Post-Katrina Mental Health Care in Mississippi: Lessons Learned

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On August 29, 2005, Hurricane Katrina made landfall on the coast of Louisiana, Mississippi, and Alabama. As a result of the storm, more than 485,000 residents of Louisiana and Mississippi were displaced initially, more than 122,000 people have been housed in temporary shelters throughout the United States, and more than 1,300 people died. A Gallup poll conducted between September 30 and October 9, 2005, among a random sample of 1,510 hurricane victims who applied to the Red Cross for assistance provides an indication of the scope of this disaster. The poll found that 40% of residents of the affected area went without food for at least a day, 53% feared for their lives, 51% were separated at least a day from family members with whom they had been living, 7% were victims of a crime, 6% were physically injured or hurt, and half were still out of their homes at the time of the survey (CNN, 2005).

Epidemiological research on large-scale disasters such as Katrina provides substantial evidence that in the months following a natural disaster, there are sharp increases in the rates of posttraumatic stress disorder (PTSD), anxiety disorders, and depression (see Norris, Friedman, Watson, Byrne, et al., 2002, for review). Moreover, a study of Hurricane Andrew survivors suggests that symptoms may not resolve on their own—the proportion of survivors meeting study PTSD and depression criteria did not change from 6 to 30 months following the hurricane. Although mean levels of certain symptoms decreased, others remained stable, and others increased (Norris, Perilla, Riad, Kaniastry, & Lavizzo, 1999). There are also individuals who experience significant distress but do not meet criteria for a psychiatric disorder (Norris, Friedman, Watson, Byrne, et al., 2002). Hurricane Katrina and the events that unfolded in the days, weeks, and months following the storm possessed several characteristics likely to increase the mental health impact of the event, including: significant property damage, enduring financial burdens, substantial threat to life, and substantial disruption of social networks (Norris, Friedman, & Watson, 2002). It is unknown what effect the degree of displacement caused by the event may have on mental health outcomes.

As clinicians and researchers working and residing in the state of Mississippi in the aftermath of Hurricane Katrina, the actions of the authors of this article were guided by two desires: (a) to assure that survivors in the state had access to empirically supported mental health care, and (b) to conduct meaningful research that might help the field better prepare for the next large-scale disaster. Although a number of well-designed studies of Hurricane Katrina and its aftermath have been conducted (or will soon be conducted), the focus of these studies, as with much of the existing research literature on the aftermath of hurricanes, is largely directed toward counting the numbers of people with clinical symptoms and determining risk factors that increase the prevalence of problems. Efforts to increase the availability of empirically supported mental health care for those with diagnosable psychopathology and to conduct research aimed at developing a stronger empirical basis for the types of interventions...
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crisis counseling intervention, administered primarily by trained laypersons, which is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning. Although PFA was developed by respected scientist-practitioners and its development was informed by best existing empirical evidence about what natural disaster survivors might need, it is not at this time an empirically supported practice. Unfortunately, gathering evidence to support the effectiveness of PFA for natural disaster survivors will not be an easy task. CCP funds are earmarked specifically for services, not for research. Moreover, the manner in which the intervention is administered (e.g., anonymously, without follow-up), makes it impossible to collect reasonable outcome data, even if research funds were readily available.

PFA could not be made widely available until months after Hurricane Katrina, and in the interim, as Gray and Litz (2005) would predict, other forms of early intervention "filled the void." It is unclear exactly what types of interventions were provided, but there is anecdotal evidence that therapies such as critical incident stress debriefing (CISD) were offered to some survivors. There is little evidence to support the use of CISD with survivors of large-scale disasters, and the consensus best practice guidelines for early psychological interventions for survivors of mass violence developed by several federal agencies describe CISD as "contraindicated" for disaster survivors (NIMH, 2002; see also Litz & Gibson, 2006). Although CISD was not the standard of care in Project Recovery, our observations after Katrina confirmed that it is an intervention that remains widely and very rapidly disseminated following disasters. Moreover, it is likely an intervention that will remain widely disseminated until (a) a true evidence-based alternative is widely disseminated in its place and (b) the lack of evidence for the efficacy of CISD is effectively disseminated beyond the academic community to those responsible for making decisions about acute disaster care (see Gray & Litz, 2005, for review).

Long-Term Katrina-Related Mental Health Needs

The ability of mental health providers in the state to provide what the ABCT community considers first-line treatments for PTSD, depression, anxiety disorders, and other conditions likely affecting Katrina survivors is clearly limited, because the number of providers trained in these techniques is low. The state of Mississippi is certainly not unique in this regard, as the sluggish dissemination of empirically supported psychotherapies is a nationwide problem (e.g., NIH, 2005). Broad dissemination efforts must target mental health professionals at all levels, from graduate school to continuing education for seasoned professionals (Calhoun, Moras, Pilkonis, & Rehm, 1998).

As noted in an editorial published in Nature less than 2 weeks after Hurricane Katrina, "Knowledge of the risk of a storm-induced flood in New Orleans has been widespread in the scientific community for years. . . . There seems to be a disconnect, however, between the process that identifies such risks and the people who make decisions that might manage them" ("Small-Minded Government," 2005, p. 169). A parallel situation appears to exist in the area of mental health treatment; the scientific community has knowledge to inform estimates of the types of disorders most likely to emerge and the types of treatments that are most likely to be efficacious in the aftermath of an event such as Hurricane Katrina. Based on observations of the post-Katrina recovery process, this knowledge has had insufficient impact on the federal policies that determine what types of psychological assessments and treatments will be offered to disaster survivors. In a special report in the same issue of Nature there was a call to academics to "tailor their research to practical needs," and a concern about the priorities of academia, which offers "more credit for journal publications than for helping a hospital prepare for a crisis" (Reichhardt, Check & Marris, 2005; p. 176). A similar call to hasten the sluggish dissemination of treatments with demonstrated efficacy has been heard throughout the ABCT organization for years.

Evidence-based practitioners in New York City described their recognition of the need for, and efforts to disseminate, empirically based approaches for the treatment of PTSD following the terrorist attacks of September 11, 2001 (Amsel, Neria, Marshall, & Suh, 2005). Their observations and experiences, as well as those of the authors, suggest that clinicians and researchers must be proactive in their attempts to disseminate evidence-based treatments on a broad scale. Although federal funds were not readily available to disseminate relevant treatments post-Katrina, the NCTSN has been partnering with agencies nationwide to fund the dissemination of community education programs and trauma services for children. Because of an existing partnership with the Catholic Charities Diocese of Jackson, Mississippi, funding had been secured prior to Hurricane Katrina for a 4-year project (2004–2008) to make services available in three counties in Mississippi. Additionally, prior to Hurricane Katrina, the Medical University of South Carolina, another partner in the NCTSN, with funding from SAMSHA, developed a Web-based training protocol, Trauma Focused Cognitive Behavioral Therapy, for children. This protocol has facilitated a broad dissemination of this approach, including dissemination in Mississippi. In addition to these large-scale dissemination efforts, smaller-scale efforts are also needed. Clinicians and researchers must reach out to community providers to offer trainings on evidence-based assessment and treatment of psychopathology, continually updating these trainings as additional postdisaster evidence-based treatments are developed.

Recommendations

Out of the lessons learned from the post-Katrina experience in Mississippi come the following recommendations to our ABCT colleagues and clinicians and researchers everywhere:

1. We must work collectively and individually to influence federal policies about allowable mental health expenditures in the wake of large-scale natural disasters and available mechanisms for funding disaster treatment research. With regard to the latter, we must push for a new research agenda, which will enable the field to assemble the necessary body of knowledge to improve outcomes for survivors of large-scale disasters.

2. We must continue conducting research to identify the best intervention strategies for postdisaster psychological needs (see Litz & Gibson, 2006). In addition to identifying problems and counting risk and protective factors, postdisaster research must focus heavily on the development of the best interventions for postdisaster situations as well as development of strategies to identify which survivors are in need of intervention, and what types. Ideally, this research should be community focused, incorporating input from affected communities in the development of interventions.

3. We must increase the dissemination of existing evidence-based psychological treatments. This will require continued research to identify the best methods for disseminating and fostering adoption of evidence-