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Fed dollars to address mental health issues post-Katrina may have been wasted: psychiatrist

By **Andis Robeznieks** | August 28, 2015

The 10th anniversary of Hurricane Katrina and President Barack Obama's visit Thursday to New Orleans have prompted a national retrospective on what is considered the country's costliest disaster.

But one Louisiana psychiatrist believes there's an untold story as the nation marks a decade since the disaster. That's how federal funds to address mental health needs didn't result in more-effective, large-scale, long-term treatment program for survivors.

The money was funneled through a grant program called the Crisis Counseling Assistance and Training Program, known as CCP, which is operated by the Homeland Security Department's Federal Emergency Management Agency. Through an interagency agreement, FEMA works with HHS' Substance Abuse and Mental Health Services Administration to provide "psychological first aid" to people coping with disaster.

After the Sept. 11 attacks in New York and Washington, $137 million was allocated for **Project Liberty**[1], a New York CCP. According to a February **2008 Government Accountability Office report**[2], FEMA allocated some $80 million to Gulf Coast states for the program and another $37 million to states that hosted persons displaced by Hurricane Katrina and its aftermath. Dr. Michael Scheeringa believes the money was not well-spent.

"I've been trying to raise awareness of this problem since Katrina," said Scheeringa, vice chair of research for the psychiatry and behavioral sciences department at the Tulane University School of Medicine in New Orleans. He noted that the GAO has alerted Congress to the program's shortcomings, but it hasn't acted and "SAMHSA hasn't budged."

Scheeringa attempted to spotlight the program's problems in a commentary he submitted to JAMA in 2007, but he said his 2,213-word manuscript was rejected.

In the essay, Scheeringa wrote that there is absolutely no evidence that the crisis counseling program is effective, that it helps people recover more quickly or more fully, or that it results in referrals to mental health professionals who can provide treatment to people who need it.

"It doesn't allow licensed counselors to do licensed work," Scheeringa said of the program. "It's a very strange system."

CCP was created by the Robert T. Stafford **Disaster Relief and Emergency Assistance Act**[3] which was signed by President Ronald Reagan in November 1988 and amended the Disaster Relief Act of 1974.

"The crisis counseling model is built on failed logic and is unhelpful for individuals with impairing mental problems following disasters," Scheeringa wrote in his essay.

The GAO report explained how states cannot use CCP allocations to provide long-term services, medications or office-based therapy for psychiatric disorders or substance abuse.

"The CCP model was designed to meet the short-term mental health needs of people affected by disasters through outreach that involves education, individual and group counseling, and referral for other services," the GAO wrote. "The main focus of the model is to help people regain their predisaster level of functioning by, among other things, providing emotional support, mitigating additional stress, and providing referrals to additional resources that may help them recover."

The model calls for all counseling to be anonymous with no diagnosis made or records kept. Counseling is not conducted in provider offices, but through outreach efforts which can include counselors going door to door.

There were plenty of people who needed help. An **April 2006 study**[4] by the Centers for Disease Control and Prevention found that 22% of New Orleans firefighters reported symptoms consistent with post-traumatic stress

disorder and 27% had signs of depression. Among the city's police, 19% of those surveyed showed PTSD symptoms and 26% reported symptoms of depression.

Another study, led by **Dr. Karen DeSalvo**[5], (who is now national coordinator for health information technology at HHS) found that 19.2% of Tulane employees showed PTSD symptoms six months after Katrina. DeSalvo (who was then affiliated with Tulane University) and colleagues noted that Tulane staff could have gotten assistance for the disorder through their health plan, but only 28.5% did so.

The GAO noted that, as of October 2007, FEMA "obligated" $53 million for CCP to Louisiana, but that doesn't mean it was all spent. Obligations of $23 million and $4 million went to CCPs in Mississippi and Alabama.

Anthony Speier led the Louisiana CCP as the state coordinator for behavioral health services. Speier, now an associate clinical professor of psychiatry at the Louisiana State University Health and Sciences Center in New Orleans, had directed all of the state's mental health emergency responses starting with Hurricane Andrew in August 1992.

In **testimony**[6] during an October 2007 U.S. Senate Homeland Security and Governmental Affairs Committee hearing, Speier said 9.3% of Katrina survivors in New Orleans suffered an injury, 18.1% had their life threatened, 10% had a family member missing or dead, and 35.5% were unemployed because of the storm.

Patterns of suicidal ideation, hopelessness, helplessness and desperation were common, he told the panel.

Speier told Modern Healthcare that the CCP program worked well, but had its shortcomings—such as its name.

"It's not 'crisis counseling' as most people would define the term," he explained. "As the term is defined in the Stafford Act, the intent is to help people regain normal functioning and help people rebuild their lives after a disaster."

The two phases of the program are meant to last 60 days or nine months, Speier said, which is usually all a person needs after a "typical" disaster. But Katrina was catastrophic, with families dispersed, neighborhoods destroyed and natural support systems gone for good.

A chief criticism by Scheeringa was that the program used local, unlicensed personnel, but Speier said that worked out well. He explained that a professional counselor was paired with an "indigenous" or local worker who knew the community.

"Maybe they didn't know you personally, but they knew your aunt or your grandmother," Speier said. "People had no social network. They were living in cramped spaces. That's not the time to do therapy."

The main goal was to establish a sense of safety and get people able to process what happened, start problem-solving and thinking about what to do next, he explained.

"Our perspective was that this would be a long-term recovery process that would take up to 10 years," Speier said. "Some people didn't think so, but there are still recovery efforts underway."

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