Opportunity Missed:  
A Lesson Learned From Evacuating Mentally Ill Patients  
Following Hurricanes Katrina and Rita

Tina C. McClain, M.D., Francis C. Hamilton, M.P.H.  
Jeffrey Clothier, M.D., Janette McGaugh, M.D.

The Central Arkansas Veterans Healthcare System evacuated seriously mentally ill veterans following Hurricanes Katrina and Rita. This report describes our experiences and makes suggestions for enhancing resident education and opportunities. Though there is substantial literature regarding the delivery of posttrauma and post-disaster psychiatric care, we found nothing regarding the actual evacuation process for mentally ill patients or for incorporating residents in the planning or execution phases of evacuation. We found only one article specifically describing residents' involvement in providing disaster support (1).

With little guidance regarding evacuation, the Central Arkansas Veterans Healthcare System (CAVHS) assembled a planning team to address the issue. Team members included administrative officers, psychiatrists, social workers, and nurses. This team held teleconferences with the Veterans Integrated Services Network (VISN) Mental Health Service Line and administrative officers at affected sites. Discussion topics included patient numbers, travel requirements, funding, clinical preparedness, safety requirements, lodging, evacuation team staffing, communication, and the coordination of multiple simultaneous evacuations. Residents did not participate in this phase of the process.

Although the hurricane-affected areas had evacuation plans to get patients to safe temporary facilities, the need to evacuate large numbers of patients to remote sites was unprecedented. Following Hurricane Katrina, the Gulf Coast Veterans Health Care System facility in Gulfport, Miss., was totally destroyed. Hospitalized patients there had been evacuated to the Biloxi facility in Mississippi prior to Katrina's landfall. However, the facilities at Biloxi did not include a psychiatric unit. A unit that formerly functioned as a domiciliary for highly functional individuals was converted to office space, an inpatient psychiatric unit, and a housing facility for displaced staff. Despite heroic efforts to accommodate all of these needs, the unit was not equipped to address the safety and behavioral issues of some patients. Environmental risk factors and a reduced staff number following Katrina necessitated rapid transfer to other psychiatric inpatient units. Just under 1 month later, Hurricane Rita compelled the evacuation of a residential facility and a psychiatric nursing home in Lake Charles, La. Many of the patients at these facilities were veterans with mental illnesses and long histories of behavioral problems, including assaultiveness and sexual inappropriateness. These veterans had been evacuated to temporary emergency shelters in Alexandria, La., just prior to Rita's landfall. Time for damage repair to the coastal facilities necessitated alternative placement.

Two trips to Biloxi were arranged in order to evacuate six patients. Residents did not make either of these trips. Two residents did participate in the evacuation of 33 patients (in one trip) from Alexandria after previously deployed team members recognized the potential educational value. On arrival at the emergency shelters, residents assisted in gathering information regarding patients, their illnesses, medication logs, and behavioral histories. Residents, along with other team members, briefly interviewed patients. Environmental and time constraints prohibited detailed histories and assessments in that setting. On the return trip, residents assisted in ongoing as-
sessments and assisted nonphysician staff with therapeutic interventions, including medication administration. Residents were able to discuss treatment issues with two attending psychiatrists and other team members.

On arrival at CAVHS, additional residents actively participated in assessing patients, contacting families when possible, reviewing electronic chart information, triage, and treatment of these evacuees. Residents on CAVHS clinical rotations worked as primary psychiatrists and treatment team members for many of the patients over the ensuing weeks.

Postdeployment, residents who participated in various evacuation roles identified several positive educational outcomes of the process: the opportunity to work with emergency preparedness and response specialists, increased insight into organizational cooperation, the opportunity to observe other treatment facilities and programs, a broader view of various emergency services, and increased awareness of the makeup and role of emergency response teams at the VA.

We noted, however, that we had missed some opportunities for education. One area for improvement involves the psychiatric evaluation. Since circumstances dictated rapid assessment and intervention, focusing on the elements of the psychiatric evaluation that are imperative for safe and effective evacuation would have been beneficial, particularly for residents in the first or second year of training who may not have had much experience in emergency settings and/or emergency rotations. A checklist or scripted interview would have been helpful in facilitating rapid assessment of a large number of patients.

Second, residents rarely have the opportunity to brainstorm with hospital and mental health administrators, especially regarding an unprecedented event and set of circumstances. Valuable insights into the interdisciplinary nature of planning disaster response, federal, state, and local organizations, and funding issues would have been gained had residents participated in the response planning.

Our residency program did not have a mechanism in place for providing residents this opportunity. When the planning team determined the need to evacuate patients and arrangements had been made to accomplish this, residents were called at home on the weekend to determine interest and ability to participate. Issues such as coverage of clinical duties, on-call responsibilities, and obligations at multiple training sites prevented many interested residents from participating. Only residents who were assigned to the VA acute inpatient unit and who did not have call duties or were able to arrange coverage on short notice were able to participate in the evacuation. This opportunity could have been provided to more residents had a list of interested residents and a plan for coverage program-wide been available.

Those team members who participated in all aspects of the evacuation reported feeling better prepared, having a fuller understanding of the needs, and having a better grasp on the situation than did those involved in only one aspect (e.g., planning or execution) of the process. Had residents been involved in the entire process, from planning to delivery of care postevacuation, they would have gained a fuller sense of the process and been better prepared to assist with future disaster situations. Residency programs should consider having in place a psychiatric resident disaster response team and plan. The team should comprise interested residents and include multiple contact numbers for the members. The plan would need to include notations, such as which residents would be interested in being deployed, possibly overnight, and which residents would be available to provide coverage for those deployed. A plan would need the support of clinical faculty at all training sites within the program.

Reference