

February 2008

CATASTROPHIC DISASTERS

Federal Efforts Help
States Prepare for and
Respond to
Psychological
Consequences, but
FEMA's Crisis
Counseling Program
Needs Improvements





Highlights of [GAO-08-22](#), a report to congressional requesters

Why GAO Did This Study

Catastrophic disasters, such as Hurricane Katrina, may result in trauma and other psychological consequences for the people who experience them. The federal government provides states with funding and other support to help them prepare for and respond to disasters. Because of congressional interest in these issues, GAO examined (1) federal agencies' actions to help states prepare for the psychological consequences of catastrophic disasters and (2) states' experiences obtaining and using grants from the Crisis Counseling Assistance and Training Program (CCP) to respond to the psychological consequences of catastrophic disasters. CCP is a program of the Department of Homeland Security's (DHS) Federal Emergency Management Agency (FEMA). GAO reviewed documents and interviewed program officials from federal agencies and conducted additional work in six states with experience responding to catastrophic disasters: Florida, Louisiana, Mississippi, New York, Texas, and Washington.

What GAO Recommends

GAO recommends that DHS, in consultation with HHS, expeditiously (1) revise CCP policy to allow reimbursement for indirect costs and (2) determine what types of expanded crisis counseling services should be incorporated into CCP. DHS and HHS generally concurred with these recommendations, but did not indicate when they would complete these activities.

To view the full product, including the scope and methodology, click on [GAO-08-22](#). For more information, contact Cynthia A. Bascetta at (202) 512-7114 or bascettac@gao.gov.

CATASTROPHIC DISASTERS

Federal Efforts Help States Prepare for and Respond to Psychological Consequences, but FEMA's Crisis Counseling Program Needs Improvements

What GAO Found

Federal agencies have awarded grants and conducted other activities to help states prepare for the psychological consequences of catastrophic and other disasters. For example, in fiscal years 2003 and 2004, the Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) provided grants to mental health and substance abuse agencies in 35 states for disaster planning. In 2007, SAMHSA completed an assessment of mental health and substance abuse disaster plans developed by states that received a preparedness grant. SAMHSA found that, for the 34 states with plans available for review, these plans generally showed improvement over those that had been submitted by states as part of their application for its preparedness grant. The agency also identified several ways in which the plans could be improved. For example, about half the plans did not indicate specific planning and response actions that substance abuse agencies should take. Similarly, GAO's review of the plans available from six states found varying attention among the plans to covering substance abuse issues. SAMHSA officials said the agency is exploring methods of determining states' individual technical assistance needs. Other federal agencies—the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and DHS—have provided broader preparedness funding that states may use for mental health or substance abuse preparedness, but these agencies' data-reporting requirements do not produce information on the extent to which states used funds for this purpose.

States in GAO's review experienced difficulties in applying for CCP funding and implementing their programs following catastrophic disasters. CCP, a key federal postdisaster response grant program to help states deliver crisis counseling services, is administered by FEMA in collaboration with SAMHSA. State officials said they had difficulty collecting information needed for their CCP applications and experienced lengthy application reviews. FEMA and SAMHSA officials said they have taken steps to improve the application submission and review process. State officials also said they experienced problems implementing their CCPs. For example, they said that FEMA's policy of not reimbursing states and their CCP service providers for indirect costs, such as certain administrative expenses, led to problems recruiting and retaining service providers. Other FEMA postdisaster response grant programs allow reimbursement for indirect costs. A FEMA official said the agency had been considering since 2006 whether to allow indirect cost reimbursement under CCP but did not know when a decision would be made. States also cited difficulties assisting people who needed more intensive crisis counseling services than those traditionally provided through state CCPs. FEMA and SAMHSA officials said they plan to consider options for adding other types of crisis counseling services to CCP, based in part on states' experiences with CCP pilot programs offering expanded crisis counseling services. The officials did not know when they would complete their review and reach a decision.

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Abbreviations

ASPR	Assistant Secretary for Preparedness and Response
CCP	Crisis Counseling Assistance and Training Program
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
DHS	Department of Homeland Security
FDNY	New York City Fire Department
FEMA	Federal Emergency Management Agency
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
ISP	Immediate Services Program
MBES	Medicaid Budget and Expenditure System
NCPTSD	National Center for PTSD
Project SERV	Project School Emergency Response to Violence
PTSD	posttraumatic stress disorder
RSP	Regular Services Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIP	State Children's Health Insurance Program
SERG	SAMHSA Emergency Response Grant
VA	Department of Veterans Affairs
WTC	World Trade Center

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United States Government Accountability Office
Washington, DC 20548

February 29, 2008

Congressional Requesters

Hundreds of thousands of people nationwide have been exposed to psychological trauma resulting from catastrophic disasters, such as the terrorist attacks of September 11, 2001, and Hurricane Katrina in August 2005.¹ Traumatic experiences such as losing a loved one, losing one's home, or witnessing disturbing scenes can affect the residents, responders, and others involved in a catastrophic disaster and its aftermath. These experiences have led to a variety of psychological consequences, including depression, posttraumatic stress disorder (PTSD),² and increased use or abuse of tobacco or alcohol. In addition, catastrophic disasters can affect a community's ability to deliver mental health and substance abuse services. For example, hospitals had problems meeting the demand for inpatient psychiatric care after Hurricane Katrina because of disruption to the health care infrastructure.³

Effectively delivering mental health and substance abuse services to address psychological consequences related to catastrophic and other disasters requires that both predisaster preparedness efforts and postdisaster response⁴ efforts be well planned and coordinated among the multiple jurisdictions, agencies, and nongovernmental organizations involved. In the aftermath of the September 11 attacks, the Institute of Medicine reported that there were gaps in the preparedness of the nation's mental health, public health, medical, and emergency response systems to

¹In this report, we consider disasters that are unusually devastating and require extensive federal support to be catastrophic.

²PTSD is an often debilitating and potentially chronic disorder that can develop after experiencing or witnessing a traumatic event and includes such symptoms as distressing dreams and intrusive memories.

³GAO, *Hurricane Katrina: Status of Hospital Inpatient and Emergency Departments in the Greater New Orleans Area*, [GAO-06-1003](#) (Washington, D.C.: Sept. 29, 2006), 13. A list of additional GAO products related to mental health and catastrophic disasters is included at the end of this report.

⁴For the purposes of this report, we are defining response to include both short-term response after a disaster occurs and long-term recovery.

meet the psychological needs that result from terrorism.⁵ It noted, for example, that government agencies and service providers were not well coordinated and mental health providers often did not have disaster training.

For predisaster preparedness, the Department of Homeland Security (DHS) is responsible for coordinating with federal, state,⁶ and local agencies to develop plans, procedures, training, and other activities. In coordination with DHS, the Department of Health and Human Services (HHS) is responsible for helping the nation develop public health—including mental health and substance abuse—systems that are prepared to meet the surge in medical needs that may occur following disasters. Within HHS the Substance Abuse and Mental Health Services Administration (SAMHSA) helps integrate mental health and substance abuse services into these federal efforts. Federal agencies may carry out these responsibilities through a variety of efforts, including the following activities: the provision of grants to states for preparedness efforts,⁷ development of training and guidance related to preparedness, assessment of state activities, and development of plans for utilizing federal staff and medical supplies to assist states.

For postdisaster response, DHS and HHS efforts may include providing states with funding to assist their response to the psychological consequences of the disaster. The primary long-standing federal postdisaster grant program for helping states respond to short-term crisis counseling needs following disasters is the Crisis Counseling Assistance and Training Program (CCP),⁸ which is administered by DHS's Federal Emergency Management Agency (FEMA) and its federal partner, SAMHSA.⁹ A state's application for CCP funds must demonstrate that the

⁵Institute of Medicine, *Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy* (Washington, D.C., 2003), 1.

⁶For the purposes of this report, "state" includes states, territories, Puerto Rico, and the District of Columbia.

⁷For the purposes of this report, "grant" includes grants and cooperative agreements. Cooperative agreements are used when substantial interaction is expected between the federal agency and the funding recipient.

⁸In this report, the program administered by the federal government is referred to as "CCP," and individual programs administered by states through CCP grants are referred to as "state CCPs."

⁹FEMA administers CCP through an annual interagency agreement with SAMHSA.

need for crisis counseling in the affected area is beyond the capacity of state and local resources. If awarded funds, states typically contract with community organizations to provide the crisis counseling services, including outreach and public education, individual and group counseling, and referral for other services. We and others have reported on difficulties with CCP. In 2005, for example, we reported that following the September 2001 attack on the World Trade Center (WTC), limited financial oversight of New York's CCP by FEMA and SAMHSA made it difficult to determine whether program funds were being used efficiently and effectively to help alleviate psychological distress.¹⁰ In addition, other federal agencies have reported on difficulties that states have experienced implementing their CCPs.¹¹

Because of your interest in ensuring that our nation is prepared to respond effectively to the psychological consequences of catastrophic disasters, we examined the following questions: (1) What actions have federal agencies taken to help states prepare for the psychological consequences of catastrophic disasters? (2) What have been the states' experiences in obtaining and using CCP grants to respond to the psychological consequences of catastrophic disasters?

In general, to address our objectives, we obtained program documents from federal agencies involved in disaster preparedness and response activities—including DHS and HHS. We also interviewed officials from these agencies, academic institutions, and national organizations that focus on mental health, substance abuse, and emergency management. We conducted additional work in six judgmentally selected states. We included New York, Florida, Louisiana, and Mississippi because they were directly affected by one of three catastrophic disasters that we included in our scope: the WTC attack in 2001, Hurricane Charley in 2004, and Hurricane Katrina in 2005. We included Texas because it hosted a large number of people displaced by Hurricane Katrina, and we included Washington because it both hosted people displaced by Hurricane Katrina

¹⁰GAO, *Federal Emergency Management Agency: Crisis Counseling Grants Awarded to the State of New York after the September 11 Terrorist Attacks*, GAO-05-514 (Washington, D.C.: May 31, 2005), 29.

¹¹See National Center for PTSD, "Retrospective 5-Year Evaluation of the Crisis Counseling Assistance and Training Program," unpublished report requested by SAMHSA (White River Junction, Vt., June 2005); and Congressional Research Service, *Gulf Coast Hurricanes: Addressing Survivors' Mental Health and Substance Abuse Treatment Needs*, RL33738 (Washington, D.C., Nov. 29, 2006).

and has features that make it vulnerable to natural and man-made disasters, such as large ports. Results from this nongeneralizable sample of states cannot be used to make inferences about other states.

To examine actions by federal agencies to help states prepare for the psychological consequences of catastrophic disasters, we identified federal grants awarded and other activities that occurred during fiscal year 2002 through fiscal year 2006 to help states prepare for the psychological consequences of disasters. We also reviewed mental health and substance abuse disaster plans from the six states in our review and interviewed officials from these agencies. To examine states' experiences in obtaining and using CCP grants to respond to the psychological consequences of catastrophic disasters, we interviewed mental health officials from the six states in our review concerning their experiences in applying for CCP funding and implementing their programs. We also reviewed CCP grant applications or other relevant documentation submitted by the six states in our review. In addition, we interviewed officials from FEMA and SAMHSA to obtain their perspectives on the states' applications and the states' experiences implementing programs using CCP funds. We also reviewed reports by GAO and other entities and pertinent legislation. (For additional information on our methodology, see app. I.) We conducted our work from March 2006 through February 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results in Brief

Federal agencies have awarded grants to help states prepare for the psychological consequences of catastrophic and other disasters, and SAMHSA has conducted an assessment of state mental health and substance abuse disaster plans. In fiscal years 2003 and 2004, SAMHSA provided preparedness grants to mental health and substance abuse agencies in 35 states for disaster planning. In addition, HHS's Centers for Disease Control and Prevention (CDC), HHS's Health Resources and Services Administration (HRSA), and DHS have also provided preparedness funding that states may use for mental health or substance abuse preparedness, but the agencies' data-reporting requirements do not produce information on the extent to which states used funds for this purpose. We found that, according to state officials, five of the six states in our review used CDC or HRSA preparedness funds to support mental

health and substance abuse agencies at least once during fiscal years 2002 through 2006. In 2007, SAMHSA completed an assessment of mental health and substance abuse disaster plans developed by states that received a SAMHSA preparedness grant. The agency found that, for the 34 states with plans available for review, these plans generally showed improvement over those that had been submitted by states as part of their application for SAMHSA's preparedness grant. The agency also identified several ways in which the plans could be improved. For example, about half the plans did not indicate specific planning and response actions that substance abuse agencies should take. Similarly, our review of plans available from the six states in our review found varying attention among the plans to covering substance abuse issues. SAMHSA officials told us that the agency was exploring methods of determining states' individual technical assistance needs. HHS is also taking steps to be better prepared to send federal resources to help states address the psychological consequences of a catastrophic disaster. For example, HHS is increasing its capacity to deploy teams of trained providers who can provide mental health services following a catastrophic disaster.

Officials from the six states in our review told us they experienced difficulties in applying for CCP funding and implementing their programs, particularly in response to catastrophic disasters. They reported difficulty collecting information needed for their applications, in part because the application guidance did not provide sufficient detail. In addition, states sometimes experienced lengthy application reviews by FEMA and SAMHSA after catastrophic disasters, which contributed to delays in executing contracts with service providers. FEMA and SAMHSA officials told us they had taken steps to improve the application submission and review process. State officials also identified problems in implementing CCPs after catastrophic disasters. For example, they said that FEMA's policy of not reimbursing states and service providers for indirect program costs, such as certain administrative expenses, made it difficult for state CCPs to recruit and retain providers. Other FEMA postdisaster response grant programs allow reimbursement for indirect costs. A FEMA official told us that the agency had been considering whether to allow reimbursement for indirect costs under CCP since June 2006 but did not know when a decision would be made. Including indirect costs in CCP and not requiring service providers to absorb these costs could expand the pool of providers willing to participate in this program, which could strengthen states' ability to assist disaster victims in coping with the psychological consequences of catastrophic disasters. State officials also cited difficulties assisting people who could benefit from expanded services, such as more intensive crisis counseling services than those

traditionally provided through state CCPs. FEMA and SAMHSA officials told us they planned to examine whether certain expanded services should be incorporated into CCP. These officials did not know when they would complete their review. Promptly determining what types of expanded crisis counseling services should become a permanent part of CCP would enable states to more effectively develop their CCP proposals and more effectively provide their populations with needed crisis counseling services.

To improve the federal government’s ability to help states respond to the psychological consequences of catastrophic disasters, we are recommending that the Secretary of Homeland Security direct the Administrator of FEMA, in consultation with the Administrator of SAMHSA, to expeditiously take the following two actions: (1) revise CCP policy to allow states and service providers that receive CCP funds to use them for indirect costs and (2) determine what types of expanded crisis counseling services should be formally incorporated into CCP and make any necessary revisions to program policy. We provided a draft of this report to DHS and HHS for comment. Both DHS and HHS generally concurred with both of our recommendations and stated that they had taken or will take steps toward implementing them. However, they did not provide specific timelines for completing these actions.

Background

A catastrophic disaster exposes residents and responders to a variety of traumatic experiences that put them at risk for adverse psychological consequences. Preparedness at the federal, state, and local levels is critical to the nation’s ability to provide the services needed to address these problems during response. In light of the emergence of threats posed by terrorism and the complex issues involved in responding to those threats, GAO has identified disaster preparedness and response as a major challenge for the 21st century.¹²

Psychological Consequences of Catastrophic Disasters

Research has shown that people who have experienced or witnessed certain incidents during or after a catastrophic disaster—such as serious physical injury, destruction of a home, or long-term displacement from the community—can experience an array of psychological consequences. For

¹²GAO, *21st Century Challenges: Reexamining the Base of the Federal Government*, GAO-05-325SP (Washington, D.C.: February 2005), 39-43.

example, studies found that 1 to 2 months after the WTC attack, the rate of probable PTSD was 11.2 percent among a sample of adults in the New York City metropolitan area, compared with about 4 percent elsewhere in the United States,¹³ and Manhattan residents reported increases in smoking, alcohol consumption, and marijuana use.¹⁴ Research has also shown that psychological effects can persist or emerge months or years after the event has occurred. For example, a 2006 study on the use of counseling services by people affected by the WTC attack found that some people first sought counseling services more than 2 years after the event.¹⁵

Certain populations may be especially vulnerable to psychological consequences following a disaster. These include children and survivors of past traumatic events. Others who may be especially vulnerable include people who had a preexisting mental illness at the time of a disaster. Research has also shown that disaster responders may be especially vulnerable because of the direct and protracted nature of their exposure to traumatic experiences, extended working hours, and sleep deprivation. A CDC survey of New Orleans firefighters and police officers about 2 to 3 months following Hurricane Katrina found that about one-third of respondents reported symptoms of depression or PTSD, or both.¹⁶

Psychological responses can also be affected by the characteristics of the particular disaster and its aftermath. Terrorism differs from natural disasters in that it can create a general sense of fear in the population outside the affected area. The Institute of Medicine noted that although terrorism and other disasters may share important characteristics, “the malicious intent and unpredictable nature of terrorism may carry a particularly devastating impact for those directly and indirectly affected.”¹⁷

¹³W.E. Schlenger et al., “Psychological Reactions to Terrorist Attacks: Findings from the National Study of Americans’ Reactions to September 11,” *Journal of the American Medical Association*, vol. 288, no. 5 (2002), 581-588.

¹⁴D. Vlahov et al., “Increased Use of Cigarettes, Alcohol, and Marijuana among Manhattan, New York, Residents after the September 11th Terrorist Attacks,” *American Journal of Epidemiology*, vol. 155, no. 11 (2002), 988-996.

¹⁵N.H. Covell et al., “Use of Project Liberty Counseling Services over Time by Individuals in Various Risk Categories,” *Psychiatric Services*, vol. 57, no. 9 (2006), 1268-1270.

¹⁶CDC, “Health Hazard Evaluation of Police Officers and Firefighters after Hurricane Katrina—New Orleans, Louisiana, October 17-28 and November 30-December 5, 2005,” *Morbidity and Mortality Weekly Report*, vol. 55, no. 16 (2006), 456-458.

¹⁷Institute of Medicine, *Psychological Consequences of Terrorism*, 4.

During the recovery phase of a catastrophic natural disaster, ongoing stress due to the perceived loss of support associated with large-scale dislocation of the population can also affect mental health. In an assessment of health-related needs for residents returning to the New Orleans area 7 weeks after Hurricane Katrina, researchers found that many respondents had emotional concerns—such as feeling isolated or crowded—and about half had levels of distress that indicated a possible need for mental health services.¹⁸

Federal Role in Public Health Preparedness and Response

The Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act)¹⁹ is the principal federal statute governing federal disaster assistance and relief. State and local governments have the primary responsibility for disaster response, and the Stafford Act established the process for states to request a presidential disaster declaration for affected counties in order to obtain supplemental assistance—such as physical assets, personnel, and funding—from the federal government when a disaster exceeds state and local capabilities and resources. The President may make a disaster declaration for both catastrophic disasters and smaller-scale disasters that exceed a state’s ability to respond.

The Stafford Act and FEMA’s regulations contain provisions related to disaster preparedness. The act encourages each state to have a plan that stipulates the state’s overall responses in the event of an emergency. FEMA regulations require that, as a condition of receiving CCP funds to respond to a disaster, states agree to include mental health disaster planning in their overall plans.²⁰ The regulations do not require that state mental health and substance abuse agencies develop their own disaster plans, but such plans are recommended by SAMHSA as important components of disaster preparedness. In 2003, SAMHSA issued mental health disaster planning guidance to help state and local mental health

¹⁸CDC, “Assessment of Health-Related Needs after Hurricanes Katrina and Rita—Orleans and Jefferson Parishes, New Orleans Area, Louisiana, October 17-22, 2005,” *Morbidity and Mortality Weekly Report*, vol. 55, no. 2 (2006), 38-41.

¹⁹Pub. L. No. 93-288, 88 Stat.143 (1974) (codified as amended at 42 U.S.C. §5121 et seq.).

²⁰44 C.F.R. §206.171(f)(1) and (g)(1)(iv).

agencies create or revise disaster plans.²¹ The agency recommends, for example, that plans describe the specific responsibilities of state mental health agencies and other organizations in responding to a disaster and responsibilities for maintaining and revising a disaster plan. In 2004, SAMHSA issued guidance recommending that state substance abuse agencies develop all-hazard substance abuse disaster plans.²² The guidance recommends, among other things, that these plans include information on working with other agencies and providers and on providing medications, such as methadone.²³

DHS created the National Response Plan in December 2004 to provide an all-discipline, all-hazards approach for the management across jurisdictions of domestic incidents such as catastrophic natural disasters and terrorist attacks when federal involvement is necessary. The National Response Plan details the missions, policies, structures, and responsibilities of federal agencies for coordinating resource and programmatic support to states, tribes, and other federal agencies.²⁴

DHS has responsibility for coordinating the federal government's response to disasters, including administering the provisions of the Stafford Act. FEMA administers funding for disaster relief by reimbursing federal, state, and local government agencies and certain nongovernmental organizations for eligible disaster-related expenditures.²⁵ The National Response Plan also gives FEMA responsibility to coordinate mass care, housing, and human services, including coordinating the provision of immediate, short-

²¹See SAMHSA, *Mental Health All-Hazards Disaster Planning Guidance* (Rockville, Md., 2003). SAMHSA's mental health disaster planning guidance is intended to be a companion to the emergency operations planning guidance published by FEMA in 1996, which recommends that state and local emergency management organizations have emergency operations plans that include a health and medical annex with provisions for responding to the mental health needs of people affected by disasters.

²²An all-hazards approach recognizes that some aspects of response to terrorism, such as providing emergency medical services and managing mass casualties, can be the same as for response to other emergencies, such as natural disasters and epidemics.

²³See SAMHSA, *All Hazards Response Planning for State Substance Abuse Service Systems*, July 2004, <http://www.samhsa.gov/csatsatdisasterrecovery/toc.htm> (accessed Nov. 6, 2007).

²⁴In January 2008, DHS issued a National Response Framework to supersede the National Response Plan. The framework is effective as of March 22, 2008.

²⁵The Congress appropriates funds for disaster relief on a no-year basis; that is, they remain available without fiscal year limitation.

term assistance for people dealing with the anxieties, stress, and trauma associated with a disaster. In addition, HHS is designated as the primary agency for coordinating public health and hospital emergency preparedness activities and coordinating the federal government's public health and medical response.²⁶ Depending on the circumstances of a disaster, HHS's responsibilities may include assessing mental health and substance abuse needs, providing disaster mental health training materials, and providing expertise in long-term mental health services. Other agencies—including the Departments of Defense, Justice, Labor, and Veterans Affairs (VA)—support HHS's preparedness and response efforts.²⁷

Primary Federal Response Program for Crisis Counseling Services

For over 30 years, the federal government has used CCP to support short-term crisis counseling and public education services to help alleviate the psychological distress caused or aggravated by disasters for which a presidential disaster declaration has been made.²⁸ FEMA administers CCP in conjunction with SAMHSA, which provides technical assistance, develops program guidance, and conducts oversight on behalf of FEMA.

States seeking CCP funding following a presidentially declared disaster can apply to FEMA for an immediate grant and, if necessary, a longer-term grant.²⁹ The Immediate Services Program (ISP) grant funds CCP services for up to 60 days following a disaster declaration, and states applying for the grant must do so within 14 days of the declaration. The Regular Services Program (RSP) grant is designed to help states meet a continuing

²⁶Within HHS, the Office of the Assistant Secretary for Preparedness and Response (ASPR) coordinates and directs the department's emergency preparedness and response program.

²⁷In the National Response Framework, FEMA continues to have responsibility to coordinate mass care, housing, and human services and HHS continues to be designated as the primary agency for coordinating public health and hospital emergency preparedness activities.

²⁸See app. II for information on other federal programs that have been used to help states and localities respond to mental health and substance abuse needs following catastrophic disasters.

²⁹Generally, only states that have received a presidential major disaster declaration are eligible to request CCP funding. However, following Hurricane Katrina, FEMA allowed states that did not receive a presidential major disaster declaration to apply for CCP funding to assist people who had evacuated from the affected areas to their jurisdictions.

need for crisis counseling services for up to an additional 9 months.³⁰ States applying for an RSP grant must do so within 60 days of a disaster declaration. If a state decides to apply for an RSP grant, the ISP grant can be extended until the RSP application is reviewed and a funding decision has been made. A state's CCP application must demonstrate that the need for crisis counseling in the affected area is beyond the capacity of state and local resources. A state must develop its needs assessment by using a prescribed formula that, among other things, includes the estimated numbers of deaths, persons injured, and damaged or destroyed homes attributable to the disaster. This needs assessment is critical for developing a state's program plan and budget request, which must also be included in its application. FEMA reviews all ISP and RSP applications and receives input from SAMHSA, which also reviews the applications. FEMA has final authority for all funding decisions. Both ISP and RSP grants are generally managed by state mental health agencies, which typically contract with community organizations to provide CCP services.

The CCP model was designed to meet the short-term mental health needs of people affected by disasters through outreach that involves education, individual and group counseling, and referral for other services. The main focus of the model is to help people regain their predisaster level of functioning by, among other things, providing emotional support, mitigating additional stress, and providing referrals to additional resources that may help them recover. CCP services, which are to be provided anonymously and free of charge, are primarily delivered through direct contact with disaster survivors in familiar settings—such as homes, schools, community centers, and places of religious worship. Services are designed to be delivered by teams of mental health professionals and paraprofessionals from the community affected by the disaster. The mental health professionals, who have prior specialized mental health or counseling training and are usually licensed by the state, typically coordinate and supervise paraprofessionals who may not have had previous training as mental health professionals. Paraprofessionals working as CCP crisis counselors provide outreach, crisis counseling, and referrals. All members of the teams are to be trained in the basics of crisis counseling and CCP. States cannot use CCP funds to provide longer-term services such as treatment for psychiatric disorders or substance abuse,

³⁰In some cases, FEMA may extend a state's RSP for an additional 90 days in response to a documented need. In limited circumstances, such as disasters of a catastrophic nature, FEMA can extend a state's RSP beyond the additional 90 days.

office-based therapy, or medications. The state programs are expected to refer survivors who may need such services to an appropriate agency or licensed mental health professional.

From fiscal year 2001 through fiscal year 2006, the majority of CCP grant funding has been used to meet needs following catastrophic disasters. According to FEMA, during this period, the agency obligated a total of about \$424 million in CCP funds, with about \$289 million (about 68 percent) obligated for states that responded to the three catastrophic disasters in our review—the WTC attack, Hurricane Charley, and Hurricane Katrina. According to FEMA, the agency obligated about \$167 million for New York and other states that responded to the WTC attack;³¹ about \$7 million for Florida to respond to Hurricane Charley; and about \$51 and \$23 million in CCP funds for Louisiana and Mississippi, respectively, to respond to Hurricane Katrina.³² In addition, FEMA allowed 26 additional states, commonly called “host states,” to apply for CCP funding to assist people displaced as a result of Hurricane Katrina. According to FEMA, the agency obligated for these host states a total of about \$37 million, ranging from about \$13,000 to about \$13 million each.³³ For example, the agency obligated about \$13 million and \$129,000 for Texas and Washington, respectively.³⁴

At SAMHSA’s request, VA’s National Center for PTSD (NCPTSD) conducted an evaluation of CCP and provided its report in June 2005.³⁵ NCPTSD researchers examined state CCPs that were for disasters occurring from October 1996 through September 2001 and that concluded by December 2003, which resulted in an examination of programs implemented by 27 states to respond to 28 disasters. The evaluation also

³¹According to a FEMA official, RSP obligations could not be provided separately for each state that received CCP funding related to the WTC attack. The \$167 million includes funds that FEMA obligated to New York as well as Connecticut, Massachusetts, New Jersey, and Pennsylvania.

³²As of October 2007, Louisiana was still providing CCP services and FEMA had obligated about \$47.6 million for the state to serve persons in counties directly affected by Hurricane Katrina, which were covered by the disaster declaration, and an additional \$3.3 million to serve people in counties not covered by the disaster declaration. FEMA also obligated about \$4 million in CCP funding for Alabama to respond to Hurricane Katrina.

³³Fifteen of the host states received both ISP and RSP funding.

³⁴According to FEMA, CCP obligation data are as of October 8, 2007.

³⁵NCPTSD, *Retrospective 5-Year Evaluation of the Crisis Counseling Program*.

included case studies of four specific disasters—the bombing of the Murrah Federal Building in Oklahoma City, Oklahoma, in 1995; Hurricane Floyd in 1999; the WTC attack in 2001; and the Rhode Island nightclub fire in 2003. Although NCPTSD’s evaluation found that CCP performed well in certain respects, it identified a number of ways in which states had difficulties implementing their CCPs, and it indicated that drawing conclusions about some aspects of the program was difficult because data were of poor quality and incomplete.

Federal Agencies Have Awarded Grants to States to Support Preparation for Psychological Consequences of Catastrophic Disasters, and SAMHSA Has Assessed States’ Disaster Plans

Federal grants have helped states prepare for the psychological consequences of catastrophic and other disasters, and SAMHSA has conducted an assessment of disaster plans from many state mental health and substance abuse agencies. In fiscal years 2003 and 2004, SAMHSA awarded grants to mental health and substance abuse agencies in 35 states specifically for disaster planning. CDC, HRSA, and DHS have also provided preparedness funding that states may use for mental health or substance abuse preparedness, but the agencies’ data-reporting requirements do not produce information on the extent to which states used funds for this purpose. In 2007, SAMHSA completed an assessment of mental health and substance abuse disaster plans developed by states that received its preparedness grant. SAMHSA found that these plans showed improvements over those that had been submitted by states as part of their application for the preparedness grant. The agency also identified several ways in which the plans could be improved. In addition to assisting states with their preparedness, HHS is taking steps to be better prepared to send federal resources to help states respond to the psychological consequences of disasters.

Federal Grants Have Supported States' Mental Health and Substance Abuse Preparedness for Catastrophic and Other Disasters

SAMHSA awarded \$6.8 million over fiscal years 2003 and 2004 specifically to help state mental health and substance abuse agencies prepare for the psychological consequences of catastrophic and other disasters. The agency awarded 35 states;³⁶ the total amount awarded to each individual state ranged from about \$105,000 to about \$200,000.³⁷ Two of the six states in our review, New York and Texas, received a SAMHSA grant. New York, which already had a mental health disaster plan, used the funds to develop a plan for its state substance abuse agency. Texas, which was already developing a mental health disaster plan, used the grant to help fund a consortium of state agencies with postdisaster mental health responsibilities—including mental health, public safety, and victims' services—and to increase the role of substance abuse providers in preparedness activities. Mental health officials from one of the four states in our review that did not apply for a SAMHSA grant told us their agency did not apply because it was already engaged in planning with the state public health agency, and officials from the other three states said they did not apply due to competing demands on their time.

CDC, HRSA, and DHS public health and homeland security preparedness grant funds can also be used by states to prepare for the psychological consequences of disasters, and we found examples of states using CDC and HRSA funds for this purpose. During fiscal years 2002 through 2006, CDC and HRSA awarded about \$6.1 billion in grants to states and selected urban areas to improve public health and hospital preparedness,³⁸ and DHS provided about \$12.1 billion in grants to states and localities for broad preparedness efforts.³⁹ CDC and HRSA require that states document how

³⁶SAMHSA awarded grants for disaster planning to the following states: Alabama, Alaska, California, Colorado, Connecticut, the District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, West Virginia, and Wisconsin.

³⁷State activities funded by these grants were completed by the end of 2006. SAMHSA has not allocated funds to make any additional preparedness grants to states.

³⁸The grant programs are CDC's Public Health Emergency Preparedness Program and HRSA's National Bioterrorism Hospital Preparedness Program. These funds were awarded annually to public health agencies in states and three urban areas—Chicago, Los Angeles, and New York City. In March 2007, the National Bioterrorism Hospital Preparedness Program was transferred from HRSA to ASPR and was renamed the Hospital Preparedness Program.

³⁹In fiscal year 2006, DHS integrated five preparedness grant programs into the Homeland Security Grant Program.

they plan to engage in certain mental health and substance abuse preparedness activities,⁴⁰ and although there is no requirement that states spend their DHS grant funds to prepare for the psychological consequences of disasters, a state may choose to do so. These grant programs fund broader preparedness efforts, and their data-reporting requirements do not produce information on the full extent to which states used funds for mental health and substance abuse preparedness activities. We found that, according to state officials, public health agencies in five of the six states in our review—all but Mississippi—used either CDC or HRSA preparedness funds to support mental health and substance abuse agencies' activities at least once during fiscal years 2002 through 2006.⁴¹ For example, in Florida, Texas, and Washington, public health agencies allocated funds to mental health and substance abuse agencies for the development of a disaster plan or to pay the salaries of disaster planners. In Louisiana, the mental health agency received funds to, among other things, develop criteria for a registry of volunteer mental health professionals and help mental health and substance abuse treatment facilities develop disaster plans. Mental health or substance abuse officials in the six states we reviewed told us their agencies were not allocated funds from their state's DHS grant during fiscal years 2002 through 2006.

In addition to awarding grants to states, federal agencies have funded training and developed guidance to enhance states' preparedness for the psychological consequences of disasters. For example, SAMHSA established its Disaster Technical Assistance Center⁴² in fiscal year 2003 to provide training and technical assistance to state mental health and substance abuse agencies. SAMHSA also distributes various guidance

⁴⁰For example, CDC's program required in fiscal years 2005 and 2006 that states document how they planned to increase the availability of crisis counseling, mental health, and substance abuse support for public health responders. In addition, HRSA's program encouraged states to allocate a portion of their funds to develop registries of volunteer mental health care providers who could provide services following a disaster. In middle to late 2006, CDC and HRSA began developing formal data analysis programs that could be used to generate standardized reports. GAO, *Public Health and Hospital Emergency Preparedness Programs: Evolution of Performance Measurement Systems to Measure Progress*, [GAO-07-485R](#) (Washington, D.C.: Mar. 23, 2007), 15.

⁴¹According to state officials, from fiscal year 2002 through fiscal year 2006, state public health agencies allocated CDC and HRSA grant funds to state mental health agencies as follows: Florida (\$140,000), Louisiana (\$500,000), New York (\$400,000), Texas (\$172,000), and Washington (\$70,000).

⁴²The Disaster Technical Assistance Center is operated by Educational Services, Inc., under contract with SAMHSA.

documents, such as guidance to help prevent and manage stress in disaster response workers before, during, and after a disaster.⁴³ In addition, CDC, HRSA, and DHS fund the development of training activities that can benefit the preparedness of states' mental health providers. For example, HRSA officials told us that the agency's Bioterrorism Training and Curriculum Development Program awarded a contract in 2006 to an accrediting body for counseling programs to incorporate mental health disaster preparedness into its educational standards,⁴⁴ and CDC's Centers for Public Health Preparedness Program awarded grants to academic institutions to develop and assess training on mental health preparedness and response.

SAMHSA Has Assessed State Mental Health and Substance Abuse Disaster Plans

SAMHSA reviewed state mental health and substance abuse plans as part of its disaster preparedness grant program. In 2007, the agency completed a review of the disaster plans of 34 of the 35 states that received a SAMHSA preparedness grant to, among other things, give SAMHSA aggregated information about states' disaster planning and technical assistance needs.⁴⁵ According to SAMHSA, the mental health and substance abuse disaster plans of these 34 states showed improvement over the plans the states had submitted in 2002 as part of their grant applications. Areas SAMHSA identified as showing improvement included

- stronger partnership for planning and response among state mental health and substance abuse services agencies;
- an increased number of unified plans that encompass both mental health and substance abuse services issues;
- stronger partnerships with key stakeholders such as emergency management, public health agencies, and voluntary organizations that are active in disasters; and

⁴³SAMHSA, *A Guide to Managing Stress in Crisis Response Professions* (Rockville, Md., 2005).

⁴⁴The Bioterrorism Training and Curriculum Development Program was transferred from HRSA to ASPR in March 2007.

⁴⁵SAMHSA did not review one state's disaster plan because it was not available at the time of SAMHSA's review. SAMHSA, "State Behavioral Health All-Hazards Disaster Plan Review Report," unpublished report (Rockville, Md., June 2007).

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- clearer identification and articulation of the disaster response role of state mental health and substance abuse agencies.

SAMHSA also identified several ways in which the plans could be improved. For example, it reported that while most plans indicated that the state deploys disaster responders to provide mental health and substance abuse services, about one-third of the plans needed to provide more detailed information on the training, qualifications, and safe deployment of these responders. SAMHSA also reported that although states were more likely to incorporate substance abuse services into their disaster planning, about half the plans still did not indicate specific planning and response actions that substance abuse agencies should take.

In reviewing mental health and substance abuse disaster plans from five of the six states in our study, we made observations that are consistent with SAMHSA's findings.⁴⁶ For example, we found that the five states' disaster plans varied in their attention to substance abuse topics. Two states in our review issued separate mental health and substance abuse plans. Each of the other three states issued a unified disaster plan to cover both mental health and substance abuse, but only one of the three plans specifically discussed both types of services. The other two plans primarily discussed mental health services and had few specific references to providing substance abuse services following a disaster. For example, these plans did not include specific information about providing methadone treatment for people with a drug abuse disorder following a disaster—information that was provided in the separate substance abuse plans. In addition, we found that disaster plans of the states in our review did not always identify specific actions or responsibilities related to serving the mental health and substance abuse needs of certain special populations.⁴⁷ Three state disaster plans did not identify specific actions for preparing to work with children, and two plans did not include provisions for specific cultural minorities.

⁴⁶Of the six states we included in our review of disaster plans, New York and Texas were also included in SAMHSA's review. We did not review a disaster plan from Washington. An official from Washington told us that the state began developing a unified mental health and substance abuse disaster plan in 2005 and was scheduled to complete that plan by January 1, 2008.

⁴⁷Experts have observed that some people—including children, those with preexisting mental illness, disaster response workers, frail elderly, and cultural minorities—may warrant specialized approaches when states plan for the psychological consequences of disasters.

Mental health and substance abuse officials from the states in our review told us that they recognized various gaps in their disaster preparedness. For example, state officials discussed the need to provide additional training to disaster responders and said they would like to collaborate more extensively with state health, emergency management, and education agencies. One observation that state mental health officials made was that schools could be an important local resource for providing postdisaster services to children but that relationships between state mental health agencies and schools are sometimes not in place prior to a disaster. Officials from several states described benefits from meeting other states' officials at SAMHSA's regional training conferences, but told us that resource limitations or the need to first plan within their own state made it difficult to continue these relationships.

SAMHSA's report recommended that the agency conduct state-specific needs assessments to identify individual states' technical assistance needs for mental health and substance abuse disaster planning. SAMHSA officials told us that the agency is exploring methods to conduct such assessments and that the agency would need to determine the availability of resources for the assessments.

HHS Is Taking Steps to Be Better Prepared to Send Federal Resources to Help States Address the Psychological Consequences of Disasters

To help states address the psychological consequences of disasters, HHS, as the lead federal department for public health and medical preparedness, is implementing several efforts to be better prepared to send federal resources to help states. For example, HHS is increasing the capacity of federal disaster response teams to provide mental health services to disaster victims and responders. Based on lessons learned following Hurricane Katrina, the White House Homeland Security Council recommended that HHS organize, train, and equip medical and public health professionals in preconfigured and deployable teams.⁴⁸ In response, HHS organized U.S. Public Health Service Commissioned Corps officers⁴⁹ into several teams—including five Rapid Deployment Force teams that

⁴⁸White House Homeland Security Council, *The Federal Response to Hurricane Katrina: Lessons Learned* (Washington, D.C., Feb. 23, 2006), 105.

⁴⁹The U.S. Public Health Service Commissioned Corps is one of the seven Uniformed Services of the United States. The Commissioned Corps provides a variety of services to help promote the health of the nation, such as delivering health care services to medically underserved populations and providing health expertise during national emergencies. At the time of Hurricane Katrina, U.S. Public Health Service Commissioned Corps officers were not assigned to preexisting teams; rather, teams were formed as they were needed.

each include 4 mental health providers and five Mental Health Teams that each include about 20 mental health providers.⁵⁰ HHS created team rosters and sponsored a large-scale training exercise from July 15, 2007, through August 24, 2007, that allowed the team members, including the mental health providers, to train together.

HHS also plans to recruit additional mental health providers into the Commissioned Corps. HHS officials told us that there has been a shortage of mental health providers in the Commissioned Corps and that requirements for deployment on short notice made it difficult for agencies to ensure that team members' regular responsibilities are fulfilled while the team member is deployed. For fiscal year 2008, HHS proposed to recruit providers to staff full-time, dedicated Health and Medical Response Teams.⁵¹ Two teams—each with 105 members, including at least 4 mental health providers—would serve as the primary responders for the Commissioned Corps and reduce the deployment burden placed on other officers.

HHS has also taken steps to increase the supply of drugs indicated for psychological disorders that should be available in the event of a disaster. Prior to Hurricane Katrina, HHS began developing Federal Medical Stations to provide mass casualty capability (i.e., equipment, material, and pharmaceuticals) to augment local health care infrastructures overwhelmed by a terrorist attack or natural disaster. These stations included a cache of drugs focused on urgent and emergency care. Given the large number of evacuees with special medical needs who required care following the hurricane, HHS revised the cache in 2006 to increase the types of drugs specifically indicated for mental health conditions from 20 to 33. For example, HHS increased the types of antidepressants and antipsychotics and added five new classes of drugs, including drugs to treat sleep disorders.

⁵⁰HHS officials told us that the teams were configured primarily to provide mental health support, although elements of the training related to substance abuse. For example, training materials list alcohol abuse as a symptom of psychological problems and note that people in recovery for substance abuse may relapse following a disaster.

⁵¹When not deployed in response to an emergency, the Health and Medical Response Team members would obtain training, provide training to other Commissioned Corps and Medical Reserve Corps members, and provide clinical and public health services to underserved communities.

States Experienced Several Difficulties in Applying for and Implementing Their CCPs Following Catastrophic Disasters

State officials told us they experienced difficulties in applying for CCP funding and implementing their programs, particularly in the wake of catastrophic disasters. States had problems collecting information needed to prepare their ISP applications within FEMA's application deadline and preparing parts of their ISP and RSP applications, including estimating the number of people who might need crisis counseling services. FEMA and SAMHSA officials told us they had taken steps to revise the applications and supporting guidance to help address these difficulties. States also experienced lengthy application reviews, and FEMA and SAMHSA officials said they had taken steps to improve the submission and review process. In addition, state officials told us they experienced problems implementing their CCPs, such as difficulties resulting from FEMA's policy of not reimbursing state CCPs for indirect program costs. Additional problems that state officials cited were related to assisting people in need of more intensive counseling services and making referrals for mental health and substance abuse treatment. FEMA and SAMHSA are considering options to address some of these concerns, but they do not know when they will make these decisions.

States Encountered Difficulties in Preparing CCP Applications, and FEMA and SAMHSA Officials Cited Efforts to Clarify the Applications and Provide Training

Officials in the six states in our review told us they encountered difficulties as they prepared their CCP applications following the catastrophic disasters included in our review, including difficulties in collecting the information required for their ISP applications within established deadlines.⁵² Officials said that the amount of information required for their applications was difficult to collect because of the scope of the disasters and the necessity for responding on other fronts, such as ensuring the safety of patients and personnel at state-run mental health facilities. For example, Texas officials estimated that the state hosted more than 400,000 Hurricane Katrina evacuees and that they had to collect information for over 250 counties to estimate how many people might need crisis counseling services. Furthermore, several state officials said that some of the information required for the ISP application, such as that on preliminary damages and the location of people who might need services, was not always available or reliable immediately following a catastrophic disaster. According to SAMHSA, because information from

⁵²According to an agency official, following Hurricane Katrina the agency did not require host states to abide by the 14-day application deadline. Once FEMA determined that 100 or more disaster survivors had registered with FEMA for federal disaster assistance in a state, the state was notified that it was eligible to submit an abbreviated version of the application for ISP funding and that it had 10 days from the date of notification to apply.

traditional sources was lacking following Hurricane Katrina, states were allowed to use other sources—such as newspaper reports and anecdotal evidence—to complete their applications. However, Louisiana and Mississippi officials told us that obtaining the information required by SAMHSA to complete the application was difficult and was sometimes unavailable in the immediate aftermath of the hurricane. Officials in three states we contacted said that the difficulty of completing their applications on time was exacerbated because multiple disasters affected the same jurisdictions in close succession and they were required to submit a separate application for each one. Louisiana, for example, had to submit separate ISP applications following Hurricanes Katrina and Rita, even though the hurricanes affected overlapping areas and occurred less than 1 month apart.⁵³

State officials also told us that the CCP application’s needs assessment formula, which they are to use to estimate the number of people who might need crisis counseling services, created problems in estimating needs following catastrophic disasters in their states. The needs assessment formula includes several categories of loss, including deaths, hospitalizations, homes damaged or destroyed, and disaster-related unemployment.⁵⁴ State officials told us that the formula’s loss categories did not capture data that they considered critical to assessing mental health needs following a catastrophic disaster, such as estimates of populations at increased risk for psychological distress, including children and the elderly, or information on destroyed or damaged community mental health centers. While states can include such information in a narrative portion of their application, several state officials told us it was not clear to them how this narrative information is factored into funding decisions. NCPTSD’s evaluation of CCP for SAMHSA described concerns similar to those noted by states in our review about the accuracy of the results produced by using the formula. Moreover, NCPTSD concluded that the formula could be a contributing factor in discrepancies it found

⁵³In addition, Louisiana had to administer each CCP separately, which included, for example, submitting separate quarterly reports for each program.

⁵⁴The CCP needs assessment formula did not include a specific category for estimating crisis counseling needs in situations, such as Hurricane Katrina, in which a state was hosting disaster evacuees and did not itself experience casualties or property destruction. Therefore, according to a FEMA official, the agency made an ad hoc decision after Hurricane Katrina to allow states hosting evacuees to develop their ISP needs assessments based solely on the number of evacuees in their state who had registered for federal disaster assistance.

between states' estimates of people in need and the numbers of people actually served.⁵⁵

Preparing the sections of the application on plans for providing CCP services and on program budgets also was difficult, according to state officials. For example, state officials said the application guidance did not provide sufficient detail to indicate what federal officials would consider reasonable numbers of supervisors, outreach workers, and crisis counselors to hire. Several officials also said it was difficult to use the fiscal guidance to determine what agency officials would consider a reasonable budget for various CCP activities, such as use of paid television and radio advertisements for outreach. State officials said that having more detailed guidance would help them develop better proposals and minimize the need to revise their applications during the review process.

Federal program officials told us they have taken steps to address various difficulties that states experienced in collecting information and preparing their CCP applications. Agency officials told us that they recently made changes intended to reduce the amount of information required in the ISP and RSP applications, modified the needs assessment formula, and clarified the applications and supporting guidance. For example, in the revised needs assessment formula the weights assigned to most of the loss categories have been adjusted for estimating the number of people who could benefit from CCP services. According to SAMHSA, the revised ISP and RSP applications were approved in September 2007; the agency made these available to states in November 2007. In 2006, in response to feedback from states regarding difficulties with the application process, FEMA and SAMHSA revised their 4-day CCP basic training course for states to increase its focus on preparing CCP applications. According to a FEMA program official, the course was also revised in 2007 to reflect recent changes to the applications and supporting guidance, and FEMA program officials have requested that FEMA's Emergency Management Institute offer the course annually instead of every other year. This program official also told us that a Web-based CCP orientation course was developed and that it is required for all those who attend the basic training course.

⁵⁵The researchers found both overestimation and underestimation of people needing crisis mental health services, with some state CCPs reporting that they served 3 to 10 times more people than had been estimated to need CCP services and others reporting that they served one-half to one-fourteenth the number of people that had been estimated. See NCPTSD, *Retrospective 5-Year Evaluation of the Crisis Counseling Program*, B27-B28, E12.

States Experienced Lengthy Application Reviews following Catastrophic Disasters, and FEMA and SAMHSA Have Taken Steps Intended to Shorten the Review Process

State officials told us that FEMA and SAMHSA’s CCP application review process was lengthy after catastrophic disasters, especially for RSP applications submitted following Hurricane Katrina. A FEMA official estimated that for CCP applications submitted in 2002 through 2006 it had generally taken the agencies about 14 days to review and make funding decisions for ISP applications and about 28 to 70 days to review and make funding decisions for RSP applications. Our analysis of CCP applications for the catastrophic disasters in our review showed that it took FEMA and SAMHSA from 5 to 39 days to review and make funding decisions for ISP applications and 58 to 286 days to review and make funding decisions for RSP applications. (See table 1.)

Table 1: Number of Days for States’ ISP and RSP Application Submission and Federal Review for Selected Catastrophic Disasters

	WTC attack, New York	Hurricane Charley, Florida	Hurricane Katrina			
			Louisiana	Mississippi	Texas	Washington
ISP Application						
Days from disaster declaration to state submission of application	8	14	14	14	10 ^a	26 ^a
Days from state submission of application to completion of federal review	5	5	24	22	39	14
RSP Application						
Days from disaster declaration to state submission of application	63 ^b	59	59	60	55	^c
Days from state submission of application to completion of federal review	213	58	286	110	125	^c

Source: GAO analysis based on information provided by FEMA, SAMHSA, and states.

^aTexas and Washington applied for CCP funding as host states to serve persons displaced from states directly affected by Hurricane Katrina. Host states were not required to abide by the standard 14-day application deadline. Once FEMA determined that 100 or more disaster survivors had registered with FEMA for federal disaster assistance in a state, the state was notified that it was eligible to submit an application for ISP funding and that if the state wanted to apply it had 10 days from the date of notification to do so.

^bAccording to a FEMA official, the agency allowed New York to submit its RSP application after the 60-day application deadline.

^cWashington did not apply for RSP funding.

State officials told us that the lengthy reviews and the resulting delays in obtaining RSP funding created difficulties for their CCPs. According to state officials, delays in application approval contributed to delays in executing contracts with service providers, delays in hiring staff, and

problems retaining staff. They told us they needed to obtain a decision on their RSP application as quickly as possible so they could better plan and implement their programs.

Federal program officials told us that several factors contributed to the time it took to review applications following these catastrophic disasters. These factors included an unanticipated high volume of CCP applications following Hurricane Katrina. CCP applications submitted by states that were directly affected by Hurricane Katrina, as well as by 26 states hosting people who had evacuated after Hurricane Katrina, created unanticipated demands that were well beyond the normal capacity of their CCP staff to handle.⁵⁶ FEMA officials told us that the two agencies typically reviewed an average of 17 new ISP applications and 13 new RSP applications each year from fiscal year 2002 through 2006, but that they reviewed 31 ISP applications and 20 RSP applications in response to Hurricane Katrina alone. According to SAMHSA officials, the agency had not planned for the surge of applications created by FEMA's decision to allow host states to apply for CCP funding and had no policies in place at the time to enable SAMHSA's CCP and grants management staff to adapt quickly to the submission of so many CCP applications within a few weeks. To respond, some SAMHSA staff had to handle double the number of applications they usually process, and the agency supplemented its six CCP reviewers by using six staff from other parts of the agency to help review CCP grant applications. FEMA hired three temporary staff to assist with the application review process after Hurricane Katrina. However, a report prepared for SAMHSA on its response to Hurricane Katrina noted that some agency staff who assisted with the review of applications did not have sufficient knowledge of CCP and the grant review process and therefore required training.⁵⁷

SAMHSA and FEMA have taken actions to be prepared for such a surge in applications in the future. A SAMHSA official told us that the agency sent

⁵⁶Louisiana, for example, submitted ISP and RSP applications to provide services in parishes that received a presidential disaster declaration for Hurricane Katrina. The state also submitted an abbreviated ISP application and RSP application to provide CCP services in parishes that did not receive a presidential disaster declaration but that hosted evacuees. According to SAMHSA officials, the state also submitted an RSP application to provide services to people affected by Hurricane Rita.

⁵⁷Educational Services, Inc., "Beyond Katrina: An After-Action Report on Improving Substance Abuse and Mental Health Response to Future Disasters," unpublished report, prepared at the request of SAMHSA (Bethesda, Md., May 8, 2006), 39.

five staff from various parts of the agency to the August 2007 4-day CCP basic training course to help them gain a better understanding of the CCP application process. In December 2007, the agency hired a staff person, whose position was funded by FEMA, in its grants management office to, among other things, assist in the review of CCP applications and the fiscal monitoring of CCP grants. They expect the addition of this employee to help to shorten application review times for RSP grants.

SAMHSA officials told us that the need to obtain further information from the states also contributed to the length of the reviews following Hurricane Katrina. In examining various CCP applications submitted by the states in our study after Hurricane Katrina and related correspondence, we noted instances in which SAMHSA sent letters to states informing them that their applications contained errors, were incomplete, or required clarification for the agency to proceed with its review. In some instances, the agency made multiple requests to a state to clarify a specific part of its application. For example, SAMHSA found that Louisiana did not provide complete information in its RSP application related to the process the state planned to use to identify the local service providers with which it would contract—a process that was different from the one traditionally used to contract for CCP services. According to federal officials, issues related to this process resulted in Louisiana not submitting a complete application until 6 months after its initial application, which in turn created enormous delays in the application review process.

SAMHSA officials told us that another reason for the need to obtain additional clarification was that the agency had established a more stringent CCP application review process in July 2005.⁵⁸ According to SAMHSA officials, the revised CCP applications and guidance should help reduce the need for states to revise their applications during the review process. In addition, agency officials told us that the 2007 CCP basic training course for applicants included information on the application process and on the new review standards.

⁵⁸SAMHSA officials told us they made changes in the application review process based in part on our 2005 report on New York's CCP, known as Project Liberty, which was established after the 2001 WTC attack. We reported, among other things, that FEMA and SAMHSA had not obtained realistic budget information during the CCP application process that they could use to effectively assess how New York was planning to spend Project Liberty grant funds. See [GAO-05-514](#).

States Faced Difficulties in Implementing Their CCPs after Catastrophic Disasters, including Problems Related to Lack of Indirect-Cost Reimbursement and Need for Expanded Services

Obtaining Reimbursement for Indirect Costs

State officials said they faced difficulties in implementing their CCPs following catastrophic disasters. For example, they told us that FEMA's policy of not reimbursing states and counseling service providers for indirect costs⁵⁹ caused difficulties for state CCPs. They also described the need for expanded crisis counseling services and cited additional concerns.

States told us that FEMA's policy of precluding states and their CCP service providers from obtaining reimbursement for indirect costs has created difficulties in implementing their programs. Under CCP guidelines, states and their CCP service providers cannot be reimbursed for indirect costs related to managing and monitoring their programs that are not directly itemized in their program budgets. However, state officials told us that it can be difficult for their agencies and service providers to determine what proportion of their overall administrative costs is attributable to CCP activities. In addition, several state officials also told us that CCP service providers often have limited capacity in their overall agency budgets to redirect funds from other services to cover the indirect costs associated with their CCP work.

State officials told us that the inability to obtain reimbursement for indirect costs contributed to difficulties in recruiting and retaining service providers. According to Louisiana officials, for example, that inability contributed to the decision of one of its largest Hurricane Katrina CCP contractors providing services in New Orleans to withdraw from the state's program in 2007. While CCP guidance precluded reimbursement for indirect costs, the provider decided to request reimbursement. In a June 2006 letter to the state mental health office, the provider stated that participating in the state's CCP had created a financial burden that included moving funds from other services to its CCP contract. In July 2006, FEMA declined the provider's request to include indirect costs in its budget, stating that under CCP guidelines all budget charges must be direct and that the provider should work with the state to see whether any of these costs could be reclassified as direct costs in the provider's budget.

⁵⁹Indirect costs are those incurred by an organization that are not readily identified with a particular project but are necessary to the operation of the organization and the performance of the project. Typical examples of indirect costs include the cost of operating and maintaining facilities, accounting and personnel services, and depreciation.

Officials in FEMA's grants management office told us that although CCP policy prohibits reimbursement for indirect costs, they were unaware of statutory or regulatory prohibitions on the reimbursement of such costs.⁶⁰ Furthermore, they told us that other FEMA disaster response grant programs do allow indirect cost reimbursement. For example, grantees can be reimbursed for indirect costs under FEMA's Public Assistance Program⁶¹ and Hazard Mitigation Grant Program.⁶² Other federal postdisaster response grant programs also allow grantees to be reimbursed for indirect costs, including the SAMHSA Emergency Response Grant (SERG) program and the Department of Education's Project School Emergency Response to Violence (Project SERV) program.

Concern about the exclusion of indirect costs from CCP reimbursement has been a long-standing issue. In 1995, FEMA's Inspector General issued a report on CCP that said that the reimbursement of indirect costs appeared allowable under applicable federal law and regulations.⁶³ The Inspector General recommended that FEMA review its policy on reimbursement for indirect costs.⁶⁴ FEMA and SAMHSA officials told us that reimbursement for indirect costs was a recurring concern for states and service providers and that states have advocated for a change in this policy. SAMHSA officials said that allowing indirect cost reimbursement would promote participation of a broader array of local service providers.

A FEMA official told us that the agency had been considering whether to develop a new CCP policy to allow reimbursement for such costs. According to this official, FEMA had been examining this issue since June 2006, when it received the letter from the Louisiana CCP service provider.

⁶⁰A FEMA official responsible for CCP told us that it was unclear why CCP policy does not allow for the reimbursement of indirect costs.

⁶¹The Public Assistance Program can provide financial assistance to state governments, local governments, Indian tribes or authorized tribal organizations, Alaskan Native villages, and certain nonprofit organizations to help them recover from disasters.

⁶²The Hazard Mitigation Grant Program provides assistance to states, local governments, Indian tribes, and private nonprofit organizations for long-term hazard mitigation projects following a major disaster declaration to reduce the loss of life and property after a natural disaster.

⁶³FEMA Office of Inspector General, *Inspection of FEMA's Crisis Counseling Assistance and Training Program*, I-01-95 (Washington, D.C., June 1995), 25.

⁶⁴FEMA Office of Inspector General, *Inspection of FEMA's Crisis Counseling Assistance and Training Program*, 25.

Providing Expanded Crisis Counseling Services

This official also told us that SAMHSA provided recommendations in March 2007 on potential modifications to CCP guidance and application materials to allow reimbursement for indirect costs. According to this official, however, FEMA still needed to examine various implementation issues, including which types of indirect costs might be reimbursed and what changes to the application review process might be needed. As of October 2007, this official did not know when the agency would make a decision about whether to allow reimbursement for indirect costs.

State officials told us that after catastrophic disasters they faced the challenge of how to assist people who were experiencing more serious postdisaster distress than traditional CCP services could resolve. According to New York, Louisiana, and Mississippi officials, some CCP clients who did not display symptoms suggesting they needed a referral for mental health or substance abuse treatment nevertheless could have benefited from more intensive crisis counseling than was provided in the CCP model. Furthermore, in the case of Hurricane Katrina, Mississippi officials told us that they wanted to be able to serve as many people as possible within their CCPs because the devastation resulted in fewer mental health and substance abuse providers being available to accept referrals for treatment.

To assist these people, officials in New York, Louisiana, and Mississippi asked FEMA and SAMHSA to allow their state CCPs to offer expanded types of services after catastrophic disasters in their states. In response to the states' requests, FEMA and SAMHSA officials allowed the existing state CCPs to develop pilot programs offering expanded crisis counseling services consistent with the nonclinical, short-term focus of the CCP model.⁶⁵ New York's expanded services, known as "enhanced services," were offered through the New York City Fire Department (FDNY) and through community-based providers for both adults and children. FDNY's services started in September 2002, about 12 months after the WTC attack. The community-based services started in spring 2003. Provided by mental health professionals, these expanded services were based on cognitive

⁶⁵In the past, SAMHSA had provided Florida with supplemental financial assistance to fund services outside the state's CCP. Following Hurricane Charley and the three other hurricanes that affected Florida in 2004, state officials found that some people required services that went beyond the scope of the state's CCP, and so officials requested federal funds to provide additional services. In response, SAMHSA awarded an \$11 million grant to help the state provide services not included in the state's CCP, such as mental health treatment, case management, substance abuse treatment, and other services.

behavioral approaches. These services included helping clients recognize symptoms of postdisaster distress and develop skills to cope with anxiety, depression, or other symptoms. Individuals referred for expanded services were offered a series of up to 12 counseling sessions. New York's community-based expanded services for adults ended in December 2003; its community-based services for children ended in December 2004, as did the FDNY's services.

In November 2006, FEMA and SAMHSA allowed Louisiana and Mississippi to plan for providing expanded crisis counseling services, known as "specialized crisis counseling services," to supplement CCP services offered to people affected by Hurricane Katrina. Each state developed and implemented expanded services based on operating principles developed by SAMHSA⁶⁶ and tailored to the needs of its population. Louisiana and Mississippi began offering their expanded services in January 2007, about 17 months after the hurricane. In contrast to New York's series of up to 12 sessions, the expanded services offered by Louisiana and Mississippi were designed to be delivered in a single stand-alone session by mental health professionals, although clients could obtain additional sessions. The states' CCPs used a standardized assessment and referral process to determine whether to refer people for expanded services, such as stress management. Louisiana and Mississippi used providers with prior mental health training to refer expanded services clients for mental health and substance abuse treatment services. In addition, the states used paraprofessionals to link clients with other disaster-related services and resources, such as financial services, housing, transportation, and child care. According to a SAMHSA official, Louisiana's CCP is scheduled to stop providing expanded services to adults and children in February

⁶⁶SAMHSA's six operating principles are (1) disaster-trained clinical professionals are a key component of specialized crisis counseling teams; (2) an active outreach must be maintained; (3) appropriate assessment and referral techniques will be utilized; (4) specialized techniques must be appropriate to the short-term, temporary nature of CCP and phases of disaster recovery; (5) specialized techniques must focus on immediate practical needs and priorities of survivors; and (6) training, supervision, and oversight are critical to successful implementation and operation.

2008.⁶⁷ Mississippi, which focused on providing expanded services to adults,⁶⁸ stopped providing services in April 2007.

Several state officials said that it would be beneficial if the CCP model could be expanded to include more intensive crisis counseling services and if states could make these types of services available sooner. For example, several officials told us that if expanded services were a permanent part of CCP it would enable states responding to catastrophic disasters to incorporate expanded services at an earlier stage in their CCP service plans, training programs, and budgets. A New York official told us that after the state received approval for the general concept of expanded services, it took the state a few additional months to prepare a proposal, obtain federal approval, and contract with and train the providers. Because the state did not begin offering expanded services until it started phasing down its delivery of traditional CCP services, fewer crisis counselors were available to refer clients from traditional services to expanded services. NCPTSD's 2005 evaluation of CCP for SAMHSA recommended that, at least on a trial basis, expanded services should become a well-integrated part of state CCPs that is implemented relatively early in state programs.⁶⁹ NCPTSD also recommended evaluating the efficacy of such services. FEMA and SAMHSA officials told us that after completion of Louisiana's program they planned to examine which elements of Louisiana's, Mississippi's, and New York's expanded services programs might be beneficial to incorporate into CCP. FEMA and SAMHSA officials also said that NCPTSD has begun to develop an additional approach to providing postdisaster counseling services that they would also like to examine after it has been developed. FEMA and SAMHSA officials said they also planned to try to determine the most opportune time to start offering expanded services to disaster survivors. These officials did not know when the review would be completed.

Additional CCP Implementation Difficulties

Officials we interviewed in three of the states in our review expressed concerns about the ability of state CCPs to appropriately refer people

⁶⁷According to SAMHSA, Louisiana's entire Hurricane Katrina CCP was scheduled to end February 28, 2008. However, as of November 2007, SAMHSA and FEMA were reviewing a request from Louisiana to extend the state's CCP through December 31, 2008.

⁶⁸Mississippi did not include children in its expanded program because it was already involved in two other initiatives related to the mental health needs of children affected by the hurricane.

⁶⁹NCPTSD, *Retrospective 5-Year Evaluation of the Crisis Counseling Program*, D148.

needing mental health or substance abuse treatment services. Several state officials said that the paraprofessional crisis counselors who generally identify people for referral are not always able to properly identify people who have more serious psychological problems. Officials said there was a constant need to provide staff with training on CCP assessment and referral techniques to ensure that they could identify people who needed a referral. In its evaluation of CCP for SAMHSA, NCPTSD also reported concerns by states related to the ability of paraprofessionals to identify people needing a referral.⁷⁰ According to SAMHSA, a CCP trainer's toolkit that was completed in August 2007 includes information on proper techniques for conducting CCP assessments and referrals. The agency is planning to distribute the toolkit to states in spring 2008 when it holds a planned training.

Officials we spoke to in all six states in our review told us that their CCPs were constrained by FEMA's policy of not allowing CCP funds to be used to provide some case management services. According to CCP guidance, case management is not typically an allowable program service.⁷¹ Several state officials told us that it would be beneficial if state CCPs could provide some form of case management after catastrophic disasters, when many survivors are likely to have numerous needs and may require additional support to obtain services necessary for their recovery. State officials said that Hurricane Katrina highlighted the difficulties that disaster survivors can have negotiating complex service and support systems. Louisiana officials said, for example, that many people who experienced extraordinary levels of stress because of the hurricane had low literacy skills and clearly needed support to make connections to additional services and resources. One state official also told us that because the practical difficulties of meeting needs involving housing can often be a cause of the emotional distress that CCPs are trying to alleviate, they would like CCP crisis counselors to be able to more directly help people connect with disaster-related services to meet these needs.

⁷⁰NCPTSD, *Retrospective 5-Year Evaluation of the Crisis Counseling Program*, E19.

⁷¹Case management involves a range of services to help people recover from a disaster, such as helping them obtain health, social, and financial services. According to CCP guidance, providers may give survivors information about other FEMA disaster assistance programs and information on other resources. However, the guidance states that it is beyond the scope of CCP for crisis counselors to serve as advocates for disaster survivors in obtaining services or resolving disputes or function in a way that might create dependence on CCP staff and programs that will not exist following the end of CCP.

State officials also told us that it was difficult to identify people in need of crisis counseling services because FEMA does not give state CCPs access to specific information on the location of people registered for federal disaster assistance. NCPTSD's evaluation of CCP also noted that the unavailability of this information made it difficult for state CCPs to locate people who might need services.⁷² Several state officials told us that FEMA had provided them with some counts of disaster registrants at the state, county, or Zip Code levels but that they also needed information on the specific locations of disaster survivors to conduct effective outreach. FEMA officials told us that the agency stopped providing information on the specific location of registrants in the 1990s. They also told us that it was their understanding that FEMA stopped providing this information due to concerns about the privacy of registrants.

Conclusions

The scope and magnitude of catastrophic disasters can result in acute and sustained psychological trauma that can be debilitating for extended periods of time. While CCP is a key component of the federal government's response to the psychological consequences of disasters, we have identified two important limitations that can affect states' ability to use CCP to respond to the special circumstances of catastrophic disasters. First, state officials responding to the WTC attack and Hurricane Katrina identified the need to provide expanded crisis counseling services through CCP. FEMA and SAMHSA recognized such a need when they permitted three state CCPs to expand their programs to provide more intensive short-term crisis counseling than the CCP model generally allows. FEMA and SAMHSA officials told us they intended to consider incorporating certain types of expanded services into CCP. Promptly determining what types of expanded services should become a permanent part of CCP would enable states to more effectively develop their CCP proposals and provide their populations with needed counseling services in the event of future catastrophic disasters.

Second, FEMA's policy of precluding states and their CCP service providers from obtaining reimbursement for indirect costs associated with managing and monitoring their CCPs has made it difficult for states to effectively administer their CCPs. State officials reported that the lack of reimbursement for indirect costs made it more difficult to recruit and retain service providers and contributed to a major contractor's

⁷²NCPTSD, *Retrospective 5-Year Evaluation of the Crisis Counseling Program*, C60.

withdrawal from Louisiana's Hurricane Katrina CCP. Other FEMA disaster response grant programs allow reimbursement for such costs. Although FEMA had been examining this issue for over a year, an agency official did not know when the agency would reach a decision on whether to revise CCP policy to allow coverage of indirect costs. Including indirect costs in CCP and not requiring service providers to absorb these costs could expand the pool of providers willing to participate in this program. This could strengthen states' ability to assist disaster victims in coping with the psychological consequences of catastrophic disasters.

Recommendations for Executive Action

To address gaps identified by federal and state officials in the federal government's ability to help states respond to the psychological consequences of catastrophic disasters, we recommend that the Secretary of Homeland Security direct the Administrator of FEMA, in consultation with the Administrator of SAMHSA, to expeditiously take the following two actions:

- determine what types of expanded crisis counseling services should be formally incorporated into CCP and make any necessary revisions to program policy, and
- revise CCP policy to allow states and service providers that receive CCP funds to use them for indirect costs.

Agency Comments and Our Evaluation

We provided a draft of this report to DHS and HHS for comment. Both DHS and HHS generally concurred with both of our recommendations and stated that they had taken or will take steps toward implementing them. However, they did not provide specific timelines for completing these actions. (DHS's comments are reprinted in app. III; HHS's comments are reprinted in app. IV).

In response to our recommendation to expeditiously allow reimbursement for indirect costs within CCP, both departments commented that allowing reimbursement for such costs will promote broader participation of local service providers. In its comments, DHS also said that the inclusion of indirect costs will help expedite the application review process and that FEMA has been working with SAMHSA to revise CCP policy to allow reimbursement for indirect costs. HHS stated that the draft report accurately reflected concerns regarding the exclusion of indirect costs and that SAMHSA had previously given FEMA a recommendation supporting a change in this policy. Although DHS and HHS indicated that they are

working on a revision of the policy to allow reimbursement of such costs, they did not provide a timeline for completing this activity. As our report notes, FEMA has been examining this issue since 2006, and it is important to complete this work expeditiously so that in the event of a future disaster, state CCPs could be in a better position to attract the participation of a broad array of service providers.

In response to our recommendation to expeditiously determine what types of expanded crisis counseling services should be formally incorporated into CCP, HHS and DHS commented that, as our draft report indicated, they plan to wait until Louisiana has completed its pilot expanded services program before making this determination. They said that because Louisiana had applied for an extension of its CCP, they cannot provide a timeline for completion of their reviews of expanded services pilots. We believe, however, that federal program officials already have a considerable amount of information about these pilots—New York and Mississippi have completed their programs and Louisiana has been providing information on an ongoing basis. We believe that it is important for FEMA and SAMHSA to expeditiously review the experience of the pilot programs and other relevant information so they can expeditiously determine which expanded services should be formally incorporated into CCP. This will help ensure that states responding to a disaster will be able to provide the appropriate range of CCP services to assist people who are in need of crisis counseling services. In addition, HHS commented that SAMHSA has initiated a workgroup to ensure that the CCP model reflects current best practices. However, we have learned that, as of January 2008, the workgroup had not yet begun to conduct its work.

HHS and DHS commented on our discussion of states' reports on difficulties they had experienced in preparing their CCP applications. DHS stated that FEMA, in consultation with SAMHSA, took action to expedite the submission, review, and approval of ISP applications submitted after Hurricane Katrina, including allowing the use of shorter applications by states hosting Hurricane Katrina evacuees. We clarified our discussion of host states' ability to apply for CCP funds to note that FEMA allowed them to submit an abbreviated ISP application. DHS also commented that it is not feasible to have one grant application or one grant for two separate disasters because FEMA must separately account for and report on funds for specific disasters. We attempted to obtain further clarification from DHS about why FEMA separately accounts for funds for each disaster, but DHS did not provide this information.

In addition, HHS and DHS commented that the draft report's description of the needs assessment process failed to capture the degree to which they had provided states flexibility in quantifying survivor needs after Hurricane Katrina. DHS said that FEMA and SAMHSA did not rely primarily on damage assessments, as few had been completed. Rather, FEMA registration numbers, newspaper reports, and anecdotal data were relied on to estimate need. Our draft report described action taken by FEMA to help states collect information needed to prepare their ISP applications after Hurricane Katrina, and we have revised the final report to make it clear that states were allowed to use other sources of information.

In commenting on the CCP application review process, HHS and DHS said that the data in our report showing that it took up to 286 days to review applications were misleading because only Louisiana's application took that long to review and the state's proposed use of a different procedure for identifying the local service providers with which it would contract caused enormous delays in the review process. However, the review of New York's RSP after the WTC disaster also took over 200 days, and the reviews for four of the five states in our study took longer than FEMA's estimated average review period. The draft report contained information on several factors that contributed to longer review times, and we added to the final report information on Louisiana's proposal to use an alternative procedure and its effect on the length of the review of Louisiana's RSP application.

HHS also commented on our discussion of states' concerns that lengthy reviews and resulting delays in obtaining funding created difficulties for CCPs in executing contracts with service providers and implementing their programs. HHS said that the report should note that these challenges were the result of state fiscal and contracting practices that do not relate to the availability of federal funds. Although state practices may contribute to delays, extended federal reviews also may contribute to delays in states' ability to implement their CCPs.

DHS commented on our description of states' discussion of the importance of case management services for CCP clients and mentioned the Post-Katrina Emergency Management Reform Act of 2006,⁷³ which amended the Stafford Act to allow for the provision of case management

⁷³Pub. L. No. 109-295, Title VI, §689f, 120 Stat. 1355, 1452 October 4, 2006.

services to meet the needs of survivors of major disasters. These services could include financial assistance to help state or local government agencies or qualified private organizations to provide case management services. In its comments, DHS also stated that FEMA has entered into an interagency agreement with HHS to collaborate closely on the development and implementation of a case management program; this agreement is for the development of a pilot program to determine the best methods of providing case management services. FEMA provided additional information indicating that its case management program will coordinate with CCP.

In its comments, HHS made observations about the importance of recognizing culture and language issues as barriers to effective responses to catastrophic disasters, incorporating behavioral health into all grantee planning and response activities, and requiring grant recipients to report on how funds were used to address the psychological consequences of a disaster. These are important points, and we would encourage HHS agencies to consider them in their disaster preparedness and response programs. HHS noted that HRSA's National Bioterrorism Hospital Preparedness Program, Emergency System for Advance Registration of Volunteer Healthcare Professionals, and Bioterrorism Training and Curriculum Development Program have been transferred to ASPR; we added this information to the final report where appropriate. HHS also identified actions it had taken in response to GAO's May 2005 report on the CCP, including improving the fiscal monitoring of grants.⁷⁴ In addition, HHS noted that the grants management position funded by FEMA that we discussed in our draft report was filled in December 2007. Our final report reflects this development.

In its comments, HHS said that instead of referring to 35 states that received disaster preparedness grants, our report should refer to 34 states and the District of Columbia; the draft report noted that our use of the word "state" included states, territories, Puerto Rico, and the District of Columbia. In addition, HHS suggested that we revise the title of the report by removing the reference to CCP needing improvements. In light of our findings and recommendations, we believe the need for expeditious action

⁷⁴GAO, *Federal Emergency Management Agency: Crisis Counseling Grants Awarded to the State of New York after the September 11 Terrorist Attacks*, [GAO-05-514](#) (Washington, D.C.: May 31, 2005).

supports the original title. HHS also provided technical comments, which we incorporated where appropriate.

We are sending a copy of this report to the Secretaries of Health and Human Services and Homeland Security. We will make copies available to others on request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you have any questions about this report, please contact me at (202) 512-7114 or bascettac@gao.gov. Contacts for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix V.



Cynthia A. Bascetta
Director, Health Care

List of Requesters

The Honorable Joseph I. Lieberman
Chairman
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Bennie G. Thompson
Chairman
Committee on Homeland Security
House of Representatives

The Honorable Mike Michaud
Chairman
Subcommittee on Health
Committee on Veterans' Affairs
House of Representatives

The Honorable Carolyn B. Maloney
House of Representatives

Appendix I: Scope and Methodology

To do our work, we obtained program documents and interviewed officials from the Department of Health and Human Services (HHS), including the Administration for Children and Families, Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), Health Resources and Services Administration (HRSA), National Institutes of Health, Office of the Assistant Secretary for Preparedness and Response,¹ and Substance Abuse and Mental Health Services Administration (SAMHSA); the Department of Education; the Department of Homeland Security (DHS), including the Federal Emergency Management Agency (FEMA); the Department of Justice; and the Department of Veterans Affairs (VA), including the National Center for Posttraumatic Stress Disorder (NCPTSD). We spoke with researchers from the National Center for Child Traumatic Stress at the University of California, Los Angeles, and the National Center for Disaster Preparedness at Columbia University. We also interviewed officials from national organizations, including the American Red Cross, National Alliance on Mental Illness, National Association of State Mental Health Program Directors, National Association of State Alcohol and Drug Abuse Directors, and National Emergency Management Association. In addition, we reviewed relevant literature.

We conducted additional work in six judgmentally selected states that had experience responding to the psychological consequences of three catastrophic disasters during fiscal years 2002 through 2006 that we included in our scope: the World Trade Center (WTC) attack in 2001, Hurricane Charley in 2004, and Hurricane Katrina in 2005. We included New York because it responded to the WTC attack;² Florida because it responded to Hurricane Charley; and Louisiana and Mississippi because they responded to Hurricane Katrina. We included Texas in our review because it hosted a large number of people displaced by Hurricane Katrina, and we included Washington because it hosted people displaced by Hurricane Katrina and has features, such as large ports, that make it vulnerable to natural and man-made disasters. Results from this

¹The Office of the Assistant Secretary for Preparedness and Response coordinates and directs HHS's emergency preparedness and response program. In December 2006 the Office of Public Health Emergency Preparedness became the Office of the Assistant Secretary for Preparedness and Response.

²Although the September 11, 2001, WTC attack occurred in fiscal year 2001, we included this event in our review because the response primarily occurred during the time period we examined.

nongeneralizable sample of six states cannot be used to make inferences about other states.

To examine actions by federal agencies to help states prepare for the psychological consequences of catastrophic disasters, we reviewed key federal preparedness and response documents—such as the National Response Plan, the Interim National Preparedness Goal, and FEMA’s Guide for All-Hazard Emergency Operations Planning—and recent reports on the federal government’s response to Hurricane Katrina.³ We identified federal grant programs and other activities that were related to disaster preparedness and were funded during fiscal year 2002 through fiscal year 2006 by reviewing relevant documents and through discussions with federal and state officials. For key HHS and DHS preparedness grant programs, we reviewed relevant documentation, such as application guidance, and interviewed federal program officials. We obtained disaster plans for the mental health and substance abuse agencies in the six states included in our review and examined the plans we received. We also interviewed mental health and substance abuse officials from these six states about their preparedness activities. In addition, we examined SAMHSA’s 2007 report on mental health and substance abuse disaster plans developed by states that received its preparedness grant.⁴

To examine states’ experiences in obtaining and using federal Crisis Counseling Assistance and Training Program (CCP) grants to respond to the psychological consequences of catastrophic disasters, we reviewed program documentation, including the applicable statute, regulations, guidance, and grantee reports. We also reviewed CCP applications or other relevant documentation that the six states submitted to FEMA for

³These reports included U.S. House of Representatives, Select Bipartisan Committee to Investigate the Preparation for and Response to Hurricane Katrina, *A Failure of Initiative: Final Report of the Select Bipartisan Committee to Investigate the Preparation for and Response to Hurricane Katrina* (Washington, D.C., Feb. 15, 2006); White House Homeland Security Council, *The Federal Response to Hurricane Katrina: Lessons Learned* (Washington, D.C., Feb. 23, 2006); U.S. Senate Committee on Homeland Security and Governmental Affairs, *Hurricane Katrina: A Nation Still Unprepared* (Washington, D.C., May 2006); and Educational Services, Inc., “Beyond Katrina: An After-Action Report on Improving Substance Abuse and Mental Health Response to Future Disasters,” unpublished report, prepared at the request of SAMHSA (Bethesda, Md., May 8, 2006).

⁴SAMHSA, “State Behavioral Health All-Hazards Disaster Plan Review Report,” unpublished report (Rockville, Md., June 2007).

declared counties⁵ in response to one of the three catastrophic disasters in our review. We reviewed documentation to obtain information on states' experiences in applying for CCP funding and on FEMA's and SAMHSA's processes for reviewing applications, including examining the length of time it took the agencies to review applications and make funding decisions for the selected catastrophic disasters. In addition, we interviewed state mental health officials from the six states to obtain additional information on their experiences applying for CCP funding and implementing their CCPs following these three disasters. We interviewed FEMA and SAMHSA officials to obtain their perspectives on states' applications and states' experiences implementing their CCPs to respond to catastrophic disasters and to obtain information pertaining to FEMA's and SAMHSA's administration of the program. Furthermore, we examined the 2005 report on CCP prepared for SAMHSA by NCPTSD.⁶

To identify other federal programs that have supported mental health and substance abuse services in response to catastrophic disasters, we reviewed GAO reports,⁷ Congressional Research Service reports,⁸ the Catalog of Federal Domestic Assistance, and pertinent legislation and program regulations. We interviewed federal program officials about these programs and obtained available information, including grantee applications, award data, and reports, to determine how the programs were used to respond to mental health or substance abuse needs following the three catastrophic disasters included in our review. We present information on the use of various federal programs to respond to needs following the catastrophic disasters in our review; the list we present is not exhaustive. To determine the amount of Deficit Reduction Act of 2005 funds used by the 32 states that had been approved by CMS for

⁵Generally, only states that have received a presidential disaster declaration are eligible to request CCP funding. These presidential declarations are county-specific.

⁶NCPTSD, "Retrospective 5-Year Evaluation of the Crisis Counseling Assistance and Training Program," unpublished report requested by SAMHSA (White River Junction, Vt., June 2005).

⁷See, for example, GAO, *Mental Health Services: Effectiveness of Insurance Coverage and Federal Programs for Children Who Have Experienced Trauma Largely Unknown*, [GAO-02-813](#) (Washington, D.C.: Aug. 22, 2002).

⁸See, for example, Congressional Research Service, *Federal Stafford Act Disaster Assistance: Presidential Declarations, Eligible Activities, and Funding*, RL33053 (Washington, D.C., Mar. 6, 2007); and Congressional Research Service, *Gulf Coast Hurricanes: Addressing Survivors' Mental Health and Substance Abuse Treatment Needs*, RL33738 (Washington, D.C., Nov. 29, 2006).

demonstration projects following Hurricane Katrina, we analyzed data in CMS's Medicaid Budget and Expenditure System (MBES), which includes claims data for health care services, including inpatient mental health care services. We analyzed MBES claims data available as of June 27, 2007, for services provided August 24, 2005, or later to eligible people affected by Hurricane Katrina. To assess the reliability of the MBES data, we discussed the database with an agency official and conducted electronic testing of the data for obvious errors in completeness. States submit all claims data to the system electronically and must attest to the completeness and accuracy of the data. These data are preliminary in nature, in that they are subject to further review by CMS and are likely to be updated as states continue to submit claims for Deficit Reduction Act funding. We determined that these data were sufficiently reliable for the purpose of our report.

We conducted our work from March 2006 through February 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: Additional Federal Programs Used to Respond to Psychological Consequences of Catastrophic Disasters

In addition to CCP, federal agencies have used other programs following catastrophic disasters to help states and localities provide mental health and substance abuse services to disaster survivors. The following list presents information on the use of various federal programs to respond to needs following the catastrophic disasters in our review; it is not an exhaustive list.

Federal agencies have used established grant programs to help states respond to the psychological consequences of catastrophic disasters, some of which are generally intended to be used following smaller-scale emergencies.

- SAMHSA awarded funds through its Emergency Response Grant (SERG) program following Hurricane Katrina.¹ The agency provided a total of \$900,000 to Alabama, Louisiana, Mississippi, and Texas to help meet the overwhelming need for assistance. For example, Texas was awarded \$150,000 and helped evacuees in the Houston Astrodome and other shelters who needed methadone medication because of opiate addiction.
- The Department of Education awarded funds through its Project School Emergency Response to Violence (Project SERV) program following the 2001 terrorist attacks and Hurricanes Katrina and Rita. The agency provided about \$14 million and \$7 million following these respective disasters to help local education agencies respond by providing services that could include crisis counseling, mental health assessments, and referrals.² For example, following the 2001 terrorist attacks, New York used Project SERV funds to provide counseling and after-school mental health services.
- The Department of Justice provided funds through its Antiterrorism and Emergency Assistance Program to help states and localities respond to victims' mental health needs following mass violence and acts of terrorism. Following the WTC attack, for example, New York used

¹SERG can be used to support mental health and substance abuse services after smaller-scale emergencies that have not received a presidential disaster declaration. SERG typically does not fund long-term mental health or substance abuse treatment, medications, hospitalization, or services that may be provided through CCP.

²Project SERV is generally used following smaller-scale emergencies, such as school shootings and suicides, that have not received a presidential disaster declaration. Grant funds may not be used for medical services, drug treatment, or rehabilitation, except for pupil services or referral to treatment for students who are victims of, or witnesses to, a crime, or who illegally use drugs. See 20 U.S.C. §7164 (2).

\$5 million of its grant award from the Department of Justice to provide additional funding to 15 service providers providing crisis counseling services through the state CCP.

HHS has also temporarily modified or expanded ongoing federal health care and social service programs to help states provide mental health and substance abuse services after specific catastrophic disasters.

- CMS allowed states to temporarily cover certain health care costs associated with catastrophic disasters through Medicaid and the State Children's Health Insurance Program (SCHIP). For example, following Hurricane Katrina, the Congress appropriated \$2 billion to cover certain health care costs related to Hurricane Katrina through Medicaid and SCHIP.³ CMS allowed 32 states that either were directly affected by the hurricane or had hosted evacuees to temporarily expand the availability of coverage for certain people affected by the hurricane.⁴ CMS allowed states to submit claims for reimbursement for health care services that were provided August 24, 2005, or later. As of June 27, 2007, these states had submitted claims to CMS for health care services totaling about \$1.7 billion, of which about \$15.7 million was for mental health services provided in inpatient facilities—such as hospitals, nursing homes, and psychiatric facilities.⁵ (See table 2 for information on the amount of claims submitted by states, including four states that were in our review.)⁶

³The Deficit Reduction Act of 2005, Pub. L. No. 109-171, §6201, 120 Stat. 4, 132 (2006).

⁴GAO, *Hurricane Katrina: Allocation and Use of \$2 Billion for Medicaid and Other Health Care Needs*, [GAO-07-67](#) (Washington, D.C.: Feb. 28, 2007).

⁵This total does not include mental health claims that states may have reported to CMS within other reportable categories—such as physician services or outpatient services—for which claims specific to mental health services could not be identified.

⁶New York and Washington did not participate in this temporarily expanded program.

**Appendix II: Additional Federal Programs
Used to Respond to Psychological
Consequences of Catastrophic Disasters**

Table 2: Amount of Claims for Deficit Reduction Act Funds Submitted by Selected States to Serve People Affected by Hurricane Katrina, as of June 27, 2007

Dollars

State	Total claims	Claims for mental health services provided in inpatient facilities ^a
Florida	1,232,069	0
Louisiana	961,645,567	2,344,421
Mississippi	491,425,133	8,812,012
Texas	12,380,827	566
Other states	243,103,398	4,571,568
Total	1,709,786,994	15,728,567

Source: GAO analysis of CMS data.

^aThese amounts do not include claims for mental health services that states may have reported to CMS within other categories—such as physician services and outpatient services—for which claims specific to mental health services could not be identified.

- HHS’s Administration for Children and Families awarded \$550 million in supplemental Social Services Block Grant funds following the 2005 Gulf Coast hurricanes to temporarily expand the program to help 50 states and the District of Columbia meet social and health care service needs.⁷ The funds could be used for providing case management and counseling, mental health, and substance abuse services, including medications. States could also use the funds for the repair, renovation, or construction of community mental health centers and other health care facilities damaged by the hurricanes. For example, Mississippi was awarded about \$128 million in supplemental funding and used about \$10 million of the funding in part to restore services to mental health treatment facilities for adults and children and provide transportation to mental health services.

Federal agencies also awarded funding outside of these established programs to help states provide disaster-related mental health and substance abuse services after specific catastrophic disasters in our review. Some of these programs focused on specific at-risk groups, such as disaster responders, while others were established to meet the mental health needs of broader populations.

⁷The Department of Defense Appropriations Act, 2006, Pub. L. 109-148, Division B, 119 Stat. 2680, 2745, 2768 (2005).

- HHS is coordinating federally funded programs for responders to the WTC disaster—including firefighters, police, other workers or volunteers, and federal responders—that provide free screening, monitoring, or treatment services for physical illnesses and psychological problems related to the disaster.⁸ We have previously reported on the progress of these programs.⁹
- SAMHSA provided \$28 million to nine states most directly affected by the September 11 attacks to provide various substance abuse and mental health services for people directly affected by the attacks.¹⁰ These services included assessments, individual counseling, group therapy, specialized substance abuse treatment, and case management.

⁸The WTC health programs are (1) the New York City Fire Department WTC Medical Monitoring and Treatment Program; (2) the New York/New Jersey WTC Consortium; (3) the WTC Federal Responder Screening Program; (4) the WTC Health Registry; (5) the Police Organization Providing Peer Assistance program; and (6) Project COPE. The WTC Health Registry also includes people living or attending school in the area of the WTC, or working or present in the vicinity on September 11, 2001. In addition to these six programs, a New York State responder screening program received federal funding for screening New York State employees and National Guard personnel who responded to the WTC attack in an official capacity. This program ended its screening examinations in November 2003.

⁹For information on the progress of these programs and difficulties they have experienced, see, for example, GAO, *September 11: HHS Needs to Ensure the Availability of Health Screening and Monitoring for All Responders*, [GAO-07-892](#) (Washington, D.C.: July 23, 2007); GAO, *September 11: HHS Has Screened Additional Federal Responders for World Trade Center Health Effects, but Plans for Awarding Funds for Treatment Are Incomplete*, [GAO-06-1092T](#) (Washington, D.C.: Sept. 8, 2006); and GAO, *September 11: Monitoring of World Trade Center Health Effects Has Progressed, but Program for Federal Responders Lags Behind*, [GAO-06-481T](#) (Washington, D.C.: Feb. 28, 2006).

¹⁰Grantees were Connecticut, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island, Virginia, and the District of Columbia. States received funds through one or more of SAMHSA's three centers: the Center for Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment.

Appendix III: Comments from the Department of Homeland Security

U.S. Department of Homeland Security
Washington, DC 20528



**Homeland
Security**

January 24, 2008

Ms. Cynthia Bascetta
Director
Health Care
U.S. Government Accountability Office
441 G St, NW
Washington, DC 20548

Dear Cynthia Bascetta:

The Department of Homeland Security (DHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report GAO-08-22 entitled *Catastrophic Disasters: Federal Efforts Help States Prepare for and Respond to Psychological Consequences, but FEMA's Crisis Counseling Program Needs Improvements* (GAO Job Code 290506).

DHS generally concurs with both recommendations that state "GAO recommends that FEMA, with the Substance Abuse and Mental Health Services Administration (SAMSHA), expeditiously (1) revise CCP policy to allow reimbursement for indirect costs and (2) determine what types of expanded crisis counseling services should be incorporated into the CCP."

Inclusion of indirect cost recovery within the Crisis Counseling Assistance and Training program (CCP) will facilitate an expedited application review process, as well as, promote participation of a broader array of local service providers resulting in a more accessible and effective program. Federal Emergency Management Agency (FEMA) is working with SAMHSA and internal agency partners to implement this change to current policy.

In regards to expanding crisis counseling services, an expansion of CCP services has been piloted in three states affected by catastrophic disasters: New York, Louisiana and Mississippi. As the draft report correctly states, a full review of each expanded program is planned in order to determine which elements of each program should be utilized in the development of an appropriate, effective and responsible augmentation to the CCP. The Louisiana pilot program remains open and has recently requested a program extension to continue the provision of services. It is not possible for program staff to provide a timeline for completion of the reviews until program services are completed in Louisiana.

www.dhs.gov

In an effort to ensure that the CCP model reflects the most up-to-date and best practices available, FEMA will continue to work with our partners at SAMHSA, as well as, state, academic, non-profit and government experts in disaster mental health throughout the country.

Even prior to the GAO report, FEMA staff was working closely with SAMHSA staff on the revision of CCP policy to allow reimbursement for indirect costs, as well as reviewing the types of expanded crisis counseling services to be incorporated within the CCP model. FEMA and SAMHSA are collaborating through workgroups charged with developing guidelines to implement these changes.

CCP Implementation Difficulties Encountered By States

Information Collection

According to the draft report, state officials indicated that the “States had problems collecting information needed to prepare their Immediate Services Crisis Counseling Program (ISP) applications within FEMA’s application deadline and preparing parts of their ISP and Regular Services Crisis Counseling Program (RSP) applications.” FEMA recognized that Hurricane Katrina was a catastrophic incident that called for extraordinary measures and solutions. Victims were evacuated, or traveled on their own, to at least forty-four states. In order to address the crisis counseling needs of the people displaced as a result of Hurricane Katrina, FEMA made the decision to allow “host” states the opportunity to apply for CCP funds. To expedite the submission, review and approval of ISP applications for undeclared counties and states receiving evacuees affected by Hurricane Katrina, FEMA, in consultation with SAMHSA, developed a simplified ISP application that states were encouraged to use. In lieu of the traditional application, the revised format asked for brief, but informative, information with the recommendation that the application be no longer than five pages. Application submission expectations were clearly identified in a guidance document provided as part of the simplified application.

The description of the needs assessment process fails to capture the degree to which flexibility was given the states in quantifying survivor needs. FEMA and SAMHSA reviewers did not rely primarily on damage assessments, as few had been completed. Rather, FEMA registration numbers, newspaper reports and anecdotal data were relied upon to estimate need and to scale initial programs.

According to the draft report, state officials indicated that “problems were exacerbated because multiple disasters affected the same jurisdiction in close succession and they were required to submit a separate application for each one.” One program application, or one grant for two separate disasters, is not feasible as FEMA must account for and report on disaster specific funds separately. However, when situations like this occur, staff from FEMA and SAMHSA work closely with the state to ensure that program implementation for both disasters is seamless to the disaster victim, planned program efforts are adhered to and separate program reports are submitted timely and accurately.

Application Review

The draft report indicates that a state's RSP application is primarily reviewed by SAMHSA. This statement is incorrect and should be changed. All ISPs and RSPs are reviewed, in detail, by both FEMA and SAMHSA program staff.

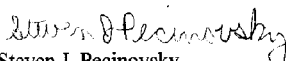
The report suggests that the application review process, post catastrophic disaster, can be lengthy; taking up to 286 days prior to a funding decision. The report indicates that these funding delays created difficulties for states in "executing contracts with service providers, delays in hiring staff and problems retaining staff." The report should clarify that the only application that required 286 days prior to a funding decision was the application submitted by the State of Louisiana. Louisiana chose to utilize a Request for Proposal (RFP) process to determine which providers they would contract with for the provision of CCP services. Using a RFP process is atypical for the CCP. The initial grant application submitted by the State was incomplete as the document simply outlined their plan for the RFP. The completed grant application was submitted six months later. This caused the enormous delays in the review and funding of this State's grant application.

Case Management

State officials advised the GAO that it "would be beneficial if state CCPs could provide some form of case management after catastrophic disasters." It is important to note that as a result of the recognized need for comprehensive case management services following Hurricane Katrina, Congress passed the Post Katrina Emergency Management Reform Act of 2006 allowing for the provision of "case management services, including financial assistance, to state and local government agencies or qualified private organizations to provide such services to victims of major disasters to identify and address unmet needs." FEMA has entered into an interagency agreement with the U.S. Department of Health and Human Services to collaborate closely on the development and implementation of a Case Management Program.

We thank you again for the opportunity to offer comments on this draft report and look forward to working with you on future homeland security issues.

Sincerely,


Steven J. Pecinovsky
Director
DHS Departmental GAO/OIG Liaison Office

Appendix IV: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

JAN 15 2008

Ms. Cynthia A. Bascetta
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Bascetta:

Enclosed are the Department's comments on the Government Accountability Office (GAO) draft report on Catastrophic Disasters: Federal Efforts Help States Prepare for and Respond to Psychological Consequences, but FEMA's Crisis Counseling Program Needs Improvements (GAO-08-22).

The Department appreciates the opportunity to review and comment on this draft before its publication.

Sincerely,

A handwritten signature in cursive script that reads "Rebecca Hemud".

for Vincent J. Ventimiglia
Assistant Secretary for Legislation

**GENERAL COMMENTS OF THE U.S. DEPARTMENT OF HEALTH AND
HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY
OFFICE'S (GAO) DRAFT REPORT: CATASTROPHIC DISASTERS: FEDERAL
EFFORTS HELP STATES PREPARE FOR AND RESPOND TO
PSYCHOLOGICAL CONSEQUENCES, BUT FEMA'S CRISIS COUNSELING
PROGRAM NEEDS IMPROVEMENTS (GAO 08-22)**

The GAO report contains several references to what was formerly HRSA's National Bioterrorism Hospital Preparedness Program (NBHPP), the Emergency System for Advance Registration of Volunteer Healthcare Professionals, and the Bioterrorism Training and Curriculum Development Program. However, with the passage of the Pandemic and All-Hazards Preparedness Act (Public Law 109-417), these programs were transferred to the Office of the Assistant Secretary for Preparedness and Response (ASPR). Our specific comments include suggestions for acknowledging these realignments in the draft report.

With respect to disaster response, health literacy is an important factor in effective disaster response. However, health literacy was only mentioned once in the draft report (Page 34) with respect to a comment made by Louisiana health officials that many people experienced extraordinary levels of stress due to limited literacy skills, and these people needed support to make connections to additional services. GAO's report should also more fully address the issue of culture and language as barriers to effective responses to catastrophic disasters. Additionally, implementing post-disaster response readiness, with practice drills and mock sessions would be helpful for eliminating future errors in disaster responses.

HHS Response to the Recommendations in the Draft Report

The draft report recommends that FEMA, with SAMHSA expeditiously:

1. Revise CCP policy to allow reimbursement for indirect costs; and
2. Determine what types of expanded crisis counseling services should be incorporated into the CCP.

HHS has no objections to these recommendations. The draft report accurately reflects concerns regarding the exclusion of indirect costs from allowable CCP expenses, recognizing that allowing indirect cost reimbursement for such costs will promote broader participation of local service providers. As mentioned in the report, SAMHSA has provided a recommendation supporting a change in this policy to FEMA and FEMA is working toward implementation.

Regarding expansion of crisis counseling services, an expansion of CCP services has been pilot tested in three States, New York, Louisiana, and Mississippi. As the report indicates, FEMA and SAMHSA have indicated that a full review of the three pilots will need to be conducted to make clinically responsible recommendations for increasing the types of services provided by the CCP as well as clear guidance on how to do so. Since one of the pilots has not concluded at this time and an extension request from this State is under review, it is not possible for officials to give a timeline for final review and conclusion.

Now on p. 31.

GENERAL COMMENTS OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT: CATASTROPHIC DISASTERS: FEDERAL EFFORTS HELP STATES PREPARE FOR AND RESPOND TO PSYCHOLOGICAL CONSEQUENCES, BUT FEMA'S CRISIS COUNSELING PROGRAM NEEDS IMPROVEMENTS (GAO 08-22)

Moreover, routine inclusion of additional crisis counseling services should be appropriately considered to ensure optimal, ethical treatment of disaster survivors and to further ensure that these services can be provided in a way that does not incur harm. In addition, it should be noted that SAMHSA has initiated a workgroup whose goal is to ensure that the CCP model reflects the most up to date and best practices available. The workgroup is charged with developing a set of strategies to achieve this goal and will monitor progress through a tracking chart.

Response to GAO Concerns Regarding FEMA Funded Grants Management Position

The FEMA funded Grants Management position referenced in the draft report was filled in December 2007. In addition to grants management, this individual will assist Project Officers with fiscal monitoring of CCP grants. The addition of this employee should contribute to shorter award times for RSP grants.

HHS Responses to Improvements Made Since May 2005 GAO Report

It is important to note that several actions were taken in response to the May 2005 GAO Report. Major improvements have been made in fiscal monitoring of grants by SAMHSA and FEMA, including the use of standardized budget tables across all programs, development and implementation of a budget adjustment request form with close monitoring procedures, and encouraging States/providers to hire financial professionals to monitor fiscal activities for large grants.

ISP and RSP applications and supplemental instructions have been revised, providing much clearer guidance. Revised instructions were made available to States in November 2007 and can be found on the SAMHSA website.

Data Collection and evaluation continue to improve. A data collection toolkit has been developed with the assistance of the National Center for Post Traumatic Stress Disorder (NCPSTSD). The Toolkit includes standardized data collection forms, surveys, and instructions.

GENERAL COMMENTS OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT: CATASTROPHIC DISASTERS: FEDERAL EFFORTS HELP STATES PREPARE FOR AND RESPOND TO PSYCHOLOGICAL CONSEQUENCES, BUT FEMA'S CRISIS COUNSELING PROGRAM NEEDS IMPROVEMENTS (GAO 08-22)

Efforts have been made to elicit feedback from our stakeholders through a cross site evaluation conducted by NCPTSD. In addition, a lessons-learned meeting about Katrina, Wilma, and Rita was held in New Orleans in May 2007 during which grantees provided information and recommendations about their crisis counseling programs. Throughout the report, reference is made to 35 States receiving disaster preparedness grants. To be accurate, the report should refer to 34 States and the District of Columbia.

Difficulties States Have Encountered Implementing Their CCPs

On page 24, reference is made to RSP applications taking up to 286 days to review. This statement is misleading and should be revised to reflect that the only application that took this long to complete was the application from the State of Louisiana.

The report should also note that Louisiana made the decision to utilize a Request for Proposal (RFP) process to determine which providers they would contract with to provide CCP services and that utilizing this process is atypical for the CCP and took many months, causing enormous delays in the review process.

In the discussion of delays in "executing contracts with service providers" on page 6 it should be noted that the challenges described are the result of State fiscal and contracting practices that do not relate to the availability of Federal funds nor does the Federal government have any influence over these kinds of State practices.

Page 12 of the draft report gives the impression that a State's RSP application is primarily reviewed by SAMHSA. This is incorrect. All ISP's and RSP's are reviewed by both FEMA and SAMHSA, with FEMA having the final funding approval authority. Also, SAMHSA plays a more direct role in monitoring the activities of an RSP, once it is awarded, than it does monitoring an ISP. RSP grants are awarded through SAMHSA and are assigned a SAMHSA project officer and grants management specialist. ISP grants are awarded through FEMA and are monitored by FEMA staff with consultation from SAMHSA staff.

The description of the needs assessment process following Katrina does not capture the degree to which flexibility was given the States in quantifying survivor needs. Reviewers did not rely primarily on damage assessments, as few had been completed. Rather, FEMA registration numbers, newspaper reports and anecdotal evidence were relied upon to estimate need and scale initial programs. As more data became available, it was incorporated into revised ISP and RSP applications.

With regard to CCP budgets, as stated in the draft report, Federal officials have addressed concerns by extensively revising program guidance materials.

4

Now on p. 23.

Now on p. 5.

Now on p. 11.

GENERAL COMMENTS OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT: CATASTROPHIC DISASTERS: FEDERAL EFFORTS HELP STATES PREPARE FOR AND RESPOND TO PSYCHOLOGICAL CONSEQUENCES, BUT FEMA'S CRISIS COUNSELING PROGRAM NEEDS IMPROVEMENTS (GAO 08-22)

Overall Comments

GAO may want to address the limited access State mental health and substance abuse authorities have to other types of disaster preparedness and response funding. Many State mental health and substance abuse officials have commented that most of these kinds of funds are provided to public health departments which often do not include behavioral health agencies in their planning and activities to any significant degree. Clear language and expectations should be attached to all disaster related funding mandating that recipients partner with and incorporate behavioral health into all planning and response activities. Furthermore, funding agencies should require all recipients of funding to quantify and report on how funds were used to address the psychological consequences of disaster.

GAO Language (Report Title)

Since many of the items discussed as concerns have been addressed or are in the process of being addressed, we recommend a revision in the title to read, "Catastrophic Disasters: Federal Efforts Help States Prepare for and Respond to The Psychological Consequences of Disasters."

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Cynthia A. Bascetta, (202) 512-7114 or bascettac@gao.gov

Acknowledgments

In addition to the contact named above, Helene F. Toiv, Assistant Director; William Hadley; Alice L. London; and Roseanne Price made major contributions to this report.

Related GAO Products

September 11: Problems Remain in Planning for and Providing Health Screening and Monitoring Services for Responders. [GAO-07-1253T](#). Washington, D.C.: September 20, 2007.

Homeland Security: Observations on DHS and FEMA Efforts to Prepare for and Respond to Major and Catastrophic Disasters and Address Related Recommendations and Legislation. [GAO-07-1142T](#). Washington, D.C.: July 31, 2007.

September 11: HHS Needs to Ensure the Availability of Health Screening and Monitoring for All Responders. [GAO-07-892](#). Washington, D.C.: July 23, 2007.

Emergency Management: Most School Districts Have Developed Emergency Management Plans, but Would Benefit from Additional Federal Guidance. [GAO-07-609](#). Washington, D.C.: June 12, 2007.

Disaster Preparedness: Better Planning Would Improve OSHA's Efforts to Protect Workers' Safety and Health in Disasters. [GAO-07-193](#). Washington, D.C.: March 28, 2007.

Public Health and Hospital Emergency Preparedness Programs: Evolution of Performance Measurement Systems to Measure Progress. [GAO-07-485R](#). Washington, D.C.: March 23, 2007.

Catastrophic Disasters: Enhanced Leadership, Capabilities, and Accountability Controls Will Improve the Effectiveness of the Nation's Preparedness, Response, and Recovery System. [GAO-06-618](#). Washington, D.C.: September 6, 2006.

Federal Emergency Management Agency: Crisis Counseling Grants Awarded to the State of New York after the September 11 Terrorist Attacks. [GAO-05-514](#). Washington, D.C.: May 31, 2005.

Hurricane Katrina: Status of Hospital Inpatient and Emergency Departments in the Greater New Orleans Area. [GAO-06-1003](#). Washington, D.C.: September 29, 2006.

Mental Health Services: Effectiveness of Insurance Coverage and Federal Programs for Children Who Have Experienced Trauma Largely Unknown. [GAO-02-813](#). Washington, D.C.: August 22, 2002.

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