

**The Impact of the World Trade Center Disaster on
Treatment and Prevention Services for Alcohol and
Other Drug Abuse in New York:
Immediate Effects, Lingering Problems, and Lessons Learned**

Developed for the

**New York Office of Alcoholism and
Substance Abuse Services**

October 2002

Prepared under the

**Center for Substance Abuse Treatment
State Systems Technical Assistance Project**

Contract No. 270-99-7070



U.S. DEPARTMENT OF HEALTH AND HUMAN
SERVICES

Substance Abuse and Mental Health Services Administration

**The Impact of the World Trade Center Disaster on
Treatment and Prevention Services for Alcohol and
Other Drug Abuse in New York:
Immediate Effects, Lingering Problems, and Lessons Learned**

Developed for the

**New York Office of Alcoholism and
Substance Abuse Services**

Prepared under the

**Center for Substance Abuse Treatment
State Systems Technical Assistance Project**

TABLE OF CONTENTS

	Page
EXECUTIVE SUMMARY	ii
SURREAL ESTATE	iii
ACKNOWLEDGMENTS	iv
I. INTRODUCTION.....	1
II. TELLING THE STORY: IN NEW YORKERS= EYES.....	3
III. IN FOCUS: A PROVIDER VIEW	17
IV. STATE AGENCY RESPONSE.....	23
V. LESSONS LEARNED.....	30
VI. APPENDICES	41
APPENDIX A: FOCUS GROUP METHODOLOGY AND INDIVIDUAL FOCUS GROUP REPORTS.....	41
APPENDIX B: ACRONYMS/TERMS.....	81
APPENDIX C: PROGRAM AND AGENCY KEY INFORMANTS.....	82
APPENDIX D: RESPONSE—A SIX-MONTH CHRONOLOGY	83

EXECUTIVE SUMMARY

The impact of the World Trade Center disaster has had far-reaching effects on New York State's treatment and prevention services for alcohol and other drug abuse. Funded by the Center for Substance Abuse Treatment (CSAT), this technical assistance report describes what happened in New York State on September 11, 2001 (9/11) and during the subsequent 6 months from the perspectives of program personnel, clients, and government officials. The purpose of this report is to help other States and those in the substance abuse field to learn from the experiences of New York in this time of crisis and upheaval.

The report is divided into six sections. The first section, "Introduction," provides the reader with an overview and the background of the report. The second section, "Telling the Story," is based on interviews with key informants involved in the everyday world of substance abuse services and describes the immediate effects of the disaster and its aftermath. These effects were gut-wrenching in the enormity of trauma, especially for those located near ground zero. The aftermath describes the next wave of effects, including relocation of some programs; reaching out to clients and community residents; creating crisis teams; setting up hotlines and Web sites; providing information and training in dealing with trauma; and, then, inevitably, dealing with relapse, staff burnout, and Posttraumatic Stress Disorder (PTSD).

The third section, "In Focus: A Provider View," describes candid discussions in a series of focus groups held with representatives of a cross section of treatment and prevention programs throughout New York City, its suburbs, and in upstate locations. Each of the 11 focus groups discussed lingering problems and the ways in which represented programs handled the numerous challenges since 9/11. Common themes touched on the serious effects on clients—especially adolescents and methadone patients—as well as on staff, the importance of having a disaster plan in place, the need for more staff training, and the need for compassion for treatment and prevention programs most directly affected by the disaster.

The fourth section, "State Agency Response," describes the role of New York State's Office of Alcoholism and Substance Abuse Services (OASAS) as the single State agency for substance abuse services, and then details its extraordinary response to the immediate needs of programs, particularly near the disaster site. During the 6 months following the disaster, OASAS surveyed providers, tracked and responded to service needs, provided information to the field, and helped staff respond to the trauma that continues to linger throughout the field. Thus far, the chemical dependence field in New York State has incurred estimated costs of more than \$222 million associated with the disaster.

The fifth section, "Lessons Learned," gives a down-to-earth account of the numerous lessons learned by the substance abuse field since 9/11 and provides practical recommendations for immediate and future action for programs as well as for government agencies. Among the lessons learned are the need for disaster preparedness and a better understanding of the relationship between PTSD and substance abuse. The recommendations include the very basic elements to be considered in a comprehensive disaster plan for New York State as well as for other States.

The final section, "Appendices," includes a methodology for the focus group interviews and detailed summary of discussions in each of the 11 focus groups, an acronym list, a list of program/agency key informants, and a chronology of OASAS activities.

Surreal Estate (9/11/01)

by Ray Simons

I.

I walked in
Hell's half acre
where the rescue dogs
wear combat boots and
asbestos snow seasons
my sandwich, as
death stands close
to us all

II.

We rise from
these ashes
again and again
accept the
sadness,
step up,
move forward,
to complete
our work

III.

With heavy heart
in a city
forever changed
I see the spark
of hope, pride
and love
The flags wave
The signs say
take courage
The crowds cheer
as we approach
ground zero

Printed with permission of the author, who works for FDNY/EMS, has been a certified alcohol and substance abuse counselor (CASAC) peer supporter for his union for 8 years, and, as an EMT, worked the Avanca and Rockaways air crashes as well as the WTC disaster. In his 20-plus years of FDNY trauma work in Brooklyn and the South Bronx, he “never saw anything like” the WTC disaster.

ACKNOWLEDGEMENTS

From an idea to reality, this study was made possible by and through assistance of the following persons:

- At the New York State Office of Alcoholism and Substance Abuse Services (OASAS), Jean Somers Miller, Paul Puccio, Tim Williams, Gerry Armstrong, Kathleen Coughlin, John Perez, John Galea, Mike Yorio, Ken Robertson, Frank McCorry, Anne Herron, Bob Bruno, AIDS street outreach workers and Vinnie Chesimard, Bob Gallati, Steve Richman, Jim O’Hanlon, Fran Harding, Bill Lachanski, Michael Chaplan, Millie Figueroa, Reba Architzel, Bill Barnette, Lucy Maynard, Gwenn Lee, Ed Freeman, Neil Grogin, Bill O’Hare, Cheryl Backus, Mary Pellman, and Rosa Torres, who all gave generously of time, talent, and resources. Bill Hogan’s editing skills were invaluable to the effort.
- At the Center for Substance Abuse Treatment (CSAT), Dr. Westley Clark, Carol Rest-Minberg, Gayle Saunders, and Rick Sampson were supporters throughout, as was Clarice Holden of the Center for Substance Abuse Prevention (CSAP).
- At Johnson, Bassin, & Shaw, Inc. (JBS)—Jerri Shaw, Larry Robertson, and Brenda Silvia made our work pleasant, despite the difficult topic.
- To Dee’s constant guide and companion while she was in the city, Yolando Martinez—this could not have been done without you! Blanche Frank, you were so kind to impart your ample wisdom to us all. Phyllis Stinson and Ed Roche—thank you for the hospitality in your lower Manhattan home, despite the dust and welcome to Agnes!
- To Commissioner Miller, a special thanks is owed to you! Your unflinching efforts to provide the best for your staff and your providers throughout this tragedy must be a model for all of us to emulate in public service.
- To the providers of service and city and county government officials who gave so generously of time and heart, we are grateful. The methadone clients interviewed were especially poignant—Gwen and Karen, a special thanks to each of you, and best wishes in your recovery. Finally, to the young people in Brooklyn, it is heartening to know that you are our future!
- To our families, who endured much while we struggled through volumes of difficult and heart-wrenching material, we give special gratitude. To those from Oklahoma City, we can never repay you—but we can honor you who came first and who helped in many ways.
- To you all, we are indebted. Thank you.

Is there a silver lining in this dark cloud? A Spanish saying is paramount: “*No hay mal que por bien no venga.*” In English, it means: “There is nothing so bad that some good can’t come of it.” As we learned in Oklahoma City, keep your eye open for the good—it will help you through the bad.

I. INTRODUCTION

Overview of the Report

The purpose of this volume is to tell the story of September 11 and the 6 months after, through the experiences and stories of New Yorkers themselves, and through the filter of the alcohol and substance abuse services system in the State of New York. These writings are designed to help other States prepare for disasters, especially human-caused tribulation. Lessons learned by New York (and, in some part, by Oklahoma City) can assist others to look at current system capabilities for response, for providing service in the face of disaster, and for protecting not only the clients but also the service providers.

By looking at the recent history of the New York State Office of Alcoholism and Substance Abuse Services (OASAS) and its response, the Federal agencies, city and county governments, and providers, it is hoped that this document will provide other States with the foundation for disaster preparedness as it relates to substance abuse services. Other agencies' reactions are also important when planning, because effective preparation is a community affair. Without cooperation and foresight, response will be limited, at best.

How alcohol and other drug (AOD) use relates to trauma is an emerging field that deserves much study; there are dual-diagnosis issues that resound throughout disaster response. Posttraumatic Stress Disorder (PTSD) is prevalent in disaster clients; when combined with AOD problems, PTSD becomes a much more difficult issue with which to deal. Relapse is an issue that has not been explored by disaster researchers, but which is seen in self-help groups after major traumas, both personal and community-based. AOD use by itself or PTSD by itself has a known relationship to suicide, so AOD use and PTSD together can be a deadly combination.

Background

On September 12, Dr. Westley Clark, Director of the Center for Substance Abuse Treatment (CSAT), telephoned OASAS Commissioner Jean Somers Miller to ask how CSAT could help. Several additional conversations ensued, and, in November, a disaster forum was held in New York City. There, Dr. Clark told the conferees that he wanted to prepare a national publication using the lessons learned in New York State and answer these questions: "How should an AOD agency respond? How should Federal agencies respond?"

This paper is an attempt to answer these questions. Through the eyes, ears, and now words of New Yorkers, the response of a city and State will be seen. The terror of these moments will become real. Over and over again, respondents said: "We thought this was it." In the city and without communication systems intact, no one knew what was happening. Those who lived outside the city and watched events unfold on television were much more in command of the facts than those on the ground in Manhattan. All they knew were smoke, body parts, F-16s, closed transportation systems, and armored cars—in other words, sheer terror.

All social services in the city needed significant assistance. Providers who survived the attacks without losing facilities found it necessary to help medicate closed clinics' clients—and they did it without a hitch. Relapse and past traumas that emerged in counseling sessions swamped an already overburdened substance abuse services system—and they handled it well. Counselors became clients, and clients helped counselors, and all knew on that day that they were not in this alone but together.

Emergency grants were put on fast tracks by the Federal Government, and some State regulations were relaxed to facilitate use of the funds. Contracts were let to provide life-saving services to clients, especially in the city and surrounding counties. City agencies worked side by side with State and Federal agencies.

Of course, there were glitches. Understanding the structure and organization of agencies in every State is a difficult task, especially in an emergency situation, and money would sometimes be earmarked incorrectly or funneled improperly, causing resentment among local agencies. Federal rules, such as how Federal Emergency Management Agency (FEMA) dollars may not currently be used for AOD services or to pay existing staff, slowed service delivery. Meanwhile, substance abuse agencies were overwhelmed by the needs of existing clients and providers, children, and families. We know from the Oklahoma City bombing experience that new clients will begin to enter the system at 6, 12, and 24 months. Without resources, the system may not be able to handle the increases.

In line with Dr. Clark's public query, OASAS requested technical assistance from CSAT to discover the "lessons learned" from the agency's response to the disaster. Key informant interviews were conducted over a 3-week period in January, February, and March in Albany, New York City, and contiguous counties. State and Federal staff, clients, and program personnel were interviewed, most at their offices or centers, and many near the World Trade Center site. Providers included those representing prevention, public and parochial schools, women/children treatment, methadone maintenance, youth treatment, residential/intensive outpatient (IOP) treatment, local government, labor groups, employee assistance programs (EAPs)/student assistance programs (SAPs), and integrated service providers with a full continuum of care.

Additionally, 11 focus groups of providers were convened in Watertown, Albany, Mid-Hudson north and south, as well as in the five city boroughs (including Manhattan north and south), and surrounding counties, including Westchester, Nassau, and Suffolk, as well. Together with the chronology of events is a verbal video of September 11 and beyond.

Author Information

Blanche Frank holds a doctorate in sociology from the Graduate Center of the City University of New York. She started working for OASAS in 1975 and served as chief of epidemiology for most of her career. She retired in 2001 as director of the Bureau of Applied Studies.

Dee S. Owens served as deputy commissioner for Substance Abuse Services at the Oklahoma Department of Mental Health and Substance Abuse Services during the Alfred P. Murrah Building bombing. She currently is director of the Alcohol-Drug Information Center at Indiana University in Bloomington. She holds a master of public affairs in policy analysis from the School of Environmental and Public Affairs at Indiana University.

II. TELLING THE STORY: IN NEW YORKERS' EYES

September 11, 2001

It was a beautiful morning, everyone said. The sky was bluer than anyone had noticed for a long time, and the air was as clear as it gets in late summer. It was a day to tarry, to take off work, to enjoy.

That morning, individuals with death and destruction on their minds were boarding airplanes in Boston and outside Washington, DC, preparing to commit the most horrific acts we as a Nation have witnessed in our lifetimes—the hijacking and use of giant, fuel-engorged airliners to murder innocent persons and cause massive destruction and terror.

One airplane crashed into the Pentagon, while another was steered into the ground by heroic passengers in Pennsylvania. Two airliners were diverted to New York City, and one each crashed into the tallest World Trade Center towers, numbers 1 and 2. Who can ever forget that sight, that picture, that hell? More than 3,000 people were lost that morning, including 343 firefighters. A single firm, Cantor Fitzgerald, lost 658 employees. That beautiful day, shared nearly universally throughout the country, was ended. September 11, 2001, will shape our future for years to come.

This is the story of the city and the State of New York, wounded but not overcome. It recounts how events unfolded as they affected the strained substance abuse services system, OASAS, and its clients. It chronicles the aftermath of these tragic events as it relates to clients, State and city employees, and prevention and treatment providers. This is the compendium of lessons learned that will be shared as a gift from New York to the States of the Nation. Finally, this is a glimpse of more heroes than we have seen on any television show, in any movie, or on any ballfield. The people of the State of New York walked together down this path and have emerged stronger for it. This is their story.

“I went running in the streets, crying, screaming, ‘We’ve been bombed, thousands are dying.’ I will never forget the fear I felt, the pain I felt. I ended up in the hospital one week to the day from the World Trade Center because of two traumas, one right behind the other.” This street outreach worker, who daily deals with trauma, addicts, “homeless, hungry, hopeless people,” sums up the feelings of New Yorkers, especially those in lower Manhattan, site of the World Trade Center (WTC) attacks.

A street-outreach program was housed on the 16th floor of Tower Two; the program services four boroughs and employs about 35. Everyone survived the attacks, but every file, every piece of equipment, and history was lost. Field sites tried to call in when they saw the tower burning; all staff were allowed to go home. Many staff watched it unfold and had thoughts like: “There are many more landmarks to destroy! Could this be militia?” Some staff left to distribute water and help. Papers were landing on

rooftops in Brooklyn. For quite a long time, cable television showed persons jumping from the towers until it appeared a blackout was imposed.

One person was at training inside the WTC that day. He went down to get coffee, and when he tried to go back upstairs, security told him he had to get out. Just then, the second plane hit; he saw body parts falling, and confusion and fear set in. What was going on? His car was several blocks away; he made it to the car, drove away, and he saw the smoke of the collapse by the time he reached Grand Central Station on 42nd Street. The radio said, "It's an attack," and even though he made it to Queens, he did not feel safe. He got back to his office, broke down in tears, and coworkers pulled him from the car. He did not remember much else.

Employees of one city agency could look out the window and see staff coming to work, when the first plane hit. After the second plane struck, employees left the office and were subsequently dislocated until December. Those staff who could not get in or who were on bridges that suddenly closed helped others, giving water to the dust-covered survivors who walked over the bridges. One worker saw it all from the Brooklyn Bridge and is tearful to this day.

A methadone maintenance program located just a few blocks from the WTC had medicated 60 patients when the first plane hit; the entire building shook. As employees came to work and as the second plane crashed and shook the building violently, they began to fax patient information while calling OASAS for instructions. It was only when the first tower collapsed, when the lights went out, and the smoke came in, that workers knew they must escape. One employee grabbed medication and patient records and ran, returning to get cloths to cover her face from the white dust that filled the air. There was a daycare center in the building, so the doctor stayed there. Staff nurses took the injured to the hospital, stumbling through other people who were running from the site screaming. Some staff made it to the Staten Island ferry while others walked across the Brooklyn Bridge.

At another lower Manhattan methadone maintenance program, one staffer heard a huge explosion and looked out the south windows to see the WTC fire only five blocks away. Some staff coming to work were hysterical, seeing people jumping from the flaming towers. Others thought someone was making a movie, until they saw the second plane hit and saw people jumping. They heard a freight-train noise. Not knowing a tower had collapsed, employees asked: "Why all this debris?" Even masks could not keep the dust out. Crowds began to arrive, covered with white dust; staff counselors gave out water to these walking, disoriented wounded. No trains were operating as employees were given the option to leave (all left by noon). Covered with dust, many walked to another clinic or a bridge until they escaped. One employee sat with a grieving stranger who happened along; she also steered an older woman who was confused, away from the site. Others worked at clinics or helped refugees with eye washing or drinks, as did clients. A clinic nurse's sister worked at Windows on the World, the restaurant that was on the 106th and 107th floors of the north WTC tower. Two staff members who worked at a recycling program, one of several operated by the agency at the WTC, were lost; an outreach program there did not start until 10 a.m., so those staff were saved. A farm produce truck was there; staff got away, but the truck was destroyed.

Students in the affected area looked out the windows to see people jumping, the second plane crash, and the tower collapses. Some students were walking or riding the subway to Stuyvesant High School. Three schools in the affected area were to evacuate to Stuyvesant, but it was emptied after the first collapse because it is only five blocks from WTC. One person's son brought home friends and strangers he found on the streets, not arriving home until 3:30 that afternoon. Teachers stayed at schools as long as possible. Substance abuse prevention/intervention specialists (SAPIS)—there are more than 700 fulltime specialists in the schools—worked through crises with students and parents and were first responders.

Youth in schools spanning pre-kindergarten through eighth grade could see the events unfold during this first week of school. Teachers stayed until 8 or 9 p.m. that night, until all students were reunited with parents. Children were afraid, asking: “Why are we letting in all these homeless people?” Crowds were coming into churches, covered with dust and screaming. One principal had to get 150 kids through a window—not one child was lost or hurt. School personnel had family in the WTC and still they assisted the children as well as the terrified people coming toward them. The crisis plans for the schools, formed after the Columbine massacre, helped with the response. Many evacuation sites were not available. Prevention staff “hit the streets” to provide triage services wherever needed, noting it was very difficult to get around, and even more scary. This was a “collective event.”

Staff at a community program in northern Manhattan first heard about the crash on the radio. A sense of “unreality” overcame everyone. They turned on a television in time to see the buildings collapse and thought it was an all-out attack. Driving through the “back roads” of Harlem and the Bronx, one worker drove to lower Manhattan to get his 9-month pregnant wife. There were no traffic lights, no police anywhere—just roads crammed with cars, headed uptown.

Staff and clients at a 200-bed therapeutic community (TC) in the Bowery noted what a stunning day it was. After the first plane hit, there was mass denial. When the second plane hit, there was chaos. Staff and clients stood on the street corner and watched the buildings fall; when the sea of people came rushing toward them, both staff and clients tried to help. All sheets and towels in the building were pulled outside because people were caked with debris; police pulled mattresses outside for the injured. Half of the project’s mattresses were gone! They gave ice and water to refugees and took them to restrooms inside; the immediate response was to help someone else, not just here, but throughout the city. Homeless clients pulled people in and tried to calm them. Staff used vans to transport patients to their homes. They sent home staff who had children or who were panicked; many staff stayed at programs for 36 hours straight. One staffer went for a walk later in the day to get away for a few minutes. There were “no souls” on the street, which smelled, was smoky, and had deep ash. All she saw was a rescue truck full of exhausted men. “It made me cry.”

A social service agency has its main offices 20 blocks from the WTC. Staff came in, shouting, “The WTC is on fire.” Staff then watched the second plane crash. Ash-covered people began to come toward them, so a crisis center of sorts was set up on the street, complete with cots, water palettes, food, eye flush, and wheelchairs. Staff just “did what needed to be done,” without direction, whether an accountant or counselor. They let people use phones, as many people were lost, and staff helped them find ways out. The Williamsburg Bridge closed. “Predictability no longer existed.” It was surreal, with F-16s flying over the city and soldiers with rifles in the streets. Seeing them made people more scared. The pandemonium was unbelievable. Many thought they would never see their families again. Two clients who were trimming trees across from the WTC did not immediately return to their program but offered to help, putting on masks and removing debris.

At a methadone maintenance clinic in the Bronx, procedures normally used during hurricanes or blizzards were put into motion, even though a disaster of this magnitude could not have been imagined. This clinic normally opened for patients at 11 a.m., but, after watching the news, several employees came in early. On a car radio, the crash was initially described as a Piper Cub accident. When the second plane crashed, it was confusing. Even in the Bronx, looking out the window revealed the towers and black smoke billows. At another clinic that opened at 6:30 a.m., staff saw the events on television and heard loud booms. Some thought it was an elaborate joke. Many found roadblocks, no buses or trains, and closed bridges, so they had to stay wherever they were. Staff could not get home, or from borough to borough. Cell phones went dead, and “communication was impossible.” The television was on, but only UHF channels, operating from atop the Empire State Building, worked. Someone got a coat hanger and made

an antenna. Some staff were arriving at the WTC for training; many sat in their cars and saw people jumping. Others were at the city's Human Resource Administration (HRA) four blocks away and walked out.

At another methadone maintenance clinic in lower Manhattan, which opens at 7 a.m. and medicates 460 patients per day, staff witnessed people streaming across Delancy Street to the bridge. Everyone was covered with soot. The staff found out about the disaster when patients began running in to tell what they saw; programs began to call to request patient accommodation. Many patients who had been on the way to another clinic came without identification (ID) traumatized, and covered with soot and blood. Clients "saw bodies flying" and were very distraught. Phones worked locally but would not dial out of Manhattan; everything below 14th and Houston was "frozen" by law enforcement.

A mother/child program in the Bronx with about 20 percent former clients as employees "didn't get much work done that day." The daughter of a staff member called to say that she had seen the second plane and said it was not an accident. A staffer's son, who was an EMS worker, went to the site; the first tower collapsed while he was in the second. It went dark, people grabbed hands, and they knew they were outside when they saw blinking lights. He found a working phone across the street at a delicatessen; as he walked away from his call, the second tower collapsed onto the eatery. He used a golf cart to transport people; it was hard to walk through all the body parts. Most staff had already arrived at the program, and they worked to get the best information they could from television and radio. If a person dialed over and over, sometimes the call went through. Women were very upset and wanted to get their children and go home; staff felt even worse. Some women had already been sent to appointments for the day and had difficulty returning.

A residential and day treatment TC for adolescents in Brooklyn remained open throughout the day. Staff decided to see what was happening before closing. After a while, they shut off the television and talked with the kids while setting up a system for them to receive calls. Youth were worried if they had parents who worked in the city. One staff person went to the harbor after work—there were no commercial planes, no normal sounds—"it was spooky." Only the F-16s could be heard. As he looked across the harbor, it was plain to see "they weren't there anymore!" Two program graduates died there, as did a staff person's firefighter father.

Another lower Manhattan methadone maintenance clinic was open that morning; staff were in sessions and went out to see the WTC flames. People were walking uptown, covered with dust. Clients stopped coming in because the facility is located south of 14th Street; the area was frozen by law enforcement. Everyone was very cooperative, but phone lines were down, and information was scarce. Staff also could not make it in, so those staff present worked doubly hard. Clients' children were running around, and it was very stressful. Clients who did get through on the phones were sent to another facility, which is north of 14th Street. Several staff were going to training at the WTC; they escaped. A patient came in and told the staff it was a terrorist; two other patients carried in a staffer who had collapsed upon seeing the second plane hit. There was panic but also a "we're all in this together" attitude, a sense of oneness. The staff doctor went to Roosevelt Hospital that evening on the way home—no survivors were there.

Staff at a 417-bed TC with a balcony with a direct view of the WTC site first learned of the disaster when a client said, "The WTC is burning." As clients watched, they saw the second plane hit the building. They did not believe it, so they turned on the television. "Everyone wanted to go hide." Staff on the way to work thought it was a Cessna, judging by a call from a spouse, then saw and heard the other plane hit from the Cross Bronx Expressway. Another staffer was not due to work until 1 p.m. Her son turned on the television, and, as they looked at the first plane's fire, he said, "How could anyone NOT see the WTC?" Just then, the second plane hit. She found her daughter, who was downtown at her East 15th Street

school, so she came to work. The phones worked, which was good because 143 clients were already out of the building, working. Clients called in, and most made it back to the building; they arranged for others to stay elsewhere, since so much was closed. Over 80 percent of the clients are mandated to be there, so they could not go to their families without being reincarcerated.

Staff at a labor EAP acted right away, responding to a call from Local 94—Operating Engineers who asked for help with 16 members who survived the WTC attacks but who lost four coworkers. An 800-number was quickly established, which in subsequent weeks, received over 1,500 calls for assistance.

Aftermath

Displaced workers asked: “Do we still have jobs? What will we do?” Those workers in recovery used crisis-counseling services along with informal and internal networks to deal with the stresses. A temporary Web site was constructed so all displaced WTC staff could check in. It now costs \$60 more a month for displaced workers to commute; one worker has to cross three bridges! Staff used personal cars to transport clients. Some staff are experiencing burnout. Many staff watched television for days. One staffer lives across from former President Clinton’s office in Harlem and was afraid it might be a target. Other staffers are now afraid to go on bridges. One noted: “We cannot feel 9/11 from 9-5, to make it through.” Another voiced being “used to war—everyday I’m on the corner, looking for submachine guns.” He has been “in the 9/11 mode for 30 years.”

Away from the immediate area, these outreach staff participated in meetings where feelings were discussed and past traumas were brought to light. In one location where a Vietnam veteran worked, his job description “changed suddenly” from substance abuse counseling to disaster counseling. It was noted that immigrants and non-English speakers were at great risk; many watched television for days, as well.

One person who escaped the WTC felt fear for 3 days, then incredible anger. He thought about never being able to tell his loved ones what he needed to tell. There was a weight on him—he did not wish to talk. He was a Vietnam veteran, yet was upset he was caught off guard. He told himself he could not let it “eat him.”

Some city staff collocated at OASAS’s offices on 7th Avenue in midtown Manhattan until they could return to their offices in December. Staff noted that substantial senior housing existed close to the site, and that the elderly were at risk. “Many adults in the WTC were caregivers to the elderly; we are now seeing abusive siblings moving in. Many canceled home visits; most watched constant television. Holocaust survivors are severely traumatized.”

A clinic near ground zero moved to two locations, returning to its still-standing but dusty building in December. One staffer took patient records home and made evening calls from home, wherever calls would go through, setting up a place for clients to receive medication. The clinic’s doctor helped children to get home. Staff responded differently to the crisis: Some decided to continue working, while others who had family in the buildings needed to stay home. All demonstrated professional conduct in the face of immediate disaster.

Some clients came to a methadone clinic near Chinatown the next day, including displaced patients. Troops were on the streets, phones were down, toxic fumes were throughout the air—“everything looked like one of those black and white pictures with color drawn on.” Bomb threats were prevalent, patients could not get through the restricted zone (below 14th Street) to get medicated, and there was a skeleton staff.

School SAPIS staff performed critical incident stress debriefing (CISD) in the days following the attacks, and staff worked overtime at school and community sites. “We were asked to be efficient while being affected.” Guidance counselors were trained about stress debriefing, and students from four schools were packed into temporary quarters. Chinatown SAPIS staff stayed all day; the residents were certain it was an all-out attack. Counselors said wives of missing fire/police did not know what to do and were drinking. Jobs were lost. The area has high- and low-end incomes and many cultures.

SAPIS pulled together materials quickly. Within 24 hours, a hotline was set up, and e-mails were sent to administrators about staff crisis communication. There are only 40 counselors for 300 schools, but “There were lots of hugs from strangers.” On September 13, a scare caused trains to stop, Madison Square Garden to be evacuated, and buildings and bridges to close. People thought—“This is it.” After the November 12 plane crash in the Rockaways, kids were afraid to hear planes. Chinese residents, many first generation, flew American flags and asked: “Who is American?” Within the first week, a prevention provider serviced over 100 schools.

Northern Manhattan counselors went to the schools to perform crisis counseling on September 13, as everything was closed September 12. Staff had an emergency meeting; one lost an EMS friend, and another tried to get under the WTC on 9/11 to find her grandson whom she thought was on a train. A Port Authority officer who works at the program lost his only son. Children were afraid for their families and also feared school attacks. Their sense of security was completely shattered, and they asked: “How can the WTC, seen from anywhere, be gone, just like that?” Other children seemed unaffected, the ones who live hard, day to day; the ones whose lives are dictated by how well they defend themselves.

Regardless, most children knew someone who died, or had a family member who died. Eighty percent of the 70,000 residents in a northern Manhattan neighborhood are from the Dominican Republic. Many consider New York City to be the capital of the Dominican Republic, outside the Dominican Republic. Television repeated crash footage, saying 50,000 people were in the buildings, with subtitles of “America in Fear.” Cell phones were out because we “keep all our communication eggs in one basket.” Staff received crisis counseling from a local hospital. One student lost three friends, with another still missing. She did not want to attend school—what if “they” bomb bridges, the Statue of Liberty, and “we can’t get out?” The schools would not let students drink water for a month, in case it was tainted. Flyovers by F-16s retraumatized everyone. The silence in the city at night was eerie. Even in northern Manhattan, the smell was there, when the wind changed.

Armed people were swarming the streets, United Nations’ trucks were driving around, and giant planes were flying low, retraumatizing clients over and over again. There were no trains, there was no clear air, and there were no referral beds. With ongoing bomb threats, clients were afraid to pass police posts to keep outpatient appointments. Phone lines, including cellular, were sporadically effective; without E-mail and computers, communication would have been impossible.

At a drop-in center, some revealed for the first time that they were Holocaust survivors. One staff member cried all day, after the worst was over; no one could believe it. The smoke and the smells were horrible. Staff worked double shifts in order to remain open; they referred many outpatient clients to residential services. Thanks to many locations, clients had their needs served.

At the methadone maintenance clinic in the Bronx, patients who were displaced in lower Manhattan came to get medication. Lists were faxed with client dosage records, when possible, and 275 persons were medicated. No client tried to get more methadone than the records indicated; in fact, one client asked for 10 milligrams less! Most patients followed the rules and carried ID. Workers lost family. Debriefings were set for staff, remembering that they listen to clients and their horror stories. “Who debriefed the debriefers?” PTSD has been noted with staff and clients. Now, attention is paid to bomb threats.

At a lower Manhattan methadone clinic, staff wore masks to and during work and gave them to clients. Staff felt they had to come to work to serve clients. Everything was so quiet. Asthma attacks were bad. Even bus drivers handed out masks for weeks and weeks. Clients could not sleep. Getting to and from Long Island was very hard. To get to work, staff had to go through three security/ID checks, and could not walk down the street unless they were going to work or home. Cars parked in the frozen zone were not accessible, and people were angry. The next day, displaced patients arrived and stayed until other clinics reopened. On the third day, the wind changed, and it was the day with the most smoke. Some patients acted as if nothing happened; others wanted to make amends to family, with one traveling to Chicago to do so. Thieves did not break into cars with American flags on them. People in the streets pulled together and directed traffic or did whatever needed to be done.

A national AOD office once had a spectacular view of the Twin Towers. As staff look out the window now, they are reminded daily of the assaults. There were anger and tears at first; all the merchants' stores were empty, and the streets were like an armed territory in another country. The supervisor at Windows on the World restaurant, a staff friend, did not go to work that day but lost all staff who did. There were some at Cantor Fitzgerald who were laid off on Monday, so they didn't go to work on Tuesday. Survivor guilt is heavy.

Staff at a women's program offered to house women who could not return home. One staff member took 5 hours to get to work because of the many security checkpoints. It was scary. All the stops required an additional hour's commute, each way, each day. Attending a conference in lower Manhattan 2 weeks later was very disconcerting for participants, with all the fighter jets flying overhead. When the building had to be evacuated for smoke, hearts nearly stopped.

A youth program looked for its graduates who were missing. Staff checked hospitals because coworkers who escaped thought Tommy got out. Tommy and Jimmy had their first apartment together, after graduating from the program. Jimmy worked at Cantor Fitzgerald, one of its first brokers without a college degree. The WTC bombing in 1993 was his first day there! Jimmy was hit, he called his house to say, and there was fire, and he was leaving. Tommy worked from 1 a.m. to 8 or 9 a.m. in the other tower at Eurobank. He was about to leave when the plane hit, and he called his wife to say he was leaving. Neither made it home.

At a lower Manhattan clinic, when the wind changed, patients and staff who smoked or had asthma found it difficult to breathe. It smelled like an electric-type burn for days, and it felt unhealthy. There were 220 stories of collapsed wired buildings, and Building No. 7, which also came down. No one could leave doors open or all would cough. Due to anxiety, patients developed an instant camaraderie; many patients wanted to be told they were all right. One staffer walked miles to the north, in the middle of the street, in Manhattan. She was all numb—"it was like a movie."

At a large TC, it became apparent that watching television was traumatizing, so all TVs were turned off, and all balconies with a view of the site were closed. Groups were formed throughout the building, and each made lists of who might be at the site. Fences were locked, security was set up, and clients were involved in disaster management all the way. Staff were quick with response; newer clients were very afraid, so "older" clients helped. Only one staffer was distraught, because her daughter was at the site. The daughter called 3 hours later. Another staffer had a daughter in the military who went to the WTC to help.

In the first week, the labor EAP created a labor support center with a hotline and then asked for help on its Internet site and through other avenues. The EAP made arrangements with local providers, such as the New York State Psychological Association and the Clinical Social Worker Association, to provide three

“pro bono” sessions to referred members. At Pier 94, “on the spot” counseling and referrals were performed.

Provider Response

“At 4 months, the site is still smoking. It’s like visiting a gravesite. You must see the site, or this is just an academic response.”

The research agency located in the WTC was able to get data-submission deadlines from Federal agencies extended because of the extraordinary circumstances. A new facility is planned. Within 2 weeks, a PTSD clinician was brought in to help with resources for staff. Some staff were sent to a specialist; many lost some ability to focus. Management said, “Take whatever time off you need,” and several staff did. Administrators must tell staff: “You still have a job! Your paychecks are covered!”

One WTC survivor finally got over being sick when he ate. He is getting better, “being in the moment.” He noted that he had somewhere to go—many clients have nowhere to go!

Westchester County, although north of Manhattan and removed from the visual effects of the disaster, is home to many of the firefighters and workers who were at the WTC. About 200 families lost members; most were young or middle-aged fathers with children. With integrated services, an agency there was able to set up a 24/7 hotline, which staff worked in shifts, and put ads on network and cable television and in the newspaper. It was fortuitous that provider staff served on the Red Cross and city government disaster teams. They were able to respond quickly, knowing what was necessary to do, who to contact for resources, and how to access services.

Westchester County found that many of the victims had good EAPs, especially the firefighters and Cantor Fitzgerald (the firm that lost 658 employees). An agency there talked to Project Liberty, which contracted FEMA services at about 100 New York City locations; it learned about the emerging system of care. A focus group was formed to determine how best to provide services, and a mental health association agreed to become project coordinator in this large and diversified county. Only then was AOD collaboration discussed! There are 23 school districts with SAPs and masters-level counselors in over 50 buildings. Letters were sent to every school superintendent, offering free services to teachers, Parent Teacher Associations (PTAs), or children. A list of 25 agencies that would work for free was included. Since SAPs were already part of the crisis teams, these counselors were first responders and on the front lines. Points of entry outside the school were established, such as churches and synagogues, family shelters and welfare offices, and even the YMCA. The schools were also opened during weekends and evenings.

A lower Manhattan local government social services agency reached out and called all agencies with which it contracted, but could not reach Staten Island (telephone cables to the Bronx and to Staten Island went through the basement of the WTC!). Staff volunteered at crisis centers, and a CISD was held for the entire department. School systems needed services for parents and teachers, but especially for middle-school students, who asked: “Where did the buildings go?”

In the city, there are 1,100 Drug Abuse Resistance Education (DARE) officers, all of whom had to deal with children in trauma. Daycare centers, two high schools, and a college were in the area, and all had special needs. September was Recovery Month, so advocacy groups and others were already invited to an event, which proceeded, but not as planned. Instead, CISD workers were assigned to those in need, and a client committee reached out to AOD clients, encouraging them to come. At about 4 months, this agency felt its clients were moving into an “angry” phase of recovery from the traumatic events of 9/11. Anger was high about even the smallest of mishaps.

School counselors noted children were afraid to go back to school, as evidenced in their art and writing, and were afraid to leave their parents. Staff had more illnesses and time-off requests; Chinatown staff were having nightmares from multiple levels of stress. A focus group with principals helped to identify needs and direction. "CISD encourages staff to support each other; go to the principal and be supportive!" This program is developing a four-lesson-plan curriculum to work with children in the classroom; prevention workers taught skill-building anyway, which helped. Counselors provided crisis services to 2,000 students, 500 school personnel, and over 600 parents. "For those directly affected, the recovery is often interrupted by daily reminders. The police and military presence, the sound of a fire truck or ambulance, and the unexpected evacuation on trains all rekindle the feelings and experiences of September 11."

Staff in northern Manhattan observed that the Dominican families felt they must do something, so there were many candlelight vigils and walks. Thousands of people sang "God Bless America," and a faith coalition developed from these activities has applied for funding to perform an anniversary vigil, to hold a resource fair in the summer, and to have an interfaith dialogue to improve tolerance. "These positive reactions must be developed, and fast!" The center became a Project Liberty site for the area, and the community appeared to be recovering.

Then came the anthrax incidents, and the plane crash in the Rockaways section of Queens. American Airlines Flight 587 was known as THE "Flight to the Dominican Republic." It carried residents who tried to get home once a year to visit family. Many who escaped the WTC attacks died in the crash, effectively erasing any sense of security for these residents. The numbers "587" were retired by the airline; these same numbers were synonymous with "home." No greater blow could have come to the Dominicans, even considering the 16 firefighters from this area who died at the WTC. Offers of help to this community were not forthcoming; residents are still afraid since the "587 bridge fell." At the same time, there seems to be more unity in the community, more volunteerism. "There is a new 'normal' now."

A TC took care of staff by realizing that they suppress their own emotions, despite a "can do," "run to the problem" attitude. Staff were scheduled for several EAP visits, which most accepted but then thought they were "done." They turned off the televisions. "We realized the healing power of the community; those who are connected to others will survive, while those who are isolated are failing." PTSD trainings will happen soon, but staff also need training on emergent anger seen with clients and street people. Staff and clients say: "I just want to have fun again." With a center in the Dominican Republic area, staff transported family members of crash victims to the airport on November 12. One staffer worked 9/11, then lost two friends on Flight 587—he could not understand how he could feel better again.

Program staff felt fortunate to have its continuum of substance abuse services in place. It already had a hotline (now with expanded hours) and began to ask the question: "Is 9/11 the reason you're calling?" Staff received some training from Project Liberty as soon as possible; even support staff were trained. Staff used the EAP, being continually encouraged to do so. Staff is exhibiting behaviors ranging from "I'm OK" to crying all the time. A mental health unit is performing outreach to tell about services.

A provider representative noted that resources, training, and special populations are the most significant concerns. September 11 showed that providers have a remarkable ability to focus, to care for clients. They took time away from their families. The system must be strong enough to accept an influx of clients, and staffing is down. Clinically, grieving and coping issues abound now, and prevention services, schools, and community-based organizations (CBOs) see this. Providers need specialized services, and they need to bolster existing services. Prevention services were immediately in the middle of the disaster response, and treatment programs received special populations who needed care. We need to ask: "Which people in the field already have trauma experience?" We should use them. We also need regional training for staff,

especially in PTSD. How do we maintain this training over time? OASAS? Provider organizations? We must stay on the radar screen!" The feedback loop with the State and field must be sustained.

Methadone staff provided information to children at clinics, and with schools closed or due to fear, more children accompanied patients on visits. Emergency procedures are being reviewed and include a patient advisory board. The clinic has tracked clients with urinalyses (UAs); in the last months, maintenance dosages are down, while intakes are up. Domestic violence incidences are up. There are many job losses for patients, as about 20 percent are employed. Many of those who lost jobs started using again, saying, "I don't care no more." According to internally kept statistics, users are taking larger amounts of both heroin and crack. Secondary cocaine usage is up 35 percent. The "old timers" resort to crack. There is a focus on community services with meetings and requests for PTSD speakers. Patients decreased loitering for 2 months but are back. Local schools are "too stressed to cope" and are sending troubled youth home. Subsequently, pills are being sold on the streets, and Xanax sticks, the "crack" of the benzodiazepines, have re-emerged. Many are "using crack to treat their depression, but in the most destructive way possible."

A lower Manhattan methadone clinic reviews its disaster plan every 3 months now. After the Rockaways crash, bridges were closed again, and all relived 9/11. Everyone was quiet, and there were no horns honking. Later, when the helicopters no longer flew over, some missed the noise. Staff are receiving training about PTSD and read fewer newspapers and watch less television. Staff and patients every day have to see the absence of the towers—a constant reminder. The daily vignettes from patients are stunning; this neighborhood had eight firemen missing. The sense of vulnerability is high now. Gracie Mansion was blocked off until Mayor Michael R. Bloomberg took office. Now it is open again, "which gives us confidence."

At the national AOD agency just blocks from the WTC site, helpline calls are up 22 percent since 9/11, and affiliate service requests have also increased. The ground zero Alcoholics Anonymous (AA) Group holds meetings two blocks north of the WTC site (and another sprung up just south of the site in Respite Center 3). These groups are attended by firemen, police officers, and construction workers. There is no regular meeting schedule, there are no officers, and it is no one's home group. For the locals, the emotional impact is heavy but not overtly evident. The energy and vibrancy of the area seems to be absent, and people at 5 months appear to be more intolerant and angry than before. The towers are not there, and six train services are gone.

The labor EAP performs services for many unions in the New York City area; it has over 1.5 million members. A support center was opened and operates with an all-volunteer team of 750, including 20 percent who are nonunion, 225 mental health professionals, and Local 94 social workers. Screenings are performed here, and then referrals are made to mental health facilities. The Building Service Employees union lost 26 people, and the Hotel Employees and Restaurant Employees Local 100 lost 43 staff at Windows on the World. Social workers and psychologists were trained to deal with ambiguous loss, and local families were pulled into a luncheon with counselors at each table to encourage discussion about lost family members and to promote contact between families for mutual support. At Pier 94, a booth was maintained to provide services to those who came to this Project Liberty site. Over 170 union peer counselors are training to provide staff short-term counseling and referrals as well as CISD. At least 253 union members have received occupational-injury prevention training as it relates to stress and substance abuse. This EAP is organizing a summer camp for 300 children of the WTC victims in addition to its usual 400-member camp for inner-city children. Including firefighters, unions in New York City lost 850 members in the WTC attacks.

Project Liberty, the FEMA immediate-assistance program for disaster victims and survivors, was established at over 100 sites throughout the city to provide both general and special population services.

Half of the sites are located at agencies with existing mental health and substance abuse contracts; some are at settlement houses and CBOs, and at providers who work with the populations now. While there seems to be a saturation of social services here, there is education to be performed, such as teaching psychiatrists not to prescribe benzodiazepines to substance abuse clients. Providers are expected to have an AOD plan when those needs present themselves, but substance abuse services need to be written directly into the FEMA grants. The lack of substance abuse services is “a huge, major piece that is missing!”

Project Liberty staff met monthly with 70 providers, using small groups, throughout the five boroughs. Switching from FEMA to ongoing services will be difficult because the mental health system was already at capacity. Hiring part-timers for 90 days does not make sense. Tapping into closed shops, such as those of the uniformed services, is also difficult. Providers must address stigma and how to ask for help and “must change the way services are delivered—this is more than just triage.” A provider representative made the point that society should view addiction services as it views primary health care services.

In Westchester County, staff provided CISD for 3 weeks after the disaster. All were so anxious to work with youth, to help them through, that employees were sometimes neglected for similar services. Just before the winter holidays, staff noticed anxiety, “work stress,” and other maladies; this was combined with a hiring freeze and the closing of an early intervention program. Many childcare staff worked double shifts; a significant number of these were young and female. Providers must learn to ask staff about stress! With a nuclear site and a large water reservoir here, there is ongoing fear, and providers must take care of staff needs.

A mother/child program had a contracted psychiatrist to provide free services; within 1 week, a CISD was held for staff. Children attended training, and another CISD session was held 2 weeks later. The logistics of getting back and forth were horrible. They plan to do more CISD in the future. Staff encourage all not to focus on the bad. “We’re good at what we’ve never done before!”

Officers of the New York City Police Department have an 800 number to call that is completely confidential, yet referrals are low. A recent court case, in which the identity of an alcoholic officer was revealed, thereby breaking confidentiality, makes it very difficult to get officers to talk now. First responders are not talking, and getting PTSD information to them is difficult. An interior unit performs CISD often, but alcohol misuse is often underidentified.

An adolescent TC talked to its residents and day-treatment youth in small groups about anger and racism. Many, if not most, of the youth in this ethnic neighborhood were already traumatized. These youth are referred from the court system and juvenile services as well as the welfare system.

Staff at one lower Manhattan clinic were emotional; they sat down and talked, and all felt better. One patient’s daughter was killed, and she is raising her grandchildren now. The sister of one staff person worked at the WTC but got out, walking to the Bronx. Another staffer’s daughter lived in a college dormitory across the street from the WTC; she and friends ran for their lives and made the Staten Island Ferry before it shut down. One staffer who is in the National Guard left in October and no one at the program has heard from her. Patients are concerned for her, and an AmeriCorps intern is assisting in her absence. Although there was initially some relapse among clients, that has diminished. The experience was “so shared, we felt supported.” This event “removed our sense of safety; changing the way we live may be the only solution. If you get shot in the head, the whole body dies. New York was hit, but the whole country is hurt.”

Some staff volunteered services in the community; others participated in the Yankee Stadium memorial. At a TC residence, moments of silence were observed, as was planning for a 6-month remembrance. One

staffer relapsed; he was in Brooklyn with 20 clients and saw it all. He and the clients were in the court building, which then closed, and they were on the streets and vulnerable. There seem to be many relapses as people avoid pain. "We still look for the WTC." The disaster plan has been rewritten. (The administrative office was below 14th Street, in the frozen zone.); they will do head counts every hour, in the future, as the computers were unreliable. They will do a 6-month CISD with staff. They have had talent shows and gong shows, trying to bring back humor. The environment there is a safe one in which to talk; men's issues are emerging as large ones. Because a study grant is in progress, there is a specialist in trauma there now, and the extra help has been incredibly important to all.

Client Effects

Hospitals discharged medical detox patients to clear the way for the survivors who never arrived. Severely and persistently mentally ill (SPMI) patients had major decompensation and relapse within 3 weeks. AOD relapse was prevalent too. There was an almost desperate attempt for some clients to get admitted to treatment, where they felt safe and could stay sober; they would then go out and relapse because "it might be my last." The homeless lost sleeping places, so they would come to detox.

At the 4-month mark, counselors were starting to see a loss of housing, with clients falling through the cracks for jobs. Drop-in centers were all full. Staff saw more hunger with those who have no other resources and are living on the brink of relapse and homelessness. There was new anger, in part because the services have been taken away, and in part as a defense against helplessness. Some tried to intimidate staff. Male street hustlers were coming in saying they were too angry to be on the streets.

On the hotline, there were many relapse calls at 4 months. At a settlement house, clients feel safer. Clients were very happy to see their street outreach workers, across all sites. Clients are coming into food pantries by the hundreds. Alcohol use is up, and unemployment checks will soon run out. There are still drugs and AIDS. One client said it was a doomsday scenario for persons on welfare and receiving unemployment. Losing a job was the end of the world, and many jobs are gone from lower Manhattan. Intravenous drug users (IVDUs) also say, "It's the end of the world so I'm using." Clients (and staff!) have anxiety about riding the subway and will only ride a bus now. One staffer put it plainly: "Our clients are now even lower on the list!" Hispanics who worked near the WTC lost their jobs, and their alcohol consumption rates are soaring, as are those of the homeless. There are new faces, new drugs on the street. There are long lines at the soup kitchens. "The forgotten people are even more forgotten."

Youth in day treatment are tough clients; 95 percent are from the city and come from foster care. These youth report putting themselves in risky situations, such as driving too fast and without seat restraints. MDMA, also called Ecstasy, use is way up. College campus staff are feeling uncertainty and depression. One client's neighbor survived 9/11 then sent his wife and two children on Flight 587 with a friend's family. Other survivors cannot talk about it; if they are first-generation immigrants, they think talking will hurt their chances to stay here. Many over-the-counter medicines are being abused, according to clients. "Some use dime tabs to ride the subway then downers to go to sleep, to calm the intrusive thoughts." Counselors are working with the Latino community to encourage members, especially those without proper documentation, to speak up. Women in treatment are angry and afraid, all at once. They say, "My life plans are messed up."

Some youth wanted to move to the country, or away from Manhattan, while others refused to consider leaving the city. Specific fears include racism, trains, tunnels, and bridges. Several know what they want to do as adults, be it carpentry, engineering, military service, or law enforcement; ALL want to be helpers in their careers. Many Russian youth are from this neighborhood, and one resident's dad fought in Afghanistan. "We came here to escape this!" Students seemed angry, some held bitterness toward those of Middle Eastern descent, but most seemed willing to work out their feelings by talking, not fighting.

Youth said: “We’re still afraid, and often, especially with television, but we must go on with our lives” and “We love our city—we won’t be run out!”

Gwen is a client who first stated: “This is my town! It is the prettiest, ugliest city in the world.” She was born in Spanish Harlem and raised in Queens. She learned to travel by herself at an early age. On 9/11, she was living in the Bronx, had the television on, and saw the flames coming from the WTC. She thought it was an accident and hoped people were all right. She then saw the second plane crash, looked at her roommate, and they both knew it was no accident. They watched people jumping out of windows—what were they to do? They couldn’t get into Manhattan and became very frightened; there was so much fear. They left the house, and at the train station, people were crying. A man came out of a store and said the towers fell. Over the next 4 or 5 days, nothing else was on television.

Gwen could not sleep. She was angry and took it personally that “they attacked my city! What did we do to deserve this?” Gwen got angrier when it became apparent that there were no survivors. By Wednesday, she got to Manhattan and was able to get through the barriers. She was medicated. It was a ghost town—sad, quiet, and spooky. People were walking around in a daze. “You could FEEL the sadness,” she said. Many had pictures and asked: “Have you seen him? Her?” At 14th Street and Union Square, memorials were already up. In the past, she had stood at 5th Avenue and 14th Street and looked to see the towers. It is unbelievable that they are gone.

She was angry, trying to place blame. Was it due to the Mideast? Did we give too much attention to Jewish problems? “I’m African American, so I’m used to being hated.” Our country has an open door for immigrants, and we try to help others—so why pick on us? Gwen recognized that her anger was misplaced; she knew she could have any excuse to use. Her group helped her to cope with this anger. Then she thought it must be some Hitler kind of people, not Arabs. Her family was taught not to hate; she knew she must now have heightened awareness. Perhaps we need to tighten immigration but not stop it? They couldn’t have flown an Afghan plane in here!

Gwen said we also need jobs for our citizens; we need to take care of home, first. We are the richest country in the world! So many people have “not had the opportunities I’ve had,” she said. Many African American kids have no direction, or aspiration, or goals. We must address this. We must also heighten awareness—we can never be lax again. This has taught her to “reach for my fellow man,” and she has learned to be more tolerant. A man stepped on her toe recently and said, “I’m sorry.” It’s like that.

Karen is another patient who lost her son-in-law and his brother from Jersey City in the WTC attacks. These men took the Port Authority Trans-Hudson (PATH) train to the city every day; the son-in-law was a lawyer. He called his wife after exiting the train and was on his way to a diner for coffee. The crashes began then. He called his wife’s pager at 10:30 a.m., and that was the last she heard from him. Karen’s daughter is in denial and still refuses to file for a death certificate. She has an ongoing dream that he is trapped in a staircase. She “spaces out a lot, and I worry about her.” The daughter pulled Karen’s grandson out of day care; he looks up to the sky and says, “Daddy is looking for me.” Her daughter is afraid of trains now. Karen’s son is a police officer in another State. So far, he has tolerated his sister’s behavior. Karen notes that her daughter is alive and must “deal with it.”

Karen went to the site for days, with pictures, and she coughed up debris for days. She did find one PATH train intact. She saw it happen live on TV. “I wanted to go to my family!” She lives in Queens, in a building inhabited mainly by Palestinians; it is hard. The Palestinians say Americans are hated in their homeland. To help, she has signed up as a nurse’s aid. She is not using.

At one program, about 69 percent of clients are African American, while 29 percent are Hispanic. About 50 percent of the program’s clients are mentally ill chemical abusers (MICAs). They discuss past trauma

and seem to be talking more openly. “This group is traumatized and angry anyway; we cannot see if it is worse, as we see it everyday. We need someone from the outside to look for us!”

III. IN FOCUS: A PROVIDER VIEW

A series of CSAT-funded focus groups were convened during February and March 2002 to try to assess the impact of the WTC disaster and its aftermath on delivery of prevention and treatment services for AOD problems in New York State. Focus group participants were selected by OASAS senior staff to represent a cross section of chemical dependence programs in various upstate and suburban New York City counties and in the city's five boroughs. The questions that participants in the 11 focus groups were asked to discuss first addressed the immediate impact of September 11 on their programs, and then they addressed the effects that continue to linger today. Finally, an attempt was made to assess what had happened and, as the moderator's introduction read, "What might have been done differently, what might have been done exactly the same and what have you learned about the functioning of your program—both the strengths and the weaknesses?"

This chapter will synthesize focus group findings. Many common themes were repeated by focus group participants and tended to validate each other as fairly widespread experiences. The discussion that follows will present these themes—clustered as clinical issues, programmatic issues, and policy issues—and then examine the themes in terms of the programs' geographic locations. Appendix A includes a detailed description of the methods used in conducting the focus groups, followed by a summary of each focus group discussion.

Clinical Issues

The clinical issues raised by focus group participants touched on adult clients, adolescents and children, the larger community, and, especially, on staff members who provided counseling and other mental health services. Adult clients presenting for treatment during the week of September 11th showed extreme reactions to what had happened. One extreme was almost no reaction, with clients so self-absorbed that they showed little acknowledgement of the disaster that occurred. Focus group participants, many of whom are clinicians, attributed this reaction to a few possible factors. Perhaps these clients were at an early stage, in their recovery; those at a later stage, were more connected to the world around them. Other discussants saw the muted reaction as a shutting down of emotions, a protective mechanism that many clients have developed. In contrast, some clients came to treatment showing anxiety and extreme irritability, verging on violence. Those who had experienced early trauma or possibly PTSD, such as Vietnam veterans, were having a particularly difficult time. Many of these individuals were now experiencing flashbacks from that earlier time in their lives.

The special case of methadone patients who could not get to their clinics because of the disaster was mentioned frequently by participants who represented methadone programs. These patients were very fearful that they would not get medicated and would be experiencing withdrawal. Sometimes, they needed counseling services when they appeared at the new clinic as "guest" patients.

Adolescents and younger children had major safety concerns during those immediate days after September 11. Continuous television viewing may have been hardest on the younger children who saw the repeated image of the planes hitting the buildings. The frequently mentioned reaction is that young children believed that planes were hitting many buildings over and over again.

Although young people seemed to be generally resilient, some adolescents also began showing extreme reactions. Some became extremely angry and racist in their attitudes. Other adolescents displayed more risky behaviors with much pessimism about their futures. Still other adolescents were showing depression, anxiety, and suicidal ideation. Some discussants mentioned an increasing number of suicides

and accidental deaths among young people in several local communities. Whether these tragic incidents were directly related to 9/11 was not clear, but problems among young people seem to have worsened over the past 6 months.

Many prevention and treatment programs were in touch with local residents in their communities and were well aware of the fears and concerns in their larger communities. General fear seemed to grip many residents, and people spoke openly about “what else was going to happen.” The anthrax attacks and the American Airlines plane crash in Queens all exacerbated the fear. Residents living near a military base and near West Point Military Academy saw those sites as potential targets. Students said they feared that the water supply would be contaminated. Workers in “Jewish” hospitals were fearful that these sites were going to be attacked. Residents in the Hudson Valley were becoming more and more anxious about the Indian Point nuclear energy plant. People seemed to stay at home more, where they felt safe and secure. Focus group participants predicted that, for many, this malaise would eventually manifest itself as alcohol and drug abuse problems.

A special subgroup in the community to which substance abuse counselors and mental health professionals were reaching out, especially in New York City and suburban New York City counties, included firefighters, police officers, and other ground zero recovery workers and their families. Given the extraordinary losses of coworkers and the horrendous recovery operation, these groups and families were undergoing tremendous stress. Focus group discussants repeatedly talked about the drinking that was occurring among these workers, the relapsing among those in recovery, and the incidents of domestic violence that were emerging. There was a strong likelihood that this special population would need treatment.

While coping with extreme reactions of clients in treatment and young people in prevention programs and working within the larger community, many program staff members who have been on the front lines providing counseling services have suffered as much as clients, or even more. Every focus group discussion underscored problems among staff that continue to linger 6 months after the disaster. Many staff members had performed valiantly, going well beyond their normal responsibilities—walking to work in locations where roads were closed and public transportation was halted, sleeping at their programs, and volunteering to help in their communities and at ground zero. For many staff members, their own weaknesses, vulnerabilities, and personal problems became overwhelming. They needed time to process what had occurred, they needed their own critical incident debriefing, and they needed a place to be themselves. As one focus group discussant described, “Often we have things in common with our clients, but usually there’s a little bit of time and emotional space. In this instance, we were simultaneously dealing with our own stuff. Many of our staff needed a place where they could go and talk about how they were feeling and not feel that they were disrupting the work process.”

In spite of the many clinical problems that occurred during the immediate months after the disaster—compounded now by clients who have lost their jobs, have developed marital difficulties, and are on the verge of losing health benefits—ways were found to ameliorate the problems. Some clinicians were able to seize upon the disaster and even use it to motivate their clients to work harder to get their lives in order. Clients in treatment programs and young people in prevention programs provided much-needed services for people fleeing from the World Trade Center on September 11 and for recovery workers at ground zero on days afterward. Staff saw strengths that they never thought that their clients had. As one administrator in the focus group shared, “I was never more proud of my agency than I was on that day.”

Other helpful moments were spent in prayer meetings, in spiritual counseling, and in memorials that programs held and in which both staff members and clients participated. Some programs were extremely sensitive to the needs of staff and appear to have gone a long way to helping staff through these difficult days, which in turn strengthened clinical services that programs were delivering. One discussant talked

about the way in which her program showed its appreciation: “We personally, the president and I and others, thanked staff for the work they did. Subways weren’t working, buses weren’t working, and they were walking over bridges from Queens to the Bronx to get to work. We got the names of those who had continuously done that for a couple of weeks, and the president gave them \$500 savings bonds. Others who also did a great job, but not as much, got \$250 savings bonds. We spent about \$10,000 as a way of thanking them, and also buying savings bonds, which was pretty appropriate.” Interestingly, this program went even further to provide its staff with workshops in meditation and yoga. The discussant described what her program continues to do today: “We’re now having yoga at the sites for the staff. Staff put out 150 percent, and 2 weeks later, they were exhausted, and it was starting to get to them. So we’re going to continue to do that. They did a great job!”

Not surprising, use of tranquilizers and antianxiety medication has become more prevalent. Clients have been receiving more prescriptions for these medications. Those without prescriptions are showing positive toxicology for benzodiazepines and talk openly about the “street benzos” they are taking. Also, some methadone patients are asking for a higher dosage of medication for the added stress that they are feeling.

Programmatic Issues

Most prevention and treatment programs, if they were physically able to, remained open and continued to operate during this period. Several programs near ground zero, however, had to evacuate and could not return to their locations until weeks or months later. For programs that were open, staff provided much outreach by phone to clients who did not return or keep their appointments. Some program staff attempted to visit clients at their homes. If Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings were scheduled, efforts were made to maintain those schedules. For programs that were forced to close, staff provided phone outreach to inform clients concerning the status of their programs and alternate programs and resources they could access.

School prevention programs were integrally involved in school crisis teams and disaster plans. Prevention staff worked along side guidance counselors and other school personnel to ensure that the needs of children and adolescents were appropriately addressed. In some instances, prevention staff, with their background and skills, were handling group discussions and crisis situations far better than faculty and other school personnel.

Since about December, many programs, especially in New York City, have been reporting an increase in the programs' client populations. Some clients are readmissions, some are transferring from other programs, and some are first admissions, frequently presenting with additional problems, including loss of jobs, marital problems, criminal justice charges, and health problems.

Since September 11, staff leaving the field have put a strain on many programs. Reasons for leaving include for some staff members rethinking of personal priorities after the disaster, a desire to start other careers, and, for some others, a need to leave the stress and demands associated with their jobs. Remaining staff appear to be taking more medical leave and continue to have personal problems relating to the trauma; some staff members in recovery have relapsed or are on the verge of relapsing. Focus group discussants say that their programs are finding it difficult to hire qualified staff to fill vacant positions. Thus, many staff members have an increased caseload, with clients having more complex problems and with much more paperwork to add to their frustration.

The experience of 9/11 has also shown the need for more staff training. According to focus group participants, mental health professionals need to be better trained in responding to crisis, conducting critical incident stress debriefing, and dealing with trauma. Substance abuse counselors need to have

more training in assessing mental health status and in identifying psychiatric symptoms. For many discussants, the conclusion was: “We were ill-prepared and caught off guard.” Also, ethnic tensions and political differences among staff, between staff and clients, among clients, and in the community have created additional problems affecting programs. Confronting these problems and resolving them may also require additional training.

Counselors working with young people have a particular need for this training, especially to identify emotional problems as early as possible. Families also need assistance in identifying problems and working with their children.

Problems associated with revenue loss have been a major concern for many of the treatment and prevention programs represented in the focus groups. Although these problems exist statewide, the concerns seemed to be greater for programs located in New York City than for programs in other parts of the State. First, discussants expect about the same level of State funding in this fiscal year as in the previous year. With inflation, this expected level of funding already represents a cut in revenue. Second, New York City has cut funding for vocational rehabilitation. At this time of welfare-to-work, when clients are being held to a higher standard and must find employment, cutting vocational rehabilitation funding puts an additional burden on treatment programs. Third, emergency Medicaid benefits associated with 9/11 are likely to come to a halt in the near future. What will happen to patients who are using these benefits to enter methadone programs is a very troubling question.

Programs outside New York City are also fearful of the loss of funding. Some are concerned that charitable donations are now going to World Trade Center disaster funds rather than to funding agencies that support them. This has become a distraction, with some administrators and directors now spending more time in fundraising than they did in the past.

In spite of these difficult issues, discussants were proud of the way in which their programs and their staff members responded to the needs of clients and to residents in the communities in which they were located. Although administrators and staff had their own personal concerns, they showed leadership, they saw needs, and they responded, “sometimes outside the OASAS box.” Many communities may even see the alcohol and substance abuse programs in their midst in a different light. As one participant said, “We all did ourselves proud! We are a caring, helping group of people. We adapted; we were there.”

Policy Issues

A major policy issue for focus group participants concerned the need to have a disaster plan in place. Most programs based in hospitals or in schools did have such a plan, which generally worked well when activated and gave a measure of preparedness on 9/11 and the days afterward. Individual programs have had some past experience with weather disasters, such as the New York City blizzard of 1996 and the upstate ice storms of 1998 that helped mobilize resources on 9/11. Even preparedness for Y2K problems gave programs some valuable planning experience. In the past 6 months, several programs represented in the focus groups have made some progress in drafting detailed disaster plans; other programs have already implemented more security measures. Focus group participants, however, suggested that OASAS lead an effort to develop a policy addressing the need for disaster plans and reflecting the thinking and planning in the field since 9/11. They urged that a meeting or task force be convened to consider the issue.

Given the experience with “guest” methadone patients, several discussants requested that OASAS draft a clear protocol on procedures for treating these special patients based on the recent experience. The chaos for some methadone patients on 9/11 and the days that followed underscored this profoundly felt need for a widely disseminated, well-articulated policy statement.

Project Liberty, a federally funded effort to provide counseling and training encompassing the trauma issues of 9/11, was generally appreciated by New York City and the suburban New York City counties in which the funding existed. In addition to providing much-needed mental health services, the project also proved to be an opportunity to network with other programs and other agencies in new and valuable ways. Unfortunately, the expectation is that Project Liberty funding will cease and will leave a void in services and training that are still needed and likely to be needed in the future. The discussants were hopeful that the benefits in local programs and agencies working together will continue and will be encouraged by local and State government.

Many focus group discussants mentioned the compassion that OASAS and its field offices had shown, especially during the week of 9/11 and subsequent weeks. The programs represented in the focus groups appreciated calls with offers of help, assistance in contacting other programs and agencies, and providing much-needed information. A discussant described her own personal experience as she sat in her office near ground zero and received a phone call from an OASAS staff member. "It was dark and I was alone in my office, but it felt good to talk to the OASAS caller. It helped me feel a little grounded...it brought me back into focus that we're connected to them. I appreciated that, and I think that's helped our relationship since then."

Another problem that was mentioned in several focus groups and has policy implications is the specific relationship between the substance abuse field and the mental health field, which, in turn, raises a training issue and a bureaucratic "turf" issue. First, with the high incidence of trauma among alcohol and other drug abusers irrespective of 9/11, there has always been a need for substance abuse counselors to have training to deal with these serious problems or at least have sharper abilities to identify these problems and refer clients for appropriate treatment. Second, in programs with substance abuse funding, it has been frowned upon for counselors to identify mental health problems. One focus group participant made the plea, "We need to stop playing let's pretend and give counselors the kind of training that they need. I'm not saying they're going to be doing mental health work, but they need to be able to bring it to supervision and be able to notice it because they're the ones seeing the client."

Finally, focus group participants frequently underscored the uncertainty that we are all living with today. We do not have all the answers, and there is no definitive handbook to tell us for sure what to expect. As one discussant summed up the sentiment, "The bottom line is this is the first time we've lived through this in this country. I don't care what anybody claims, there's no expert on this...OASAS has to keep asking programs how they're doing. We have to keep asking our staff how they're doing. It may be another year; we have to keep asking, because it's an uncertain time that we're going through." Thus, many focus group participants see the need for compassion at this time. It is a time for State and local governments to relax requirements, to limit the paperwork, to make more realistic time schedules, and, in general, to make fewer demands on treatment programs. Everyone has gone through a lot, and it is not over yet.

Geographic Findings

As one discussant observed, "Location, location, location!" had much to do with what happened at treatment and prevention programs represented by focus group participants. Clearly, the closer programs were located to ground zero in New York City, the greater the direct impact. The closest program sites were evacuated and could not be occupied again for months. Although many clients have returned to these programs, some clients have transferred to other programs, and still others have not been heard from since. Some teenagers and younger children participating in prevention programs and living in New York City boroughs and nearby suburban counties continue to have serious problems associated with personal loss and the losses of others in their communities.

Program staff members were universally affected by the disaster, but they were more affected in New York City and the suburban New York City counties. The compounding effects of personal problems, client anxieties and loss, program responsibilities, assisting in their communities and at ground zero put enormous strain on many workers in the field. The effects continue today and have caused some staff to reconsider their priorities and, ultimately, resign from their jobs.

Irrespective of geographic location, focus group participants raised concerns about staff that had been felt before 9/11, and have been exacerbated since the disaster. Staff now have increased caseloads, need to spend more hours working with clients, have more paperwork, and are in need of training to upgrade skills. When staff members opt to leave their jobs, hiring qualified substance abuse professionals to fill vacant positions has become increasingly more difficult. A frequent comment in the focus groups was, "We are being asked to do more with less." Also, there is major concern that should cases of PTSD become more prevalent, as in Oklahoma City some 6 months or more after the tragedy, that many programs will be ill prepared to treat clients with these problems.

Another universal issue, independent of geography, is the generalized fear that something else is going to happen, expressed by many discussants as "waiting for the other shoe to drop." As described above, fears have focused on local sites, such as reservoirs or nuclear power plants, which now are seen as possible targets for terrorists. Consequently, there was much discussion about disaster plans and the need to be prepared. Programs, wherever they are located, have had some previous experience with weather-related disasters and Y2K planning. Thus, the need for such plans is not something new and has only been underscored by the terrible events of 9/11.

IV. STATE AGENCY RESPONSE

System Overview

OASAS is the Single State Agency responsible for AOD services in New York. The agency develops and manages the State's AOD policy. The agency surveys and analyzes the extent of the State's alcoholism and substance abuse problem and identifies the need for services. OASAS also furthers additional State policy goals—including reform efforts in criminal justice, health care, and public assistance—by coordinating AOD resources and strategies in collaboration with other New York State agencies. Unlike most State agencies responsible for AOD services across the country, OASAS has cabinet-level status and reports directly to the Governor.

OASAS administers the country's largest and most comprehensive AOD service system. This includes over 1,350 community-based treatment programs and more than 1,700 prevention programs. New York State's community-based treatment continuum includes crisis, outpatient, methadone maintenance, inpatient, and residential services. Each day, about 115,000 New Yorkers receive treatment for alcohol and/or other drug addiction from OASAS-licensed programs. The agency also operates 13 Addiction Treatment Centers (ATCs). The ATCs comprise the largest inpatient treatment system in the country, providing services to 10,000 individuals annually. In addition to treatment services, thousands of people benefit daily from prevention initiatives carried out by OASAS-sponsored or licensed prevention programs located in schools, communities, and hospitals throughout New York State.

OASAS serves as a conduit for Federal and State funding. In New York State, OASAS administers the Substance Abuse Prevention and Treatment (SAPT) Block Grant, which is the primary source of Federal funding for treatment and prevention services. In accordance with Federal and State statutes, the agency licenses and regulates providers, ensures that fiscal resources are appropriately spent, and assists local programs in providing the highest quality services. OASAS employs a variety of mechanisms to ensure that programs provide quality services. These mechanisms include regulatory standards, local services planning, the project review process, program certification, annual program performance reviews, fiscal audits, site visits, program evaluation, services research, counselor credentialing, and peer review.

OASAS plans for alcoholism and substance abuse services in New York State in partnership with local governmental units (LGUs). There are 58 LGUs in the State consisting of New York City and the 57 counties outside the city. This process is based on the rationale that the LGUs are in the best position to assess and address local needs, while OASAS maintains a statewide focus.

To meet the statutory requirements for a local services planning process, OASAS annually produces guidelines to assist counties and New York City in developing an alcoholism and substance abuse services plan that is responsive to local needs and conditions. The guidelines provide counties and local programs with information on policies, program development priorities, and new program approaches endorsed by OASAS. Much of this information is based on presentations in long-range, statewide plan documents that provide additional details on program development initiatives. The general program development approach promoted in the guidelines is establishment of a locally based continuum of quality services designed to respond to all individuals in need of addiction services.

In accordance with the New York State Mental Hygiene Law and OASAS regulations, the agency conducts onsite program regulatory-compliance reviews prior to expiration of provider time-limited licenses. The maximum license term is 3 years. OASAS also supports efforts to improve service provider performance in those instances where providers are determined to be in minimal compliance or

concompliance. In such instances, the provider will be issued a renewal license for a period less than a 3-year term.

OASAS conducts periodic site visits to monitor service provider contractual compliance. Areas of oversight include budgeting and expenditures, provider services/accomplishments, and management policies and procedures. The agency provides technical assistance to improve service provider performance in such areas as provider case records, provider management, facility appearance, and general safety.

OASAS develops strategies to stimulate recruitment and retention of qualified professionals in the addiction field. The agency administers the largest publicly operated addictions counselor certification program in the country and currently oversees credentialing of nearly 7,000 alcoholism and substance abuse counselors. OASAS also administers a comprehensive statewide education program for alcoholism and substance abuse professionals. The agency uses its credentialing function to strengthen clinical practice throughout the field. OASAS has developed curricula to support the core competencies, knowledge, and practice base underpinning the credentials for prevention and treatment professionals. It also works with an international accrediting body, along with practitioners and their associations within New York State, to continually support and promote a high-quality counselor workforce.

OASAS conducts evaluation and research studies on issues of importance to the chemical dependence field. The studies include trends in alcohol and substance abuse; household, college, and school surveys; treatment outcome studies and best practices; the impact of Medicaid managed care and welfare reform on treatment; needs assessment; gender issues in estimating treatment need; adolescent treatment models; and the impact of the length of stay in treatment on outcomes.

OASAS Response

OASAS administrative staff are located in Albany, (the capital city), and in New York City, where many services are delivered. Additionally, there are 13 State-operated ATCs throughout the State as well as regional offices. On September 11, each office reacted according to its ability to respond.

In Albany, a high-level meeting was held that day, and the first questionnaire was devised that afternoon. Queens General Hospital called to say its detoxification unit had to clear beds for WTC-injured patients, and Albany, as well as visiting New York City staff, called other providers to find beds. OASAS staff created a command structure, a scope of authority.

Getting information from the city was very difficult; OASAS staff there was really “beat up.” OASAS management staff in Albany compiled lists of programs and felt as if they were “spinning wheels a lot.” Within an hour, however, communication was sent to all available programs, and instructions for medications were sent within 6 hours. A Y2K plan with helpful communications strategies was used. Checks could not be sent to some programs because the addresses no longer existed.

The Governor closed State government offices, so most New York City staff walked home across the bridges. Some stayed to take calls from programs, especially those below Chinatown where the major damage occurred, to help with client medication. The mood in the city was bewilderment. There was no noise. Airports would not release cars until that Friday, when they reopened. For days, staff walked to work across the bridges under incredibly difficult circumstances.

By early afternoon on September 11, the OASAS-operated ATCs that serve the city and its immediate suburbs were working closely with allied health care providers. Anticipating mass casualties, city hospitals were looking for bed space in sub-acute facilities where patients in stable condition might be

transferred. To free up bed space, the ATCs transferred some patients to local AOD crisis centers and arranged early discharge for patients who had nearly completed their treatment plans. In addition, the facilities were preparing to turn dining areas and other large common areas into makeshift dormitories with mattresses on the floor, if necessary. In one instance, a hospital in Queens expressed a need for six beds, and received them within 4 hours.

Getting food and medicine into the city for the Manhattan ATC or methadone clinics was impossible; even the sea and the air routes were closed. The ATC had no e-mail or communications capability for over 3 weeks. There seemed to be a “lack of understanding of the significance of AOD services and needs in relation to everything!” Clients concerns were paramount. Staff wondered how many people were in AA meetings throughout the city. How many clients were out there and witnessed these events?

The city systems were accustomed to labor strikes, blizzards, and other weather problems, so they used these plans as best they could. Very few complaints came to the OASAS 800-number complaint line, especially considering the enormity of the situation. Not one of the methadone providers requested reimbursement for “guest” dosages provided to displaced clients.

On September 12, OASAS staff called prevention, and then, treatment programs, as soon as lines were available, to check on staff welfare and needs. There were no discussions beyond concern for personnel and continuing client services. Prevention counselors in the schools were first responders, necessitating that they have the answers and skills useful in a disaster situation. For 2 or more weeks, prevention specialists in the schools provided counseling and CISD services, not only to children and parents but to staff as well.

Residential providers were immediately asked about availability of space so that hospital beds could be opened for the critically injured. Over 100 beds were opened but were not needed. State program managers surveyed all 194 city providers on September 13–14 to ask about needs, infrastructure, and problems, such as revenue losses, additional client-service needs, and overtime costs. On September 13, the hotline provider was advised to expand hours and train staff. On September 17, staff from the program that was located on the 16th floor of Tower 2 attended an OASAS meeting to create a temporary operational plan and to determine long-term budgeting needs. A list of EAP providers was shared with the group.

On September 20, a followup survey was administered to several prevention providers in schools, as was a followup to the 24 ground zero providers who were directly, physically damaged by the attacks. If these providers still could not receive mail, other plans were made to ensure timely receipt of contract advances. Mail for some demolished programs was rerouted to OASAS offices in the city, and electronic transfers were authorized. On September 26, surrounding counties received the survey to be completed and included in the State database.

The recovery community pulled together, as AA meetings filled to capacity—those in recovery were able to talk in a safe place, which was invaluable. Churches were full, too. Addicts in detoxification were concerned about anthrax, about how it might contaminate their supplies. Security in the city was focused on bombs, not drugs, but other crime did not increase.

Displaced staff from a city agency were housed with OASAS immediately following the attacks until Worth Street office space was deemed safe. A plan for addiction services screening, assessment, and referral was completed for inclusion in FEMA’s Crisis Counseling Assistance Program. As a result, certain providers were able to receive crisis-counseling training. Prevention providers were trained in grief and loss counseling with CSAP resources, and substitute teachers were provided for those who were overwhelmed. “CSAP got funding to the State very quickly and deserves kudos.”

The OASAS commissioner “forgot rank” and pulled people together in an ad hoc management structure. The staff put together grant applications, and programs worked diligently to provide figures and statistics, despite the hardships. Twenty-three prevention providers and 11 CISD/EAP providers received emergency appropriations from CSAT and CSAP. EAP services were intended for provider staff members; a CISD was also held for city OASAS staff. The provider-operated hotline was funded to expand its set of questions and its hours to 14 per day. Hope and Recovery printed materials were created using prototypes from Project Heartland in Oklahoma City.

On September 18, OASAS published its first online helping literature, "Traumatic Stress Reactions." Its first print publication, "Posttraumatic Stress Disorder and Alcoholism and Substance Abuse: An Overview." came later in the month. This document was distributed widely to service providers. To plan and implement the Hope and Recovery multimedia campaign, a task force was formed comprising representatives from business, schools, providers, minority associations, and the media. The task force held its first meeting on October 23 in Saratoga Springs and provided many ideas, proving to be one of the most valuable additions to the effort.

During October 4–5, OASAS staff administered a provider survey by mail and online, and regional staff followed up with a call or fax to ensure a high response rate. City prevention providers who demonstrated disaster-related needs were considered for emergency funding, and EAP and training services were included in centralized offerings from the State. The WTC Disaster Survey online at the OASAS Web site requested that providers complete or update the survey and submit it so the State would have updated and ongoing information to track service needs and provide funders with necessary information in a timely fashion.

In addition to identifying information, the survey asked seven questions, plus one followup question, as in the following figure:

<p style="text-align: center;">Increased Services as a Result of WTC Crisis:</p> <ul style="list-style-type: none">• New services provided as a result of the crisis; be as specific and detailed as possible.• More service provided as a result of the crisis; be as quantitative as possible: (i.e., six additional groups a week, two additional community meetings each week in each area, etc., 20 new clients, program participants each week).• Additional populations served: (i.e., more of the same target group? New populations: i.e., families, younger kids, community members, etc).• Additional hours of service? Explain and quantify (i.e., open 2 additional hours, 3 days per week).• Additional volume of service? Explain and quantify: (i.e., two staff members seeing four new clients, seeing each client more times per week, etc).• Estimated staff and administrative overtime to date?• Training needs (be specific)? <p>A final question asked:</p> <ul style="list-style-type: none">• In each of the above areas, tell us what you expect to see over the next 9 to 12 months. <p>(Go over each question). New? More? Additional populations? Hours? Volume? Staff and administrative overtime? Training needs?</p>

Additionally, a statewide needs assessment was funded. It includes school surveys, transient surveys, spot household surveys with a full survey planned in the fall of 2002, and client focus groups. Five Treatment Triage Centers and two Communities That Care, Inc., Prevention Resource Centers were also funded. Treatment and prevention counselor skill-building training was funded, as were print/media awareness materials. Statewide, CBO training determined from community needs assessments was let for contract; standardized pre- and post-tests will be used to assess skills learned.

OASAS offered no-cost EAP services to all provider staff in the city. These services included assessment/referral, CISD, trauma response, and grief/loss work. In a letter from Commissioner Miller, providers were told, "OASAS is committed to preserving the health and well-being of all of your staff during this challenging time." The commissioner sent thank-you notes often to providers.

OASAS requested and received Federal funding support to deliver WTC crisis-related training to AOD treatment and prevention provider staff and community and school-based counselors in the city and surrounding counties. A nonprofit training organization that specializes in developing and delivering training to workers in the human services field was selected to provide training as outlined below:

Crisis Management and Skill Building for Managers (3.5 hours)

- a. Processing with managers and supervisors how their agencies and staff are coping in the aftermath of September 11 events.
- b. Discussing issues of leadership and supervision as they relate to coping with the current crisis and with the ongoing threat of further attacks.
- c. Providing managerial and supervisory staff with strategies to help their staff cope and adjust.

Crisis Management and Skill Building for General Staff (3.5 hours)

- a. Debriefing: processing staff members' feelings about the events, their ongoing fears, coping with stress-related symptoms, etc.
- b. How to help clients/participants cope with the current crisis and with the ongoing threat of further attacks, with specific focus on maintaining healthy lifestyles and preventing relapse.

Posttraumatic Stress Disorder; Critical Incident Debriefing and Stress Management and Physical Health (7 hours), for general staff of treatment/prevention programs.

On November 26, Associate Commissioner Steve Richman sent a letter to advise providers about recordkeeping guidance to qualify for cleanup costs related to the disaster. Providers were to ask: "Would the costs have been incurred in the normal course of ongoing business AND in the absence of the WTC disaster and its aftermath?" If "no," then the cost was disaster-related. Other resources were provided, such as Pier 94 and other Project Liberty site information, Web sites, and insurance information. Many staff devoted numerous hours to create the appropriate forms, incorporate the proper rules and applicable laws, and disseminate the paperwork to affected providers.

In December, OASAS administered a random-sample telephone survey that began: "Hello, I'm <name> from the New York State Office of Alcoholism and Substance Abuse Services. We are doing a study on health-related issues, including attitudes about alcohol and drugs and the effects of the World Trade Center events on September 11. The results will benefit all New Yorkers. The phone interview will take about 10 minutes; it is voluntary, and your help is really appreciated. May I proceed? Your telephone number was chosen randomly. All information you give us will be kept strictly anonymous. We do not have your name or address, and your responses will not be linked to your phone number."

Interviewers entered responses directly into computers during the interviews, eliminating the need to transfer information later and reducing interviewer error while allowing instant tabulation. OASAS is also gathering National Institute on Drug Abuse (NIDA), Arrestee Drug Abuse Monitoring (ADAM), and Drug Abuse Warning Network (DAWN) data as well as arrest data from the criminal justice system to track behavioral and AOD use changes in the target population. The street ethnographers in the city (the only unit of its kind in the country) have increased undercover gathering of information to inform this process, as well.

In January, Commissioner Miller formed a coordinating committee of staff that will work to ensure that information is collected, all efforts in the State are in concert and not duplicating work, and to prepare this and other reports. The contracted provider was ready to roll out the components for management and staff trainings around the State: New Jersey providers were also invited to attend, because of their losses and needs.

In the 3-month period following the attacks, SAMHSA requested that OASAS identify disaster response costs incurred that were not eligible for other Federal agency support, and to project needs for the period immediately following the disaster. OASAS estimated that more than \$222 million were needed for

provider disaster-related revenue losses, increased costs from overtime and additional staff, critical-incident debriefing and EAPs, prevention and treatment professionals' training, expanded hours of operation and Spanish-language capacity for the hotline, a statewide needs assessment, implementation of science-based prevention strategies, and projected outreach services to identify and refer those in need of treatment. SAMHSA provided \$6,850,000 of which \$3.7 million came from CSAT and the remainder from CSAP.

Separately, OASAS has worked with FEMA to secure funding for ATC costs incurred in responding to the disaster. To date, nearly \$92,000 has been identified, with less than \$16,000 approved. Finally, there were two solicitations by the Health Resources Services Administration (HRSA) for revenue losses incurred by health care providers and treatment programs in the city. Against the first HRSA solicitation, which totaled \$35 million, there was no funding provided for AOD treatment, and no awards have been announced for the second solicitation, which totaled \$140 million.

V. LESSONS LEARNED

What should programs expect in the event of disaster? Are there examples from New York that might be instructive? What items should States, city and county governments, and Federal agencies consider? The following synthesizes lessons learned and offers recommendations based on these experiences so that disaster planning and response can be made relevant, meaningful, and effective at all levels.

Comprehensive disaster planning is paramount!

States/Counties/Cities/Programs:

- States, counties, cities, and programs must have a disaster plan! Each must take disaster planning seriously. OASAS had a technology recovery plan, but not a crisis management plan. The number-one weakness noted in the Project Heartland final report was that the Oklahoma Department of Mental Health and Substance Abuse Services lacked "a disaster plan or existing relationship with the Oklahoma Office of Civil Emergency Management."
- Additionally, defining roles and who is considered to be essential to the emergency operation should be delineated in advance, leading to reduced confusion during disaster response. Ask: "What is our job? Who does what?"
- Develop a provider contact/alternate contact list. Keep it updated and backed up, offsite.
- Have a plan to pay staff and to pay providers in the event traditional payment avenues are disabled.
- Plan for water, food, and supplies for residential programs in the event transportation systems fail or electricity for providers is out of service.
- Use fire drills to practice where to meet in case of a destroyed program or agency.
- Participate in State and local disaster teams for area-wide planning. Be sure to include clergy as team members.
- Even more so today, there must be a "terror" plan to anticipate human-caused disaster. New York City had blizzards and transit strikes, and Oklahoma City had tornadoes. Other locations have hurricanes and earthquakes. Terror, however, is more insidious, evokes new responses in people, and must be considered during planning. More study is needed in this area!

States/Counties/Cities:

- States, counties, and cities need to know what to expect when a disaster strikes! "If you hear nothing else, hear this." Keep it simple. Management needs to know disaster basics: "What is FEMA? We never knew FEMA had service dollars. Does FEMA help come through CMHS? What about CSAT and CSAP?"
- While developing the plan, cross-reference it with other State agencies. For example, the Health Commissioner can close down Manhattan, effectively overruling the OASAS plan. Developing plans in concert with each other is sensible.

- States, counties, and cities must assist providers to create and revise disaster plans NOW. Do not wait. OASAS will take the results of this study to the providers via forums planned around the State; the State will assist providers to plan for disasters at the local level. Providers from New Jersey will be invited to the forums as well. OASAS will convene a task force to address disaster planning for the field so that every program is prepared to anticipate the unexpected and to care for its clients in times of disaster.
- Have a central emergency number for providers to call for information and assistance. A managed care or client satisfaction number already known in the field could be quickly changed to provide needed information.

Programs:

- Some programs had a Y2K recovery plan, which helped. Some programs had evacuation plans that took them to the WTC, which did not work. A disaster plan for a parochial school was created following the Columbine disaster, but the principal had to take children out through a window.
- In the event of a disaster, reach out to mental health providers for trauma referrals. Better yet, establish these relationships now, as a part of planning.
- For methadone providers, there are special issues to consider for disaster planning. If there is no transportation, how does one get medication? One client rolled her wheelchair to a clinic to get medicated. Some clients did not carry ID—how can identification and amounts of dosage be determined? The stigma of carrying a methadone ID card is relevant here. Guest patients could not verify dosages if the home program was closed. Considerations include providing clients with alternate locations for dosing, especially if only one location is initially available; contacting clients during a disaster; and informing the alternate location about dosing information. Release forms could be developed and signed at admission to allow dosing information to be provided to alternate providers.

PTSD/AOD

States/Counties/Cities:

- Agencies must train program counselors to recognize PTSD signs and symptoms; training should be provided NOW as well as in the event of disaster.
- There must be better knowledge of the relationship between PTSD and substance abuse, and this must be communicated not just to the substance abuse agency but also to the Governor's office, domestic violence and other agencies, and to Federal agencies. This knowledge and communication can be facilitated through a working State relationship that must exist between mental health and substance abuse divisions. Where does the substance abuse agency fit in the State's infrastructure? States should have a document, updated continually, to address this relationship, which they should disseminate to providers as well. During disaster planning, this recommendation can help all to understand the interrelationships of agencies and services, facilitate cooperation, and help avoid turf battles. Preplanning can also facilitate appropriate use of scarce disaster funds to address PTSD with all clients, whatever the primary diagnosis and through whatever door the client may present.

Programs:

- Substance abuse counselors must be able to recognize the PTSD symptoms and must have adequate referral networks for related services. PTSD may be seen immediately in clients already traumatized and may lead to relapse or worsening of associated AOD-seeking behaviors.

Communications

States/Counties/Cities/Programs:

- There must be alternative communications systems available or in the plan. All VHF television and Verizon (plus roaming) cell phones were knocked out when the Twin Towers toppled, and telephone trunk lines for Staten Island and the Bronx ran through the lower floors of the WTC. Power for computers was out, even if wireless contact was possible; and the Internet was jammed from around the world, making access difficult. There was no e-mail to some programs and staff; there was no Internet access; and most Manhattan providers had no services for 6 weeks! Later, mail was feared because of anthrax scares. Revisit Y2K plans as they relate in this context; useful information abounds in these plans.

States:

- A command structure must be set up immediately, and there must be a predetermined hierarchical leadership structure. Communication between internal bureaus is important, and the disaster-coordination task force needs to be in place quickly. For example, fiscal issues and terminologies do not necessarily translate into program common sense.
- Communication between State agencies is important as well. Relationships should be established now so that the substance abuse agency is part of the State communications plan.
- Create or add hours to an existing hotline for calls of all types, and keep statistical information that may prove useful for research and for revenue applications. OASAS expanded its hotline within 24 hours and dealt with contract issues later. A provider staffed the line immediately.
- In case of disaster, put out quick communiqués, as OASAS did within the first and sixth hours on September 11. Plan for alternative methods of delivery.

Programs:

- When considering alternatives, note that communications impacted ATCs with lab tests, appointments, and ongoing operations. Some closely situated programs bought walkie-talkies to communicate in the future; many devices have a 2-mile range. However, such transmissions are not secure, so be careful with client confidentiality while using these radio frequencies.

Media Relations

States/Counties/Cities:

- Have preexisting relationships with the media so that the agency can disseminate information quickly to as many affected persons as possible. In case of a disaster, mass communication can provide information and perform outreach for services. The media need to know the agency is a primary source for information.

- Form relationships with radio and television outlets, and be prepared to brief them. The news media inadvertently helped spread panic in New York and retraumatized persons throughout the State. In lower Manhattan, providers/clients thought a full-scale war was in progress. With preexisting relationships, media will call on the State agency for news, and these problems can be reduced.
- Start with materials shared by others who have been through a similar disaster. OASAS used Oklahoma City's Project Heartland materials as a basis for several of its Hope and Recovery releases.
- A public information campaign is very important to get people to the services offered. New York's Hope and Recovery campaign was followed by PSAs with this message: "Let's recover together."

Programs:

- Form relationships with local media, and be known as a reliable source in your area. Media are invaluable, not only to get out your message of service availability, but also to provide time for PSAs or space for community meeting notices.

Fiscal

States/Counties/Cities:

- Mechanisms must be in place that will allow expedited contracting and payment, including suspension of funding rules (not accountability) when disaster strikes, as normal checks and balances for providing funds can prohibit quick flow of resources. In New York, for example, OASAS was authorized before the disaster to advance funds to nonprofit providers. In addition, providers had been encouraged to enroll in a "quick pay" program and/or electronic funds transfer to expedite the flow of approved funds. OASAS used these mechanisms and was able to get funding to providers for critical services—such as expansion of the hotline—well before the formal contract amendment process was concluded.
- New York suspended certain requirements to expedite payments to vendors and nonprofit providers responding to the disaster. For example, the Governor's Office and State Comptroller agreed to lift the requirement for public notice of State agency requests for proposals (a process which normally requires a month's notice) and increased the threshold (from \$15,000 to \$50,000) under which contracts could be effected without external review by the Comptroller and State Attorney General. The Comptroller additionally established a unit dedicated solely to processing contracts for the WTC disaster and implemented a system that flagged payment vouchers for expedited processing.
- The decision by SAMHSA to work through and with OASAS in awarding grants was also critical to programming available funds for maximum benefit. Other Federal programs, such as HRSA and FEMA, require the nonprofit provider to apply directly. As these agencies are not staffed or trained in Federal grant processes, the field was at a significant disadvantage in competing for these resources.
- It was noted that certain Federal processes and interpretations had the potential of reducing State capability to maximally use funding. For example, while the SAMHSA grants were solicited for and provided to respond to the WTC, only one award's budget period covered the period starting September 11, 2001. As a consequence, OASAS had to repeatedly request approval from Grants Management so that contract periods would not have to only apply to date of application and could include expenses from the date of disaster.

Programs:

- Programs damaged or in crisis may have a difficult time providing documentation of service need and figures for grant applications. Simplify this through online systems or other surveys and planning. Estimating may initially be necessary.
- Plan for electronic transfers to program bank accounts to keep programs operational.

Training

States/Counties/Cities:

- Training needs must be made clear. For example, as OASAS tried to determine training needs, many issues surfaced. A needs assessment was distributed; one of the questions was: “Do we train line or management staff?” Training was delayed while these assessments were administered. Additionally, contracting had to be expanded to cover the entire State, not just around the city. The provider was well known to the treatment community but not to prevention providers, causing prevention personnel not to attend.
- Be quick with training because programs and staff cannot wait for months. Expect programs to attend.
- Institutionalize this training, as well as responsiveness and preparedness. Establish a cadre that is trained and is savvy, and that can go out to train on an ongoing basis.
- Outreach is important here. Because programs are overburdened with extra requirements, the ability of staff to take time away from the job for training becomes more and more difficult as time passes. Try training onsite, where possible, gathering several closely located programs together, and place training online, where staff can participate when able.
- Use alternative methods to get training notices to line staff, because program directors are often overwhelmed and may not pass on the information to staff. Approach provider organizations and credentialing bodies as alternatives. Place availability and schedules on the agency Web site.
- Training must take ethnic issues, such as hatred and blame, into account.
- Train providers in proper referrals for mental health issues, especially as part of preparedness. Be ready to change topics as needed, such as when moving from CISD to PTSD.

Programs:

- Use all available training, whether or not it is believed to be necessary. It is!
- Request credentialing credits for these trainings, before or after the disaster.
- Providers were not prepared for the emotional intensity of client (or their own!) response and must possess a working knowledge of these issues. Administrative staff, not only direct service staff, should be trained in trauma response. Remember who answers the telephone!

Regulations

States/Counties/Cities:

- How can States, counties, and cities deal with provider needs and concerns in a quick, responsive way? State, county, and city agencies and programs should think about this ahead of time, even as part of disaster planning.
- Agencies have to be flexible to meet patients' needs. Have a provision to waive regulations in case of a disaster. For example, an associate commissioner for program operations was given the authority to suspend certain rules. OASAS subsequently gave waivers to go 5 percent over capacity to allow programs to serve displaced clients.
- Balancing Federal confidentiality requirements with the emergency need for client dosage information, for example, poses a special problem that deserves further study. See the methadone discussion under "disaster planning."

Program Relations/Support

States/Counties/Cities:

- Communicate with programs as soon as possible; let providers know your concern and offer assistance. Reach out to them—what do they need? Are they all right? Remember that the providers are dealing with tremendous client-level impacts!

Staff Care

States/Counties/Cities:

- Be certain the helpers get help—don't forget affected office staff! OASAS city staff offices were on the 67th floor of the south tower of the WTC until 1985. Staff remember the WTC fire drills and had friends there. Additionally, city staff went well beyond job requirements, walking to work for miles a day over vulnerable bridges and into a disaster zone rumored to be ready to be attacked again. The Commissioner sent thank-you notes to both programs and OASAS staff, realizing how many went "beyond the call of duty."
- Expect programs to make staff available for training. This is a component of staff care and will help reduce attrition. Staff must also learn to exercise self-care, which they will do, given training and information. Provider and State, county, and city staff volunteered at other places, often working 12-hour days. As noted by Oklahoma City's Project Heartland final report, staff in these settings should work no longer in that environment than a 6-hour day. It is too traumatic and will begin to show up in other places, as in sickness or irritability.
- Keep a journal to record what happened. Several staff said so much happened so fast that it could not be accurately remembered without such a written tool.

Programs:

- Get staff into EAPs! Staff slept in programs, volunteered after work, and walked to work. For whatever reasons, many staff did not seek services; some thought that they did not have "permission" to seek help. Everyone is affected in some way by disaster—require help, if necessary.

- Recognize staff for their service; one program found funds for savings bonds for its staff!

Miscellaneous

States/Counties/Cities:

- Outreach is extremely important. Clients/staff who need help will not necessarily come to services. This lesson was noted in Oklahoma City and is just as important in New York. Services must be accessible through multiple points of entry, such as schools, churches, and synagogues, and be readily available in evenings and on weekends. It is essential that reimbursement be secured for these vital services.
- To qualify for funding and to provide quick information, it is advised that an existing data-gathering section be available. OASAS staff was able to prepare immediately to gather information through preexisting relationships with programs.
- Establish an appropriate research cadre up front that knows what to do and how to do it. OASAS was able to ask the questions needed.
- This magnitude of disaster requires 5 to 10 years of study to properly learn about long-term effects. “For the price of one bomb,” a good longitudinal study will provide useful information time and time again.
- As in Oklahoma City, another disaster will “back trigger” a reflex reaction, so States must be prepared at anniversary dates, for example. When the anthrax scare began, followed by the crash of Flight 587, fear and vulnerability returned to the traumatized inhabitants of the area. Ongoing terror threats retraumatize those who live here. Clients and staff need continuing resources and outreach.
- Special care needs to be taken with the city's Dominican Republic residents or with any other group that has been affected by multiple traumas. Extra outreach that is culturally and linguistically appropriate must be scheduled for these special-needs inhabitants, while sensitivity to their fears must be addressed. Use local service providers to inform the process and to help with outreach.
- Those who have previously been members of “targeted” groups, such as immigrants from oppressive regimes and foreign wars, also need extra outreach. Seek advice from members of these groups. They know where to find fellow residents and how to reach them.
- Many researchers will call to “help” or to study programs, and many programs are overwhelmed. Coordination through one entity, such as the State agency, can help relieve this provider burden. The researchers must understand interview sensitivity in disasters! Clients appreciate sensitivity at these times. Institutional review boards (IRB) could be required to oversee these issues. Also, if Federal agencies could notify the State agency about upcoming research in the area, the agency could benefit from the information and provide proper assistance.
- Whenever possible, provide allocations for support staff, too. Funding is currently provided for services only, not for any staff to support them, so clinicians are further burdened.
- States helped States! Other States reached out—Oklahoma gave Project Heartland information to OASAS, which OASAS passed along to New Jersey and Pennsylvania, and eventually to the National Association of State Alcohol and Drug Abuse Directors (NASADAD), for distribution. During the upcoming provider forums, New Jersey providers are invited, because so many commuters work in

the city and because the WTC is directly across the Hudson River from Newark. Single State Agencies, and cities and counties must continue this practice to support colleagues in time of need.

Providers:

- There were many stories of handicapped persons being unable to escape. Assigning a buddy to a handicapped person to provide assistance in case of evacuation is critical.
- Have client information and contacts, within the bounds of Federal and State confidentiality requirements, in more than one secure place; for example, in a binder and on a disk under lock and key in another building.
- Providers may need to share staff and/or building space. In northern Manhattan, clients were sent to places where there was a best fit. In schools, treatment providers were invited in by prevention providers to help. In one suburban county, no one shared resources, and clients suffered, as did overworked staff.

Client Reactions

Programs:

- Both adult and adolescent clients presented to their programs with extreme reactions. Some adults showed no reaction at all, merely concerns for possible loss of benefits. In contrast, other adult clients had almost violent reactions, showing PTSD symptoms from past trauma. Children and adolescents had many safety concerns. Many young children who had seen the frequent television images were terrified that planes were attacking buildings over and over again. In time, many clients showed resiliency, while some others showed anger and racist attitudes. Some adolescents were engaging in risky behaviors; others were showing signs of depression and suicidal ideation.
- Program counselors need to expect and respond to extreme reactions and recognize that clients are at varying points in recovery and often have suffered personal trauma that emerges from the past.
- Program counselors need to engage their adult and adolescent clients in frequent group sessions to monitor the ways in which they are processing disaster events and their aftermath.
- Program clinicians may need to consider using non-verbal therapies, such as acupuncture or art therapies, to engage and calm clients. Prayer meetings brought some measure of comfort.
- Program counselors may need more sensitive assessment tools to gauge the mental status of new admissions as well as clients in treatment.
- Program staff may need to work with families and school personnel to help recognize indications of depression and behavior that may lead to serious consequences among young people.
- Programs may need to reach out quickly to other programs and agencies for consultation, referral, and placement of clients who are having reactions that can cause harm to themselves or to others.

“Good” Effects (“There is nothing so bad that some good can’t come of it!”)

Programs:

- Some clients were also able to show particular strengths at these times. Clients in programs near ground zero helped out as people were fleeing from the WTC area, worked side-by-side with staff in preparing sandwiches for recovery workers, contributed money to disaster funds, and conducted memorial services on the day of prayer. Staff members bonded with clients and with each other as they shared feelings and emotions. For some, these bonds are lasting.
- Program counselors and clinicians need to acknowledge their clients’ strengths and build on them to help clients overcome the problems in their lives, especially their addiction problems.
- Program counselors need to consider using disaster events to urge clients to straighten out their lives and finally come to grips with their problems.
- Programs need to acknowledge staff for the efforts they make with clients in spite of their own personal vulnerabilities, and for supporting clients and each other.

Living with Uncertainty

States/Counties/Cities/Programs:

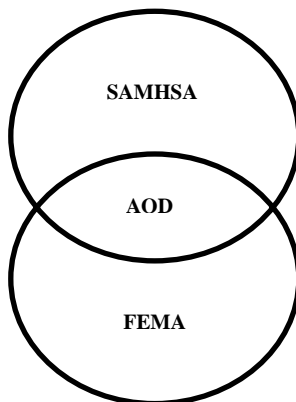
- These continue to be uncertain times for programs, staff, clients, and the community at large. With the events of 9/11, the subsequent anthrax scares, the American Airlines crash in Queens, and numerous alerts has come generalized fear in the community. Many are still experiencing the consequences. “The bottom line is this is the first time we’ve lived through this in this country. I don’t care what anybody claims, there’s no expert on this. There are no definitive handbooks.” Will there be an upsurge in PTSD symptoms among clients in 12 months? In 18 months? In 24 months? Will ground zero recovery workers and their families present as a special needs population once their work efforts end? Will staff members continue to take medical leave or to leave the field altogether?
- Program administrators need to monitor their programs and meet with staff on a regular basis to assess their well-being.
- Program administrators and States need to anticipate variations in client census figures as time goes on and be flexible enough to accommodate the changes.
- States, counties, and cities need to monitor program administrators regularly to determine what is happening on the program level vis-à-vis any lingering disaster effects.
- States, counties, and cities need to consider relaxing requirements wherever possible, curtail paperwork, relax deadlines, and, in general, show more compassion for what programs have experienced, now and in the future.

For Federal Agencies

- Federal Web sites were very helpful, especially regarding children’s issues. As noted in the Chronology, Federal agencies were quick in faxing information and providing other written assistance. SAMHSA, for instance, provided funding information as soon as it was available.

- Funding must be made available for AOD services! There are a variety of sources of Federal Government funding, such as FEMA, SAMHSA, HRSA, and Department Of Education (ED), and most exclude substance abuse services. For example, FEMA and CMHS will not fund AOD crisis services. In Oklahoma, the same problems presented themselves—and the language has not changed. For example, from “An Overview of the Crisis Counseling Assistance and Training Program” found online at www.mentalhealth.org/cmhs/EmergencyServices/ccp_pg01.htm, “The Crisis Counseling Program does not support long term, formal mental health services such as medications, office-based therapy, diagnostic services, psychiatric treatment or substance abuse treatment (refer to CCP-PG-02 for additional information).” At CCP-PG-02, “Program staff cannot ignore survivors who are abusing substances (or are at risk of doing so) as they attempt to cope with the disaster. Yet, the program is not responsible for providing substance abuse treatment and should not operate 12-step groups under its auspices.” AOD providers did crisis counseling, but this is not offered as an option. If this language implies that 12-step groups provide treatment, it is misinformed. It further states that “requests to fund staffing for detoxification programs, substance abuse hot lines and support to relief workers in substance abuse treatment programs” have been excluded “based upon the determination that the services represent specialized treatment as opposed to disaster crisis counseling services.”
- There must be certified substance abuse counselors on the triage team! AOD clients have suffered past trauma, many are dually diagnosed, and most are fragile insofar as relapse is concerned. Services are needed upfront, not after clients have relapsed and developed severe PTSD. HRSA provided \$35 million to New York for health care; ATCs and other substance abuse services providers applied for these funds but did not receive any. One hospital has 13 substance abuse treatment clinics—it did not receive funding. Over 400 prevention providers went through FEMA counseling training then received no funding to provide counseling. The city and State AOD agencies developed a plan for FEMA, only to be told AOD was “not an issue.” Staff was told Project Liberty could subcontract, but it did not happen. (To its credit, Project Liberty did its best to at least have cross-trained staff where possible.)
- The FEMA rule that disallows payment of salary funds to existing staff translates to current staff working many overtime hours for free, all under incredible stress. To expect the State to spend \$2 million for new staff for 90 days makes little sense. An unintended effect of this rule is overworking, then attrition, of existing staff, a further blow to the stressed system. For example, AOD prevention counselors worked as first responders with families and children in schools, and AOD treatment personnel worked with many previous, not new, clients. They were ineligible for payment for services.
- Overall, there seems to be a lack of vision from Federal agencies, including ED and HRSA, as to how help could be provided to addictions clients. On September 17, Education Secretary Paige announced the provision of \$4 million for the New York City Board of Education “to support grief and trauma counseling and other services;” on September 25, he provided the same agency with \$1.7 million more for “counseling services, especially for those suffering from Posttraumatic stress.” Because of ED regulations, however, AOD prevention counselors did not receive overtime or cost coverage for their heroic work.
- In light of these mixed messages that OASAS received from Federal agencies, it would be preferable to view needs in this order:
 - Immediate needs: Cleanup, revenue loss, program and staff needs, CISD for staff
 - Ongoing needs: Program services and training; CISD for staff and skill sets for counselors
 - Long-term needs: Planning and needs assessment

- If local agencies are expected to cooperate, then Federal agencies must be expected to do the same. With a Federal agency, likely FEMA, as the facilitator, we must engage other systems for mutual problemsolving. An ongoing series of meetings to talk about funding streams makes sense.



- A system must be in place that enables agencies to check the qualifications of those who volunteer services. To allow someone to work with clients without first performing background checks is a dangerous proposition.

For CSAT/CSAP/SAMHSA

- The CSAT Director and project officers from the centers were on the phone to Albany and New York City almost immediately with ideas and personal concern—it helped staff to pull through!
- SAMHSA’s program book helped providers find providers for displaced clients and was very useful.
- To Repeat: There must be better knowledge of the relationship between PTSD and substance abuse, and this must be communicated not just to the substance abuse agency, but also to the Governor’s office, domestic violence and other agencies, and to other Federal agencies.
- CSAT advocacy is necessary to convince FEMA, ED, and even CMHS that disaster “mental health” funding is often appropriate and necessary for substance abuse clients, too. When disaster money is funneled through CMHS, its rules disallow substance abuse services (see Federal section).
- CSAT could do a set-aside or separate allocation of 10 percent for 1 year for States to plan for disaster preparedness and response. Make it an important agenda item for the States.

VI. APPENDICES

FOCUS GROUP METHODOLOGY AND INDIVIDUAL FOCUS GROUP REPORTS

Focus Group Study Methods

This section describes the methods used in conducting the 11 focus groups with service providers, followed by a summary of findings for each group. Convening focus groups that address a specific topic, with questions framed and guided by a moderator, has become a popular method of gathering qualitative information by social scientists. Although the method does not provide definitive information, it does provide information that is credible and strongly suggestive if participants are knowledgeable and can speak candidly. Participants in this study, representing an array of prevention and treatment programs in several New York State regions, were extremely knowledgeable, and efforts were made to ensure the confidentiality of their responses.

OASAS senior staff were asked to select a cross section of prevention and treatment providers in several geographic areas in the State, with emphasis in New York City because of its proximity to the WTC site. The designated geographic areas were: Manhattan South; Manhattan North; Brooklyn; Queens; the Bronx; Staten Island; Long Island (Nassau and Suffolk Counties); Mid-Hudson South (Westchester and Rockland Counties); Mid-Hudson North (Dutchess, Orange, Putnam, Sullivan and Ulster Counties); the Albany area; and the Watertown area.

Expecting that each focus group would total 9 or 10 participants, OASAS senior staff selected 15 prevention and treatment programs to be represented in each geographic area. Since not all 15 programs would be able to send representatives, it was likely that at least 9 would be represented. Thus, the desired composition of each focus group would be at least 5 prevention programs; at least 2 methadone programs (except upstate areas where methadone treatment is not widely available); and at least 2 programs representing other types of treatment. Prevention providers would include school-based and community-based programs. Treatment programs would include residential and ambulatory programs and both alcohol and other substance abuse programs. Although each group did finally include both prevention and treatment programs, three groups had fewer than seven participants.

Letters of invitation from OASAS Commissioner Jean S. Miller were sent to nominated programs, and Johnson, Bassin & Shaw (JBS), Inc., the project contractor, facilitated the 11 focus groups. Ultimately, 93 prevention and treatment program representatives participated in the focus groups. The discussions lasted 2 to 3 hours. Following is a list of the geographic areas and the number of focus group participants in each:

Geographic Area	Number of Participants
Manhattan South	12
Manhattan North	5
Brooklyn	7
Queens	11
Bronx	5
Staten Island	6
Long Island	10
Mid-Hudson South	12
Mid-Hudson North	9
Albany	7
Watertown	9

In an effort to report what was said as accurately as possible, the discussions were tape recorded. A commercial service prepared a transcription of each recording, which was the basis for the summary report for each focus group. To protect the confidentiality of participants, however, the tape recorder was turned on only after the participants had an opportunity to introduce themselves to the group and describe their programs. Once the tape recorder was turned on, full names of participants and program names were not used. Furthermore, OASAS staff were not present while the focus groups were in progress, and the moderator was a consultant with the contractor, JBS.

Script

Senior OASAS staff members aided in drafting three major focus group questions and numerous followup questions that traced the experiences of the programs. The questions first permitted a discussion of the immediate impact of the WTC disaster on their programs, then a discussion of the effects that lingered—5 to 6 months later—and, finally, the lessons that may have been learned about the functioning of their programs during this very difficult time. Specific focus group questions include the following:

1. Thinking back to September 11th, let us first talk about what happened at your program on that day and in the week or so after. And let me mention some specific questions:

Did your program run smoothly on those days?

(For programs close to the disaster site, was there physical damage to your property? If so, were you able to occupy your premises? If not, were you still able to occupy the premises?)

Did your counselors and other staff get to work on those days?

Did your staff have special needs?

Did clients or people you serve show up for their appointments? If not, did they call?

Did your clients have special needs?

Did normal counseling sessions or normal routines take place? If not, what did take place at your program?

Were some program components able to function, while others were not? If so, which functioned and which did not?

Did your program have an abbreviated schedule on those days or did your program stay open later?

Was there difficulty in communication, especially by telephone? If so, what was the impact?

Was there interaction with OASAS, with other programs in your area, with other agencies, with the community? If so, what resulted from the interaction? Were changes in routine made as a result?

Thinking back to those days, what was the most valuable help you received? What do you think was the most valuable help you gave?

2. Now, let's talk about the present. What effects or consequences do you believe continue from September 11th and its aftermath? And, if possible, please address the following:

What effects, if any, do your staff show, e.g., increased absences, medical problems, work-related problems?

What possible effects, if any, do your clients or other people you serve show, e.g., need for more counseling sessions, family problems, work-related problems, social dysfunction, medical problems, problems with health insurance, need for anti-anxiety medication?

Is your program functioning as it did before September 11th?

Have the anthrax scare and the November 12 airplane crash in Queens taken an additional toll?

Has there been a change in service needs, e.g., increase in detoxification requests among methadone patients?

Has your program experienced increased fiscal problems that might be related to September 11?

Are there training needs for staff that you have identified, such as training in stress reduction, grief counseling, relapse prevention?

Is there any evidence of increased ethnic or racial tension among clients and/or staff?

Has there been any change in your interaction with OASAS, other programs, other agencies, or with the community in which you are located?

3. It may be too soon to evaluate what has happened as a result of the tragic events of September 11 and, specifically, their consequences for treatment and prevention services in the State. Nevertheless, let me ask you what, if anything, have you learned about your program during this critical time?

And let me ask you to think in terms of the following:

Looking back, are there things that might have been done differently—regarding clients, other persons you serve, staff, program routines; decisions regarding OASAS, other programs, other agencies, the community in which you are located? What would you have done differently?

Looking back, are there things you would have done exactly the same—regarding clients, other persons you serve, staff, program routines; decisions regarding OASAS, other programs, other agencies, the community in which you are located? What decisions seemed to work well for your program?

What policy issues, if any, have been raised for you or policy questions that need to be addressed for you in the aftermath of September 11th, such as responsibility for clients and others you serve, for staff, for other programs-in-need, for the community, and emergency responsibilities on the part of OASAS that need to be addressed?

Have you, for instance, identified a group or organization that should be the focus of outreach for your program or for OASAS in the coming months?

What, in general, did you learn about the functioning of your program during this period? What are its strengths?

What are its weaknesses?

Given this set of questions, the individual focus group reports that follow present the findings in terms of the “Immediate Impact,” “Today,” and “Lessons Learned.”

Manhattan South Focus Group: March 7, 2002

Twelve administrators and clinicians participated in the focus group representing AOD programs with clinics mostly south of 14th Street in Manhattan. The treatment and prevention programs represented are diverse in environment, modality, and the particular populations served. The treatment programs included hospital-based and community-based, residential and ambulatory, and drug-free and chemotherapy clinics. The school-based prevention programs included public and parochial schools. The populations served include homosexual groups, the homeless, immigrants, and parolees, among others.

The location of most of the focus group clinics was within blocks of the World Trade Center. Therefore, these focus group participants were the most immediately and intimately affected by the events of September 11th.

Immediate Impact

Many discussants described the physical scene in lower Manhattan on that day. After the attack, nearby buildings were evacuated, thousands and thousands of people were caught in the streets, rescue workers were blocking off the streets, subways were not working, and most phones were not working. One secretary who had gotten to her program near the World Trade Center said in a debriefing session: “A lot of people were watching the building until it collapsed, and when it collapsed, that’s when the panic started.”

Nearby schools had to evacuate the children even though there was no structural damage to the buildings. “Children did witness the fire and the buildings going down.” The schools’ crisis plans did not necessarily work, especially if the plan was to evacuate to the World Trade Center area. A discussant described one scene: “Here this principal was with a couple of hundred kids trying to figure out, where do I go now?” They went to a church a couple of blocks away.

The methadone clinics also had their problems. Since patients were generally working, they were already medicated by the time the attack occurred and were out of the building. Staff, however, were in the clinic, and realized that they had to devise a plan quickly because they had to leave the building. A focus group participant described her activities and her colleagues’ efforts to take with them patient records and the SAMHSA “green book,” or directory of treatment programs throughout the country, and to work from home trying to reach patients, to direct them to other clinics, and then to reach those clinics with their patients’ dosage requirements. Needless to say, by the time these staff members walked the many miles home and then tried using busy phone lines, it was exceedingly difficult to make all the connections. As it turned out, OASAS made the decision that no guest patient would be refused methadone, which prevented much chaos.

Another immediate problem involved clients’ efforts to get to programs that remained open following the attacks, especially if they did not have identification. Police officers and other rescue workers who were controlling access to streets were helpful in allowing clients to get to their programs if they showed identification. Because it is not an OASAS requirement for methadone patients to carry identification—because of confidentiality concerns—many patients who could have gotten to their clinics were not able to do so. Thus, patients scrambled to get to methadone clinics in other parts of the city.

Wherever possible, programs that were intact remained in their sites, such as residential programs represented in the focus group. Staff and residents in these programs reached out to their immediate communities and helped in very dramatic ways. According to one discussant, both clients and staff were available to the community, “passing out blankets, bringing in people, getting them calmed.” Another discussant described the efforts of his staff and clients, who set up a “trauma center” in front of their building. “As people came, we were washing, flushing their eyes with water. We had an oxygen tank

from a hospital and some wheelchairs.” He said, “I was never more proud of my agency than I was on that day.”

Unfortunately, several program sites could not be occupied for varying lengths of time, from several days to a few months. There was much effort at telephone outreach to clients to let them know what was happening. In some cases, efforts were made to reassure clients and to tell them that their programs were up and running. In other cases, clients were told that their programs were temporarily relocated to other sites. Programs did lose clients who no longer wanted to go to lower Manhattan sites. One program had accommodated criminal justice clients and undocumented immigrants. These clients were fearful of all the law enforcement personnel in the area and did not want to be stopped and questioned. Other clients no longer wanted to go to this area because of the smells and all the pain and suffering that took place there.

In subsequent days, clients were showing a whole spectrum of reactions, from being totally self-absorbed to being totally traumatized. One clinician in the focus group described the extremes as defense mechanisms: “People were looking for normality, and then there were other people looking for support.” For another clinician: “The clients didn’t respond the way most of the staff thought they would, which was to re-aggravate all the trauma and history of assault, personal, physical, and emotional. They took it in stride, which is one of their strengths.” The therapeutic community represented in the group tended to back off and be less confrontational than usual in group sessions during those immediate days.

Some clinicians tried to turn the terrible events into something that helped motivate the clients. “It was almost like people were very patient and very focussed, and everyone wanted to do the right thing.”

Staff in many programs were having more problems than clients. One discussant commented on younger staff who were very frightened and could not come to work for days afterward. Older experienced staff had seen much more of life and gravitated to the clients and their needs. Some programs continue to provide troubled staff with crisis counseling. Another discussant commented on the timing of the tragedy, as both staff members and clients were experiencing it at the same time. “Often we have things in common with our clients, but usually there’s a little bit of time and emotional space. In this instance, we were simultaneously dealing with our own stuff.” In one program, an EAP was particularly helpful to staff. As a discussant explained, “Many of our staff needed a place where they could go and talk about how they were feeling and not feel that they were disrupting the work process.”

Programs made efforts to provide as much counseling advice and trauma information as possible so that staff had extra resources to draw upon. One discussant summed up the feeling: “We were stumbling over ourselves to do as much as we could and there was no handbook on what to do when this happened.”

The focus group participants expressed particular appreciation for OASAS’s responsiveness. On 9/11 and the days afterward, discussants remembered the calls that they received from OASAS senior staff with offers of help and assistance in networking with other programs and agencies. One school-based program administrator simply remembered, “It was dark and I was alone in my office, but it felt good to talk to the OASAS caller. It helped me feel a little grounded...it brought me back into focus that we’re connected to them. I appreciated that, and I think that’s helped our relationship since then.”

Today: Six Months Later

Programs are generally back at their physical locations trying to operate as normally as possible, given the trauma the area has sustained. The situation for most of the programs represented in the focus group is best described as “trying to do more with less.”

Clinically, clients continue to show a range of symptoms and behaviors. Interestingly, one program has shelter-based pretreatment units as well as a major treatment program. The clients in the pretreatment units are “totally unaware or oblivious to the fact that anything else is going on in the world”; they are only concerned about their benefits. In contrast, the clients in the treatment program appear to be much more connected, more anxious, more violent, and perhaps more concerned about getting their issues addressed. A discussant was not sure whether this reflected a greater commitment to treatment or an outgrowth of 9/11. In any case, several discussants recognized the need for more staff training, more professional help, and professionals specifically trained in PTSD. The sentiment was further expressed: “If I can’t treat the client, the client should be treated somewhere in the system.”

Each special client population has had more needs to be addressed. For many, it is loss of jobs and loss of health benefits. For some, it has been the loss of partners and the loss of sponsors. Lesbians, gays, bisexuals, and transsexuals, for instance, have had trouble accessing benefits, “because the benefits only apply to married couples and not domestic partners.” These clients have been presenting with many more mental health symptoms, such as anxiety and depression. The cumulative effects are likely to have an impact on their recovery.

Schoolchildren, who were evacuated and housed in other schools, have finally returned to their own schools. According to a discussant, “It was very crowded in some schools, but they were welcome, and we were able to do a lot of intervention there, and it worked fairly well. Now they’re back in their schools and they’re happier, even though we still have issues to deal with.” The prevention staff continue to do crisis intervention and are alert to the fact that people may react several months after 9/11.

Staff remain a serious problem for these programs. One focus group participant stated, “I notice that there’s more staff impacted by 9/11 than the clients.” Staff members are leaving their jobs; many are leaving the field. Since some counselors are in recovery themselves, discussants thought that the effects of the disaster have caused their recovery to suffer, and “they’re not working anymore.” Also, programs are losing social workers. Now agencies, such as United Way, are paying these trained professionals thousands of dollars more than the treatment programs. Some staff members who do remain are in need of counseling themselves. Often, they are so busy at work, that they have little time themselves to use services, such as those that EAPs provide.

Program administrators in the focus group were extremely agitated by their struggle with enormous revenue issues. First, the likelihood is that State funding will be flat or even cut in the new fiscal year. Second, some hospital staff have a new union contract that was “based on the presumption that there was going to be State dollars, which we’re being told that are not going to be coming and that we have to absorb that increase.” Third, the city has cut funding for vocational rehabilitation at a time when clients must find employment. Finally, some hospital-based programs have lost revenues associated with their preparedness for 9/11 emergencies that will not be recovered. To compound problems, a community-based residential program received a letter from its insurance provider, “raising our insurance on our property to \$100,000 directly related to 9/11.”

In addition to revenue problems, the shortage of staff, staff turnover, the need for more professional training, heavy program regulations, onerous paperwork requirements, and the new level of pressure on the clients have only intensified the effects of 9/11 felt by the focus group participants and felt in the programs they represent.

Strong suggestions came from the group for—at the very least—some regulatory relief. Some discussants recommended relaxing the urine toxicology requirements. Programs could save “hundreds of thousands of dollars a year” if such requirements could be reduced or minimized. Other discussants recommended

relaxing some of the paperwork demands on staff “that make it so hard to do the daily work; the time frames that are unrealistic, when there are clients coming in that have so many complex problems.”

Lessons Learned

One lone discussant, however, was vehemently opposed to disaster planning. His position was that the very act of planning indicates some anticipation that this could happen again. He found the concept “unacceptable to even think of.”

Another lesson learned by programs was seeing their clients step forward to provide help to disaster victims. As one discussant said, “We look at our clients differently now.” There was strength in what the clients could do that neither staff nor clients themselves could have predicted. The hope was to build on that strength.

For several discussants, concern over staff was underscored once again. One discussant mentioned his bitterness over how staff were treated during the week after 9/11. Yes, staff could take time off, but they had to charge the time to vacation leave! Another discussant mentioned the monthly family gatherings that his program holds and the retreats for staff to help the healing process. Still another discussant made an interesting suggestion to relieve staff of paperwork requirements. She advised that OASAS and the Department of Labor should create a program to employ support staff with basic skills to handle the paperwork. In this way, counselors could be spending more time counseling, and possibly clients could get much needed employment.

Finally, a lesson learned is that there is much that we do not know. A discussant summed up the uncertainty: “People talked about getting a lot of training and experts. The bottom line is [that] this is the first time we’ve lived through this in this country. I don’t care what anybody claims; there’s no expert on this. I mean, there is information there, but it’s not like a recipe that’s complete, and so that’s why I say we all have to keep asking the question. OASAS has to keep asking programs how are you doing. We have to keep asking our staff how they’re doing. It may be another year; we have to keep asking. Because I think it’s an uncertain time that we’re going through.”

Manhattan North Focus Group: March 7, 2002

Five professionals participated in this focus group, representing a cross section of AOD treatment programs and prevention programs. The programs included ambulatory and residential treatment and community-based and school-based prevention programs. The programs were mostly located on the Upper West Side and the Upper East Side of Manhattan in diverse residential and ethnic communities. Ground zero is just several miles south of where these programs are located. Many subway and bus lines from this area go directly to lower Manhattan.

Immediate Impact

Once the news of the disaster was received, it took a little while to respond to program needs because, "Everyone knew somebody down there." The treatment programs were already in operation that day, but television sets, wherever they could be turned on, became the focus of staff and client attention. The directive to school-based prevention staff, however, was to help out with whatever was needed in the schools. As one discussant described the day, "It was more reactive than proactive."

The hospital-based programs generally followed the emergency procedures of their hospitals. For instance, one program closed down, and social workers on staff were sent to work in the emergency room. A hospital-based methadone program, however, remained open to medicate its own patients, and "guest" patients who intensely feared that they would not be medicated.

The residential program representative in the focus group had clients who were at appointments and job interviews at the World Trade Center on that day. Staff were "hanging out the windows" watching and waiting for their return. Slowly but surely they did come back: "Some of them came back okay, some came back with white powder all over them crying, some were hysterical." Staff spent the rest of the day helping other staff and clients with their personal concerns.

The community-based prevention program represented in the group has various city sites where adolescents congregate. Interestingly, their reactions differed from site to site. Those at the North Manhattan site, for example, were considerably calmer than those in the Bronx locations. The older teens in one of the Brooklyn sites were extremely helpful to people fleeing from Manhattan over the bridges, beckoning them to come into their building and telling them, "You can wash up here, you can clean up here, you can make your calls, you can drink water!" The focus group representative said, "We felt pretty good as an agency because we were there in that time of crisis."

The school-based program followed the lead of the district superintendent and the program director, who helped staff through that day and subsequent days. The discussant confided, "One of the things we found out sadly is that there was no crisis plan." The decision to close schools on September 12 was a good one and gave school and program staff a day to "regroup." When the children returned to school, program staff accompanied teachers from classroom to classroom to talk with the students and "to answer their questions as best as we could." The students kept asking, "Can it happen to our school? Is our school going to be bombed? Is our building going to fall?"

Finally, despite the overwhelming impact, it was necessary to focus on the problem of substance abuse. One discussant explained that very quickly there were indications of relapse. "We had to do day-to-day business, which is substance abuse and trying to keep people from using drugs."

Today: Six Months Later

Since September 11 and its aftermath, programs represented in the focus group have returned to relative normalcy with some changes, more problems, and some solutions. Several programs have seen an increase in census, which is probably related to the disaster. The residential program has admitted some people who have lost jobs because of 9/11, who had been drinking and using drugs over the past 6 months, and are now seeking treatment. The methadone program had admitted some of their guest patients who transferred from other their methadone clinics. The community-based prevention program is now seeing some older teenagers who were considering the program a safer place than the streets.

One of the major problems confronting some of the programs since 9/11 concerns staff. One participant discussed the loss of staff in her hospital-based program who have “rethought” things and now want to pursue other work. There have been financial difficulties in this hospital that have probably contributed to the insecurity felt by some employees. Another discussant said that there has been a 20-percent turnover in staff that work directly with youngsters. “Whether it is stress as a result of what they’re dealing with or directly related to the job, we don’t know, but tension is there.” In contrast, another discussant said that his staff might have somewhat more commitment today from their experiences in working together as a team during the days after the disaster.

Some programs have been able to get auxiliary help through grants and through special OASAS assistance. One program received funding to hire specialists in trauma to provide trauma training and services to trauma victims. Another program administrator praised OASAS’s efforts to fund their need for social workers. Although the funding was not enormous, it was sufficient to hire, at least temporarily, very professional and committed social workers. These social workers also counseled staff and gave the administrator additional training “to multiply their effectiveness.”

Ethnic tensions surfacing in staff and clients have been a problem that programs have also had to confront. A focus group participant talked about staff members who would agitate other staff by talking about their political feelings in meetings. The tensions that developed were also affecting their work. Clients in another program were telling their counselors about their hate for Muslims, and the violent acts they were committing against anyone who looked like a Muslim. Another discussant described a situation in his Bronx site that was successfully confronted. Some adolescents were eager to target anyone who looked like a foreigner. Staff, however, were able to calm down the teenagers, convincing them that these people were not the enemy. The youngsters then decided to do something to help the city; they donated blood. “About 16 of these kids went and gave blood, instead of taking blood.”

Clinically, some clients have been presenting with more family problems and, work-related problems and requesting more benzodiazepines. Some methadone patients are asking for higher dosages of methadone. Psychologists and psychiatrists associated with programs have also been spending more time with clients. In one program, social workers and other staff are receiving training to upgrade their skills to be better able to assess mental status among clients, especially among those who have talked little about the effects of 9/11.

Among youngsters, there was, at first, little response beyond the initial insecurity. As time went on, however, young clients have been showing signs of depression and anxiety, starting with panic attacks. In some programs, more referrals for long-term counseling have been made.

One discussant counseled firefighters and police officers who were working at ground zero. He had praise for the EAP that organized the efforts, which included having clinicians available and a mandatory debriefing for each person. Among the findings for these recovery workers were the increasing use of

alcohol and the surfacing of “survivor’s guilt.” As the discussant explained, “because a lot of them lost their buddies.”

Finally, some discussants mentioned that there has been an increase in positive toxicology for their clients. One participant in the focus group reported “street benzos.” Although some clients do attribute their use to the events of 9/11, discussants were not entirely sure and thought that for some it might be a convenient excuse.

Lessons Learned

Perhaps the lesson learned by most participants is that some disaster or emergency plan needs to be instituted. One of the hospital-based programs revamped its security force. Because this hospital is a “Jewish” hospital, the perception is that it may be more of a target. One prevention program has instituted electronic identification cards that are swiped when youngsters enter the building. This procedure gives a better accounting of where young people are, which also helps anxious parents. In addition, the program has devised an evacuation plan, hired more security personnel, and installed more security cameras.

A lesson learned by the school-based prevention program is that there is no substitute for good leadership. Since no one could have ever imagined such a disaster, a very helpless feeling pervaded the staff. The leadership within the district and the school system was crucial in galvanizing school personnel and responding almost immediately to the needs of the children.

The importance of networking with other programs and other agencies was a lesson mentioned by the discussants. For some programs, the networking goes on continuously. These programs are known in their communities, and working together appears to be the way business is normally conducted. Thus, when crisis struck, it was only natural for programs to reach out to each other for help and to provide help.

Finally, one of the administrators in the focus group commented on the value of being lenient and compassionate with clients and staff during the immediate days after 9/11. Although following the rules and procedures in the program was very important, “We had to adapt...we had to kind of play it by ear because it was a new situation for all of us.”

The Bronx Focus Group: March 4, 2002

This group included five professionals representing major AOD treatment and school-based prevention programs, mainly located in the Bronx. The multi-unit treatment programs included a variety of modalities and environments, such as methadone maintenance treatment, residential, hospital-based and other ambulatory programs. The school-based prevention programs represented Bronx public school districts.

The Bronx, the only city borough connected to the mainland, is located north of Manhattan and is connected to Manhattan by several bridges, subways, and bus lines. Parts of the Bronx are located no more than 10 miles from ground zero; one can easily see the Manhattan skyline from many Bronx locations. Given the ease in traveling to and from Manhattan, many Bronx residents also work in Manhattan.

The Immediate Impact

Most focus group participants were working in their offices or attending meetings when they heard about the disaster. Very soon the smoke from the burning towers was visible.

The school-based programs quickly deployed counselors and other personnel to every school in their districts. Parents who were able to reach the schools took their children home. Program personnel remained at the schools and other sites until every child was called for. Meetings were held as soon as possible to plan for the days ahead. As one discussant explained, there were four plans that had to be considered: first a plan for when the children returned to school (on September 13); second, a plan for staff, who may have had personal loss; third, planning classroom discussion; and fourth, arranging for outside referrals for children having serious difficulty. Individual schools had to tailor plans to their own needs.

Treatment programs were also quick to check on their clients and staff. In some programs, these individuals were in lower Manhattan that day at court appearances, training, and other appointments. For some, the personal experience was horrendous. One client who had been near the World Trade Center actually saw people jumping from the burning buildings.

Normal routines were not followed, and spontaneous groups were convened with clients. Staff, who could, did lead group sessions. In one program, a psychologist and a social worker were deployed in the following days to each clinic to convene groups with patients and staff to talk about their personal feelings and how they were coping.

The methadone program had a major responsibility to medicate its own patients, and to medicate guest patients who could not reach their regular clinics. One discussant stated, "We medicated over 200 patients who were not part of our program in the next 4 or 5 days."

Clinically, clients seemed to do relatively well. They, in fact, felt that they were doing something worthwhile as they participated in food and clothing drives and prepared food for firefighters and police officers, tasks that their programs had undertaken. Still, there were the clients who remained self-absorbed. One focus group participant explained this reaction as "just because of where they are in recovery."

Children responded relatively well, although young children seemed to be confused by the day's events. Given the intensive television viewing, children were thinking that many airplanes were hitting the

buildings over and over again. Very soon, however, children were starting to say, "I don't want to hear about it anymore!"

Staff members seemed to be most affected by the events. Many acted heroically at the outset, doing whatever needed to be done but describing their efforts as going on "automatic pilot." Memorial services convened by one of the programs proved to be healing to staff members who needed an opportunity to talk and vent their emotions. Another focus group participant described the remarkable way in which her program responded to staff and their needs: "We personally, the president and I and others, thanked staff for the work they did. Subways weren't working, buses weren't working, and they were walking over bridges from Queens to the Bronx to get to work. We got the names of those who had continuously done that for a couple of weeks, and the president gave them \$500 savings bonds. Others who also did a great job but not as much got \$250 savings bonds. We spent about \$10,000 as a way of thanking them, and also buying savings bonds, which was pretty appropriate." In addition, this program brought in a group called "Healing Works" for staff to provide workshops in meditation and yoga. "We're now having yoga at the sites for the staff. Staff put out 150 percent, and 2 weeks later they were exhausted, and it was starting to get to them. So we're going to continue to do that. They did a great job!" This program's unique response to staff was well noted by the other focus group participants.

Today: Six Months Later

The current situation in the treatment and prevention programs as presented in the focus group is generally a stressful one, with difficulties with staff, clients, and program management. The additional threat of anthrax and the trauma of the airplane crash in Queens have only added to the tensions.

Although staff performed well during the immediate aftermath of September 11, as time passed, many have been showing more fatigue, stress, depression, and the need for medical leave. Some have resigned to pursue other careers. A staff member who is a single mother seemed to have a breakdown, as though "all the dynamics are hitting at one time." Male staff, if they need help, are more reluctant to seek it, perhaps because men have to act as though they have "the strong shoulder." One discussant described the extreme situation in her programs: "Staff are like trying to kill each other." She was eager to write down the information about "Healing Works," mentioned by the administrator whose staff seem to be doing relatively well. Perhaps, the saddest finding is that some staff-in-recovery have had relapses.

Given the status of staff, the clients who remain in treatment and those newly admitted seem to be harder to deal with. For instance, criminal justice populations are exceedingly difficult to deal with under normal conditions, let alone when staff are having their own difficulties. Also, clients in this welfare reform environment need to find employment, which is often a very arduous process that requires staff to work with clients, encourage them, and arrange vocational and educational referrals. This, too, becomes demanding on staff.

The methadone program has been seeing more clients newly admitted, readmitted, and on waiting lists. A discussant representing her program described the difficulties involved in successfully helping a client to get on and stay with the therapy. "Methadone is a hard medication to be on, especially when you first come into the program. You have to come in 6 days a week. Then there's the stigma of you trading one drug for another drug. Your family doesn't understand. You're still smoking crack, but you're not using heroin anymore. 'Why are you on that stuff?' So methadone carries a lot of 'shtick', and so it's difficult." It also seems more demanding on staff working with these clients.

One school-based program reported a rise in suspensions among students because of violence and bullying. The South Bronx has been historically noted for violence. In fact, "every night kids would have to duck down because of the gunfire." According to the discussant, the violence has subsided due to

former Mayor Giuliani's police efforts. Now, one possible explanation for the increase in suspensions may stem from parents being out of work since 9/11. The financial crisis in families may be creating more tension at home and perhaps contributing to students' behavior. Another potentially serious problem among students involves talk of suicide. Mental health agencies are being alerted to this situation.

Thus, the focus group participants underscored problems with staff, staff dealing with clients, and upcoming budget cuts. They believe these are direct and indirect effects that continue to ripple through the field as a result of 9/11. Repeated anthrax scares and the recent airplane crash have only exacerbated an already deteriorating situation.

Lessons Learned

Despite the pessimism surrounding the current situation, the discussants did share the lessons that were most valuable to them. First, to remedy some of the current morale problems, taking care of staff earlier would have been very beneficial. One participant believed that "too much time elapsed before we started to do any healing among ourselves. We really needed that immediately." The program that worked intensively with its staff and rewarded them with savings bonds was respected and applauded for the wisdom of its response.

As programs are finding difficulties in the past 6 months, the participants discussed ways to reverse the trend. Certainly, being assured of some financial stability would give programs security and the ability to function and plan without the constant fear of budget cuts. In addition, a reduction in paperwork would be most appreciated. Paperwork required by the city's Human Resources Administration, especially, is extremely time-consuming, and is resented bitterly.

During the past 6 months, "disaster" Medicaid was awarded easily, especially to methadone patients. Thus, many individuals and programs have benefited from this funding. This temporary Medicaid will stop shortly, and many clients will probably be denied benefits, jeopardizing their treatment. It is important that somehow funding continues to enable these clients to continue treatment.

Another lesson learned was the importance of a disaster plan. Since 9/11, one discussant described the plan her program now has established, which includes identifying key people in the program, security measures, physical relocation, and "feeding 1,000 people a day." In fact, an accreditation agency, CARF—The Rehabilitation Accreditation Commission, now requires such a disaster plan in its evaluation criteria. Focus group participants had also learned about disaster response from their experience with the blizzard of January 1996. In that situation, what was most valuable for one discussant was working with other programs in informal networking, which was better than any formal plan. As she described, "It was amazing the cooperation that I got just by picking up the phone and calling my colleagues at other programs."

Finally, a very clear lesson was learned regarding the need for an effective communication system. On September 11, everything shut down. Some programs are now looking into a variety of options. In one program, central staff now have two-way pagers, which are working very well. "Some staff say it is working too well!"

Brooklyn Focus Group: March 4, 2002

Seven administrators attended the focus group arranged for AOD of treatment and prevention service providers in Brooklyn. A cross section of programs was represented, including hospital-based, community-based, school-based, and stand-alone and multi-unit residential and ambulatory programs.

Geographically, Brooklyn—New York City’s most populous borough—is situated to the south and east of Manhattan. The borough is connected to Manhattan by a tunnel, three major bridges and by several subway and bus lines. Much of Brooklyn’s ethnically diverse population in the labor force works in Manhattan, particularly in lower Manhattan where the World Trade Center was located. Brooklyn, because of its size, is also the place of residence and work for numerous police officers and firefighters.

The Immediate Impact

Since Brooklyn is very close to ground zero, separated only by the East River, the attack and its fiery aftermath could be seen from many borough locations. The smell from the fire permeated the air throughout the borough. The discussants described in detail the action that was taken at their programs. The school-based and community-based prevention programs responded very rapidly since children were involved. One of the school-based representatives, for instance, first checked on her staff of 36 to see that everyone was in place and if staff had personal needs resulting from the disaster. Once that was addressed, e-mail was sent to all school principals to say that their program was available for any crisis work. “Whenever there is a crisis in the system, the principals and administrators know to call us.” Although many parents were coming to the school to take their children home, there was great fear that some children would be left with no one calling for them and that no one would be at home to receive them. Staff were alerted to the concern and were there with the children. The next day, classes were canceled, but school principals requested that program staff speak to faculty on how to talk to students about the disaster, trauma, and terrorism in an age-appropriate way. In the days that followed, the program provided individual counseling for parents and students who lost loved ones or whose parents were working around the clock at ground zero. Although training for staff was available to the program in Manhattan in subsequent weeks, there was such anxiety among some staff members that they could not bring themselves to go into Manhattan.

In the treatment programs, normal counseling and routines were suspended. From some of the program sites, the staff and clients were able to see the Twin Towers and the devastation. Staff, to the best of their ability, gathered clients in groups to determine their feelings and reactions. Television sets, where they were available, were left on all day.

Some treatment programs were asked to provide services to the larger community. One discussant detailed the emergency plan that was put into effect for his hospital-based program to serve community residents. By 11:00 a.m. on September 11, a staff meeting was held to map out the plan and get volunteers. The plan that was set up included coverage in 4-hour slots, 10 hours a day, 6 days a week at one main location in the community. By the afternoon, another meeting was held to expand the plan to provide services at 40 additional sites and accept people as they walked in. As the week unfolded, the first response showed good mobilization and pulling together, but also that the shock that was still profound. Towards the end of the week, both program clients and staff were getting more and more upset. On Friday, the day of prayer, clients and staff participated in a memorial service, which became a very emotional event.

Clinically, one discussant described the way in which she tried to seize the moment of the horrendous events to urge her clients to realize how they needed to make firm choices and decisions in their lives. Rather than crisis counseling, the conversations turned to “real things about people and what’s important

because a lot of people aren't going to wake up the next day." The discussions, in fact, seemed beneficial that week, giving a more united feeling in the facility. The television set was turned off after the first day.

Although some other discussants found that their clients were anxious, angry, and openly hostile toward Arab groups, other clients seemed to rise to the occasion. In fact, on the day of prayer, clients themselves led a prayer service at one of the hospital-based programs, convening staff and clients outdoors in a very touching service.

The prevention programs had to deal with students and their parents who were showing a range of emotions. The younger students were concerned about their safety, but the adolescents were showing a great deal of anger and racism. Parents had many questions about how they should talk to their children about the tragedy and how much television the kids should be watching.

The staff reactions and needs became a major issue for the programs. For the most part, staff responded valiantly. Staff members of residential programs, for instance, came to work bringing extra clothing in case they had to sleep at the site to take over if other staff could not get to work, since bridges were closed and transportation was erratic. Other staff members volunteered many hours for community efforts and for counseling assignments at ground zero. At first, however, there were some extreme and bizarre staff responses. Some thought that they needed to be armed to protect themselves against an invasion; others thought that the event was just not as bad as the media were portraying it. There simply had to be time to process the disaster.

It was obvious that programs had to deal with many issues during that first week. One issue concerned getting back to normal, which some programs tried to accomplish as soon as possible. For a residential program, that seemed to work well. For one of the prevention programs that had staffing problems, getting back to normal did not work at all. Another issue concerned involvement with the larger community. One discussant thought that his treatment program could act as a type of Red Cross Center or a crisis center for the community. When he explained his plan to his director at another location, she wisely recommended that he first make sure that "his own house was in order." As it turned out, the need for extraordinary services in the community did not materialize.

Today: Six Months Later

Clinically, according to the discussants, clients have generally calmed down. Some ethnic issues, however, persist. Clients who are Black Muslims—African Americans and Muslim—feel particular stigma and want to talk about their faith and how they are different from those who attacked the city. Staff, too, continue to work out ethnic issues that have caused a great deal of anger and sometimes difficulty in dealing with clients.

The students have shown much resiliency. One of the discussants, however, suggested that teachers continue to feel anxious and "are probably conveying this to kids in subtle ways." The discussants believe that there is the general perception that "something else is going to happen." The prevention programs have made themselves available for meetings with faculty and making presentations regarding the effects of 9/11. Nevertheless, requests for these efforts have been much fewer than expected. Things have been calm, and it is now "a hard sell to get into the schools and say this is what you need to know."

Treatment and prevention program staff have made a concerted effort to get more training on trauma and dealing with critical events. Professionals who had been involved with Oklahoma City's disaster and also with shootings on the Brooklyn Bridge several years ago were helpful in providing such training. OASAS materials sent by e-mail were also well used.

Project Liberty received mixed reviews from the focus group participants. One administrator with a mental health background participated in Project Liberty efforts providing counseling and referrals to treatment, especially for firefighters and their families. He described the challenging effort: "I've been stationed in a house in Bed-Stuy that lost the entire company except for the driver that day. They lost 96 firefighters in Brooklyn alone. My concern is for the families, the ones who lost." In contrast, another program administrator said she did not apply for Project Liberty funding. Her understanding was that alcohol and substance abuse service providers were not included in the effort. "The feds made a decision [that] it was strictly mental health services that were going to be funded and supported, and with all the red tape involved."

An increase in census over the last couple of months was reported by some discussants who have outpatient clinics. They have been told by OASAS that the Oklahoma City experience found that associated alcohol and other drug problems may present as long as 5 years after the event. One program has now added a question on intake asking about the impact of 9/11 and whether the clients' problems are in any way related.

The fiscal problems that have resulted from 9/11 are regarded with great concern. At first, OASAS advised programs that money would be forthcoming to deal with needs in the aftermath. A few of the administrators present talked about how they have already spent that money, but, thus far, they have not received these additional funds. A second concern is the massive cuts in community services that New York City Mayor Bloomberg is promising, which will hurt many community services that bolster prevention and treatment services. Finally, the State is expecting to cut the budget, which will most directly affect program functioning. One administrator summed up his fiscal outlook: "I've already received three notices in terms of cuts. HRA pulled their vocational money out of the OASAS contract in December. I got a notice 4 weeks ago that I lost my adolescent funds. I'm losing my expanded substance abuse funds. I'm losing approximately one-third of my funding by July 1st." If the predictions of more treatment admissions come true, many programs whose funds have been cut will have difficulty responding to increasing demand for services.

Lessons Learned

The lessons learned by the focus group participants may have differed depending on the type of program and personalities involved. Administrators generally believed that their programs responded as best as they could, and that proved good enough for clients and for most of the staff. Specific lessons learned about staff, however, illustrate the differences. In a therapeutic community, for instance, staff were expected to carry out their responsibilities appropriately, and most did. Although a few staff members did have problems and were "more trouble than clients," it all worked out. The administrator of a school-based program, in contrast, did experience his own personal problems in the aftermath, and realized that he needed to do more processing with his staff, and that it was important for him and for his staff to work that out if they were to provide effective services. "You can't do a whole lot with your clients until you know where you are."

Second, in dealing with the general population, some of the participants believed that a specific group in great need of services is families of firefighters and of police officers. These families have been stressed to extreme limits and may not be getting the help they need.

Finally, training about dealing with trauma and crises was very valuable to everyone who received it. Some discussants expressed the feeling that they were caught off-guard and that this training was necessary for their profession. Training in dealing with and alleviating ethnic tensions was also identified as needed, especially at this time.

Staten Island Focus Group: March 6, 2002

Six professionals representing a variety of AOD programs located on Staten Island participated in the focus group. The programs included residential and outpatient treatment and school-based and community-based prevention programs, as well as special-needs populations, such as dually diagnosed, homeless, and HIV-positive clients.

The city's least populous borough, Staten Island, is located to the south of Manhattan and very close to New Jersey. The borough is relatively isolated with two major transportation routes into the rest of the city—a free ferry to lower Manhattan and the Verrazano Bridge into Brooklyn. Staten Island is very suburban in character, but has splendid views of lower Manhattan and the Statue of Liberty. A large workforce takes the ferry daily from Staten Island to jobs in Manhattan.

Immediate Impact

The focus group participants reported a spectrum of responses in the immediate aftermath of the disaster, from complete chaos at some public schools to implementation of coordinated disaster plans at a hospital-based program. One discussant described the chaos at the public school in which she was located. Parents came to the school frantically wanting to take their children home. Teachers were calling children out of their classes, with many children getting upset by the panicky behavior. As another discussant observed who saw her own young clients become agitated: “We didn’t do a very good job [of] shielding them from what was happening.” As it turned out, other schools in the district may have had a calmer response. Staff, however, remained as long as necessary to ensure that every child was eventually called for by a family member or a friend.

The programs that had some disaster plan in place were able to implement the plan or parts of the plan and function as well as possible, in spite of phone outages and transportation problems. A hospital-based program responded to the hospital’s disaster plan, which is put into effect even for weather emergencies. The emergency room was readied for disaster victims. The people who did come were those who were fleeing from Manhattan and were able to get onto boats heading for Staten Island. “People just totally disoriented and covered with soot were at the St. George ferry terminal and were brought to the hospital.”

Another program that had a disaster plan that stemmed from fears of Y2K problems was well coordinated. Also, as one discussant explained, her program provides crisis intervention and “very concrete services” to special-needs populations all the time. Thus, when “people came over on the ferries and could not get back,” her program was there to help.

Staff from an additional program had special training in critical incident stress debriefing after the disaster of TWA Flight 800 off Long Island in 1996. A discussant explained how his program “immediately went from a chemical dependency program to a mental health program because the focus quickly shifted away from whatever we were working on that particular day to the events outside the window.”

According to most discussants, staff responded as well as could be expected. Since many staff members had family who worked in lower Manhattan, it was crucial for them to find out about their loved ones. Some administrators were particularly sensitive to staff members’ needs, and worked closely with them through the difficult days. Staff members who could not return home because bridges and roads were closed “buddied-up” and went home with their colleagues who lived on the Island.

Many of the programs received calls from OASAS and city agencies almost immediately with offers of help. A discussant who administers a nonfunded private program did comment that he received phone calls almost immediately from unions, EAPs, and mental health organizations inquiring about his

program's availability to provide counseling and mental health services. By Friday, September 14, his program was fully attended by many new clients.

Programs tried to return to a normal schedule as soon as possible. Another incident took place, however, that unnerved almost everyone on Staten Island. There was a car chase on the island over the Goethals Bridge involving the police and closing down bridges and roads once again. The trauma of 9/11 was then as real as ever.

Today: Six Months Later

Since September 11, there has been more training for staff, more programs providing services for adults and for children, and more networking among agencies on Staten Island. Some programs have had in-house training on stress management, bereavement counseling, anxiety reduction, and dealing with trauma. Project Liberty has been very helpful in providing training as well as counseling sessions. Some training was conducted in Manhattan, which was difficult for staff members once again to take the ferry back to the city. A discussant described the feeling, "It was scary to go back into the city, but it's like getting back on the horse."

The focus group participants discussed the willingness or the lack of willingness of staff to volunteer for additional training. Some administrators accept the fact that staff do what they can do and recognize that some individuals are just having a very difficult time. Other administrators appreciate the differences among staff, that some just try harder than others do. Also, some staff members are simply more capable than others, while other staff need a great deal of supervision. It is up to administrators to know the strengths and weaknesses of all their staff.

In addition to Project Liberty, the schools have established Project Cope for youngsters. Since December, this program has identified youngsters who have sustained a direct loss of a close family member; the figure stands at 269 public schoolchildren. Some of these children have become "school-phobic," fearful of even attending school. Although the problem is great, other children who may not have lost a close family member are also needy. Counselors, however, are being diverted to this very special group of children, but more counselors are needed for the other children.

Generally, Staten Island programs are seeing an increase in census figures. According to one discussant, patients were presenting very early on with PTSD symptoms, including sleep disturbance, hyper-vigilance, and a variety of stress symptoms. Although this syndrome usually occurs later on, the discussant questioned the traditional PTSD diagnostic criteria. Other discussants found more anxiety and depression in their patients and more medication seeking, especially benzodiazepines.

According to the representative from the private program, it has been relatively easy to get health coverage for problems related to September 11. "HMOs are no longer caring about medical necessity or length of stay. They don't want to be the insurance company that denied treatment to anybody that experienced any sort of loss or grief related to September 11. So we've been getting a tremendous increase in that regard."

Finally, Staten Island, because of its geography and its transportation constraints, has usually had to rely on its own agencies and resources. Since 9/11, that fact of life seems to be truer. Consequently, there has been a great deal of networking and coordinating of services and referrals on the island.

Lessons Learned

Perhaps the lesson that was most important to the focus group participants was the value of a well thought out disaster plan. Given the losses that Staten Island sustained, the realization of enormous vulnerability, the concern that other emergencies may take place, and the need for a sense of preparedness expressed by the group, it is understandable that this issue was paramount for the participants. The most vocal discussant talked about the efforts underway at her program to produce a disaster plan manual that touched on every aspect of her program. She strongly recommended that OASAS augment the effort by convening providers and professionals to exchange information on plans that are already in place and those that need to be considered. In fact, many other programs have already instituted some procedures as a result of weather emergencies, Y2K planning, and the TWA Flight 800 disaster, and, surely, in the aftermath of 9/11.

Another vital lesson learned, interestingly, concerned all the help that Staten Island agencies are getting, and the need to get appropriate resources. The local public school district, for instance, is receiving much in the way of “stuffed animals, packages, cash, survival kits, professional sports and theater event tickets.” According to the discussant, however, what the district really needs is more counselors and professional training to help the existing staff of counselors. Thus, although help is available, it may not be the help most needed. Furthermore, other Staten Island agencies are getting requests to do counseling that they are really ill equipped to do. Another discussant raised ethical and moral issues for these agencies to consider before they take on some very challenging mental health problems. In dealing with such profound loss and grieving, it is incumbent upon agencies to provide the most appropriate service as early as possible.

An interesting suggestion was made by still another discussant who felt she could have done much more in the immediate days after September 11. If she and some of her staff could have left their hospital site and traveled in a van to places where people were congregating—churches, schools, shelters—they could have provided helpful counseling and debriefing services on the spot and made referrals for additional services. Such a mobile unit on Staten Island could have provided help to people very much in need.

The representative from the private program had some different perspectives on staff responsibility, networking, and the important role of EAPs at this sensitive time. He did express his concern that his program and other private programs are usually not included in OASAS efforts, but could be helpful to New York State if they were included.

Finally, Staten Island’s unique geography and the fact that it is “out there by itself” required working together and using the island’s own resources. The clear consensus was, “We all did ourselves proud! We are a caring, helping group of people. We adapted; we were there!”

Queens and Nassau County Focus Group: March 6, 2002

Eleven professionals participated in the focus group, representing AOD programs mainly in the borough of Queens and a few programs in neighboring Nassau County. The programs include community-based and hospital-based treatment and community-based and school-based prevention programs.

Queens and Nassau County have a common border and are to the east of Manhattan. Queens, however, is one of the city's five boroughs, and Nassau County is one of the two counties comprising Long Island. Queens is home to two international airports—Kennedy and LaGuardia—and has excellent transportation into Manhattan via tunnel, bridge, railway, subway, and bus. The borough is also one of the most ethnically diverse counties in the Nation. Nassau County is the State's suburban county closest to Manhattan, with a large workforce that commutes daily to lower Manhattan.

Immediate Impact

Most focus group participants were involved in their program activities when they heard the news. A general state of shock and disbelief took hold. As one discussant described, "The patients were in as much shock and disbelief as we were." The hospital-based programs responded to the disaster codes of their hospitals. Since little information was being received, it was not clear whether hospitals were targets or whether they were getting ready to receive emergency patients. Interestingly, one hospital with "Jewish" in its name had staff members who were extremely concerned that the hospital was indeed a target.

Many discussants commented on how crowded their programs became almost immediately. The methadone programs were concerned about medicating their own patients and possibly medicating guest patients who could not get to their programs in other parts of the city. In one program, 40 guest patients presented for medication. Another discussant commented on the fact that alcohol patients who were not scheduled that day did, in fact, come to the program, perhaps for some security. Another program saw clients bring their children with them because they had decided not to send their youngsters to school during that first week. Nevertheless, patients were generally calm and were commended for their behavior.

Programs tried to operate as normally as possible in spite of the shock. Special efforts were made to keep the scheduled meetings of AA and NA "because people needed some stability."

The adolescent and school programs had special responsibilities to ensure that children got home safely and that caregivers were at home for the children. In one adolescent program, however, a young girl just left to be with her boyfriend because "this might be the end." In a public school program, substance abuse counselors were very effective with teachers and other school personnel, since "staff were in more crisis than the youngsters at this point." This discussant explained that her substance abuse counselors learned, especially in the first week, that their skills in counseling and group facilitation were needed at a time like this.

Clinically, staff that day and in subsequent days did whatever they could for clients. As one discussant explained, "We really didn't focus on alcohol and substance abuse but [on] more crisis management by helping staff and staff helping clients." The magnitude of the disaster was such, however, that even staff who had special training in dealing with trauma were overwhelmed by the need. Given the likelihood that a substance abuse population has had experience with trauma, 9/11 triggered many reactions, and sometimes in unexpected ways. One client who was a Vietnam veteran threatened to blow up his methadone clinic. He could not accept the praise given to firefighters and police officers who had died at

ground zero when he remembered the negative response he and other Vietnam veterans received when they returned home.

The “guest” methadone patients also needed special services and crisis intervention. Some may have been experiencing withdrawal as a result of the day’s stress, and the concern that they would not be medicated. In contrast, some other clients seemed unperturbed by the disaster and only realized that things had changed when they were asked for their identification when they entered the building.

Clients were also experiencing ethnic tensions in their communities and were showing extreme concern for themselves and their families. One client from Guyana shaved his head because he thought he might be a target. A few students were beginning to experience problems, especially when they were hearing from their parents that what happened at the World Trade Center was good!

According to focus group participants, program administrators had to work closely with staff. As one discussant observed, “Staff cannot help but take in some of that anxiety that the client is releasing.” One program designated a room where staff could speak openly, vent their anger, and discuss their feelings. “There were people who were pretty angry at those who attacked us, and they could purge that in that room, but we didn’t want to hear that on the floor and to expose the clients to that.” Some programs did hold memorials and convene staff groups, which gave people an opportunity to talk and to start to heal.

Very early on, Medicaid enrollment eased, and financial assistance came through for some clients. As a consequence, “the door opened for a lot of people to come forward.”

As efforts were made to get back to normal, the plane crash in Queens and the anthrax alerts were enormous setbacks. Also, an explosion inside a Nassau County hospital set off the disaster alarm, and “we assumed it was happening again.” The discussants agreed that the reality is that people are living in fear that it will happen again.

Today: Six Months Later

Many discussants were reporting increased census figures for their programs at a time when they are receiving notification from the State and the city that program components and services, such as vocational rehabilitation, are being cut. Also, some funding expected from the City Council will probably not be available. It has been difficult to build relationships with the council since term limits have gone into effect; there are now always new council members. Thus, for many administrators, lobbying for funds has become a fulltime job with a great deal of frustration. Staff members are receiving as much training as possible in debriefing skills and in dealing with trauma. Project Liberty has been very helpful in that regard. Staff, however, are also working harder than ever to accommodate the increased caseload. Even when vacancies become available, it is very difficult to hire qualified staff. For the discussants, the statement that best describes the current situation is, “We are being asked to do a lot more with a lot less.”

Clinically, it is not entirely clear that the clients presenting do have problems stemming from 9/11. Yet, one discussant explained, “If we scratch a little bit, you’re going to find a lot of anxiety issues.” His clients are also receiving more prescriptions for tranquilizers and antianxiety medication. Also, there have been more incidents of violence at his program. The discussant described, as an example, the stabbing of one client by another client as they waited on line for the clinic to open. This administrator is concerned about the pressures on clients to find employment and the likelihood that benefits will be cut off for many in the near future: “It’s going to be a very hot summer, and I mean hot in a violent way.”

The school-based prevention program has also been doing work with “bullying, dealing with teasing, dealing with violence prevention as well as substance abuse.” Violence prevention in the schools has

become an important focus, now required by the New York City Board of Education. According to the discussant's perspective, the level of violence has increased throughout society, "in every age group and in every system."

Another focus for the school-based prevention program is reaching out to parents who are now unemployed. There is a strong expectation that substance abuse and acts of domestic violence will be increasing among these adults as a result of job loss.

In general, the present situation at the programs represented in the focus group may not all be directly related to 9/11, but surely it is indirectly related and exacerbated by the effects of the disaster.

Lessons Learned

During the past six months and in the effort to keep their programs operating, some participants in the group may not have had the opportunity to process or absorb what has occurred in the aftermath of 9/11. One representative from a Queens program realized in the interchange of experiences in the focus group that his program may not have properly thanked staff for what they had done during those difficult days and intended to reward them for their extra efforts. A discussant from a Nassau County program realized that she could have called her colleagues in other agencies to reach out and offer help. She also said that she has attended many staff meetings since 9/11, but there was no effort to take time out to memorialize what had happened and to take some moments to speak to each other about their experiences and feelings. According to the discussant, taking note in some way with each other would have been very appropriate.

A very specific lesson learned concerned the need for a protocol regarding "courtesy" methadone medication. Considering the daily need for this therapy and the stress felt by patients, having some procedures in place with dosage information would have been very helpful. As it turned out, a nurse from a methadone program that had to shut down took her records home with her and called other programs with the names of patients who might need help and their dosage requirements.

Sadly, a school-based prevention program administrator whose counselors were very responsive to the crisis needs in the schools learned that the chancellor of schools did not include substance abuse counselors in his acknowledgement of the crisis responders in the school system. It was disheartening for her to learn of this oversight, especially in view of the good work her staff had done.

Another discussant realized the importance of ongoing training for his staff and upgrading their skills. Clients present with wide-ranging problems, and staff need to be able to respond to this very needy population. Also, programs need to become familiar with Oklahoma City's experience in the aftermath of its disaster to understand what future problems may eventually emerge.

Finally, a discussant shared a developing situation that was very disturbing. One of his clients, who is a firefighter working in recovery at ground zero, described some drinking practices among his coworkers. Apparently, there is a bar nearby that offers free alcohol to recovery workers, and "these guys go in and get hammered." What might be needed is "a 24-hour AA meeting going on down there." In any case, this observation was made: "We haven't even seen the tip of the iceberg as far as treating these workers, their families and their friends who are all traumatized by their trauma."

Long Island Focus Group: March 1, 2002

The Long Island focus group comprised 10 professionals who mainly represented AOD treatment programs located in Suffolk County, with a few in Nassau County and additional sites in Queens. These programs had several components and several geographic locations, and some also provided mental health services. A few of the participants were also therapists who had private practices, which provided additional insights about the impact of September 11 on the general population.

Geographically, Long Island's two counties, Nassau and Suffolk, are located to the east of the city's five boroughs. As expected, these suburban county residents have close ties to the city for employment and other business and have family and friends there. Nassau County is home to many city police officers and firefighters, and some city residents have second homes in Suffolk County—the county further east.

The Immediate Impact

At the very outset, transportation to and communication with programs were affected. Staff who commute from the city and outlying counties had difficulty getting to their Long Island programs, especially when bridges were closed down on September 11. Some administrators had to stay in touch with their programs by cell phone. Staff and clients learned what was happening by radio, television, and word-of-mouth. One discussant described the need for information: "It wasn't an event that ended, and then you proceeded with the aftermath. It was an event that constantly unfolded during the whole day. We just didn't know the scope of the impact."

Some programs had to decide whether to remain open or to close. Some opted to close so that staff could be with families and try to gather information about loved ones. Other programs polled their staff to determine whether to close. Still other programs further out on Long Island had little disturbance in routine.

For programs that were open, security measures were put in place, with limited entering and exiting. Other programs were in lockdown; no one could leave or enter. A hospital-based program geared up for trauma cases and for acute reactions; only a small number of patients came.

Clinically, clients who were at their programs showed a wide range of reactions. Clients at evening programs were much more talkative about the disaster than day program clients. The latter were much more self-absorbed. Some clients had to talk repetitively about the day's events; others with trauma in their backgrounds had these trauma reopened by the events of 9/11. Although crisis-intervention seemed to be the order of the day, therapists were trying approaches other than talk therapies, such as writing and acupuncture in the days after September 11.

In many programs, staff were more affected than clients. Some programs were quick to recognize what was happening and held "process" groups for staff throughout the day and subsequent days. Some staff, however, quickly volunteered to help out at ground zero and other locations where rescue workers were working and congregating.

Initially, local residents were not using services that programs were offering. Those in the uniform services had their own resources and very close camaraderie. Other residents in the community who may have been affected were seeking information about family and friends or were enduring job loss as a result of the disaster. They seemed to be fairly isolated, possibly in denial and unable to come forward to participate in some form of counseling. Many people were not going out at night. According to discussants, some people may have just been spending their time at home drinking.

The status of children in the area also varied. Some parents went to their local schools and took their children home before the school day ended, although school personnel tried to discourage the action. The endless television watching seemed to be affecting both children and adults.

Project Liberty, a mental health effort funded by the Federal Government, went into action in both Nassau and Suffolk Counties. Money quickly became available for counseling and training with the intent of helping local residents. Information about these services was disseminated widely, especially at the Long Island Railroad's local train stations. Concern was raised about commuters, particularly ground zero rescue and recovery workers. One discussant mentioned the frequent sound of "popping that beer" on the train as commuters were returning home. Also, training in critical-incident debriefing and dealing with trauma was quickly made available at several sites, especially in Suffolk County. Often these training sessions were filled to capacity.

Policies that day and the days immediately following varied by program, town, and county. Some program directors were in touch with OASAS and with their association of AOD programs, seeking advice and giving advice. The mutual support was much appreciated. Some towns had past experience with responding to crisis after the TWA crash off the southern shore of Suffolk County a few years ago. Lists of volunteers and counselors became available for the community almost immediately. Finally, the Suffolk County Division of Mental Hygiene was noteworthy in organizing training sessions for the professionals in the county.

The proximity to New York City—from sites in Queens to sites on the eastern end of Suffolk County—was an important variable in understanding the immediate impact. As one discussant stated, "Location, location, location!" The closer the program was to Manhattan, the more dramatic the impact. For the sites closest to ground zero, "The mindset of the program was in a much different place than we've ever been before!"

Today: About Six Months Later

The perception seems to be that the events of September 11 are still close to the surface for the general population who are "waiting for the other shoe to drop." The crash of the airplane bound for the Dominican Republic 2 months later reopened the trauma for many, and had a dramatic impact on the Hispanic population in the community.

Clinically, the clients entering treatment are presenting with many issues secondary to their alcohol and other drug problems, such as marital problems, criminal justice problems, and lost jobs. Many clients, however, do not connect their problems to 9/11. A discussant who also has a private practice stated that her patients in a general mental health setting see the connection more than do her substance abuse clients in the program she administers.

Many of the adolescents who currently receive services have the attitude, "What do we have to live for anyway; might as well live it up now." There also seems to be more "high intensity" interaction between parents and children who come for counseling. Adolescents are also presenting with more eating disorders and obsessive-compulsive disorders. Again, the clients do not necessarily make a connection with the trauma of 9/11, but focus group discussants believed that connections exist.

There is continued concern for New York City firefighters, police officers, and for ground zero recovery workers who live in the community. Although they continue to have support from within their ranks, much of the camaraderie and rituals include heavy drinking. There has been little closure for them, and the drinking has continued over the past 6 months. Evidence of problems is surfacing, particularly in incidents of domestic violence.

Perhaps the most lingering effects are seen among staff. Focus group participants discussed the fact that staff have been resigning and that remaining staff are taking more sick days. For some discussants, it was clear that staff in treatment programs are not trained sufficiently to recognize the mental health problems that do trouble clients. Staff members can hardly deal with the effects of their own trauma. Also, staff have trouble dealing with racial problems that have developed in some programs. Here, too, training is needed. In general, the good feeling among staff has diminished, and a more somber mood seems to prevail at some programs. As a healing and commemorative effort, a discussant representing a Suffolk County prevention program was planning a 6-month anniversary event on trauma, coping, and the human spirit. Only school personnel, mental health professionals, and crisis responders in the community were invited.

Several programs are reporting a recent increase in admissions after a period of decline, which may be attributed to the disaster. Programs are also reporting fiscal problems, partially due to delays in Medicaid processing. In the past, Medicaid processing would take about 45 days, now it takes about 6 months. Staff, too, are feeling insecure about their jobs; some fear possible layoffs.

Project Liberty, which has supported much-needed training, has been thwarted somewhat by “administrative paranoia.” Unfortunately, Nassau County has been experiencing severe fiscal problems and cuts to many local services. When Nassau County programs received Project Liberty money, recipients were very protective of their funding and may not have cooperated sufficiently with colleagues in sister agencies. Nevertheless, Project Liberty has provided important support for Long Island residents and their mental health needs in the aftermath of 9/11.

Lessons Learned

Long Island’s focus group participants discussed several lessons learned since the disaster. First, discussants touched on the importance of addressing staff needs. Staff members were true professionals, working in their programs, volunteering in the community, and going to ground zero. They surely should be commended for their efforts. In addition, it was recommended that, if staff do have personal needs, their programs should be “safe environments” where they could confide their problems without fear of losing their jobs. Staff, however, do need more training, especially in critical incident debriefing, and in dealing with trauma.

A second issue raised concerned the relationship between the AOD and mental health fields. According to one discussant, alcohol and substance abusers have always been a “trauma” population, but identifying them as having mental health problems has been frowned upon, since funding comes from the substance abuse side. Thus, the recommendation was made: “We need to stop playing let’s pretend and give counselors the kind of training that they need. I’m not saying they’re going to be doing mental health work, but they need to be able to identify and be able to refer and be able to bring to supervision and be able to notice it because they’re the ones seeing the client.”

As a corollary to this recommendation, the need for better assessment tools was raised. One discussant mentioned a form now used on intake that screens for a variety of specific mental health symptoms. Although this was implemented before 9/11, it serves well in the wake of 9/11.

A third lesson learned concerns the importance of Project Liberty. The focus group participants who saw the workings of the Federal program appreciated the way in which their program efforts were bolstered by the additional training and counseling that were made available. Now there was concern that Project Liberty would shut down and disappear in the near future. The strong recommendation was that Project Liberty or a similar program should become a permanent resource for the field. One discussant, however,

advised that the traditions in the field are hard to change, and outcomes that are expected are not the mental health outcomes.

A fourth lesson underscored the importance of having a disaster plan in place. Those in the group who witnessed coordinated plans implemented by hospitals and schools were impressed with how quickly resources were mobilized. Those without a plan in place felt inadequate and helpless to respond.

Finally, discussants recommended the importance of learning from the Oklahoma City disaster. There is a strong likelihood that the major problems of alcohol and substance abuse are yet to come.

Mid-Hudson South Focus Group: March 14, 2002

Twelve professionals, many of whom are both administrators and clinicians, participated in this focus group. They represented various AOD programs located in the suburban counties of Westchester and Rockland. The treatment programs were hospital-based and community-based and the prevention programs were school-based and community-based.

Westchester and Rockland Counties, separated by the Hudson River, lie generally north of the city and have strong ties to the city. More populous and closer to the city, Westchester has a large commuter workforce that travels daily to the Financial District of lower Manhattan. Rockland is home to a large number of city police officers and firefighters.

Immediate Impact

Focus group participants were either engaged in program activities or on their way to work on September 11 when they heard news of the disaster. Although the day's events were filled with shock and disbelief, hospital programs immediately went into emergency mode, crisis teams were activated in school-based programs, most day programs remained open, and most clients kept their appointments. As one discussant described, "In the context of this incredible, unimaginable scenario, things went fairly smoothly."

The school-based prevention programs were very much involved with the needs of the children and were part of the crisis-response teams in the schools. Even though they are alcohol and drug prevention programs, one discussant described them as "broad brush programs dealing with all sorts of behavioral health issues." Their immediate concern was giving support and appropriate information to the children. The second concern was ensuring that children got home safely and did not go home to empty houses. One program was instrumental in helping children make phone calls to their parents who were working in the city, then taking the younger children home by school bus, and informing the caregiver that the children needed to be told what had happened in the most sensitive way. Also, it was recommended that television sets not be turned on for the children. This was good advice in view of the fact that some young children in another district thought that the buildings were hit about 10 times as they watched the disaster on television over and over again.

The methadone programs remained open to medicate patients and to respond to "guest" patients. Other day programs remained open with phone outreach to those clients who did not make it to their programs. Evening programs, however, were poorly attended. One discussant said that she thought people were quickly developing a "bunker mentality," staying at home and wanting to be where they felt safe. Some programs arranged to have their mental health workers and private practitioners go into the community to provide grief counseling and help in locating loved ones. Discussants shared that on 9/11, Westchester County lost 170 people, and Rockland County lost 57.

Clinically, the clients presenting on that day and subsequent days were generally responding in diverse ways. According to the discussants, some clients talked openly and easily, but others shut down and did not acknowledge what had happened other than to ask whether the clinic would be open and whether their benefits would continue. One focus group participant described his clients as either in "narcissistic denial" or "schizoid withdrawal." Clients who actually were looking for loved ones or had identifiable loss were very much connected and easier for staff to deal with.

Guest methadone clients also presented in a strange way. According to one discussant, these visitors were very quiet and acted as though "they should be seen but not heard." The administrator made a special

effort to interact with them and to put them at ease. A prayer session convened by some religious people at this particular program helped both staff and clients.

The children showed a range of reactions over several days. For one focus group participant, the immediate reaction was a lot of talk and a lot of questions: “Why do people hate us? What did we do to deserve this? Is this going to happen again?” Another discussant found that the younger children needed reassurance and the feeling of safety. The adolescents, however, were saying, “Don’t tell us we’re safe, don’t tell us it’s okay because you can’t guarantee that.” It was important to respect their attitudes as difficult as that might have been.

Many parents were having a difficult time, especially the more fragile among them. Some simply were giving up on life and were sitting at home “waiting for the next plane to hit.” Some veterans and others who had experienced trauma in their lives and perhaps had it “carefully filed away, hopefully never for future use,” found those traumas emerging once again. People were also purchasing ammunition for their guns.

Program administrators were generally sensitive to their staff members who were dealing with clients as well as dealing with their personal problems and sense of panic. In one program, mental health professionals were invited to facilitate a therapeutic process for staff. A discussant explained: “In the first moment, we reached out to our clients, and we knew where they stood. In this next moment, we needed to take care of ourselves.” Another discussant described the kindness and consideration of the administration toward the staff, which then rippled out to the clients. In other programs, staff who had never interacted before were supportive and became a source of comfort for each other.

In retrospect, the discussants by and large saw those days as a normal response to disaster. They were concerned that there had been too much talk of pathology and mental illness, when in fact there was a showing of internal strength and “a gritty kind of optimism.”

Today: Six Months Later

Normal program routines have resumed, and, on the surface, much healing has taken place. Nevertheless, adult clients are relapsing, adolescent clients are presenting with symptoms of serious problems, ground zero recovery workers in the community are emerging as a population in need of services, and staff continue to have problems.

Clinicians in the focus group speculated that the trauma that many clients have experienced in their lives may have been dormant for many years. The 9/11 disaster, which was a “collective trauma,” may have awakened the personal trauma—child abuse, sexual abuse, domestic violence—that may never have been addressed. Now these earlier traumas are coming to the surface for some troubled clients.

At least one discussant has tried to use the disaster as an incentive to stabilize. She urges her clients to stay out of jail and to stay healthy so that they can remain in the community and with their families where they are needed.

Adolescents and young adults are presenting with more anxiety and depression, and with high-risk behaviors with and without the use of alcohol or other drugs. The most serious problem, however, is the incidence of suicide and suicidal ideation among young people. Discussants talked about suicides in the past that were the impetus for forming crisis teams in some communities. Now, if anything, these events are increasing. One discussant commented, “I think that we are seeing the aftermath of 9/11.”

Also, adolescents are reporting more gang involvement. According to a discussant, the perception among these teenagers may very well be, “My family can’t keep me safe. I feel more powerful, more in control and more a part of something in a gang than I do with mommy and daddy.”

Even younger children are showing more anxiety and more fears, and in one program, they do not want to advance to the middle school. The observation was made that they are “absolutely terrified.”

Over the past 6 months, some discussants have counseled firefighters, police officers, and other ground zero recovery workers. In fact, one clinician played a tape of an interview that he had with a client who was assigned to work in the recovery operation. According to the client’s dramatic description, many people who are trying to cope with the magnitude of this act are using alcohol and other drugs, such as Vicodin and Percodan. “They feel that it’s almost their right, that if I survived this, I deserve a drink.” The client stated, “It’s replaced the grieving process, where I think people are afraid to grieve.” The most poignant moment on the tape was when the client met some other people-in-recovery at ground zero and recognized the bond when one said, “Are you guys a friend of Bill?” At that point three recovery workers held an AA mini-meeting to help each other through some devastating moments.

Project Liberty funding has been very helpful in both Rockland and Westchester Counties. Rockland has been working with families who have lost loved ones and working with firefighters and police officers in the county. Westchester funding is generally going in the direction of prevention, early intervention, and working with the general community.

Programs are trying to deal as best as they can with new clients, relapsing clients, and clients who are presenting with more serious mental health problems. Clearly, staff are in need of more training and better assessment tools. Staff are also working longer hours and continuing to have personal problems. To add to their difficulties, staff are getting further frustrated with the never-ending documentation and paperwork that are needed for each client. Thus, administrators are experiencing many day-to-day problems in trying to run their programs as effectively as possible at an extremely stressful time.

Although 6 months have passed, the consensus of the focus group is that the aftereffects are still very much part of the daily life of the area and may be increasingly coming to the surface as more and more people are seeking help. One discussant summarized the tensions as “suffering with terrorism,” explaining, “I think the closest thing would be to visit a society such as Israel or other places that live with this on a daily basis for year in and year out... For us, this is uncharted territory.”

Local residents have become very active in trying to shut down the Indian Point nuclear power plant in the region. Focus group participants discussed whether targeting the plant was something for people to do as “displacement” or whether it was a legitimate target that threatened the safety of the region. In any case, since 9/11, there has been a dramatic increase in local activity to rid the area of the nuclear power plant.

Another discussant mentioned the anthrax decontamination trailers that sit behind her hospital’s building, symbolizing for her the ongoing threat. Later in the day, she was going to participate in a discussion on “What to do when the unthinkable happens?” Thinking and planning are now heading in a direction that never could have been imagined.

Lessons Learned

Those familiar with Project Liberty efforts in Rockland and Westchester were very grateful for this infusion of funds. Given the lack of competence or training in responding to a disaster of such a magnitude, Project Liberty permitted training of “disaster responders.” More training is still needed.

Also, the experience gave counties an opportunity to use the funding in a way that suited their needs and to network in ways that they had not done in the past. For many programs, these were valuable lessons.

Perhaps the most compelling lesson for many discussants concerns the urgent needs of young people. Addressing the problem of suicide and accidental deaths has become a major focus. Although the connection to 9/11 is not clear, the number of deaths among young people have increased over the past 6 months. One discussant asked, "Can we do more to educate families and schools regarding what to look for and what behaviors lead to suicide and death?" Another discussant talked about the need for resources and information to give people so that they could better help their children. "We are the first responders in terms of mental health, and alcohol and substance abuse in our county. Frankly, we were ill-prepared." This particular program has since collaborated with other agencies and specialists for ongoing mental health needs in the community.

Finally, the response to staff needs taught many lessons. Although some administrators maintained that "People needed to stay on the job, and those that needed to go home do it, but we needed to be there for the clients." Nevertheless, administrators learned that it was very important to help staff resolve their problems as soon as possible if clients were going to get proper care.

The Mid-Hudson North Focus Group: March 13, 2002

Nine administrators of AOD treatment and prevention programs participated in this focus group. The various programs represented were located in the outlying suburban counties of Dutchess, Orange, Putnam, Sullivan, and Ulster—all north of the city.

Geographically, these counties are at the least about 40 miles from Manhattan. Although local residents do commute to Manhattan for work—especially from the more southerly Orange and Putnam Counties—the trip is substantial. Nevertheless, many local residents have family and friends who live in the city. Many clients in residential programs in this region do come from New York City.

Immediate Impact

Focus group participants discussed their initial reactions to news of the disaster. Some discussants who may not have had access to television thought at first there was an overreaction to the news; others immediately became distraught, especially if they had family or friends working at the World Trade Center. Most tried to do what they needed to do in order to keep their programs running.

Communication and rail transportation were seriously disrupted that day and for subsequent days. In some programs, telephones were not working, train service to the city was halted, and clients—especially those from New York City—and some staff felt trapped by the situation.

Clinically, clients were responding in extreme ways. Some clients were becoming very overwrought by the news. In fact, certain individuals had to be taken out of their programs and hospitalized because of psychotic symptoms and suicidal ideation. One client started saying that he was glad this happened because of his religious beliefs. This created such a stir in the program that other clients “wanted to kill him.” Staff worked quickly to quiet him, take him out of the group, and, eventually, to hospitalize him. Some clients, as soon as they could, left their programs to return to the city despite the efforts of staff and other clients to keep them from leaving. Clients in one program showed very positive inclinations by wanting to contribute to the rescue efforts at ground zero. It was decided that, by giving up one meal in their residential program, \$1,000 could be saved by the program, which could then be sent to help the rescue workers. The residents agreed, and the money was sent. Spiritual meetings and spiritual counseling were very helpful to many clients at this time.

Students were generally calm during the immediate days—and even behaved better. Although parents had wanted to call for the children as soon as they heard the news, school personnel asked that parents not frighten the children and wait until the end of the school day; most parents did listen. Interestingly, the discussants tried to explain why young people seemed to show so little response to what was happening. It was suggested that, because the disaster was not personally or directly affecting them, it was not their problem. Also, young people think they are invulnerable, and nothing was going to happen to them. In any case, the question remained: “Is there a different process in adolescence?” Young people were simply saying, “Can’t we just move on already?”

Staff did have problems, but program administrators and mental health professionals were very helpful. In the days after 9/11, staff members were anxious, getting depressed, and were working as though they were on “automatic pilot.” In programs where this was recognized, many administrators helped and supported staff. According to one discussant, critical incident debriefing was particularly helpful to her staff. A professional from their EAP worked with the staff in two phases. First, staff members, individually, talked about their own experiences on those immediate days after the disaster. Then, these staff members worked with others who came into the program who had a similar need to talk. As it turned out, it was probably doubly helpful to staff.

Staff members who may have had the hardest time were Vietnam veterans who had suffered from PTSD. The World Trade Center disaster produced numerous and difficult flashbacks. Other staff members had a profound need to go to ground zero to try to help. They worked in their programs during the week, then went to Manhattan on the weekends. They, too, had a difficult time.

Many programs had to respond to different needs as the days unfolded. The methadone program had to accommodate the needs of patients who worked in Manhattan and attended methadone programs there. Because they could not get to their city programs, they received medication in the Mid-Hudson where they actually lived. OASAS helped facilitate the guest patients. Another discussant saw the value that her community center program had for the local residents. People may not have wanted to call mental health facilities, but they were very comfortable calling the community center. She became knowledgeable about local resources, prepared packets of information, and took numerous phone calls from local residents. Clearly, as one participant observed, programs had to operate “outside the OASAS box.”

Today: Six Months Later

As time has passed, changes have occurred. Staff members in some programs seem to have better morale, have become closer, and now have lunch together. In contrast, students who had been very calm initially seem to be showing more aggression and rage. Also, young people are showing more intolerance toward people of color. Thus, there have been talks about attitudes and prejudices in several programs. In group sessions, some young people are now talking about “how they’re vulnerable and feel the world is not safe.” The comment was also made that, “Perhaps parents are still preoccupied and are trying to find support for themselves. I think the kids are feeling a little abandoned by their parents because their parents are very much taking care of themselves with all their support groups.”

Census has gone up in several of the programs represented in the focus group. Some discussants said the research is being borne out about posttraumatic stress. “PTSD comes out in 6 months. We’re seeing more people coming for services. And those people who are coming are talking more about symptoms.” Clients also seem to be presenting with more medical problems, including Hepatitis C.

With the ready availability of emergency Medicaid benefits, individuals from New York City are also presenting for 28-day heroin detoxification. In fact, the requests for detoxification are “just astronomical.” People are explaining that they wanted “to get away from New York, they couldn’t deal with it anymore, and they’re moving upstate to try to get away from that feeling of what they experienced in the city.”

Project Liberty has been very effective in some counties in this Mid-Hudson area, especially in Dutchess and Orange Counties. The agencies that are participating in these counties are working well together to provide counseling, make presentations, and provide training in debriefing. Public service announcements and community notices advise local residents of upcoming meetings and services. Sullivan County was also awarded funds, but services in that county have yet to materialize.

Although programs have been getting back to relative normalcy, the feeling still exists that something else will happen. The recent anthrax scares and the proximity of the West Point Military Academy and the Indian Point nuclear plant all contribute to an undercurrent of concern that is widely felt in the region.

Lessons Learned

Focus group participants talked about some unanticipated positive effects that came as a result of the disaster. First, there have been more alliances among staff and team building among individuals. Second,

cooperation among agencies has been noteworthy. Many programs had been isolated from each other, but now there is an appreciation for what they can offer each other in assistance and professional know-how.

Also, the experience taught the lesson that administrators and counselors need to be tuned into each other and to what can be done and what cannot be done. For instance, administrators need to know the staff skills better. As one discussant put it, “Administrators need to make more assessments as far as the staff’s strengths and weaknesses and how some of them may not be the best people to be doing what they’re being asked to do.” Similarly, counselors need to be able to improve their assessment capability. “They need to know when they can handle it and when they need to refer out.” It was thought that some professionals had overestimated their training, but, when their skills were tested, “they were feeling overwhelmed, that they knew about grief counseling and PTSD, and may have felt equipped to deal with that, but this was ‘realer’ than they thought it would be.”

Another lesson learned is that the community needs education, especially in sensitivity to other cultures. One program representative discussed her efforts in working with the Orange County Community College to provide a public program highlighting world cultures with information and cuisine. The series will begin by featuring Indian and Pakistani cultures. Unfortunately, program funds at this point are nearly exhausted.

Gambling is another addiction problem that may be increasing in the aftermath. One discussant who counsels problem gamblers finds an increase in the number coming for treatment. At this time, when New York State may be legalizing gambling in the Mid-Hudson, she urged that treatment funds be made available for what might be another problem associated with 9/11.

Some discussants emphasized the intolerance found among young clients and perhaps “misguided patriotism” in the wake of the disaster. The decision has been made in some schools “to emphasize broader issues with our students in terms of character development and values.”

Finally, there was a positive self-image that came out of the tragedy. Program administrators were generally pleased with the response their programs made and the acceptance they received in their communities. Most importantly, however, the clients were okay, and that clearly was “what we’re trained to do is help the clients.”

Albany Focus Group: February 27, 2002

This focus group included seven professionals who represented a variety of AOD treatment and prevention programs in the Northeastern Region of New York State.

The Immediate Impact

Participants discussed the varying degrees of functioning that took place at their treatment and prevention programs after they heard the news of the disaster. The residential programs tried to maintain some semblance of normalcy, whereas some of the ambulatory or day programs had difficulty functioning. Although all public schools have a crisis response plan in place, not all were activated. It became clear that in many cases, staff were having a particularly difficult time coping with what had happened.

Geographically, this region is at least 150 miles away from New York City. Yet, many area residents have direct ties to the city. Local residents commute to the city regularly, many have family and friends who live there, and a good number of treatment clients are, in fact, residents of New York City and Long Island. Also, on the morning of September 11, a group of students from the region had an outing on a boat that was sailing in the New York City harbor at the very moments that the planes hit the Twin Towers.

Clinically, a level of “self-care” had to occur among staff before they were able to deal with clients. As discussants explained, staff were exposed to the news at the same time the clients were, with no time to process the information or to find out about their own family members and friends. In fact, many staff members were showing their fears, insecurities, and vulnerabilities. As one staff member was quoted, “I can’t be here. I’m no good to the clients.” Efforts were made over the subsequent days to give staff time off and to give them space or rooms where they could find some respite.

In contrast, clients generally showed less of a reaction than staff. Although some residential clients who were from New York City and Long Island were extremely upset, most other clients showed very little response. In fact, some counselors were angry with clients because they showed so little feeling. Focus group participants tried to explain the muted reaction among clients. For some clients, traumatic events have occurred frequently in their lives, and, sadly, they have become accustomed to bad things happening. Other clients have taught themselves not to feel or show emotions. One discussant explained, “They have become good at blocking things out and shutting down.” Another insight concerned the point in recovery that the client had reached. Those early in the recovery process show little emotion because they are self-absorbed and have much to deal with in putting their problems behind them. Those later in the recovery process, however, are able to open up to what is happening around them.

In any case, residential clients may not have been talking to their counselors, but seemed to be talking to each other and helping each other get through the immediate days after September 11. One program reported an angry racial episode, involving Muslim clients. The episode was confronted by counselors and resolved with the clients. A small number of clients who lived in New York City did leave to return home despite efforts on the part of clients and staff to convince them to stay.

Students seemed to handle the first days with a variety of reactions. Younger students appeared to be more resilient than older students. Older students were more fearful about what the next target might be, such as the water supply. Some students were nervous about low-flying planes and had difficulty paying attention in class. Although crisis teams were available to the students, some principals may have shown poor judgment. For instance, one principal merely announced over the public address system with no warning that if a television set were available in the classroom, it should be turned on, “since something is

going on.” As a consequence, teachers were exposed to the news with the students without having an opportunity to consider some calm response to the students.

Students who were in New York City that day on the boat ride managed much better than expected. The boat’s crew wisely engaged the students in a number of tasks to divert them from the disaster taking place on land. A counselor went down to Westchester to try to intercept the students as they were returning and to provide psychological help if they needed it. The students, however, seemed to handle the situation relatively well.

The majority of the area’s programs were thought to have remained open, but were understaffed. Watching television and convening in groups were probably the common activities in most programs. Telephone communication was often difficult and especially frustrating to clients and staff who needed to call the city to locate family and friends. Efforts were made by some programs and agencies to put together what was called “a disaster package,” which included information and resources for a variety of needs among local residents and was left on a table in a county building. Also, a concerted effort was made by programs to reach out to clients who were not seen during that first week to assure them that the program was there for them. Prayer meetings and spiritual counseling were helpful to both clients and staff whenever and wherever they could be arranged.

The State Education Department did take an immediate lead role in convening a group of people to determine what needed to be done in dealing with youngsters at that critical time and what crisis resources were available. Faxed material was sent throughout the school system almost every day in that immediate aftermath.

Today: Almost Six Months Later

Discussants talked about the spiking of activity since December compared to October and November. At first, some programs were seeing fewer clients after 9/11, and now an influx of clients is presenting for treatment. As one participant confided, “In November and December we were afraid we could not meet our minimum quotas. Now we are ‘maxed out’.” Also, programs are seeing more dually diagnosed clients, more presenting with anxiety, and more referrals from mental health facilities. There is better attendance at parenting and family programs as well.

Whether current trends are directly related to 9/11 is hard to determine, although discussants suspected a connection. Some clients with anxiety disorders and relapse do cite the events of 9/11 as the cause for their need for help. Children at an afterschool program continue to talk about the events of 9/11. Some staff seem to be taking more sick leave and are leaving work earlier. When the November plane crash occurred in Queens, both clients and staff were having bad reactions. People were starting to move on, but now they were fearfully asking, “Was this going to continue?”

Clinically, many clients are still self-absorbed, showing little acknowledgement of the disaster. One discussant suggested that if counselors were better trained in addressing trauma that clients would be able to talk more openly about their feelings. He felt that programs are not better prepared today to respond to such a disaster. “We would probably turn off the television sets and have more groups.” Fears among students continue, but also outbreaks of racism have occurred. Muslim children have been targeted, and efforts have been made to address the anger and hate among students.

Some staff members continue to show anxiety and a lack of patience. One discussant reported that three of her staff are on medical leave, but the number of clients in the program remain the same. Thus, the workload has increased for everyone. In contrast, another discussant found that his staff members were closer and working better together since 9/11.

A program issue that was underscored by a few of the providers concerns fiscal worries. For some providers, there has been simply a delay in receiving reimbursement. In fact, an anthrax scare in the post office had delayed delivery of funds to at least one program. It was perceived as a double blow—one's financial security as well as emotional security were harmed by the latest events.

Another program was concerned about its funding from United Way. With so much money going to the 9/11 disaster fund, doubts were raised about local funding. As it turned out, United Way's level of funding for the program was maintained. Nevertheless, some program managers and boards of directors are working harder at fundraising.

One discussant whose program continues to function relatively normally interjected a cautionary statement about what the substance abuse field is experiencing now, "I don't think we are going to see the results of 9/11 for another 2 or 3 years...I would like to see us really be careful that we don't try a little too hard with something that's not there yet. We got to be realistic on what our needs are at this point. Yes, it was a tragedy, and I'm not in New York City, so I can't respond to how much it's hurt people down there. But in the field in general, we better be careful that we don't exaggerate that we may later on have to go back and say these are the real facts, these are real people now to treat."

Lessons Learned

Several lessons were learned over the past few months. First, it was generally agreed that having a disaster or crisis plan in place has merit. Very much like the schools, treatment programs could have a similar concept that would involve the community and a mechanism in place to work together and to reach out quickly to a variety of agencies. A school-based prevention provider succinctly described a simple crisis plan as "a team which would include key people in your organization who get together immediately when a crisis occurs and considers the people you need to worry about—the students, staff, parents, other community people—and how to respond to their needs." To provide information rapidly, one such program is developing a Web site where information can be accessed about the community and responding to crisis and trauma.

A second lesson, especially for treatment programs, involves providing more for staff. Although it is hard to prepare staff for all things, it is important to have an ongoing wellness program, to have good lines of communication, and to know when one needs "to cut some slack." Additional training would be helpful, but exactly what kind of training was not clear. Some efforts are being made to get training for staff in addressing trauma. Interestingly, one discussant was trying to get additional training for support staff, such as secretaries, building staff, and receptionists, especially in CPR and Red Cross training. His thinking was, "When a crisis like this happens, everybody becomes equal."

One discussant saw the importance of research, especially on the effects of 9/11 on children. Since some "Communities That Care" surveys were administered before the disaster, and now they will be administered post-9/11, he thought that having the benefit of such a comparison might yield important insights about the well-being of children over these difficult times. In closing, the discussants agreed that planning for Y2K problems gave them experience into thinking, "What if...?"

Watertown Focus Group: February 13, 2002

This focus group included nine professionals who represent AOD treatment or prevention programs in the Jefferson County area of upstate New York.

The Immediate Impact

As the discussion revealed, the news of the September 11 disaster found staff and programs in the midst of various activities. Residential programs, of course, were fully staffed and into their scheduled routines. Schools were open and students were in classes. Outpatient and day programs were getting started. Many directors and administrators were at meetings. Once the news was heard, meetings ended abruptly, public address systems in schools disseminated information, and television sets were turned on.

Given the location of Watertown where most programs were situated, there was almost immediate concern that the Fort Drum military base could be a target and the need to deploy troops. Also, fears were expressed about nearby nuclear plants and the fact that terrorists could walk across the Canadian border, which was less than 50 miles away. During September 11 and subsequent days, many in the area fearfully discussed “what else was going to happen.” Although most program staff were on the job, many staff members had personal concerns about family and friends in New York City.

Clinically, over the next few days, clients were showing a whole range of reactions. Some were showing a great deal of anger and hate. Others were very anxious, reporting insomnia and paranoia. Focus group discussants agreed that many clients showed very little reaction. Perhaps the most reactive clients were those who were dually diagnosed, those who had much trauma in their lives, and veterans with war experiences. One clinician found that nonverbal techniques, such as music and art, were very effective in calming patients. Also, television sets had to be turned off!

Some adolescents, over the first several days, sought out substance abuse counselors and guidance personnel who were on hand in the schools. Students came in pairs or groups to talk to the counselors, “wanting to know if they were safe.” Some students expressed concerns about their parents’ unemployment problems in this economically depressed area, and the likelihood that “everything was going to New York City, and they felt that their support was going to dwindle down to nothing.” One school principal assessed the students’ reaction in terms of two responses—great resiliency among most students, but an attitude of “What’s the use? Let’s party it up!” among others.

Clinical staff, in trying to respond to the needs of clients as well as their own personal needs were under a great deal of stress. Many felt that their training was inadequate for the mental health tasks confronting them. Since some staff were themselves in-recovery, they felt they needed to protect their own sobriety. AA meetings in the area, for instance, were well attended in the subsequent days and in the 5 months after the disaster.

As far as programs were concerned, efforts were made almost immediately to reach clients by telephone who had not kept their appointments and visit their homes if necessary. Telephone communication with programs was difficult, especially in some offices where a backup of voice messages was reported. Visits to homes, however, found some clients “drinking heavily, self-medicating, and talking about ‘what’s the sense!’” Nevertheless, an outpouring of patriotism did occur in programs, and efforts were made to raise money to send to ground zero. Also, some staff members and residents in the community decided to go to the city to offer their help. A special, family-like bonding took place in local treatment programs in the aftermath of the disaster.

Interestingly, before September 11, one of the focus group participants was asked to give a talk at a community function on a relevant topic. The theme of his talk: “We recover together, friends, family, and community.” It turned out to be a more relevant theme than he could have imagined.

Today: Five Months Later

In assessing the current situation, focus group participants discussed the activity in their programs. Census figures in local programs are close to capacity, waiting lists are appearing in programs where there had never been waiting lists, suicidal ideation is more prevalent than it has ever been, and requests for EAP training in stress management, crisis management, and anger management have increased. Attributing these changes to the World Trade Center disaster, however, is very difficult.

Perhaps the most direct evidence of effect is the fact that the disaster continues to be a treatment issue, mentioned time and again in counseling sessions, and especially when there are government alerts, and after the plane crash in Queens 2 months later. Also, young adults and adolescents continue to ask about the likelihood of a military draft.

Many of today’s trends in the area persist from the past, prior to 9/11, but are exacerbated by its effects. The clinical issues, for example, are growing more severe. Several students, for instance, who receive counseling from substance abuse counselors, are also showing evidence of self-mutilation. These students receive referrals, but waiting lists have delayed their entry into appropriate treatment. In a hospital-based program, it takes 3 to 4 weeks for an assessment and then an additional 8 weeks to be seen by the psychiatrist. Patients now receive medication until a physician can see them. As one discussant stated, “We are inherently inadequate in dealing with psychiatric symptoms and diseases.” There was much concern that the situation will become more serious in the light of Oklahoma City experience after its disaster. People present with alcohol and other drug problems as much as 12 to 18 months after the experience of such a trauma.

Staff continue to be overworked and are asked to do “way too much.” Focus group participants talked about the number of hours that their counselors give to their programs. One discussant estimated that his counselors averaged about 40 hours a week in counseling sessions and 15 hours for paperwork. Staff members are leaving the field, and hiring experienced counselors is exceedingly difficult. New York State’s fiscal problems due to the disaster have made remaining staff uncertain about their employment, inquiring frequently, “Is my job secure?”

The policy issues raised in the focus group discussion may or may not be related to the disaster but have become more serious in the past several months. First, the number of certified alcohol and substance abuse counselors (CASACs) have declined, and finding qualified counselors to fill vacant positions is extremely difficult. Second, accessing mental health services is very difficult. In fact, it was the perception of participants that “our field is getting a good share of the mental health clients that were once served by mental health agencies.” Third, a drug court is scheduled to start functioning in Jefferson County in the near future. Although the concept is a very good one, it places an extra burden on treatment programs to work with these clients and help ensure their employment. Given the economic problems in the area and overworked staff, yet again the programs are asked, “to do more with less.” The plea was made for more effective leadership in the field to argue persuasively for treatment and prevention needs, especially in upstate New York.

Lessons Learned

From a program perspective, the participants discussed what had helped programs function as well as they did in the aftermath of 9/11. Interestingly, dealing with the ice storms the area experienced in 1998

prepared programs somewhat and also showed the value of the OASAS Syracuse field office. That office quickly responded to the needs then and was the first to call local programs on 9/11 to find out what was needed and what they could do. A second lesson of value was the importance of networking with local agencies and with agencies region-wide for information and for client referrals. Interacting at the counselor level on a first-name basis might be the most effective way to quickly get appropriate care for clients.

Finally, perhaps the most important lesson learned was the value of dedicated staff. Despite the challenges over the past 5 months, most staff members remained committed to their jobs. The real fear among the discussants was how long staff members could provide a professional level of service and how long programs could continue functioning without an infusion of money and more qualified counselors.

ACRONYMS/TERMS

ADAM – Arrestee Drug Abuse Monitoring
AOD – Alcohol and Other Drug
ATC – Addiction Treatment Center
Benzos – Benzodiazepines, such as Valium, Xanax, and Ativan
CASAC – Certified Alcohol and Substance Abuse Counselor
CBO – Community-Based Organization
CISD – Critical Incident Stress Debriefing
CSAP – Center for Substance Abuse Prevention
CSAT – Center for Substance Abuse Treatment
DARE – Drug Abuse Resistance Education
DAWN – Drug Abuse Warning Network
EAP – Employee Assistance Program
ED - Department of Education
EMS – Emergency Medical Services
FEMA – Federal Emergency Management Administration
HRA – Human Resources Administration
HRSA – Health Resources and Services Administration
IOP – Intensive Outpatient
IVDU – Intravenous Drug Use
MDMA – Also called Ecstasy
MICA – Mentally Ill Chemical Abusers
NASADAD – National Association of State Alcohol and Drug Abuse Directors
NIDA – National Institute on Drug Abuse
NYC – New York City
OASAS – Office of Alcoholism and Substance Abuse Services
PTSD – Posttraumatic Stress Disorder
PSA – Public Service Announcement
PTA – Parent Teacher Association
SAMHSA – Substance Abuse and Mental Health Services Administration
SAP – Student Assistance Program
SAPIS – Substance Abuse Prevention/Intervention Specialist
SPMI – Severely and Persistently Mentally Ill
TC – Therapeutic Community
UAs – Urinalyses

PROGRAM AND AGENCY KEY INFORMANTS

AFL-CIO, New York City Central Labor Rehabilitation Council
Albert Einstein College of Medicine (AECOM)
Alcoholism and Substance Abuse Providers of New York State (ASAP)
Archdiocese of New York Drug Abuse Prevention Program
Beekman Clinic
Beth Israel Gouvener Clinic
Dynamic Youth
Greenwich House East
Inwood Community Center
Lower Eastside Service Center
National Council on Alcoholism and Drug Dependence
National Drug Research Institute (NDRI)
New York City Board of Education, District 2
New York City Bureau of Alcoholism and Substance Abuse Services
New York City Department of Mental Health, Mental Retardation, and Alcoholism Services
New York Police Department Employee Assistance Program, Alcohol Counseling Unit
Project Liberty
Project Renewal, on the Bowery
Project Return
The Educational Alliance
Westchester County Department of Community Mental Health
Westchester County Student Assistance/Employee Assistance