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Improving Disaster Mental Health Care in Schools:

A Community-Partnered Approach

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Abstract

Background—Although schools are often the first institution to provide recovery efforts for children post-disaster, few studies have involved the school community in research to improve the delivery of these mental health services on campuses. This community partnered study explores post-disaster counseling services ten months following Hurricane Katrina.

Methods—In July 2006, nine focus groups, comprised of 39 school-based mental health counselors and 6 program administrators (10 men, 35 women), were conducted following a two-day clinical training regarding a youth trauma intervention following Hurricane Katrina. Participants discussed types of services they had been providing prior to the training and potential barriers to delivering services.

Results—Participants identified high mental health needs of students and described populations that did not seem to be adequately supported by current funding sources, including those with preexisting traumatic experiences and mental health issues, indirect psychological and social consequences of the storms, and those students relocated to less impacted communities. Participants also described the need for a centralized information system.

Conclusions—Participants described the need for greater organizational structure that supports school counselors and provides system-level support for services. Implications for next steps of this community partnered approach are described.

Hurricane Katrina was one of the most devastating natural disasters in recent US history, with over 1.7 million people who suffered flooding or moderate to catastrophic damage.¹ One of the most striking aspects of Katrina's impact has been the pervasive mental health problems that have been identified,² with an estimated 34% of children experiencing symptoms of post-traumatic stress disorder (PTSD) or depression in the wake of hurricane Katrina³ and nearly

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half of parents reporting that their child had psychological distress related to the hurricane, such as anxiety, depression, or problems sleeping.^{4,5}

With the health care systems devastated following the hurricanes,⁶ some community organizations such as schools have provided mental health support for children and families post Katrina.⁷ Traditionally researchers have reported significant barriers in disseminating interventions in schools.⁸⁻¹⁰ A community-based participatory research (CBPR) approach can provide an alternative strategy to dissemination of evidence-based treatments and identify ways of overcoming barriers from the perspective of the community.^{11,12}

The Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) program¹³ is a school-based group intervention that has been found to be effective in treating post-traumatic stress disorder (PTSD) and depression in youth exposed to a broad range of traumatic events.^{14,15} From its inception, CBITS was developed in the context of a CBPR model, with equal partnership between school district clinicians and community members, administrators, and clinician researchers, in response to the needs of local schools to support students following traumatic experiences such as exposure to community and domestic violence, natural disasters, and school-related violence.^{16,17} As the dissemination of CBITS has expanded across the U.S., school communities have found this CBPR-developed intervention user-friendly and relevant but continue to confront organizational issues important to the successful implementation of CBITS.

To identify the facilitating factors and barriers in delivering CBITS following a disaster, a focus group study was developed and conducted through the CBITS CBPR team to gain perspective on the following: 1) the mental health needs of children and families in the first year following Hurricane Katrina, 2) factors affecting the delivery of mental health services in schools post-disaster, 3) school and community organizational factors such as existing school structure and community resources, and 4) health policy issues that may facilitate or impede the provision of mental health services for children affected by Hurricane Katrina. At multiple phases of this study, from conceptualization, development, data analysis, and dissemination of the results, a CBPR approach was used. This paper outlines how these findings are informing new partnerships with local providers in New Orleans to support students and families in schools.

Method

Participants

Following two New Orleans CBITS trainings in July 2006, research staff recruited and obtained verbal informed consent from 45 participants; 39 of whom were school mental health providers, subsequently referred to as “counselors” (Masters-level clinicians, crisis counselors, school counselors) and 6 of whom were program administrators, with 76% of the participants being female. Participants received a \$25 gift card for participating.

Participants served two communities in the New Orleans area, both highly impacted by the storm and qualified for FEMA assistance. All participants had experience providing services in hurricane-affected schools.

Procedures

Trained facilitators led nine focus groups, which consisted of 4–6 people per group. Each group was led by a moderator who used a semi-structured guide that included the following topics: 1) mental health needs of the students and families seeking services and changes in those needs following Hurricane Katrina, 2) services provided by the counselors and factors that facilitated and impeded delivery of those services, and 3) support needed to administer school

interventions post-hurricane at the system, administrative, and clinical levels. This study was conducted in compliance with the UCLA Institutional Review Board.

Data Analysis

All focus groups were audiotaped, transcribed, and reviewed by members of the research team (SK, EN, PY), using content analysis to explore general topics that arose during the groups. Process notes from the moderators were available to provide additional context. The research team used qualitative data analysis software, ATLAS.ti 5.1, to preliminarily code the focus group transcripts for major domains of inquiry based on the focus group topics. Subsequently, the research team, including a school administrator (MW), discussed the content of each domain and refined the coding scheme by expanding, collapsing, or eliminating codes until there was consensus. Additional coding was done based on the range of responses within each domain.

Results

Child and Family Mental Health Needs

Participants commonly reported that immediately following Hurricane Katrina, families had substantial needs for crisis intervention services and mental health counseling directly and indirectly related to the hurricanes, with pre-existing traumatic experiences being identified more by the counselors as a result of providing these hurricane-related services. One participant described: “The families talked about everything from Hurricane Katrina... to the killings that were before Katrina because prior to Katrina we had from 5 to 6 killings a night.” Once schools reopened, participants reported having high caseloads of students struggling with multiple traumas and losses. In addition to grieving from the loss of loved ones, they described that the loss of community and local culture was also devastating for many families. Participants commented on the powerful identification that many students had with their home school and local community and the struggles that some students had wearing a school uniform from a different school. “They aren’t with their friends, they aren’t going to the same schools that they loved, the community that they loved. And beneath the hurricane there were other issues as well.” One participant described several students that had experienced multiple moves since the hurricane, “... this is their fourth school since the hurricane. Fourth school! One has been to school in 3 states.”

After the immediate crisis period, participants discussed longer term mental health needs of their students and families and highlighted the need for mental health services that were not exclusively hurricane focused. “Most of the kids are done with Katrina, so really what you’re dealing with is post-traumatic stress that had nothing to do with Katrina.” The providers also described that in addition to trauma symptoms, the students and their families had increased needs for mental health services to deal with the ripple effects of the hurricane and displacement such as longer term financial losses. They expressed concern about secondary issues that they were seeing: “Divorces have skyrocketed; substance abuse has been out of control, and suicide.”

Clinician Factors

One consistent theme across focus groups was a call for increased recognition of self-care. Participants themselves were rebuilding homes, relocating, and coping with family and work stress. “We’re wounded healers. Things that I think before wouldn’t bother me are more emotionally impacting. I have to work harder to take care of myself, and I work very hard to take care of my team. So I think that has to be implicit in what we do to be successful clinically.” This theme of “wounded healers” was echoed by another participant: “I can relate to it, because I am that client: tearing up, heart beating all fast and everything ... As soon as that client leaves,

I'm in the backroom crying. And I have to gear up and go back ... as if there's nothing going on at my home... It is those types of hardships and making sure that you're psychologically prepared to deal with [the client].”

Others discussed reticence among counselors to seek support services for themselves. “We don't need to be so stigmatized by our own services that we offer. We need to participate in... process groups and compassion-fatigue groups so that we've got all of our stuff together before we go into someone else's backyard and try and present a program.”

School/community organizational factors

Another theme that resonated across focus groups was the role of organizational structure in delivering services in schools. There was a distinct contrast between those participants who had an infrastructure in place to support counselors and those participants who provided services independently. The two types of organizational structures that were described included counselors who were employed by a community clinic or agency and spent part of their time providing direct services on school campuses and those clinicians who were hired by a school or district as an independent contractor for a set amount of time per week. Clinic-based clinicians who co-located onto campuses described regular meetings and structure for gaining support. “We have team meetings, and we have people that we can always go to if something comes up.” This support structure appeared to help them cope with their high caseloads following the hurricanes. Consequently, when asked about barriers to delivering services, these participants focused more on tangible supports such as lack of supplies. In contrast, the contracted counselors described working in isolation and having no one with whom to discuss cases as particularly difficult following a disaster with the increased complexity of mental health issues and devastation to the health care system. “We're so independent in the school that I don't really get to interact much with other mental health providers.” These independent contracting counselors expressed a greater sense of being overwhelmed by their caseloads, a topic that was not emphasized by clinic-based counselors.

Participants across each of the focus groups discussed the necessity of a centralized information system due to a general lack of coordination of community resources following the hurricanes. “We need a centralized clearinghouse to say, ‘Here are the options. These are the trainings being offered’.” Others echoed this sentiment, “I know there's stuff out there, and sometimes I think if we don't know in the school system, how is a family on their own going to know what's available.” In fact, participants indicated that the focus group itself provided the opportunity to share information. They felt that the lack of available networking was a significant barrier to providing services. Although this was especially needed in the immediate aftermath of the hurricane, these participants continued to need centralized information ten months post disaster.

Despite a seemingly obvious heightened need for mental health services post-Katrina, participants described resistance from some school administrators about having counseling available for students on campus. “[Schools] want to get back to normal, worrying about test scores, attendance and that sort of thing.” Another clinician illustrated this theme stating, “[We'll see] if the schools are going to buy into it at all and see that there is a need. And that it's a priority just as important as academics. I think once they see the [children's] progress... [it] will catch on.”

Policy-Level Factors

Although disaster-related funding for mental health services appeared to be available for the hardest hit areas post-Katrina, participants described a lack of funding to support displaced students in areas that were not viewed as the most severely impacted by the storms. These

participants suggested that funding agencies did not recognize the needs of the communities that were supporting relocated students. For example, focus group participants in the highest impacted regions benefited from Katrina-related federal funding, “Funding is not the problem. [Name of program] has a list of schools on board for this program.” In contrast, participants from schools with less hurricane damage, perceived dwindling financial resources in the wake of a large influx of displaced families. “My hours were cut back from 20 to 6½ [hrs/week]. The financial future of the school system was pretty much in question. Rather than lay off teachers, they cut way back on our [mental health counseling] time.” These participants described not only seeing far greater need for mental health services in their schools as increasingly greater numbers of relocated students arrived, but they were faced with less paid hours to meet this demand.

Despite the need to address a multitude of mental health issues, focus group participants reported funding restrictions that permitted counselors to only provide “hurricane-related” services. “A lot of the children were going through things that weren’t necessarily hurricane related, but that’s what our grant governs.” Some participants even discussed feeling obligated to ask about hurricane-related trauma when there were clearly other more pressing concerns. Similarly, with the emphasis of funding on the immediate crisis period, even ten months post-hurricane, participants were concerned about long term sustainability of programs. “In a year or two these services are going to be gone. The money’s going to run out, and I’m going to be left right back where I was.”

Discussion

This study was conducted by a CBPR partnership that has worked together over ten years to develop and disseminate CBITS. As this partnership worked to nationally disseminate CBITS and more specifically to train providers in the wake of Hurricane Katrina, it was jointly agreed that there was significant a need to conduct focus groups to better understand the unique needs of local counselors and community members. Despite schools being recognized as a key organization in the recovery phase following major disasters and an important place in accessing children who need mental health services,^{7,18} collaboration with schools in the delivery of crisis counseling services for youth has remained difficult.¹⁹

This study highlights several key factors that affected the ability of New Orleans school counselors to respond to the needs of children and families following Hurricane Katrina. Participants identified several barriers that need to be addressed in order for school-based counselors to better meet the emotional needs of students following a major disaster. These preliminary findings also can inform the future dissemination of school-based interventions in response to a disaster.

Similar to previous findings for adults²⁰ and children,²¹ these focus group participants reported significant and broad mental health needs almost a year after Hurricane Katrina. In addition to relocation and displacement issues, these counselors were seeing students with exacerbations of pre-existing mental health problems and violence exposure, as well as family problems. They recognized that the mental health needs that they were seeing directly and indirectly related to the storms were extending beyond the scope of disaster-related crisis counseling through programs such as the Crisis Counseling Assistance and Training Program (CCP) funded through the Federal Emergency management Agency (FEMA), which focuses on helping “survivors recover to their pre-disaster level of functioning.”²²

These participants also identified the need for self-care (specific services to attend to a clinician’s own emotional needs) in providing mental health services. Described in the literature as compassion fatigue and burn-out,²³ most participants in this study described

themselves as disaster survivors who were at risk for becoming overwhelmed with high case loads and subsequent feelings of hopelessness. Despite some recognition and previous recommendations by others²⁴ that disaster planning should include provisions for self-care, this was not universally integrated into the work environments of the counselors participating in this study. This was especially true for those counselors who were working independently in their schools without structured meetings and support from other counselors. These findings suggest that schools as well as mental health clinics serving schools need to include self-care into the routine of recovery efforts. This could take the form of process groups for school or clinic staff and administrative staff allowing for flexible time and personal days.^{25,26}

Organizational and structural issues regarding the delivery of mental health services in schools post-disaster appeared to be challenging in terms of supporting clinicians, providing infrastructure, and competing with other priorities in the school. Although to some extent, these are ongoing issues for mental health delivery in schools in general, these barriers were compounded following the hurricane with such an acute and continued increase in need for mental health services in the community. Without critical infrastructure to coordinate resources and referrals, participants described challenges in knowing which agencies were open and if they had relocated. Demonstration of program effectiveness was suggested as one way to increase administrative support of mental health in schools. Efforts to respond to this need for information, all in one place, have begun²⁷ but local clearinghouses on trainings being offered and possible referral sources are also needed.

This study has some limitations that are important to consider. First, the focus groups drew from a population of counselors attending a training, who may differ from the general population of practitioners in the region. In addition, their positions are within systems that support their training efforts, and thus their experiences within systems may differ from those who may be unable to attend such trainings. Finally, this community-partnership has mainly involved school staff and leadership and future studies should include a broader partnership of stakeholders including students.

In summary, this study offers important insights into the issues that should be considered in structuring mental health services in schools post-disaster, and many of the findings that apply to clinical and structural support can be applied to implementation of evidence-based treatment in schools more broadly. It also provides an example of how the work of a CBPR partnership can take shape as it matures over time. The results of this study have also informed this community-research partnership regarding the types of support that clinicians need as evidence-based practices are disseminated following a disaster and have been a first step in the development of local collaborations in New Orleans. In direct response to the findings regarding the need for supportive infrastructure that could help clinicians to share information and resources, and be supported by one another, the CBPR team began working with local providers in New Orleans to provide them with ongoing technical assistance and support in implementing CBITS. Specifically, a learning collaborative framework was used in which local teams regularly come together to share solutions to implementation and clinical challenges experienced in the field. The structure of the learning collaborative which includes regular phone call and in-person “learning sessions” provided a structure for sharing growing knowledge of both an evidence-based practice and connecting with other professionals working in schools.

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