



Crisis Counseling Following 9/11: Implications for Policy and Preparedness

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Goals

- To determine the nature and extent of the impact of the terrorist attacks of September 11, 2001 on children and families in New York City, focusing on changes in child behavior and emotional status, and on sources of support relied upon by the family.
- To determine the availability, distribution, and potential access of mental health services intended to help with 9/11 problems. We focused on those funded specifically for 9/11-related problems by the Federal Emergency Management Agency (FEMA).

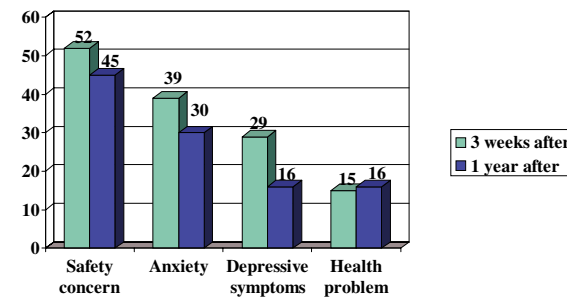
Methods

- The Children's Health Fund, in partnership with the Marist Institute for Public Opinion, fielded polls three weeks, three months, six months, and one year after 9/11/01.
 - The format was telephone survey conducted by professional pollsters. Each poll had a random sample of ~460 parents of children age four to eighteen years distributed throughout the five boroughs.
 - We designed questions to capture changes in child behavior consistent with symptoms of posttraumatic stress disorder (PTSD), depression, or anxiety disorder based on standard diagnostic criteria (APA DSM-IV).
 - Questions were also designed to identify sources of professional, personal, and community support valued by the parents, and the degree to which support was obtained.
 - The consistency of results from poll to poll and sensitivity to changes (e.g., the second poll coincided with initial reports of anthrax) leads us to infer at least adequate face validity of the questions.
 - Responses were analyzed by borough, family income, race-ethnicity, and child age.
- To determine availability of mental health services, we conducted a "snapshot" survey of agencies providing FEMA "crisis counseling" as the one year anniversary approached.
 - All FEMA "crisis counseling" agencies were contacted, first using the resource list made available by federal and state officials, next using the publicly advertised toll free number.
 - Results were analyzed by borough and by geographic distribution with each borough.
 - We focused on the disparity of resources in the city's richest and poorest borough.
- Relevant federal statute and code were consulted.

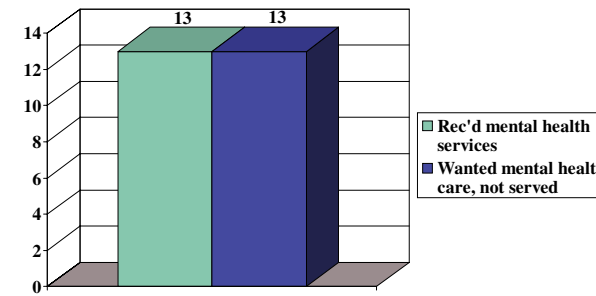
Results

- Increased child concern about safety was widespread. More than half (52%) were concerned 3 weeks after the attack. This decreased only slightly, to 45%, one year later.
 - Concern about safety was consistently higher in the city's poorest borough, the Bronx (50% one year after), compared with the richest, Manhattan (36%), the borough in which the World Trade Center was destroyed.
- School refusal after one year was reported at 19% in the Bronx compared with 6% in Manhattan.
- Depressive symptoms were twice as prevalent in the Bronx (24% to 12%).
- Citywide poll results show that, during the year following 9/11:
 - Child anxiety decreased from 39% to 30%;
 - Depressive symptoms decreased from 29% to 16%;

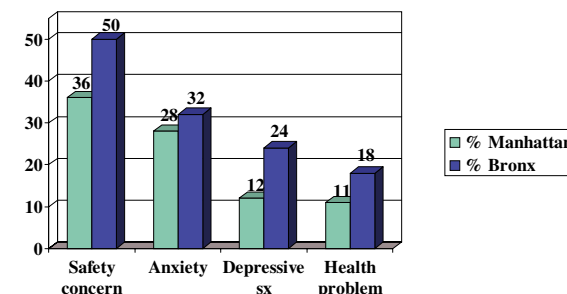
Trends: Child Reactions to 9/11 in New York City



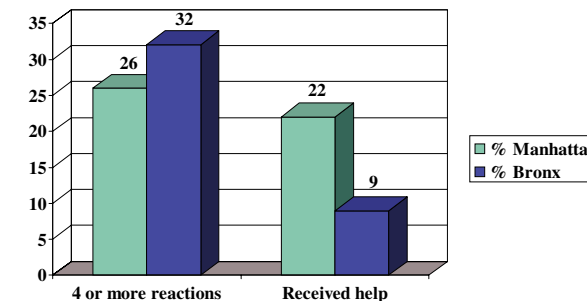
Mental Health Services Received Citywide One Year Post-9/11



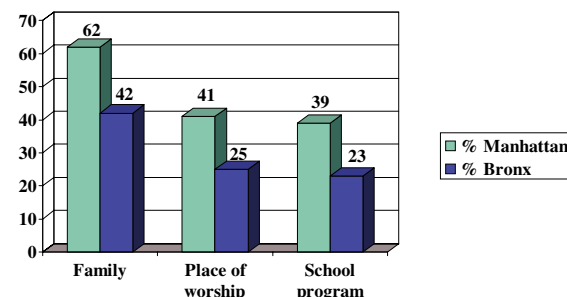
Child Reactions to 9/11 One Year Later by Borough



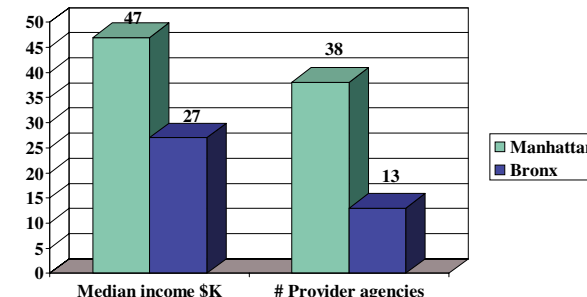
Mental Health Need & Services One Year Post-9/11 by Borough



Sources of Support Post-9/11 One Year Later by Borough



Mal-Distribution of Resources One Year Post-9/11



- Sleep problems decreased from 20% to 17%;
- Somatic complaints were consistent, 15% to 16%.
- The number of children without at least reaction increased from 25% to 31%.
 - The number with four or more reactions decreased from 36% to 29%.
- Nearly one year after 9/11, as many families that wanted mental health services went un-served (13%) as received mental health help (13%).
 - By this time ~\$150 million had been allocated by FEMA for "crisis counseling."
- Manhattan has nearly three times as many "crisis counseling" agencies as the Bronx, with a median household income 1.74 times higher than the Bronx.
- Multiple barriers to access of "crisis counseling" services were identified:
 - Transportation: large parts of the city, especially low-income communities, were without local resources.
 - Eligibility restrictions: relationship to victims of 9/11, prior mental health condition.
 - Visit limits: Sometimes as few as three total.
- The use of para-professionals was unnecessarily encouraged, making it difficult for children to get to a psychologist or other mental health professional.
- Important roles like case management and case finding were not included in the "crisis counseling" model.
- These limitations and restrictions on "crisis counseling" services are not necessitated by the relevant statute (The Stafford Act, 41 USC 5183) and/or regulations (44 CFR Subpart F Section 206.171).

Conclusions & Recommendations

- Local communities affected by an act of terrorism should be permitted to determine the geographic scope of persons eligible for federally funded sources of support.
- There should not be a pre-determined limit on the number of allowable clinical sessions. Treatment decisions must be individualized. The need for intervention may continue long after a terrorist event.
- Neither statutory nor regulatory change is necessary to make the "crisis counseling" model more flexible and responsive.
- Public information and brief intervention, integral to the FEMA public health model, should be implemented by mental health professionals with expertise in trauma treatment.
- Case management should be included as a "crisis counseling" service.
 - Families often need help navigating entitlement systems and dealing with concrete issues like paying rent, maintaining school attendance, continuity of health care, etc. if they have experienced disruption following a terrorist attack.
- Case finding should be integral to the public health model.
 - Parents, teachers, pediatricians, and others who care for children need to be informed of "red flags" that identify children who may require more intensive mental health services.
- There must be an adequate supply of mental health resources to meet newly emerging needs.
- These resources must be appropriately distributed so that high-risk communities are not shut out.
- Outreach to vulnerable communities – including individuals previously affected by trauma and loss, people with an individual or family history of mental illness, immigrants, the homeless – is needed.

Acknowledgment:

The Crisis Response Program is generously supported by Wyeth, Schering-Plough Corporation, Robin Hood Foundation, Pharmacia Corporation and Monsanto Fund, MetLife Foundation, Tomorrow Foundation, Episcopal Relief and Development, Union of American Hebrew Congregations, Jewel Heart, and New York Rotary Foundation. Continuing support is provided by Robin Hood Foundation, Andor Capital Management Foundation, and MetLife Foundation.