
Colorado[b]	348	1,167	NA	NA	NA	NA
District of Columbia	47	0	NA	NA	NA	NA
Florida[a,b]	2,712	6,900	NA	NA	3,312	9,740
Georgia[b]	1,080	3,059	NA	NA	NA	NA
Iowa[b]	244	207	NA	NA	NA	NA
Illinois[b]	368	643	NA	NA	NA	NA
Indiana[b]	193	690	NA	NA	NA	NA
Kentucky	285	0	NA	NA	NA	NA
Louisiana[a,b]	21,248	36,797	0	2,308	NA	NA
Maryland[b]	386	660	NA	NA	NA	NA
Missouri[b]	542	545	NA	NA	NA	NA
Mississippi[a,b]	4,403	19,975	NA	NA	NA	NA
Nebraska[b]	83	257	NA	NA	NA	NA
New Jersey	200	245	NA	NA	NA	NA
Nevada	10	0	NA	NA	NA	NA
Ohio	58	0	NA	NA	NA	NA
Oklahoma	366	0	NA	NA	NA	NA
Pennsylvania[b]	312	1,103	NA	NA	NA	NA
Rhode Island	40	0	NA	NA	NA	NA
Tennessee	128	0	NA	NA	NA	NA
Texas[b]	5,596	12,128	651	3,094	NA	NA
Utah	104	245	NA	NA	NA	NA
Washington	129	0	NA	NA	NA	NA
Wisconsin	203	433	NA	NA	NA	NA
West Virginia	46	0	NA	NA	NA	NA
TOTAL	**43,856**	**87,776**	**651**	**5,402**	**3,312**	**9,740**
DISASTER TOTAL	**131,632**		**6,053**		**13,052**	

Source: SAMHSA Office of Legislative Affairs, as of Oct. 18, 2006.

Notes: Numbers may not add due to rounding; ISP = Immediate Services Program; RSP = Regular Services Program; NA = Not Applicable.

a. Denotes states that received Stafford disaster declarations for Hurricane Katrina, and which may have received CCP awards both for "declared" counties as well as for services for evacuees who relocated to "undeclared" counties. States that are not marked did not receive major disaster declarations for Hurricane Katrina, but hosted evacuees from areas that did, and were therefore eligible for CCP awards.

b. Denotes states that have requested RSP program extensions.

Appendix B. DRF Allocations for CCP

Since the fall of 2005, FEMA has provided weekly reports to Congress on its allocations from the Disaster Relief Fund (DRF) for CCP activities in response to Hurricanes Katrina, Rita and Wilma. The weekly reports provide budget lines for "Crisis Counseling - NIMH" and "Crisis Counseling - SCC" for each disaster. SCC is not defined. NIMH is the National Institute of Mental Health, an Institute in the National Institutes of Health (NIH) which administered CCP in the past. NIMH staff have told CRS that the institute does not administer CCP at this time, and has not received the reported funds from FEMA.[77]

FEMA has advised that its reported SCC amounts correspond with SAMHSA's Immediate Services Program (ISP) awards—amounts that FEMA provides directly to states—and that its reported NIMH amounts correspond with SAMHSA's Regular Services Program (RSP) awards—amounts that FEMA provides to SAMHSA.[78] FEMA accounts for the discrepancy between its reported NIMH allocations and SAMHSA's reported RSP awards by noting that the RSP awards reflect amounts that have been approved, while the FEMA allocations reflect current information about states' use of the funds. The latter is subject to a lag in reporting, and is further complicated by requests for program extensions that have been made by many states.

The table below shows amounts for CCP spending for the three disasters, as reported to CRS by SAMHSA, and as published by FEMA in its weekly reports to Congress.

Table B-1. CCP Funding for the 2005 Hurricanes

(dollars in thousands)

Awards Reported by SAMHSA			Allocations Reported by FEMA		
ISP	**RSP**	**TOTAL**	**SCC**	**NIMH**	**TOTAL**
Hurricane Katrina					
43,856	87,776	131,632	40,210	43,036	83,246
Hurricane Rita					
651	5,402	6,053	1,557	4,355	5,912
Hurricane Wilma					
3,312	9,740	13,052	2,424	8,247	10,671
TOTAL for three disasters					
47,819	102,918	150,737	44,191	55,638	99,829

Source: Amounts reported by SAMHSA were provided by the SAMHSA Office of Legislative Affairs, as of October 18, 2006, as shown in Appendix A. Amounts reported by FEMA are from the Department of Homeland Security, Federal Emergency Management Agency, "Weekly Disaster Relief Fund (DRF) Report," weekly report to Congress, October 4, 2006, stating amounts as of October 4, 2006.

Note: Numbers may not add due to rounding.
Beyond the explanation provided in earlier text in this Appendix, CRS is unable, at this time, to explain discrepancies in the amounts provided by FEMA and SAMHSA.

[77] NIMH Office of the Director, Aug. 29, 2006. NIMH has not administered the CCP since the early 1980s, but is still cited in FEMA regulations as the HHS liaison agency for the program.

[78] FEMA Office of Legislative Affairs, Nov. 10, 2006.

Appendix C. Scope of Mental Health Treatment Services

Mental health treatment is a term that has been used in the fields of psychology as well as psychiatry. While psychiatric services typically include a greater emphasis on pharmacotherapy, mental health services in the aftermath of Hurricane Katrina were primarily psychological. In this context, mental health treatment can include any or all of the following services:

Education and prevention services. Information on predictors and symptoms of mental disorders, where mental health services are available, how to access them.

Emergency services. Immediate response service available 24-hours a day for persons having a mental health crisis, or emergency. This includes the National Suicide Prevention Lifeline, 1-800-273-TALK (8255).

Case management services. Functional assessment, individual community support plan, referral and assistance in getting mental health and other services, coordination of services and monitoring of the delivery of services.

Rehabilitative and community support services. Services which enable individuals with serious and persistent mental illness to develop and enhance psychiatric stability, social competencies, adjustment, and independent living and community skills.

Assertive Community Treatment (ACT). Intensive, non-residential rehabilitative evidence-based mental health service provided by multidisciplinary staff.

Treatment venues may include the following:

Outpatient treatment. Individual, group and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Day treatment. Short-term structured program consisting of therapeutic services to stabilize a recipient's mental health status while developing and improving his/her independent living and socialization skills.

Residential treatment. 24-hours-a-day program provided under the clinical supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit.

Partial hospitalization. Time limited, structured program of therapeutic services provided in an outpatient hospital facility or Community Mental Health Center to resolve or stabilize an acute episode of mental illness.

Acute care hospital inpatient. Short-term medical, nursing and psychosocial services provided in an acute care hospital.

Regional treatment center inpatient. Twenty-four-hours-a-day comprehensive medical, nursing, or psychosocial services provided in a regional treatment center.

Specialty mental health services. Services provided by mental health providers that focus on mental health issues related to specific cultures or languages, including the deaf and hearing impaired.

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