

MENTAL HEALTH IN THE
WAKE OF HURRICANE KATRINA



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especially the patients who came from the lower areas of New Orleans, did not have coverage, personal providers, or records. Not only did they not know what medications they were taking, in many cases, they did not know their diagnosis. Our commitment was to see that, in the future, there would be electronic health records so that there would be something the water could not wash away. Wherever we saw patients, whether it was on the streets of New Orleans in a health fair or in lower Alabama with Regina Benjamin at that outstanding clinic, we were going to establish electronic health records, and there would be a centralized place, such as the New Orleans Health Department, that these records could feed into. Every patient who we saw in our screening program – and we have seen many – received what we call a “thumb drive,” so that they could carry their health records with them, and the records could be accessed in the future by other providers.

We also committed to developing replicable models of tele-medcenters, especially telepsychiatry. It may well be that there is no psychiatrist in lower Alabama where Regina Benjamin practices, but through telepsychiatry,

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we have the ability to provide coverage with psychiatrists who can relate directly to patients and primary care providers. We have now identified a core of psychiatrists, and we are now putting in place that system. Technology is such that we can no longer tolerate having communities in this country that do not have access to the kind of high-level mental health services they need. Whether that is taking advantage of Carl Bell in Chicago or Noah Knight Richardson in Oregon, we are determined that, in the future, the resources will be there. (Carl Bell, M.D., is professor of clinical psychiatry at the University of Illinois, Chicago; president and CEO, Community Mental Health Council; The Carter Center Mental Health Task Force member.)

Those were our major commitments. We had one other, and in trying to use this tragedy in a positive way, one way was to try to engage more minority students in solving problems in these areas so they would be attracted to careers in the

health sciences, in medicine, and in public health. They would see that we cannot only respond to, but solve, problems.

Today, we have been able to establish electronic health record systems in several areas: 50 sites along the Gulf Coast, including coastal community health centers in Mississippi and Franklin Community Health Centers in Alabama, along with at least 13 identified private primary care sites. One of the reasons it is so hard to establish electronic health records is that there is a generation gap in the use of technology. Many physicians who have been in practice are not comfortable with computers, so when it comes to transitioning to using the computer for their records, they are not comfortable. They require a lot of training. Dominic Mack has excelled in this area and has established the electronic medical records system at the Morehouse School of Medicine. He had a difficult time with the faculty but not such a difficult time with residents and students, because they were ready to use this technology. We are training programs developing throughout the Southeast, but it is not easy.

In terms of telepsychiatry, we have engaged psychiatrists from different areas throughout the country, and we are trying to establish their availability. One of the interesting areas is Baton Rouge, La. If you had a chance to visit the trailer parks there, you know the situation people are living in, and also you know that some major mental health problems are being born out there. We are establishing one of our first telepsychiatry programs in a trailer park in Baton Rouge.

We are going to continue to face catastrophes of various kinds, natural and man-made, and they are going to affect many people in terms of post-traumatic stress syndrome. As Carl Bell has often said, it is not easy to know who is going to respond to Iraq, for example, by coming down with post-traumatic stress syndrome or who is going to experience Katrina. We know that many who go through that experience will not have post-traumatic stress syndrome. We do not fully understand that, but as we continue into the future, we will understand the impact of disasters on mental health better. Also, we hope we will understand better how to prepare people for disasters and tragedies that are going to continue to come.

Paula Madrid, Psy.D.

Director, Resiliency Program, National Center for Disaster Preparedness, Columbia University

I am going to talk about programs we developed post-Katrina, which were informed by work we had done post-9/11, some of the work I have done related to tsunami relief, and work I have done in my own country, Colombia, South America. Our program is Operation Assist, a joint endeavor of Columbia University's National Center for Disaster Preparedness and the Children's Health Fund.

In the early days after Katrina, some colleagues of mine and I met at the national center and decided to go down to the Astrodome in Houston, Texas. We were there for about 11 days, five days after the hurricane. We were able to see what was happening and what was needed and realized that much more had to be done. Soon after, Operation Assist was formed, and we sent mobile medical units to the Gulf Coast. Literally six days after the hurricane, they were parked in Biloxi, Miss.

We also held focus groups in Louisiana and Mississippi and asked people how we could best help. And we began to connect with people who were in charge and were going to be key collaborators of ours, moving forward. Our goal at that point was to develop permanent programs, to establish what are now permanent programs in significant collaborations with key partners.

The Children's Health Fund was funded 20 years ago to provide medical services to underserved children and families through mobile units. We have found mobile units to be effective ways of delivering services to people in need post-trauma or post-disaster as well as for primary care. The mental health component had not been a part of it, and I will tell you about how we began that post-

9/11. As far as a public health agenda, we also felt that there was a need to make sure that the work we do is informed by research, by an understanding of what happens post-trauma, and also by a desire to understand more how can we do this in a better way next time. So research and evaluation have always been an important component of what we do.

I would like to describe to you the rationale for the clinical services, in terms of mental health. I run a program, which continues to exist in New York City, the Resiliency Program. Utilizing the Children's Health Fund model post-9/11, we sent down mobile units to Battery Park City (ground zero) as well as to the different boroughs in New York. We went to Queens, the Bronx, Washington Heights, and Harlem, and we brought mental health professionals who specialized in trauma treatment and said to people, "How can we help you?" What we found, and what was informed by research and by Marist poll data, was that people who were previously underserved and traumatized were those who needed the services most. So we targeted those audiences in particular. We found that what became important was to provide services that were culturally relevant. It is tricky work – and we all spend a lot of time talking about that –



Marvin Nauman/FEMA



Marvin Nauman/FEMA

but what does it mean to provide a service that truly meets the need? We need to have an understanding of what the person is willing to accept, what is accessible, and how to do that work. It involves, of course, clinicians who are diverse in terms of their understanding of mental health and diverse in culture and backgrounds.

In addition, is the importance of case management referrals, so that people do not feel as though the only thing we have to offer is direct care. We also are offering the opportunity for people to connect with relevant and needed services, and post-trauma, people may not want to talk about what happened. People want concrete services. People want to be with family, to feel connected and safe, and to be a part of the world.

One model that we have found helpful has been the ADAPT model. It provides an understanding of what is needed when developing programs post-disaster, and we have been able to make that an important part of the work we do. How do you do security and safety when you are a doctor or a mental health professional? You do it by talking to people at their

level, meeting people in their homes if you need to, and bringing in the mobile unit. Simple things such as bringing food and clothing can make a difference. It is doing whatever you can to reconnect people with what is meaningful to them, such as going back to churches or to centers that they used to visit to take care of themselves.

We currently have three programs in the Gulf Coast, one in Mississippi and two in Louisiana. They are comprised of a mental health unit and a medical unit. The units are big blue vans that go to places where we have identified need, and they park in sites of need, and medical and mental health professionals provide services. We use electronic records, so that is one way in which we are able to serve people who might need to move or who do not know exactly where they will be. Our goal is to serve as a “medical home.”

The name of the program is the Community Support and Resiliency Program. It is similar to what we did post-9/11. We take into account the needs of the populations we serve. We work in schools, but we also work in FEMA trailer parks,

and our teams have spent a great deal of time in the Baton Rouge trailer parks, in particular in Renaissance Village as well as the airport sites. We realize that we need interventions such as art and play therapy. Also, we feel a need for peer educators and health promoters. People are not always willing to accept mental health services, although I do believe that, to a great extent, people are now more comfortable talking about that need. However, in order to reach people, it is important to address their needs as they come and to use those who are natural leaders in the community to gain people's trust and respect so that we are helpful to them in the long run.

An important part of the work that we have done, and will continue to do, has been contributing to the mental health infrastructure of Louisiana. We do that through training and supporting professionals who are for those who have been impacted.

Early on, we identified the need for clinicians who work in school-based health centers to be trained on how to do trauma treatment, understanding more about how a child who has been traumatized looks vs. a child who, perhaps, has attention deficit/hyperactivity disorder or attention deficit disorder. The presentations can be similar, and we need to have clinicians who are able to understand that and to know where to go from there.

I wanted to tell you about "coping boxes," because a lot of what we do in mental health, in wellness, is direct one-on-one service or group or family approaches. We wanted to offer something concrete to the children we had been working with, and the idea was that coping boxes would be an important way to educate children as well as their parents about things we can do to feel better every day. Initially, the coping tool can be concrete and tangible, but the lesson learned is that we all need a toolbox for times of stress. I do work for the National Center for Disaster Preparedness, and an important part of coping is preparing. Coping boxes also allow children who may have to evacuate at some point to collect whatever may be meaningful to them in case they end up in a shelter. We used coping boxes post-9/11. We worked in 13 different schools, and children reported using them. In times of stress and times of need, they

reported adding things to them. Boxes contain a journal, a slinky, and different kinds of toys that can have therapeutic value, but children added pictures of their family members and pets, stuffed animals – just whatever they felt would be helpful – and were talking about using them in times of need. These boxes also have been used as therapeutic tools. We have given them to 200 pediatricians in the Gulf Coast of Mississippi and are ready to deliver 2,000 to Louisiana.

We are hoping they will use them as a way to engage children and families in conversations about coping, about ways of feeling better, about ways to interact within the family, and about being prepared in case of disaster.

I started to talk about training and the importance of helping those who provide services to the people who have been impacted by the hurricane or another trauma. We did a survey, and in fall 2005, we began to develop a tool that we would distribute to 43 different school-based health centers in Louisiana. At that time, those were all the school-based health centers that were open. To inform future work, we asked about needs and about what would be helpful. At the time, we also were doing training, so we heard from people directly as well as through the survey.

We separated the schools with high evacuation rates or high enrollment rates post-Katrina vs. those who did not have that. We found a

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Robert Kaufmann/FEMA