Katrina Relief: Lessons for the Academic Medical Center

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Over Labor Day weekend, 2005, the Mayor of Washington, D.C., generously, if impulsively, offered shelter to victims of Hurricane Katrina. The American Red Cross immediately established a shelter in the D.C. Armory, inviting the Department of Health, the Department of Mental Health (DMH), and the Federal Emergency Management Agency (FEMA) to place services in the building for 400 to 1,000 evacuees.

The Red Cross recruited one of us (J.B.F.), a Red Cross mental health volunteer since 9/11, through its usual channels. Before the shelter opened, she took a memo to the Red Cross Mental Health Lead describing mental health organization for the Astrodome, forwarded through the APA Committee on Disaster (1). The Red Cross agreed in principle to modify their usual procedures and to screen the evacuees for medical and psychiatric needs.

Two planes carrying 274 evacuees arrived on September 7, 2005. The passengers had not showered or slept well for days. Many had waded through contaminated water. Some had seen dead bodies. Even those who came with families were worried about relatives and friends. Disorientation was common—some had boarded the plane to Virginia’s Dulles airport thinking they were being airlifted to Dallas, Texas. DMH personnel met the planes along with Red Cross staff and mental health volunteers, one of whom later developed dysentery, which was attributed to this first contact.

Initial Response

On arrival, clients were filthy, exhausted, and hungry. A shower, cot, and meal took precedence over the planned universal medical and mental health screening, which never occurred, in part because obvious cases almost swamped the existing services.

Initially, the Red Cross set up a “stress reduction” table in a corner of the Armory, providing mental health services discreet to the point of invisibility. As the only psychiatrist Red Cross volunteer, J.B.F. casually offered help to a DMH colleague juggling multiple crises. One man with mania had required hospitalization on arrival. At least 10 evacuees were suspected of having preexisting mental illnesses and a woman in the infirmary with skyrocketing blood pressure was refusing hospitalization.

For 2 days, helpers of every sort wandered through the shelter, acting upon unsystematic information that some person needed attention. Finding individuals whose only address was a numbered cot was a challenge all its own. While all volunteers addressed acute stress symptoms, separation anxiety, grief, and confusion, psychiatrists arranged access to medication and reassured people with ongoing psychiatric disorders. Rumors circulated that hundreds more people might arrive, making it difficult to assess the needs for services.

Recruitment

Members of the local medical schools who had trauma experience had offered to volunteer through the region’s psychiatric society, which referred them to organizations putting together missions to Louisiana and Mississippi, leaving local psychiatrists as a reservoir of untapped professional helpers. Aware that the Armory program was taxing DMH personnel to their limit, J.B.F. suggested that local faculty could support the DMH effort, which was to involve 24 hour/day, multidisciplinary coverage. The head of DMH, already swamped with staffing problems, welcomed this initiative, if someone else would organize it. Within a day, using e-mail and telephone, representatives from each institution identified volunteers; J.B.F. was the single contact for both DMH and for administrators in each school.
Psychologist and social worker volunteers were acknowledged and referred to emergency orientation sessions that allowed the Red Cross to involve them under its existing disaster protocols.

As a group, the medical school psychiatrists provided weekly coverage for five evening and four weekend shifts, usually sending one attending and one or two residents. Ensuring access to the Armory, where security tightened each day, required ongoing attention. Credentialing procedures changed frequently, to universal exasperation. DMH and the coordinators communicated daily, just to get volunteers into the building.

**Helping Evacuees**

Initially, the volunteers practiced crisis intervention on the hoof. Established medical protocols proved helpful in developing a more organized, sustainable response that made use of volunteers' unique skills. Within 3 days, DMH had a table, an area curtained for privacy, a chart box, a supply of drug samples, and a system for getting medication from the city's emergency service. Paid DMH staff provided continuous coverage, including nights. People in need of psychiatric care were referred by health department nurses and DMH social workers or on their own request.

The Armory population dwindled as people settled in apartments or found transportation to other cities. DMH clients who remained in the region were absorbed into local mental health clinics. Relocation triggered its own distress as evacuees moved into empty rooms in unfamiliar neighborhoods, receiving variable help from local employers and churches. Most made the transition, but some developed such posttraumatic reactions as insomnia, increased substance use, resentment, and passivity. Psychiatrists participated in supportive counseling but remained focused on the needs of identified patients.

By mid-September, the challenge became titrating volunteer interest against changing needs. As the volunteer enthusiasm waned, the schools maintained equal commitments. In the final weeks, several new volunteers joined from the independent practice community and from St. Elizabeth’s hospital. Overall, more than 20 academic psychiatrists and residents participated in this effort.

**Perspective on Mental Health in Disasters**

Like politics, all disaster responses are ultimately local, requiring responders to have or develop knowledge of local conditions and resources. In this example, the needs fell somewhere between community mental health (care of the seriously mentally ill in community settings and interaction with community institutions, such as schools and churches), emergency psychiatry (rapid assessment and triage of seriously disturbed patients and people in crisis), and disaster mental health (interaction with emergency management agencies and the Red Cross, outreach to survivors and responders, nonpathologizing psychological support, identification of new cases of disabling distress, and rebuilding of community institutions).

Though the need was clear, many channels for volunteering proved sluggish and unfruitful. For example, one of us (A.C.T.) approached the American Medical Association, which referred him to a private locum tenens company that required a lengthy credentialing process. The Red Cross has no defined role for psychiatrists in disasters. The George Washington University Hospital emergency department eventually found support to send volunteers to Louisiana, a process that took 5 weeks and did not include psychiatrists or psychiatry residents on the team. Psychiatric care, it seems, is an orphan unclaimed by both medicine and mental health in much disaster planning.

The previous, largely personal relationships between the three schools, the Red Cross, and the DMH facilitated an effective response. Chairmen from the three schools knew one another, and the schools had ongoing interactions with the DMH at community sites for resident training. J.B.F. had attended both DMH and Red Cross disaster mental health courses and knew of key organizers in each group. Several people from each responder group had prior disaster psychiatry training or experience, and everyone had some community and emergency psychiatry background. Having faculty and residents work together was essential, with residents knowledgeable about community resources and faculty keeping unlicensed residents from unauthorized activity. On one shift, two department chairs provided direct care side by side, showing vividly how extraordinary circumstances may confound typical hierarchies. This experience was both rewarding and disconcerting to the people involved.

**Reflection and Future Directions**

Disaster work challenges even highly skilled responders. When dealing with overtly mentally ill people (as opposed to previously healthy people overwhelmed by a disaster), quick triaging of problems and dispensation of medications after brief, nonstandard examinations requires expertise and experience. Neither nonpsychiatrist mental
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health professionals nor general medical practitioners have the requisite skills. The ability to keep one’s professional composure in the face of chaos is paramount, and overwhelmed volunteers themselves may become traumatized. In this project, keeping each school’s group together may have buffered the stress; no one reported severe reactions to participating, despite the challenging conditions.

Every disaster teaches the same lessons. Advance preparation is essential, communication among responders is critical, rules and procedures are helpful, but autonomy and flexibility within limits are key elements of a productive response. The Katrina emergency, however, affords new insights for academic psychiatry. Ideally, diagnosably mentally ill victims of disasters should find care within existing mental health services, but in an era of scarcity, fragmentation, and privatization, these services have limited surge capacity (2). Because they serve patients at varying levels of acuity, academic medical centers represent one of the few remaining reservoirs of people with the skills needed in emergencies. To mobilize these skills, planners need to understand the organization of existing disaster response plans, to train appropriately, and to value this work.

*Existing Structures*

The Red Cross, the agency federally mandated to shelter disaster victims and provide emergency services, formerly required licensed mental health volunteers to be available for 2-week remote deployments and did not allow psychiatrists to practice in a professional capacity when volunteering. The deployment policy changed years before Katrina but the practice restrictions remain. Mental Health volunteers’ core mission is to help with stress in other volunteers. Other models of psychological first aid for victims (basic needs, normalization, support, and reunion) (3, 4) subtly discriminate against disaster survivors who have or who may develop significant psychiatric disorders. Psychiatrists have a unique obligation to advocate for this small but predictable subpopulation of survivors, either by working to modify the Red Cross model or by creating parallel avenues of involvement.

*Preparation and Involvement*

Preparation should include education about mental health needs in disasters, ranging from psychological first aid to the treatment of the many posttraumatic stress disorders (not just posttraumatic stress disorder). In addition, academic departments should seek to forge relationships or prepare memoranda of understanding with the local emergency management agency, public mental health agencies, and the local Red Cross. Such advance work opens doors that will otherwise remain closed (2).

Early involvement is necessary to place volunteers within the “trauma membrane.” This term describes a self- and group-protective attitude first noted in a study of outreach to survivors of a 1981 night club fire (5), which found that people who stepped up to help and protect the seriously affected victims mistrusted mental health outreach. Moreover, psychiatric symptoms develop quickly in people without access to usual medications and supports. Because typical disaster response plans involve only rudimentary mental health care, it is naïve to think that someone will screen for disorders and issue a timely call for professional support.

Though timely intervention is critical, well-intentioned people who “run to the rubble” disrupt organized disaster mitigation. Spontaneous volunteers close to a disaster are essential before help arrives, but those who show up later offering unsolicited services may place themselves in harm’s way and distract attention from the needs of direct victims and authorized responders (2). In the case of the Armory project, prior relationships between the schools, the DMH, and the Red Cross gave the volunteers a legitimate avenue to express their concern and made it possible for them to contribute professionally and effectively.

*Research Is Needed*

Surveillance and secondary prevention are unsolved problems. The Armory response did not ensure psychiatric follow-up to monitor evacuees over time, except for those identified as patients during their stay. People who did not seek emergency shelter, including thousands who came to the region to stay with family and friends, received only fitful attention. Including the Armory residents, the DMH eventually logged 800 contacts and 80 clinical referrals (Steven Steury, Medical Director, Department of Mental Health, Washington, D.C., personal communication). Piercing the trauma membrane is as important for follow-up research as for clinical care and will require people with overlapping clinical and research skills. Studies of post-disaster outreach, service delivery, and interventions to prevent late morbidity are especially needed (6).

In sum, disaster psychiatry is a professional responsibility and an educational and research opportunity for academic institutions. Involvement in disaster relief showcases community mental health as a vital and neglected element of social services. Psychiatric disengagement only
furthers stigma and destructive professional competition. Psychiatrists must support other responders in acknowledging that most distress is nonpathological and must see promoting resilience and self-efficacy as being as much our mission as theirs. Yet we must also encourage other response groups to include the diagnostically mentally ill in their planning.

Educationally, disaster experience helps trainees deepen their understanding of systems-based care, crisis theory, emergency psychiatry, and the role of stress and trauma in psychopathology. In terms of research, though it is difficult, ethically and logistically, to study disaster survivors, academic institutions that develop disaster experience may apply for grants earmarked for rapid implementation of studies to foster knowledge of secondary prevention, epidemiology, and treatment (7).

The ad hoc program described here is only one model of how academic departments may draw on the altruism, knowledge, and commitment to social justice of their members in responding to emergencies.

References