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Effective Mental Health Response to Catastrophic Events

Lessons Learned From Hurricane Katrina

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This article describes how a mental health disaster response plan, which resulted from a collaborative effort between the Arkansas Department of Health and the Arkansas Chapter of the National Association of Social Workers, was used successfully to meet the needs of more than 1,000 displaced survivors of Hurricane Katrina. Included is a discussion of how the components of established disaster response protocols can be integrated with evolving theory on the psychological effect of catastrophic events on micro-, mezzo-, and macro-level systems to advance the field of disaster mental health response. **Key words:** *catastrophic events*, *disaster*, *disaster response protocols*, *mental health*, *traumatic response*

OVER the past decade, and particularly in the aftermath of the traumatic events that occurred on September 11, 2001, much literature has emerged highlighting the need for communities to prepare traumatic response plans that address the mental health as well as the physical health needs of disaster survivors.[1–3] Indeed, federal grants to public health organizations now include a requirement that a mental health component be part of federally funded state disaster response protocols.[4] In Arkansas, this requirement led to a collaborative effort between the Arkansas Department of Health (ADH) and the Arkansas Chapter of the National Association of Social Workers (NASW-AR) to develop a response plan that addressed both physical and mental health needs.

Although originally focused narrowly on bioterrorism and pandemic events, the response plan was unexpectedly put to the test in the field when service systems within Arkansas became part of a region-wide effort to assist and support thousands of displaced survivors of Hurricane Katrina. What quickly became apparent was that accepted protocols for disaster mental health response were inadequate to meet the needs of survivors of catastrophic events (ie, those involving thousands of displaced survivors, requiring resources from multiple communities or states, or both).

This article adds to the current knowledge base on disaster mental health response by describing how evolving information regarding the effect of catastrophic events on micro-, mezzo-, and macro-level systems was integrated with the components of traditional

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disaster mental health response to create a more effective and holistic intervention effort.

DISASTER MENTAL HEALTH RESPONSE

Modern disaster mental health response protocols, the beginnings of which date back to the Civil War, are grounded in research on stress reaction phenomena, and include data collected during such events as the first and second world wars, the Holocaust, and more recently, the attack on the Murrah Building in Oklahoma City and the events of September 11, 2001.[2] It has also evolved from clinical work with survivors of plane crashes, natural disasters, and other traumatic events.[5] Many mental health professionals now believe that an effective disaster response plan must address the mental health needs of survivors to the same extent as it addresses the physical health needs.[3]

Currently, the literature lacks data on how the response to an event that is catastrophic in nature has to consider factors beyond the scope of current disaster mental health protocols. Traditional disaster mental health response in many ways parallels the physical health response. The needs of identified victims, whether primary, secondary, or tertiary, are prioritized on the basis of a system of triage. Mental health first responders then provide emergency services such as crisis intervention and psychological first aid to victims in the field, and refer those needing further, more extensive mental health services and support to appropriate clinicians in the community (L.A.W. and S.A.H., unpublished data, 2005).

However, during the Katrina response, it became increasingly clear that these traditional response services alone were not adequate to address the multiple issues at all system levels that had a direct effect on the mental health of survivors. In addition to the focus on micro-level needs (ie, those of individuals and families) to be effective, the mental health response teams also had to assess and address needs at the mezzo level (groups and organizations) and the macro level (community). They also had to be aware of how the catastrophic nature of the event exacerbated its effect on survivors.

RESPONSE TO HURRICANE KATRINA

Background

In spring 2004, the disaster response coordinator of the ADH approached the board of directors of the NASW-AR, to see whether they were interested in pursuing federal grant dollars to develop a mental health response protocol to be used in the event of an act of bioterrorism within the state. The board agreed to the project and formed a subcommittee to oversee the grant.

From August 1, 2004, to July 30, 2005, this subcommittee developed a training manual outlining a detailed mental health response plan, and formed 7 statewide teams that could be activated in the event of a bioterrorism attack. These interdisciplinary teams were composed of a team leader who was a licensed certified social worker and 5 to 7 team members who also were licensed mental health professionals (eg, social workers, psychologists, psychiatric nurses). As the second year of the grant began, the ADH asked the subcommittee to add content regarding a mental health response to a pandemic event that would include a section on quarantine. Plans for adding the new content and training the teams on the protocol began. Then on Monday, August 29, 2005, Hurricane Katrina made landfall in New Orleans, and the limited purpose of the NASW-AR response teams drastically changed.

According to the Centers for Disease Control and Prevention, by September 5, 2005, Arkansas had established 75 evacuation centers to accommodate the influx of hurricane survivors, a number that grew to 182 centers by September 22.[6] During the first week of September, as the evacuation camps began to fill, the immense physical and mental health needs of the people arriving from Louisiana, many of whom had been housed at the

Superdome and the Convention Center, became apparent. At that point, the ADH hospital disaster preparedness representative contacted the NASW-AR and the mental health response teams were activated.

To respond effectively, the NASW-AR trained more than 200 additional mental health professionals in central and northwest Arkansas and formed 6 additional response teams to serve in the 52 camps across the state sponsored by the ADH. By December, when the shelters in Arkansas were closed, these teams had provided mental health services to more than 800 individuals and 250 families. The disaster mental health response to Hurricane Katrina involved assessment and intervention at all 3 system levels. The ways in which this occurred are described next.

Micro-level response

An effective micro-level response requires an assessment of the level of physical and psychological trauma experienced by the individual, as well as the extent to which the disaster has affected family relationships and functioning. Individuals are likely to be experiencing a wide range of emotional reactions including guilt, fear, shock, and numbness. These reactions in and of themselves are expected, and most survivors will be able to return to preevent functioning levels within 4 to 6 weeks (L.A.W. and S.A.H., unpublished data, 2005). However, if these reactions are combined with dissociate symptoms and result in avoidance behaviors or signs of hyperarousal, the survivor could be experiencing early signs of posttraumatic stress disorder, sometimes referred to as acute stress disorder (L.A.W. and S.A.H., unpublished data, 2005).

Family functioning can also be affected by traumatic and catastrophic events. According to Dayton,[7] psychological reactions can include the avoidance of emotional and physical closeness, as well as withdrawal of support, and may result in an increase in impulsive behavior, intrafamily violence, and divorce rates. Since an individual's ability to move past the event and regain postevent levels of functioning depend, in large part, upon having an emotional safety net provided by members of her or his social support network (L.A.W. and S.A.H., unpublished data, 2005), disruptions in family functioning must be identified and addressed as early as possible.

The mental health response with micro-level survivors of Hurricane Katrina included the use of specialized crisis intervention techniques as well as psychological first aid (L.A.W. and S.A.H., unpublished data, 2005). Crisis intervention with disaster survivors includes 6 essential components[8]: (1) assessing the survivor's physical safety; (2) providing security to interactions by insuring confidentiality; (3) allowing the survivor to vent any and all emotional reactions without judgment or censure; (4) validating the survivor's experience through the use of empathy and active listening skills; (5) helping the survivor develop coping strategies by predicting some emotional issues that might arise in the aftermath of the traumatic event; and (6) preparing the survivor for the future by providing practical information about the types of assistance that will be available within a given timeframe.

Along the same lines, the psychological first aid employed was composed of 8 core actions designed to promote the mental health of survivors during the days and weeks following the traumatic event.[9] The first core action, establishing contact and engagement, is the beginning of postevent intervention that occurs in the field. This is followed by 7 additional core actions that parallel and complement the components of crisis intervention described above. These include (1) providing safety and comfort, (2) promoting stabilization, (3) gathering information, (4) offering practical assistance, (5) promoting connection with social supports, (6) providing information on coping, and (7) linking survivors with collaborative services.

Early in the response, team members experienced difficulty employing both psychological first aid and crisis intervention methods. This was due to the ways in which the

camps were structured. To accommodate the large number of survivors seeking shelter, the governor requested that the Southern Baptist Convention allow the ADH to house people in their church camps. This resulted in a generous donation of volunteers and resources. Unfortunately, it also resulted in some unforeseen challenges.

First, the camps did not lend themselves to a discreet offering of mental health services. Team members realized that this presented problems for ensuring confidentiality and impeded attempts to encourage contact and engagement with mental health services. The answer to this challenge was to offer services using an outreach approach, or what came to be known as "coffee cup therapy."

Successful contact and engagement that could lead to confidential interactions hinged on team members being able to blend into and become part of the camp community. To facilitate this process, team members began spending time in the dining halls and other camp areas where community members gathered. Through interactions in these casual settings, teams were able to gain trust, which facilitated their entrance into other community domains, and enhanced their ability to informally assess the mental health needs of community members. Through these interactions, team members were able to have conversations with camp members experiencing ongoing distress, discern those who appeared to be at risk for developing posttraumatic stress disorder, and identify those in need of psychotropic medication or hospitalization, or both. When appropriate, referrals were made to local community mental health centers and the state hospital for more extensive services.

A second challenge encountered was promoting the survivors' connection with social support systems. The biggest issue facing response teams was the fact that many survivors had been separated from family and friends during their evacuation from New Orleans. This was addressed fairly quickly through the establishment of phone banks and computer banks with Internet connections, where survivors could attempt to locate family members and friends at other camps both within and outside of the state.

The more vexing problem again was tied to the structure of the camps. Because the church camps were designed to segregate campers by gender, family members often were separated and sent to gender-specific housing barracks. To remedy this, team members mediated on behalf of members of the camp communities by educating volunteer camp personnel about the importance of maintaining family connections and support in the aftermath of a traumatic event. In most cases, housing arrangements were quickly restructured to allow family members to remain together.

A final challenge faced on the micro-level involved problems with transportation that thwarted attempts to link survivors with needed collaborative services. This is discussed in the next section, since the issue of lack of transportation was essentially a mezzo-level problem. However, this barrier to services highlighted how the interconnections and interactions among micro-, mezzo-, and macro-level systems must be considered in any effective disaster mental health response plan.

Mezzo-level mental health response

Mezzo-level mental health response is focused on ensuring that services for survivors are available and can be accessed easily (L.A.W. and S.A.H., unpublished data, 2005). Intervention at this level requires effective use of both task and process group skills to promote collaboration among and between private and public service agencies. The problem of lack of transportation to connect survivors with needed services grew out of the fact that, for the most part, the church camps used by the ADH were in rural, isolated settings far from the resources most needed by camp members. This was complicated by the fact that virtually all of the survivors were without transportation.

Although an attempt was made to solve this problem by using camp buses a couple of

times a week to transport survivors into more urban areas, this proved to be inadequate due to the limited number of buses available in relation to the immense need. Attempts by team members to bring service providers to the camps also were met with resistance, and attempts to overcome barriers were largely unsuccessful. In the end, lack of transportation proved to be one of the most intractable problems faced, and emphasized the need for pre-event collaboration, which was perhaps the most valuable lesson learned during the response.

Macro-level mental health response

Macro-level response begins with an assessment of the degree of loss and trauma the community has suffered (L.A.W. and S.A.H., unpublished data, 2005). Obviously, the survivors of Hurricane Katrina who were unable to evacuate before the hurricane made landfall had suffered numerous losses and repeated trauma. What was unusual in this case was the fact that, in addition to losing homes, possessions, and even loved ones, large numbers of survivors also had lost their community and with it their sense of identity and history.

Katrina resulted in the largest displacement and relocation of people in the history of the United States[10] and mental health response services were ill prepared to deal with the psychological repercussions. Early in pre-Katrina media coverage, survivors of the storm were often referred to as refugees, a phrase to which many took offence. However, in practical terms, to respond effectively, mental health response teams had to review literature on the psychological effect of refugee status. The factors identified that were most relevant to the persons with whom the teams worked were the loss of close relatives, having an uncertain social status, being in a difficult economic situation, having strained relations with the local population, and the nostalgia and longing for the lost community.[11] These factors can result in long-term issues of depression, anxiety, and stress-related psychosomatic disorders.[11]

To address the psychological need for a renewed sense of community and belonging, team members collaborated with community groups, policy makers, and service providers to try to identify long-term solutions. All agreed that efforts to integrate the survivors who had decided to stay in Arkansas into the community as quickly as possible was key. A task force was developed to streamline processes needed to acquire housing and jobs, and an effort was made to get children enrolled in school as early as possible. The NASW-AR collaborated with the William J. Clinton Foundation and the Arkansas Department of Education to educate teachers and other school personnel about the social and psychological issues these children were likely to face, as well as ways to intervene to insure the child's successful transition.

CONCLUSIONS

The disaster mental health response provided by NASW-AR teams used in the aftermath of Hurricane Katrina was an integration of established response protocols, the application system–theory assessment and intervention methods, and the use of evolving theory on the psychological effect of catastrophic events. Although many challenges were encountered, many lessons were learned that would improve and enrich future catastrophic response efforts.

Perhaps the most important lesson learned is that effective disaster response of any type requires the establishment of connections and collaborations among first responders and service providers well in advance of the event. Many of the barriers to services faced by both survivors and responders were due in large part to a lack of previously established relationships. The NASW-AR is now working with the Arkansas Department of Emergency Management to establish connections with other first responder groups and with state and local providers of services to identify ways to

circumvent red tape and other barriers. Even while hoping disaster intervention strategies never again are needed in response to an actual event, the teams remain committed to ensuring that the best possible services are available.

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