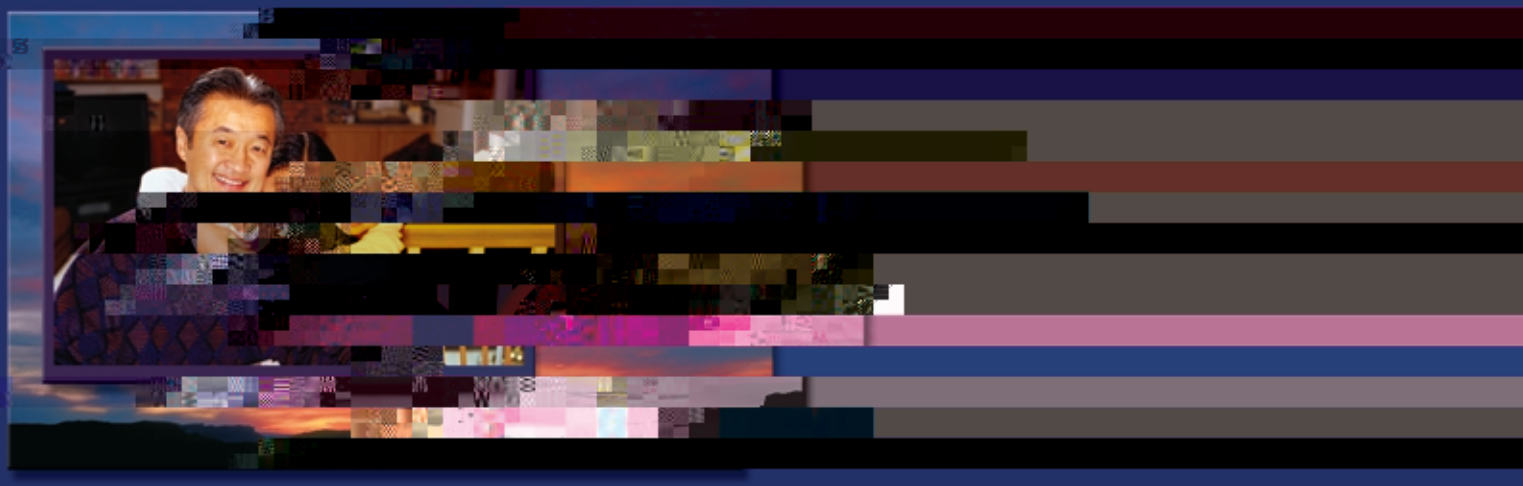

Status Report:

Meeting the Mental Health Needs of the Country in the Wake of September 11, 2001

The Eighteenth Annual Rosalynn Carter
Symposium on Mental Health Policy

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Our country has experienced one of the most painful events in our history, and we still are sorting out the effects, especially the psychological impacts on all of us. We are not the same as we were before September 11th, and we never will be the same. We will never have to say to what year we refer.

Most of us remember where we were at the time of the tragedy. Jimmy and I were in the car on the way to The Carter Center from home. We got the message through the Secret Service radio. I was coming for the first day of the annual meeting of our fellows for mental health journalism. When we got here, we found that some of the fellows and advisory board members had come in the night before. A few others had gotten up very early in the morning and made it to Atlanta. But some of them were stranded in airplanes on runways or in airports. Two of our fellows were from New Zealand. Of course, they were as shocked as we were about what was happening. And we had no explanation for them.

When Jimmy and I arrived at The Carter Center it was quiet. People were not frantically running around or hysterical. Everyone was glued to television sets. After we had watched for what seemed an eternity, Jimmy decided that we needed to call the staff together. So we all met, and he reminded us that our country is strong, that we have been through adversity in the past and always overcome it, and we will again. He also said that we should keep our heads up and not be defeated by the tragedy. So we all went back to work, maybe calmed a little. We had our meeting with the journalism fellows and, while this is always a wonderful meeting, I do not think many of us had our minds solely on what was being discussed that day.

The problem of mass violence is a reality for countries all over the world. No country is immune. Disasters and traumas are part of the lives of millions of people on earth. The causes of all this violence are many. They are complex and hotly debated. But it is clear that civil society is now a frequent target. We have to assume that all institutions serving the general public are potentially at risk. This means that the mental health world is going to have to fashion preventive strategies for a

When I realized it was a person, I grabbed the police commissioner's arm and I said to him, "We are in uncharted territory. We never prepared for this."

I was actually wrong about that, because we had prepared for it, and we had prepared for it in a way that I recommend that we prepare now. We had prepared for everything we had thought about. We had prepared for anthrax, sarin gas, bombings, hostage situations, plane crashes. We had done drills, two of them in which we had gone out on the street and reconstructed what would happen if there were a plane crash or a sarin gas attack. We did drills around the table, and we wrote down plans for how we would act. That was enormously valuable to me and all of the people who worked with me, because we could go back to a reference. We could go back to something that we had thought out in a calmer time.

Even though we were acting on instinct, the instinct was educated by planning. And even though it was not exactly an incident we had planned for, there is not much difference between what you have to do if a building collapses—the response of hospitals, public health, even police and fire—or an attack by an airplane on a building.

I urge you and everyone that we should prepare. I named a chapter in my book *Prepare Relentlessly*. Relentless preparation is advice I have given to people who run organizations. You can never prepare too much. The more you prepare, the better you will handle the situation.

When I walked into The Carter Center lobby, I saw the booklet *Communicating in a Crisis*. If you have to deal with a crisis, it is better to have thought your way through it before than to have to do it for the first time in the middle of the crisis. Organize and figure out what to do.

Two things that gave me great assistance on September 11 would have escaped notice during the days they were happening. People would say to me, "I do not know how you do it," or "I do not know how you are able to get through it." Two things make me feel that it was not I who got through it—it was the people who helped me who got me through it. One thing was relentless preparation—all of the drills, the exercises, the planning, the plans that had been put down on paper. We had had many emergencies to handle in the past, whether it was a building collapse or a crime or a subway derailment, a blackout in a large section of the city, Washington Heights, that had occurred several years earlier in the middle of summer.

We had had experience as a team dealing with these things, so that helped a lot.

The second thing that helped, most important of all, was teamwork, having really good people to rely on. One of them is Neal Cohen. I remember when I first appointed Neal as public health commissioner, the only criticism—because Neal was a superb candidate —was that he was a psychiatrist, and would a psychiatrist know enough about the other aspects of public health, the ideologies and the other disciplines.

they had just lost a firefighter who died in the line of duty. And very, very special issues come up as a result of that.

Just before September 11th, we had a young firefighter die of a heart attack right after fighting a fire. We had had three who died in a fire on Father's Day. But the idea of facing 343 members of the New York Fire Department all killed at the same time and then having to deal with each one of their families—the realization was that we could not give them the personal care and comfort that we normally would have given them.

If a firefighter or a police officer, or a person who works for the city, dies in the line of duty in New York City, the family is embraced. The family is made to feel that they are not isolated. The family is given a realistic sense of just how important their loved one was and the heroic or dedicated thing he or she did. It was impossible to do that in this situation. So we tried very hard to organize people to try and help. Dr. Kelly did an absolutely magnificent job.

Those are things that we now have to learn how to do and practice—how to deal with mass fear, mass grief, mass mourning. The more we can think these things through and figure out how we are going to respond, the better we are going to handle it and create effective methods for dealing with it.

Then there is the aftermath of what happened on September 11th to all the people who are still suffering from it, including me. I have never really been able to describe completely what happened or the things that I feel about it. Talking about it has been helpful for me.

HBO filmed a documentary about September 11th roughly two months afterward. I realized in the middle of my four hours of interviews that I had not talked about this to anyone until then. And I also realized about halfway through the interviews that this was a therapy session—except it was on camera. It got me a little nervous, actually, but I realized that it was very valuable to talk about it.

The HBO producers interviewed a hundred people, and I talked to a lot of them afterwards. Some of those who had been interviewed came up and thanked me. They said, "I really was glad I was interviewed, because I had not talked about this before, and it was helpful to talk about it."

I thought, "Well, that really illustrates the whole wisdom of therapy," which is to talk, to get out your fear and your problems and put them in perspective and realize that you are afraid, or you are upset, or you cannot really process it, you cannot really understand it.

Why is it that every time I go down there, I keep looking for the two buildings? I close my eyes and say, "I think they are still there." Why is it that when I go down there I feel anger all the time? I do. When I go down there, I feel really, really angry at the people who did this to us. But I let myself feel it, and then I move on to the things that are constructive, the things I can do now.

People need a lot of help. There are a lot of issues to deal with and to try to figure out, in an organized way, how we deal with the aftermath. What does it mean to us, and then how can we prepare in the future for the kinds of attacks that may take place? How can we deal with mass fear?

Our public officials probably would be well served by spending some time doing what you are doing, so they communicate as precisely and as effectively as possible.

We have to accomplish two things, and they appear to contradict each other. If we do not understand that they contradict each other, we will do both of them wrong. The first thing we have to communicate is that America needs to

out how to put together this vast web of public safety that often overlaps and is confusing, so that it figures out how to work with each other. All of that is necessary, and voices out there have to keep reminding us not to forget what happened and keep criticizing us for not being prepared enough so the motive is there to prepare.

All of that produces tremendous fear and anxiety, like the warning from the State Department that there will be an attack.

The second thing we have to do is to relax. That's where the contradiction enters. At the same time that we are preparing for the worst, we have to put the risk of terrorism in proper perspective. The reality is that terrorism is not the worst risk that we face. Every day we face much greater risk than the risk of terrorism. Those risks do not hobble us and do not stop us from doing the things that we are supposed to do. By and large, they do not have an impact on our mental health, except in very individual, unusual circumstances.

No matter what happens in Iraq and no matter what the reaction to that or the ongoing effort against terrorism, we are never going to lose as many to terrorism as we do to drunk drivers. In 2001 drunk drivers killed four or five times more people than terrorists killed, and they killed them with something that is preventable. Drunk driving is far more preventable than terrorism.

Fear does not lead people to stay home because of drunk drivers. Fear does not lead them to avoid their automobiles simply because there is a risk. Now, people may get into an automobile, but they will not get into an airplane

The other thing I found out, which I am sure you all know, is that there is no one way to respond to the loss of somebody you love or the fear of a possible additional terrorist act. Some people respond to it, and very quickly they are able to put it all together and want to move on. Maybe later they are able to feel the grief. Other people feel it right away, so I decided to try to deal with it with Neal's help and the help of some other people.

I tried to deal with it by saying to people,

Panel I: Child and Adolescent Mental Health

William R. Beardslee, M.D.

We face daunting challenges as a country, and we face daunting challenges because we are responsible for the mental health care of children. We know more and more about what works to help children when they are ill, and what works to prevent difficulties from developing, because of advances in the neurosciences, developmental epidemiology, and research on treatment—and also because of the activities of the advocates for those who suffer from mental illnesses.

The interdependence of our lives in the modern world requires that we live more and more together. We depend heavily on one another for the basic necessities of life—food

and shelter—and even more heavily on one another for the essentials of companionship, learning, and finding common ground.

These connections are threatened by terrorism. The threat from terrorism involves what actually happened in the attacks—and also the fear that more attacks will come. Terrorists attempt to strike at the very heart of a democracy and to destroy, through fear and violence, the essence of who we are and what we are. They attempt to keep us from coming together. And our children are particularly vulnerable.

But we have much that we can do—and much that we must do—to combat terrorism. We must reaffirm our faith in democracy and the actions that show we are unwilling to compromise our values. We must learn from those who have suffered through terrorism, endured, and survived. We all must learn from the best available evidence provided by those who have done the research or cared for the victims of terrorism. We must learn how healing from terrorism is similar to healing from related conditions—depression, posttraumatic stress, and so forth—and how it is different. Above all we must consider how to build strength and resilience in our children and their parents. In the long run, this will serve us best as we face the huge uncertainties in the years to come.

Perhaps the most important development in mental health and medicine over the last 20 years has been the requirement that we use only evidence-based treatments supported by data from randomized trials and from carefully evaluated approaches. Now also we must learn how to apply such approaches in large-scale programs.

In this panel on child and adolescent mental health, four experts in response to terrorism share the most important evidence-based findings, combined with humanitarian care and innovative approaches.

Some things work. Some things do not. We need to know what works and what does not. We need to think about how to deliver supports to schools, to health care clinics, to families, to neighborhoods, to houses of worship, and to other structures where people come together. We need to know how findings that have worked in one setting—in this country or abroad—can be transposed to other settings. And we need to know how findings derived in one culture or in one language are applicable to another culture or another language. As all people in America are threatened by terrorism, how we can bridge our extraordinarily diverse cultures and populations must be forefront in our minds.

Meetings such as this can serve a vital purpose, because another intent of the terrorist is to break us apart and to keep us from talking. We need to talk openly to one another. We need to remember that we are deeply challenged in that the very things we hold most dear—open communication, respect for diversity, democracy, the challenges of discourse and free speech—are threatened. But I think it is equally important to remember to take the long view. We have been challenged as a nation by extraordinary threats in the past—during our revolutionary times, during

The terrorist attacks of September 11, 2001, and their anthrax aftermath may not have changed everything, but they have changed how the nation views public health—and we need to continue to change the way we view public mental health. We are more aware of how unpredictable and unsettling acts of terror can be and that they interfere in profound ways, with consequences extending beyond directly exposed individuals.

We have learned—and we continue to learn—some painful yet valuable lessons about these consequences from prior disasters, including events such as the 1995 bombing in Oklahoma City, the attacks in New York and the Pentagon, and terrorism in other parts of the world. We also have learned about the human response to psychic trauma from work with victims and survivors of other kinds of violence and trauma. We know that in one's lifetime in this country, exposure to one or multiple traumatic events is a serious public health issue. We can look to past experiences to help us understand and respond to the effects of terrorism—although there may very well be significant differences with implications for mounting responses.

Traumatic events are experiences that overwhelm us, eroding our capacity to cope, to put things in order, to make sense out of the world. Certain characteristics of these events hold greater risk for adverse mental health outcomes—those that instill fear, helplessness, and horror. And catastrophic events hold enormous public health consequences, including death, acute and enduring disruption, distress, fear, illness, and enormous social and economic burdens.

We can discuss the range of effects of terrorism from both a human services and a public policy point of view, focusing on population-level effects and individual effects, as well as from a mental illness or mental disorder perspective—each of these is important.

In a review of more than 130 populations exposed to disaster, including those affected by terrorism and other human-caused disasters, researcher Fran Norris and colleagues report many different effects:

- Specific psychological outcomes such as post-traumatic stress disorder (PTSD), depression, and other anxiety disorders
- Nonspecific distress outcomes, including psychosomatic symptoms and psychological

distress that do not reach the level of a disorder or illness
- Health concerns and problems that manifest themselves in taking increased sick leave and increased physiological arousal or indicators of stress, declines in immune functioning, sleep disruption, and relapse/decline in existing illness
- Increased use of substances, alcohol, and smoking

Norris et al. also note changes and problems in living. These include troubled interpersonal relationships, social disruption, family strains and conflicts, occupational stress, financial stress, and environmental worry, as well as declines in perceived social support, ability to cope, and optimism about the future.

They also point out that such events have consequences specific for children and adolescents, including regression in development (age-inappropriate behaviors) and emotional problems related to anxiety and separation from parents in young children and in older children and adolescents. In older children and adolescents, problems look more like what adults experience and include the range of depression and anxiety concerns, and also aggression, agitation, and disruptive behavior problems.

The research on severity of impact shows that responses vary greatly, largely dependent on the sample or age range of the population affected and the type of event. Children are generally more susceptible to severe impairment, followed by adults and first responders (rescue personnel, firefighters, etc.). The research also shows that acts that involve widespread loss of both life and property, as well as those that take on a more symbolic meaning, are likely to have more pervasive effects that extend into the population, beyond transient distress.

I want to mention two examples of data collected since September 11th that do not focus on children per se, or mental illness, but are useful for thinking about population-level issues in response to trauma. Roxanne Cohen-Silver and colleagues' national survey of people's responses to September 11th supports the commonsense view that:

- The impacts of a major national trauma can extend beyond those directly exposed; psychological reactions such as nightmares, cognitive and behavioral avoidance of reminders, and heightened anxiety and arousal are widespread.
- These responses are associated with exposure, but also with denial or inactive coping in people who shut down or did not do something to address their feelings.
- Perhaps most importantly, these effects decreased over time.

David Vlahov and colleagues' New York Academy of Medicine study of the New York area (oversampling below 110th Street) reports similar findings over time on symptoms related to memories and unwanted thoughts:

- Four months after September 11th, significant numbers of people reported avoidance behaviors and lack of interest in things that used to engage them.
- Significant problems for large numbers of people also emerged in their ability to be startled easily and their inability to sleep and concentrate.

These data do not describe people with a

Dr. Shalev has observed that not all persons expressing even the full set of PTSD symptoms are otherwise "impaired" or "distressed" when these variables are measured in a clinical interview; they do not report being unable to function, to care for their children, to go to work, etc. They are distressed and fearful, and they have a lot of these symptoms, but they are not meeting criteria for a disorder. Dr. Shalev also observes that the fears associated with the traumatic events—the terrorist activities in that plagued community—are specific; people attribute them to certain situations where the terrorism has occurred. They do not generalize them; people are, for the most part, carrying on.

What do we know specifically about children's reactions? Children who experience catastrophic events show a wide range of reactions. Some will suffer only worries and bad memories. With good support and the passage of time, those will fade. Other children will be more deeply affected and will develop more enduring problems, including fear, depression, withdrawal, and sometimes anger, as well as age-inappropriate behaviors. These certainly should be warning signs for parents.

Children who develop PTSD or depression or other persistent disorders clearly need, and can benefit from, effective treatment. The bottom line is that children are physically and emotionally vulnerable, wonderfully resilient, but not immune to the effects of trauma.

What can we expect to see in children exposed to catastrophic events? We know that children who lose immediate family members, friends, and relatives are most likely to show immediate symptoms of posttraumatic stress than children who are not bereaved. But research by Dr. Pfefferbaum and others shows that even children not directly involved in an event can be impacted. Dr. Pfefferbaum's study of responses up to two years after the Oklahoma City bombing of children geographically removed from the area showed that many (16 percent) were still reporting substantial levels of stress-related symptoms—not necessarily PTSD, but still significant levels of distress that may interfere with healthy development.

Just as with adults, some children are more vulnerable than others. A history of maltreatment or other traumatic experiences, a history of mental health problems, and importantly a lack of good family support do not bode well for child victims of trauma.

I want to underscore what may be obvious—that children take a lot of their cues from their parents. Anytime we talk about understanding children's responses and potentially intervening, we really are talking about work with parents and families as well.

What type of guidance can we offer based on past experiences? About a year ago, representatives of the U.S. Departments of Health and Human Services (HHS), Defense, Justice, and Veterans Affairs and the Red Cross reviewed what we know about effective early intervention after mass trauma. A year earlier, HHS partnered with the Department of Justice to review what we

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lessons about what we can communicate to people from a public health perspective. We know that credible, consistent, and clear messages about what to expect physically, emotionally, and behaviorally for children—and also for parents—can be a good thing to deliver, as well as how to provide comfort and how to recognize signs of both transient symptoms and persistent problems, and where and when to seek help.

We also have learned some lessons about what to avoid—these are things that engender mistrust or erode credibility. This focus needs to be part of the planning process in terms of who will communicate what, as we learn about events, in the most credible and reassuring way.

From a clinical perspective, we know that outreach and naturally occurring gatherings to help screen and refer youth, based on their risk by virtue of their exposure, their individual vulnerability, and their acute responses, are a smart thing to do. Good but limited evidence exists about early interventions that help reduce the incidence, duration, and severity of acute and chronic disorders such as posttraumatic stress and depression. We also have preliminary information about the usefulness of early intervention for people who are bereaved, including children.

We know that early interventions in the

population, as well as active coping strategies to help people carry on. And we have good information about formal mental health treatment strategies, when indicated, that are successful for many people. The NIMH Web site contains a good deal of information on these issues: www.nimh.nih.gov.

Much remains to be learned about how to enhance resiliency, perhaps looking at research and work that has been conducted internationally and in other cultures where people live with terrorism on a regular basis. We also need to work harder to bring effective treatment to all who suffer. We have a great deal of interest, energy, and need in the area of early intervention and prevention—scientific progress here holds great promise for improving the nation's health in uncertain times.

It is critical that we integrate behavioral and mental health issues into planning and response initiatives. Terrorism has profound implications for national mental and behavioral health.

I am excited to share with you some of the current work at RAND's Center for Domestic and International Health Security to better understand terrorism's effect on children. The attacks on September 11th affected children across the country. In a national telephone survey we conducted immediately after 9/11, almost one-third of parents reported stress symptoms in their children. Most parents told us that on the day of the attacks they talked extensively with their children about what happened, trying to reassure them. Following many other traumatic events, children so far from the event might not have been considered directly affected by the trauma.

We know that children are particularly vulnerable to many traumatic events, but we know very little about the mental health effects of terrorism on children, for example, how it is similar to other traumatic events and how it is different. To begin to develop a better understanding of terrorism's effect on children, we conducted a second nationally representative survey in November 2001. This survey included interviews with almost 400 adults across the country with a child age five to 18 living at home; many of these adults had been interviewed

children might be having, so we also asked about other depressive and anxiety symptoms, like feeling sad or hopeless, worrying a lot, or wanting to spend more time with the parent.

In November we asked whether parents still perceived that their children were affected by terrorism. Among adults who participated in both surveys, 44 percent reported substantial stress in September, but the number dropped to slightly more than 20 percent in November. Compared to the reduction of symptoms in adults, children's symptoms decreased far less from September to November.

One finding is that the symptoms the parents most commonly endorsed in their children as a result of terrorism were not the classic PTSD symptoms, but rather the more general depressive and anxiety symptoms. This finding highlights what may be one of the important differences between terrorism and other traumatic events.

Children's mental health response to terrorism may not be just a response to the trauma and loss of the events of September 11th. Anxiety and sadness also may be a response to the climate of fear—the sense of danger—that continued to be felt across the country in November 2001.

children a lot about the children's worries and also about what they should or should not be doing to be safe from terrorism.

Schools are a major source of support for our children; in some areas in New York, the schools are very active. What are schools in other areas doing? The majority of parents across the country told us that their children's schools were active in providing information or support to the children or their families. Nearly two-thirds of parents reported that their child's school had held a special school assembly or classroom program in response to terrorism, were providing counseling to children in response to terrorism,arents r fof

We need to learn more about what types of counseling and clinical interventions are effective for the few children who need those interventions. But the survey findings suggest that beyond those few children who need those types of clinical interventions, many more children are affected by terrorism. We need to learn more about how to help this larger number of children across the country.

In this effort, parents and schools will be critical. Right now, we know something is happening—but we do not know what. We need to know more about the details of what parents and schools are doing. Is what they are doing effective? Is it helping children? And, despite their best intentions, is any of it harmful? Right now we do not know.

What about others in the community? Other institutions and people play important roles in children's lives—churches, synagogues, mosques, and pediatricians, for example. What roles are they playing? What are they doing? Across all of these groups, we need to think about what kinds of support they need to do a better job. Beyond just clinical interventions, we need to think about how to support parents, schools, and others in the community to help promote better coping and resiliency in children.

An environment of sustained danger and uncertainty seems here to stay. But if we can begin to answer some of these questions, as a nation we will be in a much better position to help our children meet some of the mental

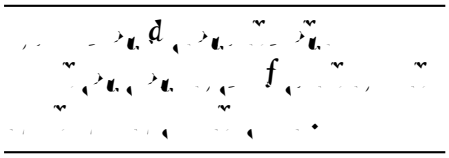
Most of the teachers were at work on the day of the bombing and with children at the time of the incident. Their acute reactions were intense, similar to those we might expect in other populations. The reactions included a sense of helplessness, fear, worry, arousal, and rapid heart rate. Women reported more intense reactions than men.

The findings with respect to interpersonal exposure in this sample were alarming to us at the time. More than one-half of the teachers reported that they knew someone who was killed or injured in the incident—but most of those relationships were through friends and acquaintances, rather than family members. That is a key point, as we try to understand the reactions of various groups.

Findings regarding television exposure were interesting. Three-quarters of the teachers reported that all or most of their television viewing in the aftermath of the bombing was related to the bombing. This was not surprising given the intense focus on the incident in the national and local media—particularly in the local media, where major television stations did not return to normal broadcasting for four or five days after the incident. We asked teachers how much stress they experienced associated with media coverage. Forty percent said that they felt some or a lot of stress associated with the media exposure. Our findings indicated that media exposure was related to later posttraumatic stress in the teachers. This was true in the children as well, but other factors, for example, the stress related to media coverage and the teachers' acute reactions, were more important than the amount of media coverage in later posttraumatic stress. Other factors undoubtedly influenced later symptoms even more than media exposure, but the media concerns provided us an opportunity for intervention or prevention.

Therefore, we suggest that media exposure at least be monitored, if not limited, following disasters like the bombing. One approach our schools can take, for example, is to develop a strategy for dealing with media coverage. On the day of the Oklahoma City bombing, teachers and schools engaged in a variety of practices with respect to announcements and use of the media. Some teachers brought televisions into their classrooms and watched live coverage of the rescue and recovery.

The relationship between ongoing post-traumatic stress and media exposure does not mean that media exposure causes posttraumatic stress reactions. In fact, it may be that people who are aroused or who are more symptomatic may be drawn to the media, perhaps to obtain information about an event or to maintain this heightened state of arousal. We need more rigorous studies to address this issue. Our study used a very brief survey with only two questions about the media. We need studies that explore both positive and negative aspects of the media before drawing any conclusions. And posttraumatic stress symptomatology is not the only outcome we need to examine.



Posttraumatic stress reactions did occur, primarily reactions of intrusion and psychological reactivity, but emotions such as worry and concerns about safety are more salient following a terrorist incident. A major goal of terrorism is to create fear and intimidation in the public. In our study seven weeks after the Oklahoma City bombing, 40 percent of the teachers reported that they were somewhat or very worried about their own personal safety.

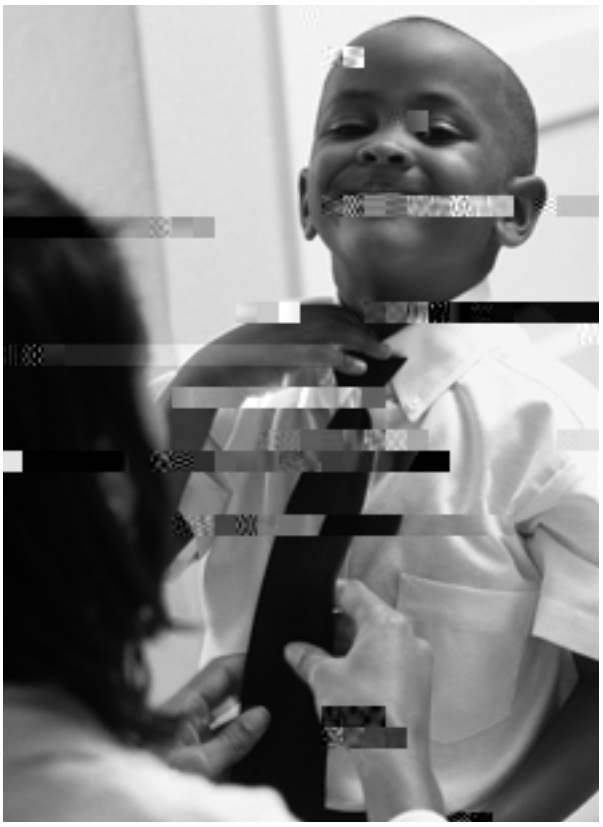
We asked teachers about the stress they experienced as they were trying to deal with the needs of students; 30 percent acknowledged some or a lot of stress. Teachers overwhelmingly reported satisfaction with the support they received from their colleagues and administrators.

Some reactions are normal after a terrorist incident and do not necessarily translate into need for clinical attention or intervention. Seven weeks after the bombing, 18 percent of the teachers surveyed said that they were experiencing difficulty handling the demands at home and school, yet only 5 percent had sought counseling. We know that parents and teachers tend to underestimate the traumatic responses of children. When teachers are stressed, experiencing ongoing worry, or having functional difficulties themselves, they may be even less able to identify children in need.

Women teachers tended to report more intense reactions acutely and over time, and they were more likely to report impairment in their functioning than men teachers. This may reflect

actual differences in gender in response to

Fears of recurrence can be fed easily by myths, rumors, and misconceptions and are not bound by the same trauma-exposure parameters that typically predict PTSD. Schools, families, and communities can have procedures to keep properly informed about these, help with



issues of accountability can lead easily to wide intolerance of members of cultural groups. Because of the developmental vulnerability of the appraisal process for children and adolescents, they need added support to understand the challenge to their appraisals and to counteract intolerant beliefs and behavior.

Spiritual support and beliefs are extremely important in contending with threats and finding meaning in the face of danger, trauma, and loss. At the same time, catastrophic events can challenge our basic beliefs. History has shown, however, that when such events have a wide destructive impact on a large population, spiritual schemas can become pessimistic and apocalyptic. On the family level, studies around the world have found that, in situations of chronic war or terrorism, demoralization among parents can have a profound effect on their children.

Specific risk factors relate to danger, including children and caregivers with prior anxiety conditions. After the earthquake in Northridge, California, anxious children had much more anxious responses independent of their exposure, as did children of parents who were anxious. Several other risk factors are a history of insecure attachment, parents in high-risk professions, group identity misappraised as dangerous, single parents, reduced family resources, and prior or current living in dangerous environments. Terrorist events, such as 9/11 or the anthrax bioterrorism, can redefine who has parents in what are now deemed or perceived as high-risk professions—for example, airline personnel or post office employees.

Following trauma and loss, large segments of the population have general traumatic stress responses. A community's real goal is to make sure there is an appropriate public mental health approach that provides surveillance, screening, and identification, so that triage and tiered interventions can be employed properly. Support provided for the more general reactions, shared by many, differs from what is needed to assist children and families with more specific exposures and responses. As studies have shown, there is a tremendous reservoir of unaddressed prior trauma in the lives of many children and families. A public mental health program needs to be able to take that into account and meet their special needs, as the current event may well bring back distressing reactions to their prior experiences.

We know that the impact of loss after disaster or terrorism can be both concentrated in certain pockets and widely spread. Traumatic loss does not follow the type of exposure parameters most predictive of PTSD. It reaches far and wide, across the United States and beyond. We have come to appreciate that traumatic bereavement not only entails normal grief reactions, but also includes continued preoccupation with the manner of death, including its details. This continued intrusion actually can interfere with the more usual, although difficult, task of contending with the impact of the loss itself. Complicated bereavement also carries posttraumatic stress-like risks that are different from the depression, anxiety, and substance abuse that can follow the loss of loved ones. After the loss of a loved one, 15 percent of adults and children may develop depression by one year. This is a serious issue, sometimes affected by other risk factors, such as family histories of depression or prior history in the child. In New York we suggested that experts in depression be included as part of the team providing consultation to the grief counselors in order to monitor those who were most at risk and provide timely and proper treatment.

Adversities that abound after disasters can

disturbances in academic functioning. Probably the most underrecognized and untreated factor in the United States in efforts to increase academic excellence is the reservoir of trauma and its effects that impact on academic performance.

A public health model has three tiers: (1) general posttrauma response, (2) postterrorism response for the general population and a specific response for high-risk children and their families, and (3) identification of children with prior

Questions & Answers

Q What was the definition of terrorism in the RAND study?

A Dr. Stein - We said "terrorist attacks" and "effect of terrorism," and we left it up to parents to interpret as they saw fit. The experience of terrorism and its meaning are seen through the prism of people's daily lives. For some populations in this country, the experience of ongoing fear and danger is something that they deal with on a daily basis.

Q How can we address the needs of underserved communities where many people appear to be at greater need?

A Dr. Pynoos - In the last 15 or 20 years, we have experienced an epidemic of violence in the United States. We provide every police officer, rescue worker, combat soldier, and fireman with a standard of care that has not been applied to our children. We ought to give proper support to children and adolescents who have gone through these exposures to violence with no assistance. That would be an important step—to address the trauma in their current lives and in past experiences. We have made little public policy in that regard in the United States.

Q What is the state of our research in understanding the separation of the

Without question Mayor Giuliani is the master of communicating in times of crisis, and of doing so with vision and clarity. I was pleased that the mayor took a copy of our booklet *Communicating in a Crisis: Risk Communication Guidelines for Public Officials*. It's a volume that we're formally releasing right here at this symposium. It helps teach the language of safety, security, and hope—critical ingredients in risk communication. It's the product of collaboration among SAMHSA, CDC, and FEMA and is designed to assist public officials—mayors, county commissioners, public health officials, public safety officials, and law enforcement. The efforts of many people who worked to make it a user-friendly tool cannot be overstated. We will make the booklet available not only through SAMHSA, but also through state mental health authorities, emergency authorities, and drug and alcohol authorities.

On the back of the booklet is a "Top Ten List for the Savvy Communicator." The top tip reads like the Hippocratic oath: "First, do no harm. Your words have consequences—be sure they're the right ones." To help SAMHSA ensure that we have the right words and programs, we are hiring an emergency services coordinator for the agency to serve as our point person, our voice in times of crisis.

Over the past 14 months, America has held its breath, cried, mourned, and drawn strength from family, friends, and faith. We are recovering and, without question, we are learning. Over the past 14 months, America has been learning what we in mental health have known for some time. Mental health is not to be taken for granted in these times of uncertainty. It can no longer be an afterthought. Mental health in today's world is, and will remain for some time to come, at the heart of public health.

Theodore Roosevelt had insight into how best to function in crisis, how to manage risk communications, and how to move forward in changed times such as these:

It is not the critic who counts, not the man who points out how the strong man stumbled, or where the doer of deeds could have done them better. The credit belongs to the man [and, I might add, the woman] who is actually in the arena; whose face is marred by dust and sweat and blood; who strives valiantly; who errs and comes up short again and again; who knows the great enthusiasms, the great devotions, and spends himself in a worthy cause; who, at best, knows in the end the triumph of high achievements; and who, at worst, if he fails, at least fails while daring greatly, so that his place shall never be among those cold and timid souls who know neither victory nor defeat.

So let us stay in the arena. Let us keep daring greatly to meet the challenges of a changed tomorrow. In doing so we can only meet with victory. The people we serve deserve no less. The good news is that we have a strong, solid track record. I look forward to continued partnerships to help promote the resilience and the recovery of America.

Preparing the States

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were available. Some frustration was evident about the lack of consistency and coordination at all levels of government.

publication will be followed up by a number of regional trainings and activities that NASMHPD will sponsor to help states jump-start the planning effort.

The National Mental Health Association's Blueprints Project is developing a number of modules that look comprehensively at disaster or emergency mental health in terms of different populations, funding, and planning strategies and how to bring communities together to plan. Its curriculum will be implemented in many communities around the country.

In addition, SAMHSA and CMHS will award grants to 40 states to help them begin to build capacity for preparedness. The grants will provide resources to hire people to do this work and to build coalitions. It is an extraordinarily wise move on the part of SAMHSA and CMHS to try to cover as many states as possible. We do not have the luxury of starting with one or two states and seeing how it works and then moving on. This is a strategy built on recognition of the emergency situation that exists.

There is also the potential—at this point largely unrealized—of state mental health authorities accessing funds given by the Department of Health and Human Services to state health authorities. Not more than a half dozen states have accessed those funds.

In terms of weapons of mass destruction, relationships between the mental health authority and the health authority are critical. I urge all of us to help foster those collaborations, to try to access available resources, and to ensure that mental health planning is proceeding in step with what the health authority is doing.

In summary, I am left with genuine and deep ambivalence. I am frankly worried, more than I have ever been, about the challenges and potential threats that this country faces. We simply are not as prepared as we need to be. The science is not there. The resources are not there. The public policy is not there.

On the other hand, I have never been more optimistic and hopeful, because so many things are coming online. Resources are becoming available that can begin to move us toward where we need to be. This issue has gotten the attention of the nation. We have an unprecedented opportunity to actualize delivering mental health in a public health model, as was discussed in the Surgeon General's Mental Health Report of 1999. This is what disaster mental health is all about. We have an opportunity to lead the way for the rest of the mental health community, as we move forward in disaster mental health.

This is also a unique opportunity to reduce stigma. Terror terrorizes everybody in this situation. We have opportunities, out of our pain, to accomplish things that we have not been able to accomplish before. And we have an opportunity to expand the field of mental health to where it ought to be. We have an opportunity to lead. It is just as much, if not more, about mental health as it is about mental illness. We know far more about mental illness than we know about mental health at this point. Building systems to respond adequately and getting the research done will show us a lot about health, about resilience, in ways that will balance the field the way it ought to be. As we move forward in preparedness for disasters and appropriate response and recovery, we have an opportunity to help promote health and to combat disease in a way we seldom have had in other fields. I will end on that note of hope.

I am pleased to represent the District of Columbia. It not only is an honor to be the first mental health director for the district,

With anthrax we had a lot of confusion. Communication issues were paramount, and we learned lessons about responding to an unfolding event. From the sniper attacks we learned that our suburbs can be as vulnerable as our city. We lost more adults to other violent acts in Baltimore and Washington during the same period of time than from the sniper attacks, but our suburban communities had always felt safe. Also throughout the year, our gang violence had begun increasing again from its previous rates over 10 years ago. Violence is a way of life in our city.

But immediately on 9/11 the mayor asked me to help craft what we needed to say to the community. I saw this as an opportunity for a department of mental health and a system that had never been asked to speak on behalf of anyone anytime. We used the opportunity as well as we could, talking to the community as much as possible. We formed a community network, thanks to support from the Federal Emergency Management Administration (FEMA), and we got funding from the Office of Management and Budget and funds from the Substance Abuse and Mental Health Services Administration (SAMHSA).

We did an action-oriented needs assessment in the community. Since we had little time to do it, we decided to do structured interviews. With this method we got a great deal of information consistent with what the more formal researchers who had more time have reported from traumatic events. We developed a community support network with 18 indigenous paraprofessional workers in our neighborhoods, who are still out there working, and we are doing our all-hazards plan.

The District of Columbia can serve as a case study of continuous threats and of different types of threats. I urge researchers to join in our resurgence of mental health research practice and policy in the district.

I have been asked to provide you with lessons learned from this experience. The first lesson we learned is that "afterwards" counts as much as the event. The District of Columbia has an ongoing need for recovery and community support. We know a lot already about community support for people with mental illnesses. We know a lot about support for communities that are tragically underserved; many of our neighborhoods in the district are underserved and have high needs. We understand recovery. We understand that this is a community event. We are still talking to each other on the elevators. As a matter of fact, people are hugging on the elevators. I have never seen so much hugging in all my life as when the snipers were caught.

It is also important to find secondary victims and beyond. For a long time after 9/11, no one talked to our Latino population or gathered their community networks together. About 100,000 workers in the Washington area were out of jobs because no one was patronizing our hotels, our cabs, and our retail establishments. But people who did not have TV or did not speak English did not know why they were out of work, because the communication to those communities was so sparse in the very first days.

People do not self-identify as secondary victims, particularly in communities where there is a lot of violence. What is different today about being a victim from the day before? Everyone who opened mail in the District of Columbia was a secondary victim. People avoided going to their mailrooms. A lot of people did not pick up their mail, and they did not pay their bills for months at a time.

days of community mental health, when we reached out into our community, we learned that one-shot education—like a module in second semester social studies—is not enough.

We know that somatic stress does not show up right away. In D.C. when we go to a certain level of emergency, fighter planes go into the air. At 1:00 a.m., they hit the sound barrier, which sounds like a bomb, and then at 2:30 and at 4:30 the planes go overhead again. How do I know that? Because I was awake at 1:00 and 2:30 and at 4:30. We knew that the symptoms from that subsequent stress go back to the same level as the original stress every time there is a new event. That seems to hold true in the people who are appearing for services.

People do not seek traditional mental health services. The entry points for most people looking for help are primary health caregivers and clergy or other natural caregivers in the community. In D.C. when we broadcast the hotline number in a scroll across the bottom of the television screen, we have a spike of calls and people do come in. But people do not identify as needing mental health services.

Gender differences also matter in recovery. Men want different types of community support from women. For the Brentwood workers, we ran two different types of support groups. We are learning that we must build overall social systems for ongoing support. We cannot just assume that that will occur on its own.

For policy and practice in a state or a city—and for the folks on the front lines asked to do this work—sustainability is a major issue. In our network more than a hundred volunteers are currently credentialed to go out in the event of an attack. How can I pique their interest a year or two years from now? In the district, that does not seem to be a problem, because we keep on having events—but it is an issue.

Can state budgets fund mission expansion? In today's world the public mental health system at all levels is experiencing mission retraction. This is an issue that must be on the table. Preparedness builds on training and practice. Becoming prepared and sustaining preparedness for an emergency must be a continuous process. Over time we will not be prepared if we do not constantly work on it.

The importance of the social context is evident in our Brentwood case study. The Brentwood post office is the upstream facility through which the mail with deadly anthrax passed on its way to the Hart Senate Office Building. The Brentwood post office, a large facility, has a large work force that does not have a significant turnover. In fact, many families have a number of family members working there, and many are second- or third-generation employees. A significant and historical labor-management distrust has built up over time.

In the post office, if you ask for help through the employee assistance plan, the request goes in your personnel file jacket. People do not ask for help.

Ninety-seven percent of the work force at Brentwood is African-American, mostly unskilled labor. We also learned that if you do not attend to recovery support, the issue rightfully becomes a social justice issue. Most of the workers at Brentwood are not D.C. residents. Most live in Maryland. But at a community meeting in April 2002, Brentwood employees came to our staff and asked us to support them, which we do through weekly support groups and through remembrance groups. The opportunity had been missed between October and April, and now it is a major political issue in our community—and rightfully so.

Several significant symbolic events best characterize this experience. The federal government closed the Hart Senate Office Building, but they kept Brentwood open following the anthrax exposure. Brentwood employees were told to go to D.C. General mps. TheT*lemxpounity—anld to go t thihempTjT*(ada.81

The Brentwood employees have said to me and to all our staff repeatedly, "You are the only ones who have been there for us." It was not just because of our mental health work. It is because of the social justice issues.

A bioevent has no identifying start or stop point. There is no visual image. We do not know what the long-term effects will be. We do not know how the characteristics of a bioevent might correspond with a natural disaster or another terrorist attack. The continuum is undefined for clinical follow-up.

In a bioevent, mental health is integral to the public health response—much more so than it was in 9/11. This is very important. It is an opportunity for mental health. In our community the Department of Mental Health was asked to be part of this response, to be full partners with public health and law enforcement.

What about the lessons we have learned from the sniper event? It is difficult to be a community under siege. When a community is under siege, many groups, including school children, are forced into a situation we call "sheltering in place." We need to learn more about sheltering in place. Our community had a debate about whether or not children should go to school. In discussions with some of my colleagues in the school system, many said that children should not go to school.

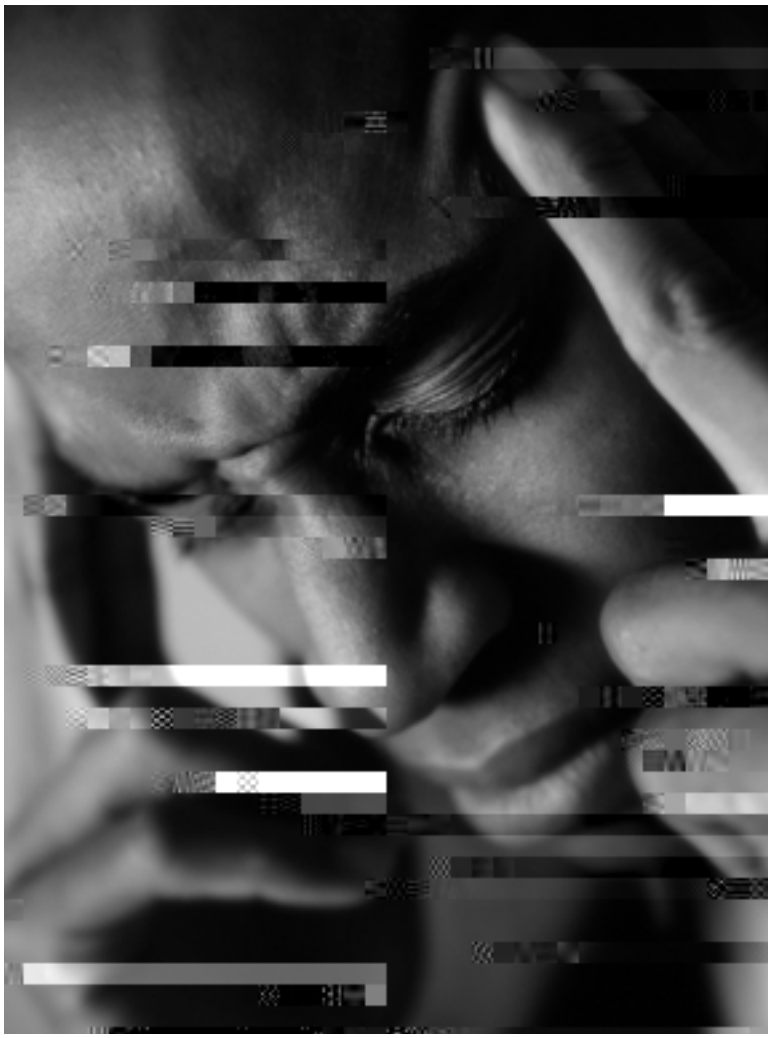
I responded, "Where would you want them to be? The issue is getting in and out of school with safety, but children want and need that structure."

If we learned nothing else from the sniper events, we can learn what our fear did to our children. We must fear fear itself. The day after the snipers were caught, a reporter from a local radio station asked me what people were feeling. I said they were feeling a great sense of opportunity.

He said, "A great sense of opportunity?"

And I said, "Yes, it is the 21st century in the United States. We all get to go back to Wal-Mart."

The people really were relieved and ready to go, and the media still wanted to talk about feelings. They missed the point that Americans are very resilient.



Several issues relate to caregivers. We must consider how to take care of our caregivers if we were under siege for a long period of time in our communities. That is the one aspect of our all-hazards plans across the country that probably is the weakest.

We have had many challenges—probably too many to bear in this short period of time. But at least we can identify together how we go forward. It is an opportunity, and I am sad to say that. But my colleagues and I in the district see this as an opportunity for our mental health system to become a helpful part of our community as part of our recovery as a mental health system in the district. Our country needs us now to come together as a mental health community. It needs us to come forward, to stand up, to be counted on. We have a great opportunity. We have an obligation. We have been asking for notice from the world. This is it, sorry to say, but it is true.

This topic has been an area of pursuit—almost passion—for me for the last two decades, starting in California. Infrastructure does not sound exciting, but it is absolutely essential.

Let me describe first how I became interested in this area and how the Texas program evolved to meet the needs for an all-hazards plan and all-hazards system. California has myriad disasters every year, from floods and fires to earthquakes. Early in my career I was involved with the response to those events. I recall the hundred-year flood in the Central Valley, standing on I-5 and seeing nothing but water as far as the eye can see, thinking I was in the middle of the ocean, doing crisis counseling and interventions with folks who had lost everything—every picture, every album, every trace of their family history and things that meant so much to them—and understanding how important those interventions were to individuals like that. I worked to put a program together in the aftermath of the Loma Prieta earthquake that collapsed the freeway and stopped the 1989 World Series. I had done the CISD (critical incident stress debriefing) interventions for organizations in which

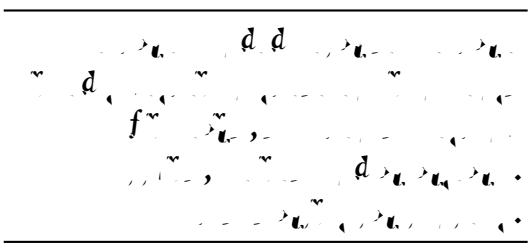
Going back to that 5:00 a.m. plane ride two months after I arrived in Texas: I was sitting with strangers from the Department of Public Safety and the Office of the Attorney General's Victim Assistance. We had never met each other before. Yet those relationships persist to this day. The work we did together in the six days in Tornado Alley cemented a bond among us all. You will find this happens as you get actively involved with these processes.

As many of you know, the American Red Cross is the federally designated agency to set up shelters. Folks from Red Cross were there. Often there is friction among state and federal agencies. The person from the Red Cross came up to me and said, "Dr. Shon."

I looked at her and she said, "San Francisco."

And I said, "Oh! Helen, how are you?"

She had been in charge of setting up all the shelters in the Bay Area for the 1989 earthquake, when I had been in charge of coordinating mental health services. Immediately we shook hands and gave each other a hug. It cut through so many things, because the frictions were not there. We had a working relationship.



We strive to develop relationships with sister agencies in our state, agencies whose missions may seem a hundred miles from ours, like the Department of Public Safety and state police. We have bonded because we have worked together in these environments for years, so when something occurs, we respond as a team. This is a critical concept.

Now our State Crisis Consortium is expanding. This is another outcome of the New York summit. We had the opportunity to relook at what we were doing and to expand. Several other agencies are part of our consortium now, including the U.S. Attorney's Office, local agencies such as the City of Austin's Emergency Management, and a variety of others, including education agencies. The concept of collaboration and a network that prepares and looks at issues far down the road before they ever occur are important. Our program is the lead agency. We chair, convene, and provide direction for the consortium.

In cooperation with the consortium representative from TCADA, the substance abuse agency, our program currently is pursuing a capacity-building grant from SAMHSA. This funding would provide for dedicated staff to build on the current foundation and even expand the network and the role of the consortium further.

The federal Crisis Counseling Program grants available to states following a presidential declaration of disaster are crucial. The application is due to FEMA 14 days after declaration, with certain data in a certain format. States often miss out on an opportunity to bring resources into their agencies that can help the most vulnerable people in need. This grant program has enabled our consortium to take advantage of needed resources.

The Crisis Counseling Program is a preventive mental health program for victims of disasters. It funds everything from CISD to crisis intervention to preventive activities such as working with schools, distributing written materials, videos, etc. to schools. It works with clergy in the area—often they are the first place where people go if they are in need—giving them educational materials, helping them to define what they can do and when they should refer folks to professionals. Finally it provides guidance and supervision to grant staff and works with local agencies to provide services. In 1993 we began a training process for every mental health agency in the state of Texas. We did it by region, and it took us a year and a half. We have gone through that cycle three times now, training on disaster response. All 42 of our community centers and all our state hospitals have teams ready to go if there is a disaster in the area—from a shooting, to flood, to whatever—within a matter of a few hours.

Since 1994, our Disaster Assistance and Crisis Response Services has managed 21 Crisis Counseling Program grants from FEMA and CMHS. We have secured $12 million—an enormous amount of needed money—and we have provided mental health services to more than 250,000 citizens in our state since 1994.

The State Disaster Mental Health Plan, a comprehensive and complete plan, describes standard operating procedures and guidelines for what centers do in a federal disaster event. NASMHPD has recognized ours as one of the most comprehensive plans. Information about it is presented on our Web site, www.mhmr.state.treatment.us. We currently are developing a training manual for our crisis response programs across the state of Texas. Funding for this manual came from SAMHSA and Texas' general revenue funds.

The governor's office allocated $100,000 in CDC funding to our crisis response team for training. That would not have happened without our longstanding presence and support from—and networking with—other agencies. Because mental health is so important, we are using that money to do another round of training with the manuals and other materials from NASMHPD and SAMHSA. Seven regional trainings are planned between January and August 2003.

Research has been more focused, particularly since 9/11. It is crucial to have the infrastructure ready and available to use the kinds of tools, information, and research that are coming out. It is not the interesting, sexy thing that people may think about, but if you are not prepared to do it when disaster strikes, everybody runs around wondering what they should do next. If you do not have relationships cemented, it makes the job a hundred times harder.

Questions & Answers

Q The National Mental Health Association is putting together a manual and a set of trainings in the community on how to infuse mental health into disaster preparedness—how to do mental health plans and also how to get us to the table with public health, with security agencies, etc. It is focused on a broad spectrum of audiences, particularly community groups. As part of this project, we did a series of focus groups and case studies. The issue that came up again and again was the importance of coalition and partnership and the absolute necessity to reach outside the traditional mental health community to do this work.

One of the anxieties is that the mental health system is so underresourced. How can we take on another challenge? What can we do as a community, both to partner with these other entities and also to take advantage of the many resources that are out there now for homeland security, for public health preparedness, that mental health does not seem to be able to access?

A Ms. Knisley - Reaching out beyond the mental health system, you have to use your imagination and creativity to add value to what you are doing and the resources you are creating. For the District of Columbia, for example, it has resulted in more people coming in for services.

Workers in our neighborhoods and communities are financed by FEMA dollars. Since we kept having emergencies, we kept being eligible for FEMA dollars. That is the downside and the upside. But we used every opportunity to do outreach, and it resulted in more demands on our system. But those were good demands, because we could use the data we collected to document the resources we needed.

I went to public safety officials who were getting the resources into the community. We were in line with everyone else, so I said, "Here is the large number of people who may need to be served." We partnered with public safety. You have to listen to the way they talk, and you have to talk their talk. You have to figure out what it is they are looking for and to be there when they are looking for it. Being at the table, talking their talk, working outside, and being ready to handle surge capacity through volunteers or prior arrangements are critical. Relentless preparedness is absolutely essential. If you can handle that surge capacity, people will come back to you the next time. They will recognize you, and they will ask for you to be there.

We need to think about this as public health. We do not know a lot about public mental health. If we can incorporate it, through preparedness and all-hazard plans, our new role may mean some job description changes and some different work and preparation. But if your existing staff can become that surge capacity and you can be there, you can build on that momentum.

Dr. Shon - I approach it from two levels. In the state or local authority, the ability to bring people together and to coordinate a process is critical. In disasters the response is always local—and the local area is different in our state in east Texas, west Texas, south Texas, central Texas. They are all very different kinds of communities. The issue is to give the local mental health authorities the tools to be able to pull people together and to help them to plan—not to do it for them, not to impose on the local level how it should be done, but to give them the framework and support. If you can do that, they can bring in the right spiritual entities, the right educational entities, the right health entities, the right law enforcement entities.

The problem often is that every single one of those entities has crises that they deal with day to day. We are overloaded with children in our school system, for example. It is necessary to have the commitment of people who will sustain the energy, who will say, "This is important." Since September 11th, it has been a lot easier—but that will wax and wane. The larger authority needs to provide individuals with the commitment to go into the communities and help them create their structures. Finding the right role and responsibility is part of that coordination.

Questions & Answers

Q In the wake of September 11th, we know that people's needs differ, particularly in relation to age and culture and current mental health status. Can you discuss strategies for addressing people with existing mental health problems who are in your systems and your communities and other vulnerable groups as well? What kinds of strategies would you recommend to identify the most vulnerable in our communities and to work in advance around these needs?

A Dr. Flynn - One suggestion is to look at the CMHS brochure "Responding to the Needs of People with Serious and Persistent Mental Illness in Times of Disaster," available at www.mentalhealth.org.

In my experience in disasters over many years, people with pre-existing serious mental illness often do not become visible in the early days. In fact, they may hang together fairly well. There is a myth that these people will break down first, but that does not happen. One of the most important strategies is to get back online the myriad services that these folks depend on to live in their communities, particularly in large-scale disasters.

We also have a significant training challenge with regard to this population. We have an opportunity in disaster mental health to reduce stigma significantly. But we also have the risk of further stigmatizing people who have serious and persistent mental illness, because sometimes when they go into treatment for disaster-related stress, their symptoms are inappropriately interpreted as an exacerbation of their pre-existing illness. But that is not the case most of the time. They often have the same kinds of stress-related problems that the general population experiences. We need to make sure that we train our providers to differentiate what is happening with that group.

Ms. Knisley - We asked our consumers about specific communications targeted to them. Your materials and communications and messages are very important. Bringing together focus groups of individuals and asking them what they want offers two benefits. First, you can get a lot of good information, and second, you can provide support.

It is important to get into a routine as quickly as you can. During the sniper attacks, we urged people to keep up their routine, to overcome fear as well as possible, not to shut down. For people afraid to get out, we went by and picked them up for appointments or to get them out of the house.

Another important strategy is to include in the all-hazards plans a clear planning process for sheltering in place, making sure that people do not have to be evacuated into mass care, which can be very frightening to people with long-term disabilities. "We will come to where you are, rather than you having to come to where we are." That may be difficult if your whole city is under siege; you will have to be credentialed by your public safety officials to be allowed to be on the street.

Q Among the National Voluntary Organizations Active in Disaster agencies, the American Red Cross is the one nongovernmental organization mandated by the U.S. Congress to respond to disaster. Regarding the surge response, would you address the role that the American Red Cross' Disaster Mental Health Services may play as part of a state disaster plan?

A Dr. Flynn - In almost every disaster, the Red Cross has played a central role. They are often the first on the scene. They have played an enormously helpful role in charting the federal response, because they are the first ones there who can gather data and identify needs.

Historically there has been a lot of variation in states and disasters in the Red Cross' coordination role in the public mental health response. One of the significant challenges we face is to make sure there is a consistent and positive relationship between the Red Cross and state and local mental health authorities. In the NASMHPD "Guidance" document is an example of a draft memorandum of understanding (MOU) between the mental health authority and the state Red Cross chapter.

Dinner Address

Mental Health Leadership in Times of Terrorism

Stephen Mayberg, Ph.D.

Never in my training or in my mental health experience did I believe I would deal with terrorism, yet I stand here today and acknowledge that it is awesome and awful to be here talking about terrorism. Terrorism is now something that we all need to deal with. It is an issue that we would prefer to deny. We would love not to have to worry about or have to work with the impact of terrorism. Terrorism as the conference topic seems such a paradox because we are here at The Carter Center, and President Carter so recently received the Nobel Peace Prize.

The mission of The Carter Center is to talk about peace, hope, and empowerment. Yet we are talking about war—a new war, a war that no longer allows us to be insulated and isolated as we were before; a war that has forced us to look at ourselves, our systems, and our cultural fabric to determine how we respond. One thing we know about terrorism is that it forces us to deal with the uncertainties of our society. Terrorism attacks along fault lines—psychological fault lines, racial, ethnic, and economic fault lines—and is a force that has much more impact than we would ever expect.

When I was asked to talk about this subject, I wondered, "Why me? Do I know anything more about terrorism than anyone else?"

Perhaps it is the fact that I have been a state mental health director for 10 years and I have been living with circumstances for years that are, at times, unpredictable, disheartening, and threatening, while trying to manage a system out of control. The question becomes, "How does one lead successfully?"

I have learned that to be a successful leader in the mental health field, one must have certain personal characteristics. First, one must have a very high tolerance for ambiguity, because there are no easy, clear answers. There are, in fact, no answers for some issues. Second, one must have a fortified denial system, because when you objectively look at what the issues are and the number of issues, it can be overwhelming, creating the potential for existential despair.

I am constantly aware that there are things that I need to know and learn, but I do not know what I do not know. I also am reminded that

and difficult to negotiate sometimes. Access is difficult; place and race matter. One parent summed it up very well in his testimony to the President's Commission. He said that to him, as he tried to get services for his child, "the system was opaque." This father had no clue about what the system was or how to negotiate it. In Alameda County, California, there are 100 different funding streams and 800 different providers of children's services. How would anybody know where to go? The commission also was struck by the huge gap between what we know and what we do. As our knowledge evolves, we are not integrating it into our practice.

All of these compelling arguments illustrate the need to improve the system. The good news is that there is good research and there are motivated people. We have seen the involvement and the dedication to make the system better of clinicians, providers, family members, and consumers. The surgeon general's reports, which include the reports on children and on culture, race, and ethnicity, set out a framework that we can build on to look at mental health—from prevention to treatment—of persons with serious mental illness and also to look at mental health as a public health problem rather than as an isolated problem. Public opinion is changing to some degree. People want mental health services; they demand mental health services. So, it is a time for change.

In that context, with a somewhat dysfunctional system as a backdrop, how was I going to talk to you about terrorism? I had a fascinating notion of turning the lights out at The Carter Center, creating total darkness.

I would say to you, "I want you to get back to downtown Atlanta. There is a national emergency. We do not know what has happened. There won't be any available transportation. We know the roads are closed, so we cannot tell you how to get to Atlanta. You have two hours before curfew. You have to figure out who is going to lead you. And, by the way, your performance will be critiqued by the media and by politicians. They'll have the opportunity and advantage of looking at it in a day or two and will tell you what you should have done."

What I presume would have happened in that scenario represents what happens in most disasters. First, we are reactive and not proactive. Second, whatever planning takes place is spontaneous, and because the situation was not thought out ahead of time, the responses would be fragmented.

In detail, each of you would have chosen a different alternative to get to Atlanta. Some of you would have decided on someone as a leader to trust. Most likely the people with successful results would be the people who collaborated with the locals, because the residents know the lay of the land better than the out-of-towners, which should tell you something about disaster planning and terrorism. It is a local issue. When we start thinking about what we need to change in how we function as a mental health system, these are all things we need to pay attention to.

Terrorism's purpose is to disrupt. Loss of life may be less significant to terrorists than disrupting the way that we live and function on a day-to-day basis. In that context the role of wi shs lth—ts ntowmny avnge gap betw lepre3.9(5 -1.1818

would be required to formulate a plan to go to downtown Atlanta under emergency conditions and then gave you a couple of days to work on it, chances are you would all do a good job. But if I were to turn out the lights right now, you probably would not. You have to know now what it is and whom it is you are going to be dealing with.

The SAMHSA-sponsored summit meeting in New York on terrorism on the heels of 9/11 was the first step in doing just that—introducing people to each other who normally do not have a reason to talk to each other. Some of my best, most relevant new partners are sheriffs. People ask, "Why law enforcement?" The issues of homelessness and of criminal justice involvement with mental health make the partnership viable and indispensable. In the event of disasters or terrorism, law enforcement personnel are out there as first responders. If I know them and they know me, it makes my job a lot easier when mental health steps up to the plate.

That is not to say that having one meeting to develop relationships and shake hands makes a difference. People change and government changes. There may be a different cast of characters at any given time, so you must have regular meetings to develop a partnership system. You need a memorandum of understanding to be clear on how to work together, who is in charge, how to notify people, how to communicate, what is the chain of command. You need to learn new technology and new terminology, such as vector control and incident command. You learn where you fit into the solution while other people learn what you have to offer.

I thought California had a fairly sophisticated disaster response system; in fact we routinely respond to disasters. But now I know that California did not have a carefully thought out plan of disaster or, more specifically, terrorism response. On 9/11 most of the hijacked planes were headed to California. When the planes were crashed and with the assumption there were affected families in California, we immediately mobilized to provide support services to the families. We called the airlines and asked for the passenger manifests in order to begin our outreach to support the families and loved ones.

The answer to our request for the manifests was, "Absolutely not."

We asked, "How can we help the people who have lost loved ones? Why won't you release the names?"

"Because the hijackers' names are on the manifest. We cannot release that information because it is an active investigation."

Suddenly we learned that the world was different, that we would have to figure out a new way of doing business.

Planning is essential. I cannot emphasize enough how many times you need to plan and replan and to plan continually for different circumstances. Brian Flynn talked about weapons of mass destruction and biological warfare. His remarks serve to underscore the necessity to plan differently for explosions or snipers or biological weapons, and that exacerbates the problems of training.

We were trying to develop a plan for biological warfare. I started meeting with all the constituents and, once again, realized that we were ill prepared. Questions were raised. How do you know when a biological event happens? How do you get primary care providers and hospitals to recognize that an incident may be occurring, and then to notify the state health department and CDC, and then have the loop from state and federal agencies returned to start notifying every other entity that may be involved in interventions? We do not have a communication system in place all the time. Telephone communications can be disrupted. Roads can be blocked. People may not be able to get where they want to go.

How do you deal with the anxiety of the first responders who might say, "I am not going to go in an ambulance and pick up somebody if they have the plague or smallpox. I do not want to be exposed to that"? How do you deliver the necessary medications? How do you staff the emergency rooms? People have to make personal choices. They may not be altruistic and come to work if they feel they or their families are in danger. Most of us have families and a potential moral dilemma. Do you stay home with your family and make sure they are safe, or do you leave to try and help somebody else, worrying about who is going to take care of your family? It is a very difficult choice, and I do not think that there is a right answer—but it is something that must be addressed.

a person who does mental health, has a family, and has a variety of other interests and complexities. Making that shift is going to be difficult, because change is difficult amid strong-willed forces for homeostasis.

What does it all boil down to? I am ambivalent. I am very optimistic about this country. We have the energy, the will, and the resilience to deal with just about anything. I am very proud of the mental health community and its remarkable resourcefulness. It pushes itself. It challenges itself. It raises the bar. And I know that it can succeed.

But I am also afraid, because we do live in that world of denial. I think that we underestimate the impact in ways that we never expect that terrorist-caused disasters can have on us. Until we start working with our other systems and leaders in other fields, we are not going to be able to deal effectively with this very large problem.

But what we do in working together to anticipate a disaster or a terrorist attack is the very thing that we need to do to make our mental health system work for everybody in this country. Whether it is about terrorism or about a good mental health system, proactivity, integration, cooperation, collaboration, creativity, flexibility, and acknowledgement of the complexity and resiliency of people are all part of the value system we must adopt.

Panel III: Integration of Mental Health Into Public Health

Carl C. Bell, M.D.

In this panel we focus on what most of us do when we need help and where most of us get services. Surgeon General David Satcher reminded us that probably there will never be enough mental health professionals. It is just not going to happen. The fact that it is not going to happen will inhibit our ability to deliver mental health and mental wellness.

Even if there were enough mental health professionals, the reality is that most of us have enough sense not to go and see them! We go to our natural support systems. We go to family and friends and business support systems, primary care physicians, and pediatricians. We go to church. If we are children, we go to our teachers. If there is a disaster, we get contact from first responders.

The conversation here is: How do we cultivate resistance? How do we cultivate resiliency? How do we cultivate skills of resourcefulness and problem solving, curiosity, compassion with detachment? How do we convince people of their right to survive? How do we help people to retain and remember good, warm, and loving images? How can people be in touch with their emotions? Mayor Giuliani talked about being in touch with his affect, but not being overwhelmed by it. How do we give people a goal to live for? How do we give people a vision and desire to restore moral order? How do we get people to conceptualize the need and ability to help others? How can we be altruistic? How do you turn learned helplessness into learned helpfulness, because those are the resistance skills that get us through these sorts of tragedies.

I hope we take some lessons from other cultures. Other cultures cultivate resistance skills and strategies. East Indians talk about the development of the *Atman*, the true self, that core inside rock. It is an anchor in times of difficulty and trouble. Martial artists talk about *kokoro*, or heart, or indomitable fighting spirit, and how people cultivate it. We know that in sports, some people have an indomitable fighting will—and other people wimp out. Native Americans talk about totems and identify with animal spirits. Those things help. Chinese people talk about *chi*, cultivating life force in their techniques and strategies. And in the black church, we talk about spirituality and we cultivate that.

I just finished an Institute of Medicine report on suicide. One finding was that African-American women have the lowest suicide rates of everybody in the country. But sisters catch hell! They catch hell from black men. They catch hell from society. They catch hell from racists—yet we have these low rates of suicide. What is that?

We have to study and cultivate this whole issue of resistance and resiliency.

units—the squads and the rescue companies—sustained the heaviest losses, with entire firehouses completely lost. Many of our most senior officers, the most respected and most seasoned officers, were killed. And the recovery

disorder—although it should be noted that people were working at the same time that they took this medical. More than 90 percent of the people who took this medical were on full duty when they answered these questions, so this is a group that is coping despite having symptoms.

We asked questions about people's patterns of sleep. A third said they had no problems. The remaining two-thirds had at least one or more symptoms consistent with either depression or posttraumatic stress disorder.

We asked questions about people's ability to function and changes in their appetite. People had more difficulties at home than they had at work. Work is often a haven for these individuals, who are used to being active, used to having a goal or mission of helping people.

We had to develop programs that drew people in and encouraged them to get help when they needed it. The programs had to be specific for the individual group we were dealing with, whether it was firefighters or the paramedics. We encouraged people to get help so they could be helpful to their families. We encouraged people to talk to other people and to go back to the associations that in the past have given them so much help and relief.

People continued to work. They continued to function during these times. Many of the

There is church arson and also other forms of community arson. Recently in Baltimore a family that had protested drug use in the community was burned out. The mother, the five children, and later the father died. The entire community is affected by these events. Floods, even those too small to qualify for federal funding, affect the entire community. Chemical spills in a community, a train that derails with chemical spills, fire, plane crashes, shootings, gang wars—they occur all the time. Marlene Wong helped me understand that following gang wars at night, children often come to their school grounds the next morning and find bodies on their playground. Communities are experiencing trauma all the time.

Local communities sometimes are devastated if they sustain damage to their single economic base. If farm communities lose their silos or grain elevators where they store everything, the entire community is affected. It is rural. It is urban. It is everywhere.

I want to stress that individuals find ways of coping. With all of this going on, people still go to work every day. They still perform their duties, often experiencing symptoms, but still they continue. National survey data on means of coping show that in these incidents, people turn to family and friends—but also, they turn to clergy. Ninety percent turn to religion, an important concept to embrace.

I suggest that we enlarge our concept of primary care. The defining characteristics of primary care are: It is the first point of contact; it is a place where we can begin with early identification of symptoms and coordination of care; and it is a place where individuals and

in New York there were prayer stations. There were all kinds of expressions of the faith community to respond to that tragedy, and it translated throughout the entire country. The means of coping are diverse. The various faith communities need to be recognized for the role they play in keeping a community healthy, keeping a community on the road to wellness.

I present an opportunity. We can begin to use all the information we have gathered from national planning and apply it to the local setting, not only lessons from national emergencies and disasters, but also from international events—for example, lessons we learned from the U.S. Embassy bombing in Nairobi, Kenya. We look at the Oklahoma City bombing, but we should not forget Nairobi, particularly in thinking about how communities frame events. To illustrate, in Nairobi, Kenya, the community framed the event and the anticipated impact in interesting ways. If the impact was thought to be psychological, people wanted mental health treatment. If it was considered more spiritual, folks who were hurt by the bombing sought counseling. Within the counseling there was a strong demarcation between secular counseling and faith-based counseling. There were opportunities for Christian counseling, Muslim counseling, and Hindu counseling, all of which had to be established for that community to accept care. We need to learn from these kinds of lessons as we continue to prepare.

The mental health and faith communities cannot wait for each other to find each other. We need to be proactive in developing our relationships, because it has been shown that our combined efforts increase the effectiveness of all the care that is provided. There are benefits to partnerships. They create a holistic approach to care giving. We become more efficient and more effective. Sometimes we forget about the research in primary care that shows the impact of one's faith on recovery and healing. We need to draw from that literature. In addition, the literature on refugee stress and distress adds to our understanding of recovery. Torture is a topic of interest in the refugee trauma literature. Torture means that you, as an individual, are personally identified for a specific traumatic event. In some community-based disasters, communities are specifically identified for certain types of f spesancon

The faith community was instrumental when Hurricane George went through the Florida Keys. The Counseling Ministry of South Florida, a faith-based organization, was able to fax information on how to respond to a disaster to churches in the Keys, and they were able to carry out the recovery effort. We need to understand the collaborative role the mental health and faith communities can play in such situations.

Other problems we must avoid include using professional jargon—especially by helping folks to understand the language of FEMA, CMHS, SAMHSA, Red Cross. We need to help the faith community understand that they have a role, and we can find the language to include them. For example, the faith community/mental health coalition in Baltimore was given the task to find language for treating depression. It took a full day for the two communities to come up with the same language: "healing the brokenhearted." There are ways to build consensus, and we need to think about a way we define trauma that is not too narrow.

Baltimore has been engaged in faith community/mental health dialogues. It usually takes about four dialogues for a community to come together, understand, and work together.

Another barrier is the absence of care for caregivers. Who will help those who are helping others? With the faith community hearing so many of these stories, it is important that mental health services be available to them in a way that they can accept them.

Finally, we need to take action. Action is the antidote to despair. We need to take action by improving our communication between these two communities, defining the leadership role, recognizing the leadership in faith communities, providing training to communicate with each other, and providing guidelines on the use of facilities. We have discussed what we will do for children in schools, but have we considered what happens when disaster strikes when school is out? There are faith-based organizations in communities where kids go in the summer for recreation, and the kids are familiar with those persons.

The final action step is to apply our dollars to make collaborations work, so both communities have the responsibility for relieving suffering. An aspect of recovery can be enhanced when we recognize and respect the roles that we play in each other's lives. Every community has different dynamics, but within all communities, a glue tends to hold it together—faith in the future and faith in tomorrow. When that faith is shattered, where do people turn? We find that they seek the vision that there can be peace in their lives from their faith community.

We need to take action. The right action at the wrong time is a mistake. The wrong action at the right time is a disaster. The wrong action at the wrong time is tragedy. But the right action at the right time is success. I wish us success in our collaborations.

My presentation covers three major areas; the first is barriers to the integration of behavioral health and primary care under any circumstances, not specifically with regard to terrorism or bioterrorism. Importantly, if we can improve our systems of care on a regular, everyday basis, we also can improve our systems of care in the context of a bioterrorist or terrorist event. The second focus of my talk is on the implications of caring for the mental health

are geared toward specialty, not primary care, settings. Finally, primary care providers have limited training in mental health.

At the practice or delivery systems level, the relationship between the primary care sector and the mental health specialty sector is not well-delineated. There is limited understanding of who is responsible for care. There is a lack of clarity about the roles and responsibilities between primary care and behavioral health. There is limited communication and teamwork between the specialties on key issues, including: How should care be provided? What is the nature of the interaction and the linkage? Do things need to be totally integrated? Is a consultative role needed? Is there a longitudinal, as compared to cross-sectional (i.e., "one-shot deal"), focus in terms of when care is provided?

Thinking about the responsibility of care, where along the continuum of primary care and behavioral health services do we cut things? Is it delineated in any specific way? What kind of relationship do we have between primary care and behavioral health? Are things well-integrated or collaborative, or are people working along parallel-play tracks with little interaction? By and large, the primary care and mental health systems of care are totally autonomous. We need to figure out ways to move toward collaboration and integration.

Looking across the longitudinal continuum of an individual's health care, much of what goes on now in primary care settings is focused on the diagnosis/assessment and short-term management phase. That may be so in a bioterrorist event as well. But we also need to think about risk factor identification and prevention on one end of the spectrum and on continuing and consultative care on the other end.

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suddenly has problems sleeping. To get to sleep, maybe he took a drink again. We need to be prepared to deal with these kinds of issues as well as the exacerbation of pre-existing mental health conditions across the board (e.g., PTSD).

Regarding population-centered responses, we need to think about people directly exposed, people indirectly exposed, relatives and friends and other people, and subgroups of the general public that are generally vulnerable. Strategies need to be developed with regard to each of these populations.

We need to be time/phase sensitive. We need to think about interventions using a longitudinal perspective that not only postdates the event, going out years, but also predates the event. As Mayor Giuliani said, ruthless preparation is necessary—preparation for evaluation, triage, treatment, and prevention.

Finally, our approaches must have relevance for the particular health care delivery structure and the particular sector (i.e., primary care, mental health specialty care) where people are treated for the types of problems they present with. We need to begin to develop rationality to this process. We need to think about where people go under certain circumstances, or ought to go for care under certain circumstances, as compared to other circumstances. We need to expand the presence of behavioral health specialists in primary care settings to avoid huge cracks that people can fall into if they are referred out of the primary care context.

To summarize, we need to understand the complexity of the interrelationships and barriers between primary care and mental/behavioral health and also between the health care system and the overall terrorism/emergency response system. We need to develop strategies that are agent-specific, problem-focused, population-centered, time/phase-sensitive, sector- and role-relevant, and developmentally appropriate.

We need to consider the psychological effects on health care workers themselves and how that impacts in a number of different ways, including the availability of people to do the work and our ability to respond appropriately. What are the implications for a terrorist or bioterrorist event for people who need "usual care" and for people with serious illnesses unrelated to the terrorist event, but who need significant health care at a time when the system is overwhelmed as it provided acute care in response to an attack? We need to engage primary care providers, behavioral health specialists, and the public in a partnership for effective risk communications, so that we might mitigate or reduce potential harmful psychological impact.

We need to develop innovative ways to study and evaluate the effectiveness of some of these methods and strategies and to study new models for integrating primary care and mental/behavioral health.

My final message is that we need to get away from the notion of separation of physical health and mental/behavioral health, of mind and body. It was best expressed by Frank Degruy, a primary care practitioner, in the 1996 Institute of Medicine report:

> Systems of care that force the separation of "mental" from "physical" problems consign the clinicians in each area of this dichotomy to a misconceived and incomplete clinical reality that produces duplication of effort,

As the last panelist, I have the opportunity to summarize previous presentations. What are the issues we need to grapple with to bring together mental health, public health, and primary care? Most pointedly and importantly, we also need to bring them to communities that have resources as well as needs. By linking the communities together, we hope to solve some of the difficult problems we face in confronting the issues of terrorism.

This issue is highlighted by language problems in discussing this issue. We have lost the word "evil" in the issue of medical care. Terrorism brings it back to us. Torture is feeling targeted to create pain. That is perhaps what was done in New York City, where a particular community was targeted to create pain. Words such as leadership, communication, and distress are not words of the medical care system. In the medical care system, we speak of illness, disease, health, diagnosis, and treatment. In the public health system, if we think of malaria, we speak of a host who is getting a disease. We speak of an agent, the vector that is transmitting the disease. We

the direct impact. The goals of terrorism are to alter our sense of national security, to disrupt the continuity of our society, and to destroy its social capital, its morale, its cohesion, and its shared values. In doing that, terrorism opens the fault lines of our society and has the potential to identify cracks present in our society about which we have known for years and have ignored or been unable to repair. Those fault lines include racial and ethnic divisiveness, economic differences, and religious differences. These have the potential to destroy communities, an unanticipated result of the terrorist attacks.

Our nation's security traditionally has been built on military power, economic power, and perhaps our information systems. Given the target of terrorism, health must also now be a part of our national security plan and the security of our communities—in particular, mental health, because our mental health is the target of terrorist events. Terrorism tries to undermine our sense of morale, our cohesion, our ability to look to the future with hope and to sustain our communities and our families.

Traumatic events come in many forms. Individuals and populations are exposed to traumatic events. When we speak of individuals and traumatic events, we think of intentional events such as assaults and robberies and unintentional events such as accidents, motor

Importantly, 50 percent of people evacuated in groups larger than 20. Why is that important? One of the key findings in this study was that large groups—groups greater than 20—took more than six and a half minutes longer to initiate evacuation. Six and a half minutes. In the most recent World Trade Center disaster, six and a half minutes may have meant death rather than survival.

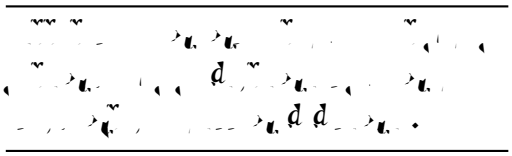
How do we educate people about how to evacuate and how to respond to alarms? How can community support systems and community support groups keep active their knowledge about how to evacuate?

This last piece of information may not be surprising to people who work in large groups or bureaucracies. To make a decision in a committee is very difficult. But that is what happens in these large groups—committee decisions are made on whether to evacuate. If you knew more people in the group, you also evacuated more slowly. For good or ill, crowds of people known to each other inhibit individualistic solutions in favor of a shared norm. We might think of this as an autoimmune disorder. In many settings we want to foster social cohesion and attachment. But social cohesion and attachment in this setting may be dangerous.

Other disaster behaviors are similar. Lars Weisaeth has spoken about disaster behaviors following a paint factory explosion. People ran from the paint factory towards their friends, who happened to be in the same direction as the smoke was blowing, increasing their risk. If they had turned left and run 50 yards, they would have been safe. Similarly, in the evacuation of oil rig disasters in the North Sea, Dr. Weisaeth reported that when individuals jump into the sea, in which they have a bit more than a minute to live, they will swim towards the boat with their countrymen—even if another boat is closer.

These behaviors increase risk. We need group strategies, plans, and policies for families as well as organizations and information about appropriate behaviors that protect against exposure and decrease injury. Practice is needed.

Posttraumatic disorders are not uncommon after many traumatic events. But it may not be the most important mental disorder or outcome. Nearly all of us have had the acute form of posttraumatic stress disorder (PTSD) at some time in our lives. Many of you have been in a serious motor vehicle accident. If for the following month or two you experienced difficulty sleeping, you did not want to go back to where the motor vehicle accident took place, you took several days off from work, you noticed that you jumped when someone hit the brakes, then you had PTSD. You also probably recovered from it.



This illustrates how terrorism may also bring an opportunity to reach out to decrease stigma in psychiatric illnesses and diseases. There are bumps, bruises, and sprained wrists of psychiatric illnesses and disorders, as well as cancers and pneumonias. PTSD may come in both a chronic, severe form and as an acute disorder, which many of us have and for which we need guidance, counseling, evaluation in the primary care system, tincture of time, and re-evaluation at another time to ensure that it has not become pneumonia and return to our community with the appropriate support, guidance, and relief of pain. These early interventions call for a tight-knit collaboration among primary care, mental health, and community support elements.

There are a number of other trauma-related disorders. Traumatic grief is of substantial concern after a terrorist event, because intervention and treatment for traumatic grief are different from that for exposure to threat to life that we see primarily with PTSD.

MIPS or MUPS are terms used to indicate multiple idiopathic physical symptoms or multiple unexplained physical symptoms—shorthand for preoccupation with somatic concerns. Why is that important? In the face of a bioterrorist event, somatic symptoms may be the most common presentation of distress in the primary care setting, in families, and in schools. Our ability to understand why people have somatic concerns and how to respond to somatic concerns will be an important part of our responding to a bioterrorist event. Depression is a well-known issue following disasters, as well as sleep disturbances, increased alcohol and cigarette use, and family violence and conflict.

It is also important to recognize that the events both prior to and following a trauma or disaster influence the risk for subsequent disease, disorder, and illness. If you have lost your job, if you have gone through a divorce or separation, if you have had a death in the family, your risk for depression and PTSD is higher. Events that have occurred before or after a terrorist attack affect mental health outcomes. These contribute to the risk of disease and illness and offer opportunities for community intervention.

We have good studies to indicate that everyone is at risk following exposure to trauma and disasters: Carol North's work in Oklahoma City, our own group's (Ursano et al.) work on prisoners of war and their exposure, and True and Goldberg's studies on Vietnam combat exposure in twins. These studies all indicate that even without previous psychiatric risk factors, people are at risk of disease after exposure to severe trauma and disaster.

In Oklahoma City, 40 percent of the individuals developing PTSD had no previous history of psychiatric illness. Why is that important? First, it offers us opportunities to deal with the issue of stigma. Everyone is at risk. Second, it highlights important differences in the training of primary care providers. When you work with an algorithm of how to provide treatment, it often makes assumptions about the people who are coming into your office. The assumptions may include the fact that a person has had a previous disease or illness, or, for example, that a person does not have a support system or has a history of disorder. These assumptions will not be true in populations after a terrorist attack. The algorithms must be different to address the patients who come in. These studies also provide an opportunity to talk to communities about how they are all at risk and therefore how their communities can operate to aid in protection as well as resiliency following terrorist events.

Questions & Answers

Q Frequently primary care practitioners guide people away from treatment and toward religious help or psychiatric help or other kinds of help. The tragedies of the traumas and the terrors rally the troops to collaborate and cooperate, but then people go back to the old system of not working together. How can the primary care community become part of the total resolution of the problem?

A Dr. Kelly - Our pre-existing presence has helped. Our Bureau of Health Services and the Counseling Services Unit have partnered for years. We faced disaster on June 17, 2001, when we lost three firefighters and dealt with the losses and bereaved family issues. We had near-death experiences of other firefighters who were brought to local hospitals. We had to address both their physical and emotional well-being and the concerns of their families. In those cases several firehouses were affected. We sent counseling services to each of those firehouses, and we provided follow-up for members who were injured. We had a single point of entry through the Bureau of Health Services for everyone out with an injury and illness to be cleared by our physicians to go back to full duty. Those encounters may take a minute or two or they may be more lengthy, depending on the situation.

Are primary care physicians perfect in picking up on behavioral changes? No, but it helps when you know the members and you have a sense of what the people are like.

I wear another hat. I am a primary care physician with a private practice. My community is Staten Island, which was much affected by the World Trade Center attacks. Many of the people who worked in Manhattan came from that borough. Many people came into my office with complaints related to cough and congestion and eye irritation. That became the avenue for, "Let us talk about what is going on." Many times those one or two or three encounters are enough to let people acknowledge what is going on. They do not need more complicated care than that.

As a family physician, I feel very comfortable talking about the spirituality of healing and utilizing the resources that are available from a faith-based community and from the mental health community and from traditional medicine. The problem with mental health from a primary care perspective is that we have a division of care. Psychiatrists are seen as people who hand out pills, and others are clinicians who talk to people. Insurance issues create barriers for people trying to get help to get better.

Speaking as a primary care physician, we are very concerned about the behavioral issues of our patients. We see patients when they are well and not well, and we are able to address those issues.

A Dr. Pincus - I agree that huge barriers exist, but it is a two-way street. Problems on the specialist side create some of these barriers as well. The strategies are educational, organizational, and financial to overcome them. Educational: If you test for it, they will come. Expectations for knowledge and training in behavioral health must be built into the testing certification of primary care providers and accreditation of training programs early on. Organizational: Place more behavioral health specialists in primary care settings. Financial: Change the financing incentives.

Q How do you forward people coming in to the counseling realm for clinical care if they need it?

A Rev. McCombs - With regards to forwarding persons to counseling, pastoral counselors are dually trained. They are trained within their faith and also in the mental health tradition. Sometimes it is not necessary to forward persons, but in those cases where it is, a couple of things take place.

One thing to consider is the medicalization of suffering. Often in community-based disasters, communities experience suffering and pain, loss and grief, on a daily basis. At certain times it becomes medicalized. We have to help the faith community understand when it exceeds their capacity to respond. This is a learning and training issue. Sometimes it is appropriate to provide care within the faith community, and sometimes it is appropriate to refer people to the

children in a variety of crisis situations and assist them in identifying or developing appropriate materials
- Educate parents about how best to prepare their children for a terrorist threat or event and about the short- and long-term responses children might exhibit

Central Command Center

- Develop at federal, state, and local level
- Provide evaluation of mental health situation in the long and short term
- Develop a database on best practices and case studies to assist federal, state, and local leaders
- Provide information to the public on preparing/responding to mental health emergencies
- Provide technical assistance to response team in the event of a catastrophe
- Provide information on where citizens can get proper mental health treatment
- Provide mental health services in aid stations, disaster centers, and other field locations

Conversations at The Carter Center: In the Wake of September 11th

On the morning of September 11th, I went to the World Trade Center site as soon as I learned that the first plane hit the North Tower, where I met up with Mayor Giuliani. I had gone there in anticipation of accessing the emergency operations center, which was located at 7 World Trade Center. Some people had put the name "bunker" to that facility; a great deal of money was spent to create a very elaborate, well-developed telecommunications system. But we could not get into the building, because there were concerns about its structural integrity. And later in the day, that building actually did collapse.

We were, therefore, in need of a site where we could communicate with Washington and seek air cover for New York City. We went into a nearby building on Barclay Street, where the mayor did reach the White House, learned that the Pentagon had been under attack, and was able to secure air cover. We were positioned there when the first tower collapsed.

From there we attempted to relocate the seat of government, to find a location to convene governmental leadership and coordinate a response. Within a few hours we settled into the Police Academy, about two miles north of the World Trade Center site. A few days later, we relocated the emergency operations center to Pier 92 overlooking the Hudson River.

At the Health Department we activated an emergency response protocol within minutes of the second plane hitting the South Tower. Seven emergency preparedness committees were activated immediately, including surveillance, medical/clinical, sheltering, environmental, laboratories, operations, and management information systems. We previously had practiced and drilled in anticipation of a possible Y2K crisis. Although that crisis never materialized, it

gave us the opportunity to anticipate what we needed to do when we faced an "all hands" disaster of any type.

One of the first lessons we learned is the importance of drilling, practicing, and expecting the unexpected—creating an incident command structure with designated titles, jobs, responsibilities, and a plan of action, including communications, to get information across the various sectors of our own agency, as well as to communicate with other governmental sectors at the level of the city, state, and federal government. It is very important that you do not meet your governmental counterparts for the first time in the midst of a disaster.

The CDC has had a close and historical relationship with the New York City Health Department. Within hours we had activation of the national pharmaceutical stockpile, which arrived in New York that evening, providing us with several tons of medical supplies if we were to need it.

Epidemiological Intelligence Service officers from the CDC joined the effort within a few days. They manned, on a 24/7 basis, 15 hospital emergency departments, because we decided that we needed to carry out active surveillance for the potential release of a biological agent. To do that, we would look for any unusual clinical manifestations or clusters of symptoms that might signal a bioterror event. To do that, we needed to have staff in the emergency rooms. As weeks went on, we were able to substitute electronic transmission of clinical data, but we could not have made the transition without the support of the CDC.

Our most immediate concern was monitoring the ability of the hospital system to respond to what we anticipated would be large numbers of casualties and injured individuals—whether we had enough hospital beds and whether emergency departments would be able to care for all the sick. And as you know, tragically, we did not get to test that. The surge capacity of the system was not challenged. But we did learn that

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With the World Trade Center tragedy, we expected a tremendous mental health impact in New York.

New York felt very different to those of us like myself who are native New Yorkers. It felt like a much smaller town and community. Normally in New York City people do not speak to each other in an elevator; you look up at the numbers and await your turn to get off. But in those weeks after 9/11, we chatted with each other. We felt a need for communal support.

We then put together a public education campaign. Project Liberty focused on recognizing the health and mental health impacts on New Yorkers—those who would never think that they would be in need of mental health services. We needed to do that in a manner that would be destigmatizing. The slogan for the campaign was "New York Needs Us Strong"—since we are all in this together. We wanted New Yorkers to know that if their emotional pain and stress are not getting better, they might benefit from accessing a mental health professional's care and services.

The good news at this point is the evidence derived from surveys done in New York four to six weeks after 9/11 and follow-up surveys six and nine months later and one year as well. Telephone surveys recorded significant distress and posttraumatic stress disorder-like symptoms. Over time we have seen a diminution in the incidence of significant levels of distress. We also are seeing more people who are phoning the 24/7-day-a-week hotline, 1-800-LIFE-NET. While we are receiving more calls for help, we do not have a sense that we are seeing new cases, but people who are now accepting that this is time for them to get the help that they need. We would like to think that the public education campaign is contributing to that awareness and opportunity to take action.

I am a psychiatrist who was asked to serve as health commissioner with a vision of unifying the two public health agencies, the Department of Mental Health and the Department of Health, to create a more integrated vision of public health that would place mental health issues into the mainstream of the public health agenda. Surgeon General David Satcher had advocated strongly for an integrated public health model, and the aftermath of the 9/11 tragedy speaks to the value of this approach.

Dr. Bornemann

Dr. Ursano, you have spent a career as both a clinician and a scholar in the area of trauma, with soldiers and civilians alike. Perhaps you could give us an idea of what we might expect in terms of reactions from both individuals and communities?

Dr. Ursano

The challenging question, following on where Dr. Cohen left off, is the question of why is mental health prominent at the table following terrorist events. Those wiser than I have said that

mental health becomes an important part of the nation's security. The maintenance of the mental health of the nation becomes an important target for our public health system.

We make an error not to remember that the goal of terrorism is not the tragedy of 3,000 people dying in New York; it really is the induction of terror in the nation. It is the impact on 300 million people that is the goal of terrorism. The task of mental health interventions is to counter this with counter-measures, with interventions, that allow people to regain a sense of their future, to establish it if they have lost it, or to hold onto it if they fear that it may slip away.

In the face of terrorism, we usually think about at least three vulnerable populations. There are those who are directly impacted, certainly those who have lost loved ones, and first responders, who are exposed to the death and the dying and the grotesqueness of a disaster; the leaders, who must deal with tremendous stress in those environments, having to make some rapid decisions with small amounts of information; and the rest of the nation. There are those who experience the disaster through exposure to the media. So we have the vulnerable, the directly impacted, and the rest of the nation. We must consider broadly what are the mental health needs of all three of those populations and those in each group who are at greatest risk.

Terrorism is a particular type of disaster—a disaster that stirs terror that spreads rapidly through communities. If you think of terror as the agent, this agent can spread rapidly around a nation, particularly if we have terrorist attacks in multiple sites and the terrorism comes in multiple forms.

Our communities, of course, have experienced terror as an endemic aspect of life. Recently in Baltimore, Angela Dawson died. She had protested the drug abuse going on on her block. Subsequently her house was firebombed. She and her five children died. Her husband survived. The house was firebombed by the drug abusers—not primarily to kill Angela Dawson and her family, but in fact to intimidate the rest of the neighborhood.

So terrorism comes in many forms and has been present in our nation for a long time. It can come in single events. It can come in multiple-site events. It can come in continuous events over time. Each form has different mental health implications that we need to think through.

Bioterrorism carries particular concerns and worries. We know that the impact of being exposed to a threat to life, for those who experienced that impact at the World Trade Center or in motor vehicle accidents, can be responses such as posttraumatic stress disorder. From the acute form, most people will recover; in the chronic form, it can be intractable and disabling.

In studies from New York City, as Dr. Cohen has alluded, we know that PTSD occurred in somewhere between 15 and 20 percent. I believe the studies, which were from south of 110th Street, looked at both PTSD and depression. PTSD is perhaps one of the most widely talked about of the trauma-related disorders, but perhaps not the most important. Depression occurs, altered smoking, altered drinking, perhaps family violence (for which there is some good literature), and, perhaps even more importantly, altered behaviors.

protect people in a chemical attack. A third thing, people trained at all levels of the response system who know what their job is during a crisis and who are truly prepared to deal with their responsibilities. And finally, the very most important thing of all is practice. We must practice all of these plans if we expect to do the very best we can.

This summer, CDC used the system of public health preparedness to deal with West Nile virus outbreaks, because we wanted to practice our system. We learned lessons from that experience also. You will begin to see throughout the entire public health system, when there is a crisis or a problem, we are going to use this emergency response system model to exercise the people in the capacities that we have. Each time we do it, we will get better and better and better. We certainly are more prepared now than we were in the fall, and I think our preparedness will continue to increase exponentially as some of these investments come to fruition.

I feel really optimistic, but what frightens us most is complacency. In the context of terrorism, part of the mental health issue is to try to deny that it will happen again. But as soon as we forget or we resist the knowledge that it is not over yet, our preparedness can drop way down. I am sure that there is probably a psychological term for it—"forgetfulness" would be one word. We all are concerned that we need to sustain the vigilance and the interest and the investment, no matter how tempting it is to pretend that it will not happen again. The reality is that it probably will, and we need to be prepared.

Dr. Bornemann

You have all challenged us to think the unthinkable. Each of you in your own way has done it in your domains. What advice might you give the public about how they may prepare themselves and their own families? We understand how agencies have done it through better communication, better preparedness activities. Is there a parallel for families?

Dr. Cohen

When I was growing up we were told to go under our desks in school as preparedness for nuclear attack. I think we generally thought that that was going to do us some good, because authorities told us that.

But today there is a lot more sophistication about real threats and appropriate actions to be taken. We are living with cable TV, with 24/7 news coverage, and access to new information constantly. People are going to hear about potential threats from any distance. So our reality is that we live in a society where vast amounts of information are out there, with the need to digest it and to find guidance from leadership that will help us understand what to do with that information. The communication among government, public health, and health care leaders with local stakeholders who care about the quality of life in their community is needed to create partnerships that will allow people to sit at the same preparedness table.

There is a literature that demonstrated, in the response to the Oklahoma City attack as well as to the 9/11 attack, that greater watching of the events on television was associated with greater stress levels and symptoms. This doesn't establish causality, but it is evidence that television is a powerful force to influence the way people absorb and mediate the information that is given to them externally and what they do with it internally. This suggests to me that we need other options to digest information, such as this forum, providing a dialogue between community stakeholders and the governmental leadership, public health, and health care communities.

Dr. Gerberding

I would take a different spin on that, which is to think about preparedness in the home from a more practical standpoint. At CDC we discovered that many people did not have plans for what they would do with their children if they suddenly had to stay all night in the laboratory or where the focus would be for telephone communication if they wanted to account for all the members of their family.

Questions & Answers

Q I am interested in how to cope with the difficulties in getting treatment. Maybe mental illness has been destigmatized and the insane asylums are gone, but people I know who have had mental health problems still have trouble getting treatment.

A Dr. Ursano - When we talk about the public health system and mental health, we traditionally have meant mental hospitals, particularly prior to the 1960s. In the 1960s and early 1970s, the public mental health system was the community mental health center. In no place, however, have we developed a systematic approach to the provision of public medical care for mental health problems across the entire range of needs, from the outpatient client to the inpatient clinic to the primary care setting, where most mental health problems currently are dealt with. Terrorism challenges that system tremendously, because we have to deal not only with those who need direct care, but also with populations that may need assistance, guidance, and knowledge.

What you are pointing out is the absence of a public health system directed toward mental health care across all of its needs. I believe it is a very important missing element of our health care system.

Q I was struck by the comment about a sense of community that developed after the tragedy. Does that sense of community still go on or did it go back to the way things were before, when people looked up in the elevator and did not talk?

A Dr. Cohen - My sense is that while that sense of community has not shut, the window is closing. To some degree, there is the need to heal and move away from the pain, so that will lead people naturally to try to restore their pre-9/11 level of functioning, feeling, and their sets of relationships with their peers, their families, and their community. At the same time, we also continue to learn of new threats on a daily basis. A majority of people in the New York area expect that something will happen again that will be very traumatizing. So there is still a shared feeling about vulnerability that we carry with us on a daily basis that has to be addressed and transformed into some constructive opportunity for communities to relate to these threats in ways that are compatible with their values and vision.

Dr. Ursano - It also highlights the fact that we know that certain phases follow disasters. There is the experience of cohesion of communities after nearly all disasters. It also is an opportunity, as Dr. Cohen suggested, to mobilize communities and natural support groups to contribute to the recovery of the community. We also have to remember, however, that a phase of anger often occurs after a disaster. You can predict that after a certain period of time, a community becomes angry about why were things not stopped, why did they have to happen, couldn't things have been done better. So we need to plan for those elements.

You highlight a very important issue, that terrorism also strikes at the fault lines of our society. It increases the chances of the rupture of society across issues of ethnicity, religion, race, and socioeconomic background. Terrorism highlights those divisions in our communities. We need to plan for those, because they will occur—as they did in Washington during and after the anthrax exposures in the post office. There is a fault line around race. The decision to provide Cipro to people on Capitol Hill and dicoxicillin to those in the post office was interpreted as discriminatory (in fact, people at the Supreme Court also got dicoxicillin). Both were appropriate medications, but that was not how they were experienced at that time.

Q As we become more a global village, in our country we are seeing more diverse groups coming in—the Latino community, the Asian community—with their own sets of values. How do we reach out and spread communications through these different groups?

A Dr. Cohen - Your reference to ethnic communities is relevant to the need not to create a "one size fits all" approach, but, instead, to find relevance in the values and vision that derive from many communities. There are a great many public health problems

goes down afterwards. If we talk about

Now we are coping with life in the post-9/11 era with the new reality of terrorism that is impacting us all. The challenge to our health and mental health in this environment is very strongly felt, and it underscores consideration of mental health issues as a major component of our public health agenda. We will also need to rethink the public health research agenda in relation to this reality.

Q We talked about the capacities we will need to develop, capacities that we may already have, and some that need to be furthered. I am concerned about the stigma issue. We know a lot about how to treat some of the major mental disorders likely to be outcomes of the next attack, just as they have been for previous ones—PTSD, depression, substance abuse. But even when we have the treatments available and the people and community infrastructure in place, often people do not come for treatment. The biggest challenge may be getting those people who need and who would benefit from treatment to engage in it. What might be done around destigmatizing both the syndromes and the treatments, so we can match those two things together for better health outcomes?

A Dr. Ursano - A couple of thoughts. I will come back to the point that you are making, but terrorism also raises stigma in other forms. That is, we begin to see threats where they are not present. Following 9/11 a component of our community was stigmatized. Many people reported that when they sat next to an Arab male on an airplane, they were frightened. If in fact an Arab lived in your community, I'd bet that people talked to him less often. So stigmatization following mass violence of all kinds and terrorism in particular, needs to be a target for mental health intervention, even beyond our patients.

Going back to your other question, destigmatization of individuals with a mental illness can benefit greatly from leadership by community leaders. It is an aspect of a leader's willingness to talk about what is in fact unspeakable that allows the rest of the community to talk about it.

A good friend of mine coined the term "grief leadership." He was trying to capture the process of how different leaders lead a community through a mourning process. Mayor Giuliani is a wonderful example of that. A major part of the skill of a leader is the leader's sensitivity to what is going on in the community and the ability to speak the right phrase at the right time—because then a community can speak that as well.

A leader who says out loud, "We need help," allows others to say, "I need help." If leaders do not say that, they essentially prohibit other people in the community from being able to say that.

In the mental health arena, I think we have done ourselves harm. We have done ourselves harm by treating all mental disease as if it were cancer. And in the medical realm, cancer has great stigma attached to it. All psychiatric illness, all mental disorders are not cancer. People recover from them. In particular, there are what we like to call "event-related disorders," such as PTSD, which have been in some way caused by a life event. Good treatments are available, and people can recover from it.

We also need to change our way of approaching mental disease and to recognize h a mre t-0.sre notdisease and to as cauadeave begettinck t

Questions & Answers

Closing Remarks

Rosalynn Carter

Chair, The Carter Center Mental Health Task Force

September 11th served as a warning signal, and across the country, efforts are underway to ensure that we'll not be caught off guard again. From the federal government to neighborhood watch groups, Americans are creating crisis management plans to deal with any future violent or terrorist acts. Those of us in the mental health community have a tremendous opportunity – and obligation – to make sure that the designers of such plans recognize the importance of including psychological and emotional supports in any preparedness activities. Rudy Giuliani immediately saw the value of incorporating an understanding of mental health into New York City's response to the World Trade Center attacks in something as basic as communicating shock, grief, sympathy, and strength to our nation. Judging by the reactions he received from the world, his approach was successful and serves as one very simple example of how crucial a mental health component is in effectively dealing with disaster.

Biographies

William R. Beardslee, M.D., is psychiatrist-in-chief and chair of the Department of Psychiatry at Children's Hospital in Boston, and Gardner Monks Professor of Child Psychiatry at Harvard Medical School. He received his bachelor's degree from Haverford College and his M.D. from Case Western Reserve University. Currently Dr. Beardslee directs the Preventive Intervention Project, an NIMH-funded study to explore the effects of a clinician-facilitated, family-based preventive intervention designed to enhance resiliency and family understanding for children of parents with affective disorder. He also serves on the advisory board of the Center for Mental Health Services of SAMHSA and on The Carter Center Mental Health Task Force. He is the author of more than 100 articles and chapters and two books: *The Way Out Must Lead In: Life Histories in the Civil Rights Movement*, a story of what enables civil rights workers to endure; and *Out of the Darkened Room: Protecting the Children and Strengthening the Family When a Parent Is Depressed*, a book about how parents and caregivers can help families overcome depression.

Carl C. Bell, M.D., serves as president and CEO of the Community Mental Health Council & Foundation, Inc. He also serves as director of public and community psychiatry and as clinical professor of psychiatry and public health, University of Illinois. He is principal investigator of the NIMH-sponsored study Using CHAMP to Prevent Youth HIV Risk in a South African Township and a co-investigator of the Community Partnership to Prevent Urban Youth HIV Risk with Columbia University's School of Social Work, Social Intervention Groups, and a co-principal investigator of the Chicago African-American Youth Health Behavior Project. He also is a collaborator with the Chicago HIV Prevention and Adolescent Mental Health Project (CHAMP) at the University of Illinois.

Dr. Bell served on the Violence Against Women Advisory Council and the White House's Strategy Session on Children, Violence, and Responsibility. He was appointed to the planning boards for the Surgeon General's Reports on Mental Health: Culture, Race, and Ethnicity and on Youth Violence. He is a member of The Carter Center Mental Health Task Force.

Neal Cohen, M.D., served as the Commissioner of Health of New York City from 1998-2002 and oversaw the public health responses to the West Nile virus outbreak, World Trade Center tragedy, and anthrax bioterrorism outbreaks. Subsequent to the events of September 11, Dr. Cohen established the Project Liberty initiative to ensure that New Yorkers receive support services, counseling, and treatments to address the impact of the trauma. Prior to serving as the Health Commissioner, Dr. Cohen served as the Commissioner of the Department of Mental Health, Mental Retardation and Alcoholism Services.

A native New Yorker, Dr. Cohen received a B.A. from Columbia University and M.D. from New York University School of Medicine. He is currently the Executive Director of the newly created Center on Bioterrorism.

Charles Curie, M.A., A.C.S.W., serves as administrator of the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services. Mr. Curie has more than 20 years of professional experience in the mental health and substance abuse arena. Before joining SAMHSA, he served as deputy secretary for mental health and substance abuse services in the Pennsylvania Department of Public Welfare. Mr. Curie is a graduate of the Huntington College in Indiana and holds a master's degree from the University of Chicago's School of Social Service Administration.

Brian W. Flynn, Ed.D., currently serves as associate director of the Center for the Study of Traumatic Stress, Department of Psychiatry, Uniformed Services University of the Health Sciences, and has an independent consulting practice. He is a former rear admiral/assistant surgeon general in the U.S. Public Health Service, where he served as director of the Division of Program Development, Special Populations and Projects in SAMHSA's Center for Mental Health Services. Dr. Flynn received his M.A. in clinical psychology from East Carolina University and his Ed.D. in mental health administration and human systems design from the University of Massachusetts at Amherst.

Julie Louise Gerberding, M.D., M.P.H. is the director of the Centers for Disease Control and Prevention (CDC) and administrator of the Agency for Toxic Substances and Disease Registry (ATSDR). Prior to assuming the position of CDC director, Dr. Gerberding served as acting deputy director of National Center for Infectious Diseases (NCID) and director of the Division of Healthcare Quality Promotion, NCID. Previously, Dr. Gerberding worked at the University of California at San Francisco (UCSF) where she was director of the Prevention Epicenter, a multidisciplinary service, teaching, and research program that focused on preventing infections in patients and their healthcare providers.

Dr. Gerberding earned a B.A. magna cum laude in chemistry and biology and an M.D. at Case Western Reserve University. In 1990, she earned an M.P.H. at the University of California–Berkeley. She is an associate clinical professor of medicine (Infectious Diseases) at Emory University and an associate professor of medicine at UCSF.

Brooklyn-born Rudolph W. Giuliani graduated from Manhattan College and from New York University Law School, where he graduated magna cum laude. In 1970 he joined the office of the U.S. Attorney, where he eventually rose to serve as executive U.S. attorney. Then he was recruited to Washington, D.C., where he was named associate deputy attorney general and chief of staff to the deputy attorney general. He served there a number of years before returning to private practice in New York. In 1981 he was named associate attorney general, the third highest position in the Department of Justice, where he served until being appointed U.S. attorney for the Southern District of New York. He was elected and re-elected mayor of New York City.

On September 11th, Mayor Giuliani narrowly missed being crushed when the towers fell. He immediately began leading the recovery of the city as it faced its darkest hour. He worked tirelessly to restore the city and the morale of its residents.

In January 2002, the mayor founded Giuliani Partners, a professional services firm that specializes in public safety, financial management, leadership during crisis, and emergency preparedness.

Kerry Kelly, M.D., serves as chief medical officer for the New York City Fire Department. She is responsible for the Counseling Services Unit of the FDNY. As a board certified family physician, Dr. Kelly is a graduate of Vassar College and Brown University School of Medicine. She received her residency training at Downstate University Medical Center, Kings County Hospital, Brooklyn, New York.

Martha Knisley serves as the first director of the new Department of Mental Health of the District of Columbia. She led the system from federal court receivership in the first year following her appointment. She has spent her entire 32-year professional career in public mental health, serving earlier as director of Ohio's Department of Mental Health and deputy secretary for mental health in Pennsylvania's Department of Public Welfare.

Stephen W. Mayberg, Ph.D., has served as director of the California Department of Mental Health since February 1993. Since then he has embarked on an ambitious agenda that includes major initiatives to reform the mental health system. These reforms reflect changes based on programmatic research and program outcomes and accountability. Dr. Mayberg received his undergraduate degree from Yale University and his doctorate in clinical psychology from the University of Minnesota. He completed his internship at the University of California–Davis, and he has worked for the California mental health system since that time. During his public service career, he has been an advocate for interagency programming and planning. His primary interest has always been as a clinician, and throughout his career, he has continued to provide clinical services. Dr. Mayberg serves on the President's New Freedom Commission on Mental Health.

Reverend Harriet McCombs is associate minister of Payne Memorial African Methodist Episcopal (AME) Church, Baltimore, Maryland. She received a doctorate degree in psychology from the University of Nebraska at Lincoln and attended the Lutheran Southern Seminary in Columbia, South Carolina. She has served on the faculties of Wayne State University, Yale University, and the University of South Carolina. Rev. McCombs has served as a pastor in the AME Church, drafted legislation on mental health for the AME Church, designed training for mental health promotion for the faith community, and promoted local mental health and faith community dialogues. Rev. McCombs has led national efforts to provide mental health services to clergy affected by church arson. She is the recipient of numerous professional and service awards, including an award for her work with the U.S. Agency for International Development in Nairobi, Kenya, where she provided on-site technical assistance for implementing a trauma mental health program for people affected by the bombing of the United States Embassy.

Betty Pfefferbaum, M.D., J.D., is a general and child psychiatrist, as well as professor and chair of the Department of Psychiatry and Behavioral Sciences at the University of Oklahoma College of Medicine, where she holds the Paul and Ruth Jonas Chair. She has treated many victims and family members and is actively engaged in research related to the bombing. Dr. Pfefferbaum assisted in mental health clinical and research efforts related to the 1998 United States Embassy bombings in East Africa. She has provided consultation regarding clinical and research efforts associated with the terrorist attacks of September 11, 2001. She has been selected to direct the Terrorism and Disaster Branch of the National Child Traumatic Stress Network, a federal initiative to improve treatment and services for traumatized children.

Harold Alan Pincus, M.D., serves as professor and executive vice chairman of the Department of Psychiatry at the University of Pittsburgh School of Medicine. He also is a senior scientist at RAND and directs the RAND Health Institute in Pittsburgh. Dr. Pincus directs the Robert Wood Johnson Foundation's National Program on Depression in Primary Care: Linking Clinical and Systems Strategies. Dr. Pincus graduated from the University of Pennsylvania and received his medical degree from Albert Einstein College of Medicine in New York. Following completion of residency at George Washington University Medical Center, Dr. Pincus was named a clinical scholar of the Robert Wood Johnson Foundation clinical scholars program.

Robert Pynoos, M.D., M.P.H., is professor in the UCLA Department of Psychiatry and Biobehavioral Sciences. He also serves as co-director of the National Center for Child Traumatic Stress funded by SAMHSA, director of the UCLA Trauma Psychiatry Service, and executive director of the UCLA Anxiety Disorders Section. A graduate of Harvard University and Columbia University Schools of Medicine and Public Health, he has edited several widely respected books on posttraumatic stress in children and adolescents and has authored numerous published articles in professional journals. He has written extensively on child development and the impact of disaster, violence, and loss on families and school communities.

Steven Shon, M.D., serves as medical director of the Texas Department of Mental Health and Mental Retardation. He received his undergraduate degree from the University of Southern California and his medical degree from the University of California–San Francisco. He completed his residency in psychiatry at the Langley-Porter Neuropsychiatric Institute of UCSF. He is a clinical assistant professor, University of Texas Health Science Center, San Antonio, and clinical associate professor, University of Texas School of Pharmacy, Austin. Dr. Shon is co-director of the Texas Medical Algorithm Project (TMAP). Dr. Shon has served on the National Advisory Council to the Center for Mental Health Services and is board chair of the National Asian American/Pacific Islander Mental Health Association (NAAPIMHA) and consultant to several local, state, and national organizations.

Bradley Stein, M.D., Ph.D., is a natural scientist at RAND and an assistant professor of child psychiatry at the Keck School of Medicine, University of Southern California. He also serves as a psychiatric expert with the Los Angeles Unified School District Mental Health Services Unit and is director of the School Consultation Program for the USC Division of Child Psychiatry. Dr. Stein has extensive experience in crisis response following violence and disasters. He has been involved in responding to a variety of traumatic events, providing crisis services to direct victims through multiple organizations, including the American Red Cross, the National Organization of Victims Assistance, and the University of Pittsburgh Critical Incident Stress Debriefing team, and spent 1994 working as a humanitarian aid worker in Croatia and Bosnia. In addition to research on the mental health effects of terrorism, Dr. Stein's current research involves efforts to improve the quality of mental health services delivered to children in schools, including the evaluation of a program providing school-based mental health services to traumatized children in the Los Angeles Unified School District.

Farris Tuma, Sc.D., is a health scientist administrator with the National Institute of Mental Health in the Division of Mental Disorders, Behavioral Research, and AIDS. He completed his formal training in public health at Johns Hopkins University. He also holds a master's degree in health policy and management.

Dr. Tuma manages two extramural programs of research, one on disruptive behavior disorders in children and adolescents and another on traumatic stress and victimization. The Traumatic Stress Program supports research on the mental health sequelae of interpersonal violence as well as the institute's portfolio on major traumatic events, such as combat and war, terrorism, natural and technological disasters, and refugee trauma and relocation. This includes research on psychobiological and behavioral reactions to trauma; behavioral and biobehavioral risk factors and markers for developing mental disorders and adverse functional outcomes; service delivery and treatment for victims; and effectiveness of programs designed to reduce, delay, or prevent trauma-related mental health problems in children, adolescents, and adults.

Robert Ursano, M.D., is professor of psychiatry and neuroscience and chairman of the Department of Psychiatry at the Uniformed Services University of the Health Sciences in Bethesda, Maryland, where he also is director of the Center for the Study of Traumatic Stress. Dr. Ursano was educated at the University of Notre Dame and Yale University School of Medicine and received his psychiatric training at Wilford Hall United States Air Force Medical Center and Yale University. He was a national consultant for planning clinical care responses and research programs following the September 11th terrorist attacks.

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