

MENTAL HEALTH IN THE
WAKE OF HURRICANE KATRINA



The Twenty-second Annual Rosalynn Carter
Symposium on Mental Health Policy

NOVEMBER 8 AND 9, 2006

THE
CARTER CENTER



Waging Peace. Fighting Disease. Building Hope.

DISASTER MENTAL HEALTH
IN THE WAKE OF HURRICANE KATRINA



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MENTAL HEALTH PROGRAM

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CONTENTS

Opening Remarks

Rosalynn Carter, Chair, The Carter Center Mental Health Task Force	4
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Keynote Panel: Hurricane Survivors

Norman Robinson, News Anchor, WDSU-TV, New Orleans, Moderator	5
James Cooper, Office Coordinator, The Extra Mile	5
Jeff Wellborn, Assistant Commander, Crisis Transportation Services, New Orleans Police Department	7
Sally Sullivan, Project Recovery, Mississippi	10
Verlyn Lewis-Boyd, Executive Director, Louisiana Federation of Families	12
Questions & Answers	15

Video Presentation

Norman Robinson, News Anchor, WDSU-TV, New Orleans.....	18
---	----

Panel I: Science and Research

Greg Miller, Writer, <i>Science Magazine</i> ; 2004-2005 Fellow, Rosalynn Carter Fellowships for Mental Health Journalism, Moderator	20
Robert Ursano, M.D., Professor and Chairman, Department of Psychiatry, Uniformed Services University of the Health Sciences	21
Joy Osofsky, Ph.D., Professor of Pediatrics, Psychiatry, and Public Health; Head, Division of Pediatric Mental Health, Louisiana State University Medical Center	25
Monica Schoch-Spana, Ph.D., Senior Associate, Center for Biosecurity; Assistant Professor of Medicine, University of Pittsburgh Medical School	30
Questions & Answers	33

Dinner Address

Scott Cowen, D.B.A., President, Tulane University	36
Questions & Answers	46

Panel II: Science to Practice

Jane Hansen, Staff Writer, <i>The Atlanta Journal-Constitution</i> , Moderator	48
David Satcher, M.D., Director of the Center of Excellence for Health Disparities; Poussaint/Satcher/Cosby Chair in Mental Health, Morehouse School of Medicine	50
Paula Madrid, Psy.D., Director, Resiliency Program, National Center for Disaster Preparedness, Columbia University	53
Dennis Derr, Ed.D., Senior Professional in Human Resources; Partner, Signature Resources	57
Questions & Answers	62

Panel III: Policy

Bill Lichtenstein, President, Lichtenstein Creative Media, Moderator65
 Anthony Speier, Ph.D., Director, Disaster Mental Health, Louisiana Office of Mental Health66
 Craig Fugate, Director, Florida Division of Emergency Management68
 Brian Flynn, Ed.D., Associate Director, Center for the Study of Traumatic
 Stress; Adjunct Professor of Psychiatry, Uniformed Services University.....71
 Questions & Answers76

General Discussion

Thomas Bornemann, Ed.D., Director, The Carter Center Mental Health Program
 Lei Ellingson, M.P.P., Assistant Director, The Carter Center Mental Health Program79

Closing Remarks

Rosalynn Carter, Chair, The Carter Center Mental Health Task Force82

Biographies84
Planning Committee88
Participants List89
Task Force Members95
Funders96

OPENING REMARKS

Rosalynn Carter

Chair, The Carter Center Mental Health Task Force

These symposia on mental health policy give us a wonderful opportunity to look at the latest research in mental health, to connect that with best practice models, and then to try to develop some action steps that we all can take in our different organizations that can lead to some positive changes. We come with a variety of missions, some directly related to the mental health field and some in other fields. We bring together leaders whose decisions can have a positive impact in their communities and on policy issues.

Hurricane Katrina is arguably the most significant natural disaster that has occurred in the United States, causing serious and long-lasting mental health effects. It is important to take the lessons learned from this tragedy and make sure that mental health is a priority in the planning, preparedness, and response policies for potential future disasters, including pandemic flu and terrorist activities.

The topic of the symposium was selected by the Carter Center Mental Health Task Force in an effort to impress upon the public health and mental health communities that improvements to the infrastructure of the public health and mental health systems need to be made. We also need to prevent future breakdowns within federal and local organizations vital to the delivery of services in anticipation of another catastrophic event.

Having a keynote panel is new this year. We did this, in part, because we felt it was important not to lose sight of the many individual stories from the disaster. Sometimes when we hear about huge numbers of lives lost, extensive property damage, numbers of people evacuated, it is easy to forget the personal stories of hardship and heroism. We all know that the response to Hurricane Katrina was inadequate. The long evacuation and widespread displacement are taking a terrible toll on the mental health of survivors and evacuees. We are looking to help the mental health community take the lessons learned from this catastrophe and translate them into concrete actions that will lead to more effective policies.

This symposium is meant to contribute to the much broader discussion about the mental health ramifications of disasters, including terrorism. Our objective is to leave this symposium with specific things that we can do, in services and in policies, to improve our mental health planning, preparedness, and response to future significant disasters.

KEYNOTE PANEL: HURRICANE SURVIVORS

Norman Robinson

News Anchor, WDSU-TV, New Orleans

Like my fellow panelists, I am a victim of Hurricane Katrina, so this is cathartic for me, as I suspect it is for the entire panel, for we are among the walking wounded, of which there are thousands. As professionals in the

mental health field, you will hear the panelists' personal experiences in their own words as you, the experts, attempt to assess the mental health needs of the devastated Gulf Coast.

James Cooper

Office Coordinator, The Extra Mile

I was going through cancer treatment when the hurricane hit, and I got stranded in New Orleans for eight days. I was not able to get out in Metairie, Jefferson Parish, La. There was no way of communicating, of getting in touch with doctors, of getting in touch with professionals to help, of being able to get out of the area. Cell phones and phones would not work. We were stuck there.

Finally, after about the third day, they did bring in ice and water. We had about 95-degree temperatures, and trying to live in that heat without water, ice, electricity, and communications was terrible.

I live near what was the staging area on the causeway, and during that time, I am sad to say, not only were we victims of the hurricane, we also were victims of looters and people taking advantage of our situation.

Three of us were stuck in my neighborhood, so we banded together. Finally we found an old three-quarter Chevrolet truck. I siphoned gas from all the cars in the neighborhood and left notes for my neighbors to let them know where their gas went and that I would repay them when I got back.

I want to thank the Jefferson Parish Sheriff's Office and the New Orleans Police Department. They were a big support in getting the help that we needed during the time that we were stranded down there.

I am a person with co-occurring disorders. I am bipolar, plus I am a recovering alcoholic and have been clean for quite a few years. I am going on my ninth year.

Once we were evacuated, we went to Baton Rouge and were able to stay in a friend's apartment for a short time. We had no way of getting our medications and no way of receiving the services we needed. I went with a friend to the Health and Human Services headquarters in Louisiana, and they asked me to help out in Baton Rouge. I went into a couple of the shelters, but people – whether clients or people devastated from the storm – did not want to talk to professionals. They were willing to open up to other clients, or they would talk to people in the same situation, but they were afraid to talk to professionals. This was especially true of those who were new to the system, because they were afraid they were going to be forced into treatment by mental health professionals. Most of them just wanted an ear for listening. Because of the devastation they just went through, they did not want to have to do exactly what professionals said to do.

I thank God every day that I survived Hurricane Katrina. No matter how devastating things are in your life, or what happens, there is

I thank God every day that I survived Hurricane Katrina. No matter how devastating things are in your life, or what happens, there is always hope.

always hope. My wife and two sons were killed by a drunk driver. After that, I went through treatment for throat cancer. And during Hurricane Katrina, I lost everything I owned. But thanks to Dr. Anthony Speier of the Louisiana Office of Mental Health and other professionals in Louisiana, I was able to get medications I needed.

I have devoted my whole life to putting together a program that would help people with mental illnesses. If I had not known people in the field, I do not know what would have happened to me after Katrina. Many clients still are not receiving services because the services are not up and running yet in our area. There is something wrong with a system that is not able to get services to the people after this amount of time.

Still, we try to implement programs that get clients to the professionals they need or get them to talk to people they will be comfortable talking with. Our area in Jefferson Parish finally was able to acquire a new van from the state of Louisiana so we can transport clients. In Jefferson Parish and New Orleans, we have two different sides of the river – the east bank and the west bank. Our east bank offices were destroyed. But now we

have a van in which we can collect clients from the east bank and take them to the west bank so they can receive services. This is the kind of implementation we need.

We also need to implement a plan for people who might have to be evacuated. They will need a copy of their medication, or we could give them medications for two weeks in advance. We need to have all this set up before the storm actually hits so people are not wandering the streets wondering what will happen to them.

I still run into clients who are suicidal, have gone back on drugs, or are finding any way they can to cope with the situation, because they have not been able to receive the services they need. It is time for the whole nation to pull together – whether it is Hurricane Katrina, the Twin Towers in New York, or another part of the country – so clients can be taken care of. Also, the professionals treating these clients need to know that they themselves are going to be taken care of. We need stress relievers for the professionals, somebody they can talk to from our area, feel comfortable with, and not feel like outcasts. It is hard for our professionals to deal with what they had to go through as well as dealing with clients all day long.



Win Henderson/FEMA

It is difficult for me to tell you how dire the situation is. I thought about showing you pictures, but without actually living it every day, it is hard to know the impact Katrina had. You could be the head psychiatrist at a hospital or the governor of Louisiana. Whoever you are, if you went through devastation during this hurricane, there are issues that need to be brought out. People need to have a safe place to go where they can talk, get their stress relieved, and deal with what they have lost. I had a staff that supported me and was there for me, or I would not be sitting here today. The compassion and caring of that staff carried me through.

Jeff Wellborn

Assistant Commander, Crisis Transportation Services, New Orleans Police Department

My unit in the New Orleans Police Department (NOPD), Crisis Transportation Service, helps those with mental health issues when they come in contact with law enforcement. We try to keep them out of jails and see if we can get appropriate services for them, if needed. We have been in operation since about 1982 and are back in operation after the Gulf storms.

I work for the department itself. I was stationed at 1700 Moss St., the operational center for many police activities. We were told we were going on 12-hour shifts and, just as we normally do when a hurricane approaches, we were sitting in the office responding to whatever calls we could. At some point, the Police Department shut down, saying the weather conditions and flooding were so bad that we could not be reached until it became safer. Emergency medical service and fire services also shut down until the area could be accessed.

We were shut down for that time period, and we noticed the water starting to rise. We were sitting in my office on the second floor, and we said, "This is unusual." We had never seen it quite like this before, and it kept rising, and rising, and rising. We took in about 5 feet of water in our station, at which point all of our cars were submerged. Operations were down. There were no telephones, lights, or plumbing,

I hope this symposium can help people find solutions that can be implemented so that if we know another disaster is coming, we can take care of not only our consumers but also our professionals. Many mental health and physical health doctors have been leaving our area, and it is a shame we cannot keep them here.

There is hope for everybody, whether it is the homeless person on the street or someone in an executive office. We need to find solutions to help these people, and sometimes that is giving them someone to talk to rather than forcing them into treatment. Some of them are going to need treatment, but unless we can talk to them, how are we going to know what their needs are?

and worse for the Police Department, our communications went down. My wife later told me that when she saw that Doppler radar was going down in the area, she knew there was going to be trouble, because it knocked down our communications.

We did not know what to do, and we are the guys who are supposed to have the answers. We are always supposed to know what to do and how to resolve situations, but when, all of a sudden, your communications are gone and your lights are out, it's a whole different story. Everybody starts getting nervous.

We waded over to the 610 ramp, which is part of our expressway around New Orleans, and we saw people just milling around. People had gotten water in their homes and walked out. We tried to walk down to the 610, but it was completely underwater, because at that time, the levees had fully broken, and everything was coming in. So our captain said, "OK guys, we're going to try to go downtown."

We managed to get downtown and went to the Convention Center. We asked the captain, "Why the Convention Center?" and he said, "I do not know." We avoided the Superdome for that time period, thank goodness, but the Convention Center was not much better. The Convention Center and the Superdome were two points of refuge that were more or less declared at the last

minute, by default, as places where people who were frightened could come and stay. The NOPD is charged with the security of that, as well. We met up with some fellow officers, and they said, "What is going on? We cannot talk to each other, and we have hundreds of people sitting around wondering what is going on." People saw us coming in, walking through the water and coming down, and they said, "Let's follow the police and see where they are going." But we did not know where we were going! We were just walking.

People started telling us stories about what they had seen, and that increased the anxiety of the people who had left

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before the water started rising. They heard stories of the water rising and people being trapped, and everybody started to worry, "What about my home? What about my neighborhood? Is it flooded?" Remember, we were in a total blackout, so we could not answer people, and that is how rumors get started. All of a sudden, it was much like kindergarten, where one kid says one thing, and it passes around the circle, and at the end of the circle, the last person to hear it has a completely different story. Anxiety levels were up, and we were asked questions like, "What do I do? How do I do this? Where can I go?"

We knew people could not get out on 610, and then we heard that the other evacuation route also had been taken out. We did not have any idea whether the water was going to keep coming, so we were all scared. And on top of the rumors and the anxiety, the looting began. After the storm, people stopped me and said, "On television, we saw a guy walk out with a 42-inch plasma TV. Why did you not just shoot the looters?" I told them this: I saw people walking out with televisions and all sorts of things, but I knew they were not going anywhere and that there was not any electricity for televisions. And I thought to myself, "Yes, I could shoot this person, but if I shoot him, I have got to bring him to a hospital. If I arrest him, I have to bring him to jail." There were no hospitals, because the hospitals were evacuated. There was no jail, because the jails had to evacuate. Everything was underwater. At that point, I had to ask, "Is a human life worth a television?" Not in my book.

Let them have it. So we, many of us, did not do anything with the looters. They were not going anywhere, it was not worth hurting them, and there was nothing we could do with them even if we did something. If I arrested someone, what was I going to do – handcuff them to the railing of I-10 or to the lamppost on Canal Street and leave them there? I could not do that either.

Everybody was just walking, and everybody had a stare or look of disbelief on their face. We had all heard the stories, and we'd been told, "If this happens, you are going to have 20 feet of water." We knew that was a reality, but we did not think it was going to be a reality in our lifetimes. It became a reality.

After a couple days, we had not seen anybody who was not at the Convention Center. We were unable to communicate. There were families there, mamas with their little babies. Traditionally, when New Orleans comes to the Superdome or the Convention Center, they are advised to bring three days' worth of food, water, and whatever else they need, because the department does not provide that. They are pretty good about doing that. But after three days, there was no water left, and there was no milk for those babies. The mamas were not eating, and the babies started crying and didn't stop. They were hungry, they needed their diapers changed, and everything else. And the mothers were stressed out and said to us, "Here, officer, take my baby, because I cannot help it. I cannot feed it. I cannot change it. I cannot do anything." And we could only say, "We cannot do anything either." That was a hard time. That did not happen much, but it happened a couple of times. People were just disturbed and overwhelmed, wondering what was going to happen next. Surprisingly, the first assistance I saw for us at the Convention Center was a Canadian Mountie, which I thought was unusual. We said, "Why is a Canadian Mountie in my city? Where did you come from?" and he said, "Quebec!" But it was nice to see somebody.

The military eventually came out to help, but when they came in, they were scared too. We had a lot of young people armed with M-16s in flack jackets coming in patrol uniform in 95-plus-degree temperature, and many were back from the Iraqi war and were ready for action. You combine that with a population that is already

anxious and nervous, and it is not a good mix at first. In fact, General Oneray, I believe I was told later, had told his soldiers to lower their weapons when they talked to citizens. People were fearful of them because they had big weapons, and they were fearful of us because they did not know what they were going to find down there. So anxiety increased again, but it got smoothed over fairly quickly.

The one time I was at the Convention Center and met General Oneray, he looked at me and said, “Son, get a shave. You are working with the military now.” And, surprisingly, a sergeant handed me a razor. I do not know where he got it, but he had one. I said, “Yes, sir!”

I teamed up with the military, and they asked me to ride along in their high-water vehicles as we searched for people who could not get out or who were so disabled that they were unable to get out. We went house to house, riding through the high waters, and we talked to people on their second floor. We had elderly people who were just covered with ants and cockroaches – which had no place to go either. The people would tell me stories. I would say, “Sir, you have got to come out with us.” And he would say, “No, I am waiting for my wife.” “Sir, is your wife alive?” “No, she’s been dead for 10 years.” “Sir, you have to come.” We needed to bring them to a place where they could get even temporary care. I keep talking about the causeway. We actually found out that assistance was not at the causeway for a time, and all these people were left out in the heat with no water and no food, and we in New Orleans had been advising them to go to the causeway. That made us kind of angry.

We had a lot of mental health professionals come up to us and say, “We want to help you get through all of this stuff.” They said, “When you see your neighbors who died in the flood floating



Joeelyn Augustino/FEMA

by, it is pretty traumatic. And when the person has been out in the water for a couple of days, it is even worse.” We sat there in the boat, and people came up to us, and we all looked at the body. The police showed what I heard termed one time by the professionals as “image armor.” That means we are the police; we are invincible. We cannot be touched, because nothing can touch us, because we see everything. We see it all. The basic conclusion I came to at that time was that I did not have time to bleed. I had to help get my city back and save my people.

Sally Sullivan

Project Recovery, Mississippi

I have had a lifelong dream of living by an ocean. I love the pelicans and the seagulls and the sand and the sun. My husband had decided to semiretire because he wanted to do more mission work. So, guess what? He moved me to the Mississippi Gulf Coast. For one-and-a-half years we lived in an RV and watched our new home being built. After living there for five months, Hurricane Katrina came through and took everything we owned. She took our new home. She took a car. She took motorcycles, and she took all those precious years of memories.

The week before Katrina hit, my husband and I were in Kansas City, Mo., visiting our daughter and having a wonderful time. But we were not getting much news about a hurricane. By Friday, news was starting to come in about a hurricane out in the Gulf, maybe somewhere between Mississippi and Louisiana. By Saturday morning, it was known that it was going to hit the Mississippi Gulf Coast within a couple of days.

Our tickets to get back home were for late Sunday night. I called the airlines and they said, "There is only one more flight into the Mississippi Gulf Coast, and you had better get on it if you are going to get in." So early that Sunday morning, we left to go back to evacuate. We had nothing with us, and my husband said, "We need to get our RV out if we can and, at least, one car."

As we approached, the coastline was like a ghost town because of the mandatory evacuation. We lived in Long Beach. There was nobody there. Our condo was right on the beach and as we drove up into our driveway, a fire truck followed us in, telling us that we could not stay and that we had to leave immediately. I do not know if you can imagine how frightened I was getting by that time. The sun was shining. It was a beautiful day, but the waves were starting to come in and the sand was really blowing, and I was scared. I was getting really nervous. By 4:00 that afternoon, we left. A four-and-one-half-hour trip took us about 10 hours, but we did get out.

The first time we got back to see our property was something I will never forget. As we were standing on the front of the property and looking

at nothing except a few posts that were left, my husband put his arm around me, and we looked at each other and said, "What do we do now?" This hadn't happened before. Just getting to our property was a major undertaking. The debris was piled so high that only a car – one car at a time – could get through it, and we sometimes thought we were going to scratch up the car because of all the debris.

The weeks following the hurricane were filled with shock, anxiety, and survival. Often in those weeks, I had to remind myself that this is the United States of America. Helicopters constantly flying over; National Guard standing with guns on every entrance to the beach area; barbed wire stretched from one city to another on the railroad tracks. These were just a few things that made us feel like we were in a war zone, that war had actually taken place on the coast. Granted, this was for our protection. But this is the United States of America. We should not have to live that way.

There was no communication between family and friends. All of the power lines were down. All of the cell towers were down, so there was no way to communicate. The National Guard was setting up distribution areas, trying to give out water, food, clothing – anything they could possibly do to help people in this desperate time. There was no gasoline or propane, and I was in an RV. We had to run a generator with gasoline. That got hairy sometimes, wondering if we would have enough gas to run our air and our electricity.

In three months, my husband and I moved six times. FEMA, insurance companies, and debris removal companies took over all of the RV parks on the Mississippi Gulf Coast. So we lived in parking lots of mall areas, fishing camps, and anywhere else that we could find.

[There was no] water or electricity on our property or leading up to it. Searching for days for anything that I might find, moving around parking lots, intense heat, long lines, dealing with insurance companies and adjustors, loss of our church as well as our home – these were factors that were leading me into depression,

frustration, and anxiety. But that is when the Lord stepped in and had someone call me about starting to work with the organization Project Recovery as a crisis counselor.

Project Recovery is funded by a grant through Homeland Security, given to FEMA, and then given to the state Department of Mental Health in Mississippi. We assist people in finding ways to cope with stress caused by Katrina. We help people find resources like food, clothing, medication, and even long-term therapy: whatever is needed to help them. To date, we have reached more than 270,000 people in the state of Mississippi, and we have answered more than 600 helpline calls. We literally knock on doors, tents, and trailers and just listen to what people have to say. They have a story and need to be heard, and we are there to hear them. Then we ask, "How are you doing and what can we do to help?"

One goal my husband and I have is to see hope in peoples' eyes again. We're working with mission groups who are volunteering their time rebuilding homes and lives on the Gulf Coast.

In closing, I would like to read you a brief newsletter article I was asked to write for an international mission organization, titled "One Year Later."

"Isn't the Mississippi Gulf Coast back to normal yet? I heard that question all the time and have a question of my own. Will someone please define normal for me? If you can call slab after empty slab, gutted house after house, acres of FEMA trailers, cities operating out of temporary facilities, churches meeting in schools, and several schools meeting in one building normal, then yes, we're back to normal. One year later, hundreds of people are still waiting on insurance settlements and asking, 'What do we do?' Some have gutted homes but are unable to put their homes back together because of the lack of insurance, materials, honest workers, and extremely escalated cost. Still, others are trying to decide whether it is worth the time and effort to even rebuild. Since January, I have talked to many confused, depressed, and discouraged people in the Long Beach and Pass Christian areas. I have

cried with them, and I've looked into their eyes of hopelessness. Many do not know what to do or how to get their lives under control again. Some relive the day of Katrina over and over, remembering what it was like as they clung to trees or formed human chains to brace themselves as a 30-foot wave came into shore. All of their stories are unbelievable, and some are extremely tragic. However, I serve a mighty God, one who has sent Christian after Christian to work and minister on the Mississippi Gulf Coast. After working with mission groups this summer, in June, July, and then in October, I saw smiles return and eyes full of hope once again. I have seen some residents of the area reach out to others now, because teams of youth and adults came to be servants to them. What a rich mission field the Lord has given us. One year later, are things back to normal? Unfortunately, no. There are many major problems to overcome, and there is plenty of rebuilding left to do. But with the help of people who come from all over the United States to bring comfort, love, and hope to this area, we will make a new normal in the weeks, months, and even years to come. In return, these helpers and new friends receive a promise from us. We will be there for you, should you need us. So please, do not forget us. We cannot do this without you. Thank you for serving, and may God bless you."



Greg Henshal/FEMA

Verlyn Lewis-Boyd

Executive Director, Louisiana Federation of Families

Unlike most of the panelists, I was not directly affected by Katrina. You see, I left town early. I went to north Louisiana because that is my home. As we watched television that Monday morning and heard the news that Monday evening, I knew Tuesday morning that I had to get back home to Baton Rouge. Needless to say, when I got home, home had changed drastically. Overnight, we went from having a population of perhaps a quarter-million to half-million. Traffic was a mess to say the least. But what really got my attention was when families started calling me. These were families that had left prior to Katrina but had all of a sudden found themselves in a hotel and no longer able to pay the hotel bill because they expected to be there a couple of days. I started calling in favors from everybody who owed me anything. I need you to allow this family, this mother, and her two children to spend at least a couple of more days with you. I was still in the dark, not realizing that this was going to be as extensive as it really was.

We got a lot of those families out of the hotels, and then what I call “all hell” broke loose. The shelters began to fill up. We had shelters, but, as

an organization, we were unable to get into the Red Cross shelters. At first I was really disoriented by Red Cross because I thought that these families were there and needed somebody’s help, guidance, and direction. But I am not one to give up, so my staff and I started going over to the Family Call Center, the center that the Office of Mental Health had set up so people could call in and list family members who were missing.

We were working there, and the chaplain asked what our profession was. We told him and he said, “We need you in the shelter.” I said, “Thank you, God!” I knew there was a way to get in that shelter. So, through the FEMA chaplains, we were able to get into the largest shelter in Baton Rouge.

I would like to say that when I walked in, everything was OK, but things were so bad and so far from my expectations that I wandered around with my mouth open. Eventually, one of the doctors walked up and held my hand and started rubbing it, saying, “Honey, are you all right?” I said, “I am fine; leave me alone!” They thought I was one of the residents. It was just that bad. I knew that that was something that I could not handle. So I went home and got on the

phone with my sister organizations across the state. The first person I called was Connie Wales. Connie was not only an executive director in Florida, she was a personal friend, and I knew Connie had a lot of hurricane experience. Within 24 hours, Connie had managed to pull together a program called the Family Recovery Project. When Connie called me the next day, there were five other states – Louisiana, Texas, Mississippi, Alabama, Georgia, and Florida –



Win Henderson/FEMA

all of us that had been affected by Katrina – online with Connie. We started working on what families needed.

I think the worst thing that I saw in that shelter was black trash can liners. To this day, I do not care if I ever see another black trash can liner. Families were sitting there with their worldly possessions in a black trash can liner, and for as far as you could see, there were cots with those liners on them or under them. I told Connie, “We need something to get these people’s possessions out of these liners.” We first thought about foot lockers, and I checked around Baton Rouge and could not find a foot locker. You have to remember, college had just started back, too, so all of the foot lockers were out of stock. The next idea, then, was plastic containers. The Family Recovery Project had sent the Louisiana Federation of Families calling cards and gift cards. Some of the gift cards went directly to family members because they had no way of making telephone calls. Some people still did not have shoes, perhaps because a certain size was hard to find. But with the remainder of the gift cards, we purchased plastic containers for people to put their belongings in.

Then we noticed that the children needed backpacks. I sent out the call for backpacks. In about a week and a half, I had more than 2,000 backpacks for kids. We also realized that moms probably needed something to put their belongings in, so someone in the process of sending backpacks sent some fabric tote bags that would be just the thing for carrying paperwork in. You have to realize that these people were getting everything all over again. Two of my staff members sew and collect fabric, so we set up sewing machines in the office, made tote bags, and gave every parent who wanted one a tote bag.

I would like to say that the worst problem we had was getting people something to put their stuff in. We had one family who had a family member with them, and he was a very large man. The things that came into the Red Cross shelter did not fit him. So we worked with the chaplains and took up money, and we went to Big and Tall and bought him a couple of outfits so he could change clothes, because he had been in the shelter for a week with the same clothing that he

had worn out of New Orleans. Somebody questioned why we did that because we were helping families. He was not a child. But he was part of a family of a child, so we helped him too.

I went in the shelters with my little packet of information on children’s mental health and what you need to expect, and I had to learn that those families were not interested in what I had to say. For some reason, being the parent of two children with mental illnesses, I know you have to take care of basic needs first. I do not know how I forgot that, but I had to change my whole agenda to help take care of basic needs.

One of the basic needs we found was getting children reunited with their families. I had one family I will never forget, and I am sure the Red Cross will not forget either. Originally, the mother was from Kuwait, but she lived in Plaquemines Parish and the family made their living as shrimpers. They were a family of six who got separated. The mom and the two older children ended up in Lafayette, La. The dad and the two smaller children ended up in Utah. Mom was lucky enough that she found a day job. But after they had been there for 10 days, she got a call that her husband was gravely ill and was in the hospital.

One of the basic needs we found was getting children reunited with their families.

Without a vehicle and without knowing anybody, she knew she had to get to her two younger children. So she “borrowed” her employee’s car and went to Utah. Once she got there, my phone rang. Normally, I could understand what she was saying, but I could not get her to slow down. I did not know what to do for her because I did not know what her problem was. So, once again, I turned to Connie and to our Family Recovery Project.

Connie gave me a number for the embassy for Kuwait, and we got a translator. I called her back, and by threeway, I connected her to the translator, and she was able to tell him what her problem was. Then he translated it to the Red Cross. What had happened was that whoever had her children planned to keep them and did not want to give them to her. We were able to help them understand that they were her kids, and they released the kids.

Then we had another problem: We had to figure out how to keep her employee from pressing charges on her “borrowing” his car. I called him and talked for what seemed like hours, and I tried to explain to him what it meant to her to be separated from her two smallest children. Her husband was ill. We got him to drop those charges, and he agreed because, by then, she had made it back to Mississippi. He agreed to go to Mississippi and pick up his vehicle.

These are the kinds of things we have done for families. Children who were separated from their parents did not want to go to school when they came back, when they did get reunited. I had shelter directors tell me their moms were too lazy to get up and send them to school, with no consideration of the trauma that the family had

gone through. We decided we needed to educate those directors and the staff of those shelters and started putting our information in the hands of the people who were working with the families.

Fifteen months later, families need mental health information, because things are happening at school and at home with kids who were “well” prior to Katrina as well as kids who had problems. At the Louisiana Federation of Families, we work extensively with families, but we did not work alone. We worked with the other family organizations across the nation. If it had not been for their help, we could not have helped anyone because, frankly, I had no idea what I needed to do, how I needed to do it, and who I needed to do it with. And every day, we are still learning new avenues for doing things for people and new ways of getting the job done.

Questions & Answers

Q Two of the 90 studies that the National Development and Research Institutes are involved in at the moment deal with the impact of Hurricane Katrina on individuals who were involved in use of substances at the time the hurricane struck. I would be interested in your observations about the issues that faced individuals who were involved in substances, their concern about their supply being cut off, yet having no access to treatment. Other individuals were in treatment but were unable to continue treatment. Others evacuated to other locations, such as Houston.

A James Cooper: I deal with a lot of people as the office coordinator for the Extra Mile, where we serve clients in Jefferson Parish Human Services Authority. We serve those with addictive disorders, mental health issues, and the developmentally disabled. How did the hurricane affect those using substances? After the hurricane, it seemed that those who were using were getting worse. They would do anything they had to do to get what they wanted. We had looters break into our offices. The first place they tried to break into, although we did not carry drugs that the normal addict needs, was our pharmacy. They got so angry when they could not get into our pharmacy that they went throughout our whole building destroying equipment, records, and state vehicles that were left out back. They took baseball bats and broke out all the windows and stole the equipment. They were so angry that they could not get to the drugs, they just destroyed the office and vehicles and left. They did not steal anything.

Regarding the second part of the question, I am sorry to say that three of the clients who I knew personally overdosed and died. That touches me. There are still a lot of them out roaming the streets because we do not have all of our services up and running yet. Jefferson Parish Human Services includes New Orleans and the metropolitan area. We are just about there, but we are not there yet. And trying to reach these people requires resources we just do not have right now. Every day, I see them walking the streets. How do I get services? They run into me in grocery stores and restaurants.

How do I get them services? Most of them are going back to using, and it just tears me apart to see this.

Q I am having parents or grandparents who are coming in, and they are either just discovering that their teenagers are on drugs or are just beginning to use. I have one grandmother who has four grandsons, and they are all in detention for possession and use of marijuana. These kids had no problems prior to Katrina.

A Jeff Wellborn: From our standpoint, Katrina was like seeing a natural detoxification of the entire city. There were people walking around who you could literally see shaking and sweating, and they could not get their preferred drugs. After Katrina, and after we started coming back to a semblance of normalcy, we definitely saw increases and the related things that go with it.

Q In Katrina, 20 community mental health centers' outpatient satellite facilities and outpatient offices were destroyed. A full state psychiatric hospital was rendered inoperable, and three of the four emergency inpatient psychiatric units, the crisis beds in the city, were also rendered inoperable. About 65 percent of the public mental health system in the city of New Orleans no longer exists. Mr. Cooper, what experiences have you had, what challenges have you experienced in financing services in the wake of Katrina, and then in attempting to reconstruct the service capacity for the city with regard to its public mental health system?

A James Cooper: We were able to secure a social service block grant, which tremendously impacted our area because we were able to get into some facilities where we could treat our clients again. We lost so many beds, psych beds and social detox beds, and we still do not have those back yet. We do have a few beds opening back up. They are using the New Orleans Adolescent Hospital even for adults. But as far as financing right now, it is

Questions & Answers

very soft because the social service block grant is a one-time deal. We are trying to implement plans right now in Jefferson Parish. We get donations coming in from different corporations to help us better serve clients. We need more than a one-time fix. We need something that is ongoing because this is not going to go away for many years to come. And now it is getting to the point that even one year after, in some areas it is getting worse.

Q I want to get your perspective about what needs to be done differently in terms of shelter responses and in terms of organizing communities to which people have been evacuated so that people can pick up services and be integrated into those communities.

A James Cooper: Our organization, the Extra Mile, provides educational services for family members and for judges, law enforcement, and nursing students so they can better treat people with mental health issues. Now we are working on a program to pull

all of these people together so we can be more prepared, get the information out better to the clients – especially the family members and children who were affected by this – and keep these services going. To improve the system for every client that comes through the door in our area, we are making sure we have family members' names in different states, including different areas of Louisiana; contact numbers; and an immediate contact. We are putting all of this information into our database so if these people are evacuated and if we know where they are evacuated to, we can contact their family or friends to let them know where they are. We also can contact the mental health professionals in different areas where these people might be showing up with a letter that outlines their medications.

Q Mr. Wellborn, I understand that part of what you do is to make sure other people are healthy. Both my brother and sister-in-law were on the front lines at 9/11 in New York. They both were asked to come down for the Katrina catastrophe, but she could not do it. Both are mental health professionals; she has



Marvin Nauman/EMA

Questions & Answers

not received any mental health help since the 9/11 experience. I am curious what you and your fellow officers have received and how you are coping with what you saw. What you described was horrific, and I would like to know who is helping you.

A Jeff Wellborn: The standard, pat answer is, “We are the Police Department. We do not bleed.” But we do seep, and that seeping is seeping out on the citizens we serve. We are not always handling our calls in the most judicious or expeditious manner, and it is causing some problems within the department. We want to see our officers get the help they need, but it is difficult when you have officers who are uncooperative. They say, “There is nothing wrong with me.” Then, you know what? You do not have to beat up the guy on Bourbon Street or the woman who ran the stop sign. That’s uncalled for. Coping happens more or less, I find, when we get together out on the street on a fairly easy call for service. Then most of us will stand around and talk to one another, and we support one another. We look at it like: You were here, I saw you, you are my brother,

and I can talk to you. Also, I find that a lot of our humor, which was not too great to begin with, has turned morbid, and the public is not going to see that. Basically, officers are relying on officers. For some reason, the perception is that if you turn to a professional in the mental health field, particularly if it gets out into the department, nobody is going to ride with you anymore. We are going to say, “You have some mental illness. We are not sure what it is. We do not understand it, and we do not want to understand it, because we want to go stop crime.” We think, “I do not want to ride in the car with you, because if I get into a situation, how do I know whether you have taken your medication? And do I want you watching my back?”

Comment:

Sally Sullivan: I have a certification in critical incident stress management, and I think all cities, towns, and governments ought to find people who have that certification, to talk with police officers and firefighters and all first responders. It works, and it is wonderful.

VIDEO PRESENTATION

Norman Robinson

News Anchor, WDSU-TV, New Orleans

I am a television reporter. It is my duty to stay on the air and report to the people. We had a plan that half of us would evacuate to high ground and the other half would stay on the ground, in the eye of the storm, because our transmitter is located in the southern end of New Orleans, which was affected by 25 feet of water. Our transmitter went off the air, and those of us who were selected to go to higher ground went to our sister station in Jackson, Miss. We were on the air there for about three weeks, nonstop.

I was separated from my family. I had been pleading with my wife for a week to get out. She said, "I am not going anywhere because the last time I evacuated, I was stuck in the car for 19 hours, and I am not going to do that. This storm is going to turn, and it is not going to affect us." Well, that Sunday morning when my news director called to say, "You know, you are going to higher ground to get on the air when we get knocked off the air down here," my wife said, "Whoa, I guess I'd better leave." I said, "I guess you'd better."

So she got in the car and left. But our granddaughter, whom we are raising, was staying with my ex-wife for the weekend, and we wanted to evacuate with my granddaughter. My ex-wife decided she was going to go to Picayune, Miss., with my granddaughter. I did not know where in Picayune, so, for five days, I did not have any idea whether they were alive or dead, because Picayune is where the eye of the storm passed over. I called every evacuation shelter, every Red Cross, and every emergency operation center I could find, and no answer.

In the meantime, I am getting text messages. Because phones did not work, I got text messages from people all over the southeastern part of the United States wondering about the condition of their homes. As [Jeff] Wellborn expressed to you at the outset of his presentation, people had no idea that the levees had broken. They had no idea that the water had been rising. They had no idea that their entire neighborhood had been inundated. Eighty percent of the city had been

inundated. Because we were news reporters, we were supposed to know. We did not know, because we had no idea the extent of the damage, but we had people text messaging us all the time, "What happened to my neighborhood? Where is my home? What does it look like?"

It was three weeks before the mayor let us back into our neighborhood, because it was one of the first hit. It is in the eastern part of the city. My house was under eight feet of water for 12 days. The mayor finally let us back in in the middle of October, so I thought the best thing I could do was to show what had happened to my home, so people could get some sense of what their home looked like if they were in a flood plain, as I was.

In the meantime, I had finally discovered where my granddaughter was, and I had to go rescue her. She was trapped in Picayune. I was reunited with her in the middle of all that, and then they helicoptered me down to New Orleans so I could see my house.

That sets the stage for the video clip that you are about to see.

Video Clip

This is the gut-wrenching view of the Spring Lakes subdivision, my community. This is one of the oldest communities in what's called New Orleans East. This is one of those places where the first African-American middle class migrated to out of the city. There are many African-Americans and whites living in this community. This is a very diverse area, but there is not much left of it, as you can see. This gives you some appreciation of the widespread destruction, devastation. It is like no man's land here. It is like someplace that you would imagine how it would look if no one lived here for 20 years and the place just continued on a downward spiral.

You can see that the destruction is just totally thorough. It is overwhelming. This is the second day that we have been on the ground here, and we have

had people asking us questions all over the country, “What does the East look like? What does my neighborhood look like?” Well, this gives you some appreciation, I hope.

You can sense, this is my neighbor’s house – a young couple who moved here with their little boy not too long ago. They were up-and-coming postal workers, and they took a lot of pride in their home, recently completed an overhaul of the landscaping, and you can see all of their latticework is gone and the wrought-iron fence. My neighbors’ recently purchased BMW is covered with water and now the debris from what’s left of the fence. All of the foliage is dead. Everything is just bleak, gray, silty. Furniture is strewn about. That used to be one of my cabinets, the drawer from one of my cabinets, and my pet palmetto tree, which I took a lot of pride in. It is gone. The magnolia tree is dead. It is littered with debris – just complete wreckage.

We’re going to try to venture inside. You can see the lanterns here that are just totally gone. And, so I am going to go in here with my photographer, Drew McCallister, and we’re going to try to stay on our feet. It is rather slippery inside. The big circle with the line through it means the search-and-recover people have been here. In fact, they marked the date, 9/12, Sept. 12, they were here and they found nobody inside

because we evacuated ahead of the storm, the Sunday before it hit. Let’s see if we can get this door open. As you can see, we had to force the door open because it was swollen from all the water. This is what’s left.



Joselyn Augustino/FEMA

PANEL I: SCIENCE AND RESEARCH

Greg Miller

Writer, *Science Magazine*; 2004-2005 Fellow, The Rosalynn Carter Fellowships for Mental Health Journalism

I was struck earlier by the vivid and moving picture that we got of what individuals experienced in a disaster like Katrina. In this panel, we are going to take a step or two back, look at a bigger picture, and ask what researchers can tell us about disaster mental health and planning for it. One of the overall goals of this symposium is to examine the situation in Katrina and look for lessons that will help us be more prepared and to take care of mental health issues in future disasters. And, Katrina, of course, is not the first disaster of this magnitude. Several of the panelists will be drawing on research and experiences in other disasters, and I will tell you briefly about some of my own experiences in reporting on the Asian tsunami.

Last year, thanks to The Carter Center, I was able to visit Sri Lanka in India and see some of the camps where displaced people were staying. I also visited with the psychiatrists and other

people who were trying to care for their mental health. A few things struck me, and we may even hear echoes of some of these themes in the panelists' comments.

In Sri Lanka, the area of the country that was hardest hit was the east coast, the home of the Tamo people, who are an ethnic minority in that country. They make up about 15 percent of the population. Sri Lanka has a long and bloody history of ethnic violence, and a lot of that violence has taken place in this eastern part of the country. There is a lot of economic deprivation there. Before the tsunami, there was little in the way of mental health infrastructure. So to make a long story short, a lot of the people who were most impacted by the disaster had the fewest resources to deal with it. The response was chaotic, especially in the initial stages. There were literally hundreds of groups, medical charities and other international groups, that came flooding into Sri Lanka wanting to help people and provide mental health care in particular. But there was little coordination and oversight, and it was largely a mess in the beginning. Many of the groups that came focused primarily on post-traumatic stress disorder and set up clinics to diagnose and treat people for PTSD. But the more I talked to international mental health experts and disaster mental health experts, the more I came to realize that PTSD is just one of several ways that people can react to a traumatic event. Psychiatrists I talked to told me that they were observing more symptoms of depression in the people who they were seeing than they were real classic cases of PTSD.

The other thing they saw a lot of, which sometimes tends to get overlooked, is a tremendous amount of resilience in people. When I visited about six months after the disaster, certainly there were people who were still really struggling to cope, but the vast majority of people were getting on with their lives remarkably well. Many of the people I spoke with attributed that, in part at least, to the strong social networks that people have in this area, unlike in the United States, where I think we



Andrea Booher/FEMA

tend to move around in pursuit of education and careers. There, people will live in the same village for generations and live very close to their extended families. There is a sense of community welfare in that the good of the community is viewed, in that culture, as being above the good of the individual. Many people told me that they felt that was something that helped get people through a very hard time.

As bad as the situation was, there is also a sense in Sri Lanka that the tsunami provided an opportunity for change. There were 40 psychiatrists in the entire country for about 20 million people, almost all of them concentrated in big

hospitals in the capital and other cities, with very little out in the community. As a result of all the attention that has been brought to bear on mental health issues in the wake of the tsunami, and in consultation with the World Health Organization and other groups, the Ministry of Health in Sri Lanka has drawn up a mental health policy. It passed through their Parliament last year, so there are signs that some good will come out of this, that they may be able to build a better community mental health infrastructure. I think there may be some parallels with Katrina, but that will be left to our panelists to pick that up or not.

Robert Ursano, M.D.

Professor and Chairman, Department of Psychiatry, Uniformed Services University of the Health Sciences

It is a pleasure to be here to think through some of the issues about Katrina and disaster. We will try to echo some of the lessons from other disasters that may show up in Katrina and try to highlight some areas for further study.

I approach the topic with some trepidation, because, as Greg [Miller] pointed out, there are problems with science. Science is a wonderful tool; however, it is a tool. The application of that tool first requires distance from what one is studying, and, secondly, it is always a study of opportunity, no matter whether or not you are studying the gene, the cell, or the community. One's tools will only be able to reach certain questions, and they will not always, in fact, most often will not, reach the questions closest to our hearts. Oftentimes, they will not reach the questions most important to our policies. However, they can inform us in ways that other tools cannot. When they do inform us, it is probably at great risk that we avoid what they say. That means that I will not be able to address subjects such as improvisation, creativity, and flexibility. Perhaps these are the absolute most important issues in disaster response, whether one is talking about individuals responding or whether one is talking about how our organizations respond.

Similarly, I will not be addressing issues such as what happens when you have cancer and you have to evacuate for a hurricane or what happens when, in fact, the call goes out, "I am sorry, but our EMS system cannot get to you." It also is true that we cannot answer the question, "Why is it that black trash bags can become so overwhelming, so frightening, and such a terrible reminder of what we have just experienced?" Those are all questions critical to thinking about mental health, the provision of mental health care services, and they are critical to answering the questions in our heart. But, I will not answer any of those.

I am going to highlight three areas. One is disaster behaviors, the second is disaster mental health, and the third is specific issues around public health related to response and preparedness. I am going to do this through the work of two different groups, and I am going to arrive at some thoughts I think are conclusions.

I will start with the conclusions first. I think the data that I will present will raise questions for us that have to do with defining the mental health needs and mental health services needed in the face of all types of disasters, not just Katrina. One of the issues for us to struggle with – again, leaving our hearts for a while and returning to our heads – is, "What about future disasters?" What is disaster behavior and how do

we plan for it if we do not know what the emergent mental health needs are and, firstly, recognize there are emergent mental health needs – meaning ones that are not expected, not planned for, not anticipatable? One of the service needs will always be more than what we need, what we can expect, and how might we plan for those.

What about the experience of loss of care? Perhaps we need interstate networks to respond to that.

We have not begun to think about the restoration of community, thinking of flexibility, improvisation, and creativity. Individuals restored their community through the use of cell phones, television, satellite maps, safe lists. But there are better ways to plan for continuing and perpetuating a community that may be destroyed, including possible other virtual communities that

we have not begun to think about. Psychologist first aid is a new form of intervention. Perhaps it has always been done and is just now being

We should think continually about the next disaster rather than our last one.

better articulated. It needs more to be tried, tested, revised, and tried again. First responders, as we have already heard, have raised questions about their care needs. How do we establish mental health surveillance for our entire community, as well as for first responders, and, of course, a wide panoply of special populations? I will list just a few that have been on our minds now for many years – those who are pregnant at the time of disaster, those who receive renal care or chronic renal care, all those who receive home health care and lose services, and issues of substance abuse and child neglect.

I am going to present data from two different groups, one a large collaboration, which we have had the pleasure of being a part of, headed by Ron Kessler. (Ronald C. Kessler, Ph.D., is a professor in the Department of Health Care Policy at Harvard Medical School.)

The sample frame for study – the collaborative Harvard study, which is called the “Katrina Community Advisory Group” – includes about 1,043 people across the entire disaster region. That means I am not just talking about New Orleans, and I am only occasionally talking about the New Orleans metropolitan area.

We’re talking about the entire FEMA-declared area that was put together through lists from the American Red Cross, random-digit dialing, and actual sampling of hotel rooms and also safe Internet sites.

Let me tell you about who I represent, when I am not joined with another group. The Center for the Study of Traumatic Stress is part of the Uniform Services University of the Health Sciences, your federal medical school. It is the only federal medical school in the nation. We train people to be physicians for the Army, Navy, Air Force, and Public Health Service, and we do education consultation, research, and training.

We have studied more than 25,000 people, spanning across all types of disasters. The study includes doing research in order to generate new knowledge, educating health care providers and community leaders, developing best practices, and disseminating that information across the nation as well as just-in-time education and real-time consultation, which we provide. There are a number of books as well as guidelines for practice that we have been involved in creating.

These two particular Web sites will contain almost everything I am going to say. The first one is the Harvard collaborative study, of which we are a part, and Ron Kessler is the leader. If you search for “Kessler Katrina Harvard” through an Internet search engine, it will come up. The second is our center, and if you put my name in somewhere, it will come up.

Let’s talk data from lessons learned. Remember that disasters come in several forms – human-made and, secondly, natural disasters. This is an important distinction, because although we are focused primarily in this symposium on natural disasters, it is true that human-made disasters are even more devastating and cause more complicated and longer-enduring psychiatric illnesses and distress.

Disasters threaten our nation’s security. In general, our nation’s security used to be thought of as, primarily, protected through military power, economic power, and information systems. There is now a much better recognition that it is the health of our populations that is critical to sustaining the security and function of our nation.

We should think continually about the next disaster rather than our last one. What are we talking about today that may also relate to the risk of a pandemic? Pandemics are not new. You will remember that influenza A has had multiple pandemics. In 1918, it killed somewhere between 20 and 50 million people throughout the globe. Those of you old enough to recall polio will remember that we had things such as iron lungs to deal with pandemics. We also had, in school systems, the collection of dimes to be turned in. And, we had large public education campaigns. What are public education campaigns? What are our mobilizations of students and children in order to deal with the next hurricane disaster?

Types of responses that we see following disasters fall into three different categories. First are the traditional issues of mental health and illnesses and, of course, post-traumatic stress disorder. Secondly are the issues of distress responses that include sleep disturbances as well as a decreased sense of feeling safe and how that might change our behavior. And lastly, there are health-risk behaviors, which include increased smoking and alcohol and also things such as overdedication in our first responders that can lead to risks of morbidity as well as mortality.

Whenever we think of disaster response and responding to protect the public's health, it will require the integration of our public health system, medical care system, and emergency response system. And, as we all know, those do not fit together well. At best, they are a patchwork quilt when they are working well.

Responses to trauma and disaster span a wide range. Resilience is, of course, the expected response, also true after Katrina. Responses can include illness, disease, altered feelings of safety, anger at our government, the scapegoating of others as well as feelings of fear and trepidation.

As you think about any disaster, including Katrina, one could probably mark the different phases of the disaster. First is the honeymoon phase, when you can expect that we all feel we

did OK. We pulled together, we joined, we were cohesive, we were a collective, we responded as best we could. However, after a honeymoon, disillusionment follows. That is the time in which we are angry and disappointed: It should not have happened, someone should have prevented it, who did not do their job, the government did not do enough, somebody did not do enough, and we should not have to suffer.

It is important to remember that our disaster communities are also no longer defined by the geography in which the disaster strikes. Disaster communities span the globe as individuals and families hear about their loved ones and their friends and neighbors who may be at risk or may be ill or injured. Communities now have become global communities, connected by communities of meaning.

The screenshot shows a web browser displaying the Harvard University Gazette article. The article is titled "Harvard to study Katrina survivors" and is written by Ken Gewertz, Harvard News Office. The article discusses a new project funded by a \$1 million grant from the National Institute of Mental Health, which will recruit Katrina survivors across the country to serve on the Hurricane Katrina Community Advisory Group. The group, numbering 2,000 survivors, will speak every three months by phone with trained interviewers who will solicit specific information as well as give the survivors an opportunity to tell their stories in an open-ended fashion. The information will appear in a series of online reports available to the general public. The article also mentions that the project plan to solve using what Kessler called "a multitiered sampling approach." Interviews will include a variety of questions about experiences during and after the hurricane, emotional reactions, opinions about the performance of government and private relief efforts, and practical suggestions about how these efforts could be improved. Each interview will also include a recorded oral history with descriptions of each advisory group member's experiences during and after the hurricane in order to build a permanent archive that can be used by historians, policymakers, the press, and the public to understand the experiences of people who lived through Katrina. These recordings will be placed on the initiative's Web site: <http://www.HurricaneKatrina.med.harvard.edu>. Both oral histories and quantitative information will be collected and presented to policymakers. Telling their stories should also help the advisory group members themselves, according to Anthony Speier, director of disaster mental health operations for the Louisiana office of mental health and one of the advisory group's scientific collaborators.

There is also another community important to think about, as we think of preparing and responding, and that is the workplace. We often forget workplaces as a community. They provide a way to reach out. They also provide tremendous resources at the time of the disaster, as is certainly true at the time of Katrina. Within the workplace, it is the integration, in fact, of human resources, security, and employment assistance plans and occupational health that usually provides services and prepares for disasters.

As we hone in a bit, post-traumatic stress disorder (PTSD) looms its head. I spend lots of time thinking about PTSD, but the important topic is that PTSD is only one of many potential disasters. It is, perhaps, the most common of our psychiatric illnesses. Over a lifetime, there is almost 100 percent probability of being exposed to one or more potential life-threatening events. If you have been exposed to such an event and, for the month or so afterward, you develop some sleep disturbance, appetite disturbance, do not want to go out and drive by the place where your car was hit, and you are perhaps a little jumpy when the brakes go off, then you have PTSD. You probably also recovered from it.

Importantly, particularly for disaster planning, those with no previous psychiatric illness are at risk of developing post-traumatic stress disorder. That has been proven through the Oklahoma City studies done by Carol North, as well as studies done in our own group in military populations. (Carol North, Ph.D., is a professor at the University of Texas Southwestern Medical Center.) Following the Oklahoma City attacks, 40 percent of those who developed psychiatric illness never had a psychiatric problem in the past.

Another important aspect shown true in Katrina (it was also true in Hurricane Andrew, where these data come from) is that loss of access to routine medical care and home care is a critical aspect affecting morbidity and mortality, not only for mental illnesses but for other illnesses and diseases in times of disaster. Following Hurricane Andrew, 1,000 physicians' offices and four mental health facilities were closed. Home health care was totally lost, including nursing, oxygen, suction, IV, antibiotics. The same occurred with Katrina.

We have certain assumptions that we often make in times of disasters. Again, Katrina and other disasters have taught us otherwise; most search and rescue is done by bystanders, not, in fact, by our trained rescue crews. The majority of casualties are not transported by ambulance. In fact, they hobble, they travel by car, and they travel by taxi.

Disaster behaviors are an important element of responses to disasters, and I want to illustrate that first outside of Katrina, and then we will move to Katrina rapidly.

In the first World Trade Center explosion, about 76 percent of people thought something serious had happened between the two towers. Large groups took 6.7 minutes to decide to evacuate, which meant that some would not make it to the bottom.

In 9/11 studies done by Robin Gershon, 21 percent of those people who had to evacuate had disabilities or a medical condition that might have impaired their ability to evacuate, and 58 percent did not know that there were three stairwells. Ninety-four percent had never exited the building as part of a drill. And 49 percent stayed around at the bottom floor, rather than leaving, after they had evacuated. (Robin Gershon, Dr. P.H., is a research professor at the Mailman School of Public Health, Columbia University.)

Now to hurricanes: In data from Robert Blinden, 48 percent of the community had been damaged by a hurricane the previous year.

People who would stay rather than evacuate comprised about 33 percent. The top reason for not evacuating was because they believed their home was strong enough.

More than 500,000 people evacuated. It covered an area larger than the United Kingdom. Ninety percent of people in the New Orleans metropolitan area heard of the hurricane more than one day before, and 75 percent of the New Orleans metropolitan area evacuated. That compares with one-third of the people of the rest of Louisiana, Alabama, and Mississippi that was in the disaster region.

Importantly, and perhaps the strongest and most important element of this study, there is data on this region from the national co-morbidity study prior to the hurricane event

itself. Post-hurricane, adding together serious mental illnesses and mild to moderate mental illnesses, all of which would reach *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) criteria, about 31.2 percent of the disaster region would meet criteria for mental illnesses. That compares with 15.7 percent prior to the hurricane. The rates of mental illness doubled. This now is about six months post-hurricane. It is true when one looks across the questions of serious mental illnesses, mild to moderate mental illnesses, or any mental illness.

If one looks at New Orleans itself, versus the remainder of the affected disaster region, 49.1 percent of those who lived in New Orleans and 26.4 percent of those living in the rest of the disaster region met criteria for serious or moderate mental illness prior to the disaster.

Joy Osofsky, Ph.D.

Professor of Pediatrics, Psychiatry, and Public Health; Head, Division of Pediatric Mental Health, Louisiana State University Medical Center

I am from New Orleans. I evacuated from New Orleans. I returned to Baton Rouge on Aug. 31, joining my colleague, Dr. Tony Speier.

I want to acknowledge Howard Osofsky, M.D., my husband, who is chair of the Department of Psychiatry at Louisiana State University Health Sciences Center. This is a joint presentation with him. We did a lot of work separately prior to Katrina. There were not many mental health people around, so we partnered to work very closely just to see what we could do to help in the response. I was one of the fortunate ones. Our house had some minor wind damage, but we did not get flooded out. We work with many people who lost everything, and we try to build resilience as much as we can.

I want to give you the context of our work. We flew back to Baton Rouge, got back at 10:00 p.m., waited for two hours in line to get a rental car and thought they would run out of cars. People were sleeping at the airport. We did not know where we were going to stay, but we knew we had to be back. We got a call from the head of the state police that there was a police room over at the Marriott Springfield, where we went. The next day, we went to the command center,

About 30.3 percent of New Orleans metropolitan area and about 16.3 percent of the remainder of the area would meet criteria for PTSD.

So let's return to the question of disaster behavior. For Hurricane Katrina, in the study of evacuation of 1,043 people, which comprised the entire sample, 25 percent of people decided not to evacuate.

Deciding not to evacuate is, in fact, a risk behavior. It is a disaster behavior in

nearly all disasters. In this particular case, that comprised 25 percent of the 4 million people who were in the disaster region. In a more serious event, a large percent of those would also have suffered great morbidity and mortality.

Deciding not to evacuate is, in fact, a risk behavior. It is a disaster behavior in nearly all disasters.

where we paired up with Tony Speier and others from the Office of Mental Health to see what we could do related to the mental health response.

You have heard a lot about the individual stories of destruction and response in other ways. I had been in a command center before. The day they walked in and said they needed 10,000 body bags for initial net was an eerie time. Fortunately, they were wrong, but they expected the death toll to be much higher.

We came back to New Orleans within a few days with permission from the state police, entering the first time with state police with semiautomatic weapons. We walked up to the ninth floor of City Hall where the police had a small room as their headquarters (police headquarters was flooded out), and, as we walked in this small room, we knew we had worked with these officers since 1992. The chief and deputy chief and others came over – hugging is a big thing in disasters. The first thing they talked about was the suicide of the two police officers that occurred during the time of the flooding. Those of us from New Orleans know that they were very well-known, well-liked officers. One was the public information officer for NOPD. They really needed to talk about the suicides and

all kinds of things that were going on, and we got interrupted. Then a couple of officers went to the side and really needed to talk about what they were going through and what they worried about.

Eighty percent of first responders lost their homes.

At that point, we realized that this was the city we had adopted 20 years ago and raised our children there. We needed to do what we could to help, so we worked on the streets of New Orleans.

It was mentioned that first responders do not reach out but keep to themselves. We reached out to the first responders. We did psychological first aid. We dealt with basic needs. These were people who had been in the same wet clothes for days. Eighty percent of first responders lost their homes. And when the Carnival Cruise boats came in, the Ecstasy and the Sunation, we also stayed on the boats with the first responders when we were in New Orleans. We also stayed in Baton Rouge, back and forth, and tried to see what we could do to help.

We got a call from many of our colleagues from the National Child Traumatic Stress Network, including Melissa Brimer. Melissa said, "We got the screener. It is almost ready." They had been working on a hurricane screener, based on work that had been done in Florida. We took that screener, went to some of the few schools that were open, adapted it, and started doing screening of children coming back to New Orleans. The first children coming back were the children of first responders. If we were going to create normalcy in this abnormal environment, we needed to have families back. People needed to have the support of their families. At first, there were 45 dispirited children who came on the boat, and by November, there were about 460 children. But if children are coming back, you need programs for children. You need schools for children, and schools were not open in New Orleans. You needed activities on the boat. We proceeded to work with the Department of Education and the Police Department to set up schools so that school buses would pick up the children, and we set up child care centers on the boat. It was October and Halloween was coming, so we had a Halloween party on the boat. Various things helped create normalcy in an abnormal environment.

I am going to go through some of our data and then end with some lessons learned that I think we all can use to help children and families in future disasters. One of the things that became clear to all of us is there really is no clear disaster plan for children and families.

First, children of all ages are impacted. They are more impacted depending upon their level of direct traumatic experience. Children who have had prior traumas are going to be more impacted. Those who have been exposed to community violence, to abuse and neglect, to domestic violence are going to be more impacted. But also, children are impacted more if they have less support. If we look at the limited disaster literature related to children, we find that one thing that impacts them most is loss of community, loss of neighborhood, loss of friends – everything that happened with Katrina.

We saw a great deal of resilience. The majority of people will be resilient, and they will be more resilient if they have family, community, and schools to support them. We have to remember that everybody was traumatized, so it was really hard to put that kind of support in place. Under those circumstances, children will be resilient. We talked with some of the displaced children and adolescents in various places in Louisiana the first week after the hurricane hit. The first thing they said to us was, "We miss our friends. We cannot communicate." We could not communicate, and they could not communicate. They had no cell phones and no e-mail, and they missed their friends.

We started screening with the National Child Traumatic Stress Network Hurricane Screen in November 2005, and now we have screened more than 7,000 children. We have been able to enter data on approximately 5,000 of them. We are continuing to screen. We screen in collaboration with schools, and we give information back to the schools. Some of the children request services. We will outreach to parents to see if they want services, and we will try to get services in place with them. We are working collaboratively with the Office of Mental Health and others to have many more services in place for children.

So you have a sense of what children have gone through: The average number of moves was three, but the range was much higher than that.

The average number of schools was two; however, children were in from one to nine schools during the displacement. Right now, 27 percent are living in trailers. I do not know how many of you are familiar with FEMA trailers, but they are tiny. They are boxes. They are crowded. If we have a thunderstorm with 40 mph winds, they are not safe. This is the circumstance under which many children are living. Many children have come back to heavily devastated areas in New Orleans, and, when they came back, there were no electricity and no services, and in some areas, grocery stores just opened a month ago.

A great percentage of children experienced loss. Many of them are in new schools. Parental unemployment and other issues such as living in a FEMA trailer contribute to stress and marital problems. We are seeing an increase in marital problems and domestic violence, and frequency as well as quantity of alcohol as a self-medicator.

Quite a number of children lived in shelters. From the point of view of those of us who know about effects of trauma on children and the idea of witnessing injury and death, those percentages are high. Those children are going to be more impacted by the trauma than children who did not go through that.

In our spring 2006 sample of fourth- through 12th-graders, 49 percent met cutoff for mental health services. That does not mean they necessarily needed them, but they met the cutoff in terms of their symptom picture. The symptoms were primarily PTSD and depression, although depression is the bigger story for us. Thirty-seven percent reported previous loss. Thirteen percent requested counseling. And – think of this – these are teen-agers asking to talk to somebody. That is pretty unusual, and people are reaching out. One of the pluses for those of us working in the area post-Katrina is that mental health has been destigmatized to a great extent. On the one hand, we have the outreach of Louisiana's spirit, crisis counselors, and many more people who are willing to seek out mental health services.

Anybody who was from the New Orleans area during the hurricane season last summer, anybody who lost everything, is going to worry. Children worry when it rains. Children get very anxious under those circumstances. It is important to think about how we understand some of these kinds of reactions diagnostically.

In the fourth through 12th grades in fall 2006, 41 percent continued to meet the cutoff for mental health services. Some have been receiving services, and we are going to look at them and how their symptom picture changes. Seven percent still want to have counseling services, 11 percent say they feel worse, and 52 percent are feeling somewhat better (whatever that means).

As I turn to the data on younger children, I want to mention a compelling story that we heard on the boat – from both younger children and older children – that makes us think about magical thinking. They would come up to us and their parents and say, “We will just take a broom, and we will sweep everything up and it will be all better. The house will be all better.” Is that magical thinking? It really is their way of coping with something that is difficult to understand and putting it back together. Children cope in various ways. These scales were filled out by parents for the younger children. They were

We are seeing an increase in marital problems and domestic violence, and frequency as well as quantity of alcohol as a self-medicator.

Traumatic Experiences

- Did the child live in a crowded shelter? 18%
- Were family members or friends injured? 16%
- Were family members or friends killed? 12%
- Did the child witness injury? 12%
- Did the child witness death? 2.4%

pre-K to third grade, and, again, look at the high parental unemployment. Thirty-two percent of these met cutoff for referral, and 44 percent of these parents said their children wanted to talk to somebody. We think they want to talk to somebody themselves, and we are outreaching to parents as well as teachers. Last spring when we talked to schools about the fact that we needed to outreach to the teachers, they would say they were too busy, they had more classrooms, they had more responsibility, they would not have time to do it. This fall, they are asking us to talk with the teachers.

We did a matching comparison sample: three to five months post-Katrina and 14 to 15 months for the younger children. There was no significant difference between the percentage of children meeting cutoff last fall, and now parents still say they want services for their children.

This fall we are seeing an increase in severity of symptoms: difficulty concentrating, disregulation, and disregulated behaviors. We think the

disregulated behaviors relate to the chronic slowness of the recovery and the extent of devastation in the community. It is a serious mental health concern that needs to be addressed from a prevention point of view. One very young child said, "If I had my own room back, I would be good." That is the kind of wise thing that children say.

For prevention and intervention, it is crucial to build capacity and provide services where children and families are. We cannot wait for people to come to us. We need to outreach to children in schools and in community centers. Most will be resilient, but they are most resilient if there is community support. We have lost much of that. Some behavioral and emotional reactions to trauma may be normal, or represent a new normal under circumstances of a disaster of this type.

Regarding the national plan, implemented at local levels, there has to be federal will, and it has to get to local levels to be helpful. We also



Keith Riggs/FEMA

need to take into account the impact over time of the devastation and slowness of the recovery. If we had known what was going to happen in the New Orleans metro area about a plan for rebuilding, it would have helped us as mental health professionals a great deal.

It is important to gather data. We started gathering data the first month out, and we continue to gather data. We need to use this data for planning, to see what is happening over time, to use it to help rebuild our infrastructure, and also to guide the evidence-based services that are going to be put in place by the continuing crisis response. The issue of vicarious communization and compassion fatigue and self-care is very important to keep people effective.

I want to mention the Youth Leadership Program we put in place in summer 2000 in one of the parishes in the New Orleans area. We plan to spread it. This was a program in which wonderful, creative teachers who had been principals, but no longer could be principals because their schools were destroyed, came together with a group of about 20 10th graders. They chose 10th graders because they felt that they would then be able to influence the school. They spent a summer with these kids and had a program designed to build self-efficacy and resilience. Some of these children were doing well in school. Some of them were really struggling. In fact, one of the young people

Spring 2006 NCTSN Screen for Younger Children (parent report)

- 787 children, pre-K-3rd grade
- 55% Caucasian, 37% African American, 3% Hispanic
- One parent unemployed – 77-80%
- Meets cutoff for referral - 32%
- 44% of parents reported wanting counseling services

brought in a friend who had dropped out of school, because she felt this was so important for her friend. They worked together for four weeks, and it will continue during the year in some ways.

I want to tell you about a young woman who was not a good student. She was dressed Goth, in black, and she had “Bad Girl” on her T-shirt, and she came in and told us the story that she had learned from this program. She said, “When my mom comes home from work to the trailer, she sits in her car with the motor on. This is what I learned from the program. I go over to the window of the car. I knock on the window, and she rolls down the window, and I say to her, ‘Mom, I love you.’” She said her mother then is able to turn off the motor of the car and come into the trailer, and she said that really helped her in her relationship with her mother.

Monica Schoch-Spana, Ph.D.

Senior Associate, Center for Biosecurity; Assistant Professor of Medicine, University of Pittsburgh Medical School

I am actually a cultural anthropologist, so my tribe is social science, not mental health. But I do consider myself something of a “wannabe,” and definitely a fan, so it is a real pleasure to be on this panel. It would be important for you to know that I have been working on public health preparedness and response issues since 1998 and working with a multidisciplinary team interested in first preventing, and if prevention fails, helping to alleviate the human suffering associated with large-scale outbreaks of infectious disease. I am speaking from the perspective of someone who is keenly interested in multidisciplinary problem-solving around extreme events. By multidisciplinary, I mean drawing from all relevant academic disciplines. I will pull in sociology, political science, anthropology, and risk communication. And by multidisciplinary, I also am referring to the need to cross the boundaries of policy, practice, and scholarship, because extreme events – whatever the hazard that is implicated – are complex social problems that require an intense kind of problem-solving. It cannot be left up to one particular group.

The impact of Katrina, both in terms of response and reverberating events, will be inter-generational in nature. Katrina survivors are not my research subjects, and I have not had direct, personal experience with Katrina. Katrina does, however, constitute a political and cultural

context for what I have to say as a scholar working in the extreme events arena. The bottom line is that how we currently approach

I would argue that the act of engaging the U.S. civic infrastructure in disaster-related policy decisions is a mental health intervention.

disaster mitigation, preparedness, response, and recovery in the United States is not what it could be. Presently, we are not applying our extensive and diverse knowledge base well to the problem of extreme events. What I have to say is intended as one small remedy for this state of affairs, because as Robert Ursano and Joy Osofsky have underscored, we can help minimize the impact of future disasters.

The Biosecurity Center has convened a working group on citizen engagement in health emergency planning, which I currently chair. The mission of that working group, which is multidisciplinary in nature, is to provide guidance for mayors, governors, health officers, emergency managers, and anybody who will listen regarding the practical feasibility and societal value of more actively involving citizen stakeholders in the formulation and implementation of public policies regarding disasters. So I am talking about high-level, pre-event intervention. I consider this to be a mental health intervention, and it is a mental health intervention that is way upstream. I am not focusing on the response period.

I would argue that the act of engaging the U.S. civic infrastructure in disaster-related policy decisions is a mental health intervention. By civic infrastructure, I mean that vibrant whole comprised of citizens’ collective wisdom and their ability to innovate and problem-solve. In addition, it is also voluntary associations (whether they are virtual or face to face) that arise around shared mutual interests or around some public good and nongovernmental groups that look out for the well-being of various groups. In offering such a definition, I am deliberately staying away from the concept of the amorphous “public,” because I think it has been easy to use the phrases “the public” or “public preparedness” rhetorically but still fail to back it up with real programs in the United States.

I want to roll out the core arguments of the working group and share the different kinds of findings that come out of sociology, anthropology, and political science that bear on issues of disaster-related policy-making. The core argument for the working group is that disasters, including epidemics and other mass health emergencies, are immense, shocking disturbances that necessitate the moral courage, judicious action, and practical innovations of large numbers of people, and not simply those who serve in an official capacity. These findings come out of decades of more sociologically and anthropologically informed research about how

communities and individuals deal with extreme events. Robert [Ursano] referenced issues of improvisation, so I will speak to that literature.

I also want to speak to what we have learned from the risk communication literature and from the theory and practice of deliberative democracy. Here we learn that leaders – by which I mean elected and appointed officials as well as health officers, emergency managers, and other heads of governmental agencies – have a range of techniques through which to mobilize elements of the civic infrastructure in and for disasters. These techniques include public communication, public consultation, and public participation. In comparing what is possible with what is practiced currently, we find significant gaps. Public participation methods are, by far, the most underutilized techniques by leaders in the United States. This is despite indicators from research and practical experience that this tactic, in contrast to mass communications, may help leaders tackle some of the more intractable problems posed by extreme events.

The sociological literature tells us that there are particular characteristics of extreme events that compel citizen judgment and action. First are the shock-producing damages that rupture everyday expectations about physical survival, social order, and the meaning of life. Conferring meaning upon a large-scale tragedy and recovering a sense of safety are both highly personal and public matters. A second finding suggests that disasters require the judgment and action of citizens to “response system overload.” These are the recurrent instances in which it becomes apparent that successful remedies and recovery for a community from crisis are neither conceived nor implemented solely by trained emergency personnel nor confined to pre-authorized, predetermined disaster procedures. People have the capacity to self-organize and apply innovative solutions in seeming chaos.

The third generalized finding about disasters is the finding of disproportionate impacts. Opportunities for disaster victimization and loss, and for enhanced safety and security, are unevenly distributed in society. Unfortunately, this is a robust finding. That which makes citizens more or less likely to be victimized by an extraordinary disaster event are often the more ordinary social policy issues, such as access to

health care, affordable housing, and a living wage. Thus, emergency management, that whole realm of policy and practice, which is seemingly the domain of specialized knowledge, actually cannot be neatly excised from broader policy matters with which U.S. citizens have immediate and direct concerns.

The fourth robust finding around disasters is that they are history in the making. Disasters and epidemics provoke political aftereffects. They transform social expectations and institutions, and they create indelible personal memories.

There is something distinct about these phenomena we call “disasters” – at least from a sociological point of view – that calls up the need for greater involvement and decision-making by citizens themselves, because disasters are both life-altering and society-remaking events. They have both immediate personal and public dimensions to them. Extreme events are not simply physical phenomena left for decoding by seismologists, meteorologists, epidemiologists, and other experts. They are not stress conditions for civil engineers to build into buildings or medical administrators to build into health care systems. They transcend managerial concerns such as responders to command, hazards to regulate, or crises to manage.

All of those aspects and actors are absolutely critical to sound disaster policy and practice, but together, they still fail to represent the complete human experience of catastrophe and the full societal resources that can be brought to bear on widespread tragedy. We have the civic infrastructure, which is an absolutely essential management tool for catastrophic events based on what the sociology is telling us about extreme events, but we are not adequately accessing the civic infrastructure.

Risk communication and deliberative democracy literature tells us that there are three ways in which leaders can access the civic infrastructure, or mobilize citizens and civil society organizations. The public communication mode is one-way, leaders to public, typically with the intent to educate and inform. Public feedback is not part of that model, so in the disaster preparedness realm, this mode takes the shape of pamphlets, press releases, public

meetings, and Web sites such as ready.gov or pandemic.gov. These are all absolutely essential, but they constitute one-way communication.

In the consultation mode, leaders listen to the public, typically through polls and surveys about their attitudes, beliefs, and own behaviors. But there is no obligation on the part of leaders to act on that knowledge. It is simply input to the policy-maker, who then makes decisions or takes action. So we get things such as trying to understand what people's risk communication needs are with regard to particular hazards – radiological, biological, and the like.

The third approach, the participation modality, is a two-way flow of information between authorities and citizens in which dialogue helps foster a more nuanced understanding of the societal problem at stake through joint problem-solving. Formal authorities, citizens at large, and opinion leaders in a community work together to come up with a set of appropriate solutions for complex issues. This is a power-sharing model, a modality of public involvement. Public participation, in contrast to consultation and communication, currently is not used in the realm of disaster policy-making and implementation.

We are learning that there are tools that we can use. The risk communicators and the deliberative democracy scholars are telling us there are problem-solving mechanisms that we have not yet exercised in the realm of disasters. An example of the latter is the group in Alameda County, Calif., named "CARD," which emerged in the aftermath of the Loma Prieta earthquake and the Oakland Hills firestorm. CARD, Collaborating Agencies Responding to Disaster, was meant to be a publicly minded mechanism to train, unite, and coordinate the social service organizations in that area, so that they could serve as the safety net for people typically left out

of disaster planning, including seniors, children, the disabled, the homeless, non-English speakers, and low-income families.

From a political science perspective, we currently are doing well with household readiness and with tapping our community-based organizations to effect positive policy change with regard to extreme events. While those developments are commendable and essential, we are having a significant citizenship gap with regard to disaster policy in U.S. citizens paying closer attention to the politics of disaster, a characteristically uncomfortable position for most Americans. By the "politics of disaster," I mean the difficult trade-offs that often are associated with societywide measures to mitigate against losses. On the one hand, these associations mean people mixing with like people. We have less practice with the more "agonistic" and pluralistic sides of democracy. Scholars of U. S. civic life say we will talk about politics in private long before we will talk about it in public, particularly with other people who are not of a similar mind-set. We are predisposed to defer to objective, but largely invisible and unaccountable, elites for policy deliberation.

If most Americans do not care for the messy side of policy-making, per the political science research, and if leaders typically have little experience and expertise in public participation approaches, per the risk communication literature, why are they still worth contemplating in a disaster context?

Go back to Katrina and post-Katrina as a political and cultural moment. In a policy matter with such high personal and public stakes, it seems well-advised to provide more organized opportunities, both to whet and to satisfy the full range of appetites for civic engagement in disaster policy-making.

Questions & Answers

Q We learned in Dr. [David] Satcher's Youth Violence Report and the Institute of Medicine's Reducing Suicide Report that risk factors are not predictive factors because of protective factors. Some of the studies show that self-efficacy is a protective factor. With a disaster like New Orleans, could you give us some concrete examples of how a group so devastated could get a sense of self-efficacy, and could you speak to how we can cultivate self-efficacy as a protective factor so that we could prevent people from not developing depression or PTSD?

A Robert Ursano: The questioner is alluding to the five principles of psychological first aid that have an evidence base behind them as predicting positive outcome. One of them is self-efficacy. Self-efficacy occurs in two forms. One is the belief that one can do it. The second is actual skills with which one can respond. How can we foster the belief that I can do well, that I can go forward, that I can get through this, and how would we develop skills to be able to do such? Skills relate also to resources, so we have to think about different populations. Here is one piece of data: In the study of Katrina done by the Kessler group, there were actually measures of post-traumatic growth. One of these was optimism, and another was a measure of whether the person thought they gained something and were going to be a stronger person. Both of those increased dramatically in New Orleans following the disaster. So first, post-traumatic growth occurs. If you then look at people who felt they had learned skills about how to respond next time, what you would find is that among people with mental illnesses, who also reported that they gained skills as to how to respond, they had

lower suicidal ideation and lower suicide attempts than in populations prior to the disaster. That is the National Co-Morbidity Study. Self-efficacy may be particularly important in people with mental illnesses to protect against negative outcomes. Therefore, how do we develop self-efficacy among those with mental illnesses, in particular? We have some data to say it may protect against suicidal ideation and suicide attempts. How we do that is a good question. We know that, in fact, one cannot get somewhere if you do not have transportation. If you have transportation and you know how to reach it, you have a higher probability of being able to get to where you want to be, whether that is to evacuate or to get care. So making available resources becomes critically important. Secondly, active parenting has been shown to be a positive intervention for children, such as asking your child, "Are you using drugs? Are you drinking?" If we teach active parenting to parents, we may be able to both foster the parents' sense of self-efficacy and protect the children.

Joy Osofsky: One comment on the findings coming out of Kessler's study is that I was concerned about the people who refused to do the interview and wondered whether they may represent a group that did not feel any post-traumatic growth. Because frankly, clinically, for those of us who were there all the time, that was



Robert Kaufmann/FEMA

Questions & Answers

not the majority kind of reaction we were getting, even for people who are coping quite well. Building self-efficacy came up a great deal this summer with the hurricane season, where people were very frightened when it rained or stormed and many people were living in trailers that were not safe. When the first storm came, parents started to plan. Everybody planned what they would do if another storm came and what they would do about living in a trailer. They came up with plans such as having a backpack and knowing where they were going, how they would evacuate, and how to get in touch with each other later. It really relieved a lot of the stress and built self-efficacy.

Q My comments are regarding the participatory process in decision-making, in policy-making. I think one of the reasons that we see consistency in negative indicators with people's emotional health is that they genuinely feel that they are but players in a much larger drama, or subjects for observation, rather than truly being involved in their own recovery as it relates to this life-altering and society-remaking event. Are there models of a participatory process that might, in some way, be embedded in a recovery that has taken place around people and to people, rather than actually involving people?

A Monica Schoch-Spana: For folks who have actually evaluated the public participatory processes, political scientists will tell you that the people most apt to be involved in "public matters" are highly educated and economically comfortable, so what you find is a sense of political self-confidence or efficacy. Those are the people who typically will participate in these processes, unless there are deliberate planning and financial support to implement those plans, to draw in people whose voices are typically left out of the decision-making process. Public participation processes that are poorly executed can actually have adverse effects. There are a number of good guidebooks about how to have

more effective and more representative public participation processes, but done poorly, they can cause damage.

Q Joy [Osofsky], I want to ask you about the positive youth activities that you discussed briefly. Other than Katrina itself, are there things that made it possible to get positive reactions from young people? I work with youth murder and youth violence, and we are thinking about the development of a positive code of the streets, something that would take negatives and make them positives. This may not be applicable to the group you are talking about, but it seems that there may be some applicability in turning people into positive activists.

A Joy Osofsky: The model we used in the school was one of building on the strengths that the youth might have: taking responsibility for individual projects that they wanted to get involved with, helping younger people in the school, and also helping elderly people. We also have heard many young people in the community talking about wanting to rebuild their community. That is a motivation they have. Respecting that young people can take on responsibility is enormously helpful to them in rebuilding and helping to prevent negative things from occurring as well.

Q Civic participation in disaster planning is such a central issue. In the mental health community, we have three sets of problems. The first is that when disaster planning is done, we have to fight just to get mental health considered, even when it is public health planning. Second, once we get over that hurdle, we have to worry about the content of the plan. And the third problem is that the end-users of the service are the people who are most affected: mental health consumers, people in communities, and people with low incomes. They are included in the process in a very token way, or we make the process so complicated and time-consuming that the average person who has to work for a living outside of the policy

Questions & Answers

arena cannot participate. The National Mental Health Association (now Mental Health America), which was very effective in helping mental health stakeholder groups, was developing coalitions with the state and local levels to push communities to do disaster plans for mental health specifically. One model I would suggest is the Blueprint Project. Any research you have done to talk about processes that are more accessible to the average person would be enormously helpful. Putting out a regulation and saying “please comment within 20 days” is not a way to get civic participation. Nor is it helpful to say to someone, “You can be on this committee. We meet once a week on Wednesday at 4:00. Please take time off your job to be here.” The more models we can come up with, the better disaster plans we are going to have and the better-prepared we are going to be for the kind of events that we have been talking about.

A Monica Schoch-Spana: It is helpful to think of a civic infrastructure as a critical infrastructure, since there are presidential directives regarding their protection, and these public participation processes do have

a bill attached to them. They, like any other public works, whether roadways or sewages, require adequate funding, realistic schedules, and trained professionals who can help facilitate them, and the like. So these things do not come cheaply. It is an issue of whether we can be satisfied with the status quo with regard to the making of disaster-related decisions in the United States. I think it is certainly worth the investment. As far as models that work well or not, there is good guidance that comes out of Health Canada, which has fully embraced the public participation modality in its work, and its new sister organization, the Public Health Agency of Canada.

A Joy Osofsky: I do speak from the perspective of somebody who has been involved in trying to respond and do as well as we can in the last year, and, unfortunately, some of the lessons that were learned from previous disasters that might involve public involvement were not put in place. It is time for us to learn from the lessons from each disaster and be able to share those so that we are ready the next time with participation at all levels.

DINNER ADDRESS

Scott Cowen, D.B.A.

President, Tulane University

It is a great honor for me to be here this evening, especially at such a prestigious forum where you are focused on the psychological consequences of Hurricane Katrina on the people of New Orleans and the Gulf Coast region. These are absolutely critical discussions you are having these two days, because they will ensure that, in future disasters, mental health issues are part of the preplanning.

I am also delighted to be here today because this function is at The Carter Center. And I, like many of you in this audience, am a great admirer of President and Mrs. Carter. In our lives, we look for role models, those we want to emulate and want others to emulate, because they have displayed all the characteristics of leadership and courage and boldness and contribution to society. I cannot think of two people more deserving of our respect and honor than President and Mrs. Carter for their extraordinary work as public servants and as private citizens.

I should say one thing, Mrs. Carter. You mentioned that *U.S. News and World Report* named us as one of the hottest schools in the country and, indeed, they did. But the reporter was in New Orleans in July when it was 110 degrees, and he got confused! That is the only time the school was listed, and they meant it literally, not figuratively.

I have a confession to make to this group as I stand before you tonight. My doctorate is in the fields of finance and management, so I doubt that I can contribute anything to your dialogue on mental health issues. But I can say this: I have witnessed the consequences of Katrina on people's mental well-being, and I have seen it firsthand. And I have to tell you, I am deeply worried and troubled about the long-term consequences of Katrina on the people of New Orleans who, to this day, are not getting the care that they so need at this critical moment in their lives. I cannot emphasize enough how much our children need the work that you are doing and the help that you can provide them.

I know there are others at this conference who are much better able to speak on issues of mental health. Instead, I will talk about Tulane University and what we experienced over the last year, the lessons we learned along the way, and how these events have affected our lives on a personal level.

Before Aug. 29, 2005, Tulane University and New Orleans were enjoying a period of forward momentum. Then, suddenly, a monster of a hurricane came to the Gulf Coast. At first, it seemed to only get us by a sheer glance. What you may not know is that the eye of the storm actually veered 30 miles to the east of downtown New Orleans, unfortunately obliterating the Mississippi Gulf Coast on the storm's most destructive eastern side. In the campus recreational center, where I rode out the storm with four other senior people, we actually breathed a sigh of relief after the storm passed, thinking we could deal with whatever damage the winds had brought on. As a matter of fact, one hour after that storm, I walked out of the recreational center and there was no water on my campus, and I could not see water anywhere. I went back to the recreational center to pack up my things and go home, and then I heard the levees had broken, and our world changed forever. That campus, which one hour after the storm had no water, had within 48 hours an average of 4 feet of water as far as you could see.

I have a story of my own escapades, as I was trapped on a flooded campus – a story that includes hot-wiring a golf cart, raiding vending machines, commandeering a dump truck, siphoning gasoline out of cars, and making a bizarre escape by helicopter. I have committed any number of crimes during this past year, and I beg forgiveness of whomever is out there capable of giving me that forgiveness. The question people always ask me is, "Why was the president of the university on campus during that storm and afterward?" The university has a very well-developed hurricane preparedness plan. That plan says if a hurricane 4 or 5 is to come to New Orleans, the president of the university goes to

the recreational center with three other people. I had never read that plan before that storm – and I am convinced to this day that my enemies wrote that plan – but I did survive it, despite their efforts. A year later, I can look back and actually smile at what happened in our exploits. But I have to tell you, laughter was a rare commodity throughout fall 2005 as we dealt with the largest disaster to befall a major American city in this country's history.

Let me repeat a few facts that you may have heard. The great majority of lives lost in Katrina were in New Orleans, where there were more than 1,500 dead in the greater New Orleans area – most drowned in their homes or expired in the 100-degree heat of their stifling attics. More than 160,000 homes were destroyed, and many more hundreds of thousands damaged. About 80 percent of the greater metropolitan area population was displaced for at least six weeks, many people for months, and still others, to this day, unable to return for the lack of a place to live. More than 80 percent of Orleans Parish (a

parish is a county) was flooded, a land mass equivalent to seven times the size of Manhattan. If you want to get a feeling for the utter destruction, you begin to think in those proportions. One of America's major and great historic cities became a ghost town within days, and parts of it remain so even today, more than a year later. The population of Orleans Parish prior to the storm was 465,000 people. Within about two weeks of that storm, there were probably 10,000 people in that parish. Today, and we really do not have hard numbers, we guess it is about 200,000. So now, 15 months later, 60 percent of that population is still displaced someplace else, and I am sure many are right here in Atlanta.

Our health care system was decimated, as all the hospitals in Orleans Parish were flooded, stranding hundreds of patients and health care workers and destroying facilities, including all of Tulane University's hospitals and clinics. There were 22 million tons of debris generated by this storm, enough to fill the Louisiana Superdome 13



Andrea Booher/FEMA

times. If that image does not drive it home for you, this amount of debris is equal to four times the amount realized in the 9/11 tragedy, and the debris collection is still going on today.

You are talking about a disaster of epic proportions, never to be seen in the United States before, and, of course, Tulane University was not immune to this trauma. Eighty percent of our main campus and our entire health sciences campus were under water after the storm. Our physical facilities suffered more than \$400 million in damages. And here are a few other

Eighty percent of our main campus and our entire health sciences campus were under water after the storm.

facts. Our 13,000 students and 8,000 employees were scattered after the evacuation, and we had no idea where they were. The city

would remain under mandatory evacuation orders for more than six weeks, much longer for harder-hit areas. Our communications systems were nonexistent: no phones, including cell phones. All the cell towers had been destroyed, and only text messaging worked, for reasons I still do not understand to this day. When Katrina hit, I did not know how to use text messaging. Today, I am an expert. I am prepared for the next natural disaster.

Our information technology system was inoperable for weeks, and our student and personnel records were trapped in New Orleans, including vital payroll and enrollment information. Tulane University became the first major research university to close for an entire semester since the Civil War.

Five days after the storm, when I evacuated from New Orleans, I went to Houston. When I got to Houston, the only thing I had was the same pair of Bermuda shorts I had worn for a week, the same T-shirt I had for a week, and no money. I went to a hotel and was met by 20 of the other senior people of the university. We were, and this is no exaggeration, on the brink of extinction as a university. Tulane was founded 172 years ago and is considered one of the great major research universities in this country, yet within 72 hours of Hurricane Katrina, we were on life support and fighting for our very survival.

The Saturday before the storm, we closed the university in anticipation of Katrina. We planned to resume work and classes in five days. That has been our history in the past. I have gone through nine hurricanes, and we are usually up and running again in three to five days. Obviously, that did not happen this time. After the magnitude of the disaster was realized, we knew that Tulane University would not be able to reopen anytime soon. Even getting the university reopened by January seemed like a very daunting task. But that January opening became our rallying point, and we began to work long days and nights toward that goal. We knew if we could not reopen Tulane University in January for the spring semester, it was highly unlikely we would ever reopen again as an institution.

In the short term, we had to find our students, let them know that Tulane would not reopen in the fall, and find a place for them to study for the semester. It would have been impossible without the incredible support of the entire higher education community in America. Universities across this country stepped up and took our students for the fall semester, while, in many cases, allowing Tulane to keep the students' tuition monies, which we needed in order just to stay alive. In fact, our 13,000 students wound up at 600 different colleges and universities, including every single college and university in Atlanta. When I talk about the heroes of Katrina, I talk about the higher education community and how it stepped up to the plate right away for us. It is so ironic, is it not? I have lived my entire life in the academy with people saying, "You know, you and the academy have your head in the clouds. You would not know the real world if you saw it." Lo and behold, we are the only ones that saw it and survived it. So much for the real world, if that is what the real world is like.

Our other immediate need was to re-establish contact with our employees and reconstruct our payroll. We felt it was imperative that we continue to pay our employees during the period that the university was closed, so they could devote their time to their homes and families that had been impacted by the hurricane. This was accomplished through the tireless work of a group of people in Houston, and we never missed a payroll. During the time we were closed, that

cost us \$40 million a month at a time where no cash was coming into the university. That tab wound up being \$200 million, and it is the best investment I have ever made in my life because that kept the loyalty and dedication of our faculty and staff. When it is all said and done, great universities are composed of great faculty and staff. If you lose them, you lose the university. I could lose a building, but I cannot lose my faculty. That allowed us to keep the faculty.

With the immediate issues somewhat in hand, we looked toward January as our rallying point. Our challenges to reopen centered on people and place, and we talked all the time about people and place. In terms of place, there was the sheer physical destruction to contend with. Even while the city was under evacuation orders, as soon as the water receded from our main campus, we hired remediation teams to come in and begin the laborious process of ripping out floors, walls, and even ceilings that had molded as they sat in water for several weeks in nearly 100-degree temperatures.

Our uptown campus is 115 acres. About 80 percent of that was under water, and we had to remediate 84 buildings. Imagine the basement and the first floor of all of those buildings had to be rebuilt while, at the same time, we had to make sure that mold did not get through the rest of the buildings. How did we do that, given there was no electricity all during this period of time? We had more than 75 generators brought in from around the United States, and you could not tell the difference between the generators and the buildings. I have never seen generators so large.

Within a month of the storm, we had 700 people working on our campus, sleeping in tents and living in dormitories, all of which were on generators because nothing else worked in the city itself. But after many long days for hundreds of workers, we got our campus ready for January.

In terms of people, we had a number of concerns, because it turned out that the easiest task of rebuilding was actually rebuilding the buildings themselves. We realized in October and November that the rest of New Orleans was not functioning, so we were going to have to build our own village to be self-contained. This would allow faculty, staff, and students to return. In terms of our people, we had a number of

concerns that had to be addressed in order to ensure that they all came back. Our employees had to have schools for their children to attend when they returned to New Orleans, and our employees and students alike had to have places to live.

Despite the challenges and the obstacles, we did what we had to do to survive. There is a school in our neighborhood called Lusher School. It is a fantastic school, K-8. In October of last year, we decided to charter that school so it could reopen in January. But, of course, you may have heard that we have one of the most dysfunctional school boards in America. They were AWOL in October, but we had to get their approval. We put out scouting teams and said, "You find every one of those board members. We want to have a conference call with them because we want them to charter the school." We got them on the phone and made our case. We said, "By the way, if you are willing to charter the school, and we are giving you 24 hours to make the decision, we will guarantee the financial wherewithal to open it up in January. This is regardless of whether the city or the state has any money. We will pay for it."

That school board, despite how dysfunctional it was, was smart enough to pass that charter unanimously. We then hired the teachers who used to teach in that school and brought them to Houston. We said to them, "By the way, you have to be prepared to open the school in January. We will put you on our payroll, and we do not want it just opened K-8. We want it opened K-12, because we do not know if there is going to be a high school available."

I am pleased to tell you that whole high school opened up on Jan. 17, 2006, and had 1,400 students in it. About 500 of those students were the sons and daughters of our faculty and staff, and the rest were the sons and daughters of people in the neighborhood. So just getting that school was a critical aspect in repopulating the area itself. We now have an elementary school, a middle school, and a high school. There is the potential to form an association with perhaps six to eight other schools to bring them all under the Tulane umbrella and make sure they have the support system they need to thrive in New Orleans over the next several years.

The most rewarding moment, I think, besides all the thank-yous we get from people whose children are there, occurred two days ago. I was in New Orleans and got a phone call. My chief of staff said, "Would you come back to the office? There is a group of students who want to see you." I went back, and there were 10 students there. They were the string quartet from Lusher School. They gave me a private concert for 30 minutes, playing Mozart. It was unbelievable. After crying like a baby, I sent them away, but I have to tell you, it was unbelievable.

In terms of housing, we decided to buy as many apartment buildings as we could find in October and November. We built modular housing on our campus. And when all else failed, we leased for six months a cruise ship that had 2,000 berths in it. We brought the cruise ship in, and everybody thought it was a joke, but it was down there for six months. Anybody who we could not get into the apartments or into modular housing, we put on the cruise ship.

After that, we had to re-recruit all of our students, because they were at 600 different colleges and universities. We knew they would be

leery – but in particular, their parents would be leery – to send them back to New Orleans. So

It was the largest academic restructuring of a major university in the history of the United States.

we fanned out all over the United States to every major city where we had students, and we held forums to answer their questions. Also, we used the Internet in interesting ways to get our students back.

I will tell you one story that really touches my heart. It was about November of last year, and I got a call from a parent of a student who said, "Scott, you know, you folks are doing a terrific job. You have convinced us that your campus will be open, that your campus looks terrific, and that everything will be fine around campus. The problem is the students do not know whether all the bars that they would go to will be open." And he said to me, "Could you make a video of all the bars and haunts that the students go to and put that on the Web?" Now, this is against my religion as the university president, but it was not a bad idea. I said to him, "This is such a terrific idea that I will sanction it if you will pay

for it." This individual put together a video that ultimately cost \$1 million and hired actors to come down. He did the entire production. I saw it when it was done, and it was on the Web. It was the last thing that all students saw, and to this day, we still use it as a recruiting tool. I learned a valuable lesson. All these years that I have been trying to close those bars and restaurants, they are the real pulse of the institution, and if that pulse is beating, those students will come back. Much to our surprise, on Jan. 17, 2006, 88 percent of our students came back to the university. Eighty-eight percent. The other thing you should know is that when we opened up that week of Jan. 17, the population of the parish went up 20 percent in one week, just because we opened. The bars and retailers that had not yet opened then opened up, and our economic impact was quite extraordinary.

I wish I could tell you that the challenges ended in January of 2006, but we knew going into our first semester back that there were two serious issues that we still had to address: one within our control and one over which we had very little power. The issue we had control over was how Tulane would move forward as an institution in response to the impact of Katrina. Rather than sit back and wait to see what happened with New Orleans and our university in the coming year, the board of Tulane University and I decided to address our financial issues head-on by restructuring the university in order to save costs and maximize efficiency. At the same time, it was important to ensure that the university would continue to grow academically in stature and quality over time. I have to tell you, it required some incredibly tough decisions on our part and by all of us. But last December, we unveiled the new Tulane, a university reinvented to build on its strengths, to be small and more focused, but yet stronger, and to take an active role in the rebuilding of New Orleans.

According to experts around the country, it was the largest academic restructuring of a major university in the history of the United States. Only time will tell how successful that restructuring has been, but I can tell you one year after it, we have no regrets about any of the tough decisions we had to make. There were many who did not like or understand all the

decisions we made, but I believe we took the difficult steps necessary to secure Tulane's future so that we could continue to excel academically in the future.

I mentioned earlier that there were two major concerns in moving the university forward and that the second concern was something over which we had little control. This is the recovery of the city of New Orleans itself. It was heartbreaking to watch a city I have come to deeply care about knocked to its knees, and it has been even harder to watch the pace of recovery.

The city's problems have been well-publicized, and the media coverage has been both a part of the problem and a part of the solution. On the one hand, we need people to realize the magnitude of the destruction in New Orleans. On the other hand, we want people to know that parts of our town that our visitors see and that Tulane students see are back in business and are as great as ever. The revival of tourism is absolutely essential to New Orleans in terms of getting the city back to economic viability. And the revival of New Orleans is critical to Tulane's long-term future.

Walter Isaacson, a trustee of our university, former CEO of CNN, editor of *Time* magazine, and now head of the Aspen Institute, wrote a wonderful article for *The New York Times* in which he called New Orleans "A Tale of Two Cities." He said that about 70 percent of the city looks, feels, and functions as well as it did pre-Katrina, and that is true. The rest of the city looks almost as bad as it did after Katrina, and that also is true. The problem is that people outside of Louisiana do not know the difference between the Lower Ninth Ward and the Garden District. So when they hear or see stories about the Lower Ninth Ward, they ask, "Is that true of all of New Orleans?" To this day, I still get asked, "Are you open? Is your campus still flooded?" This is a real problem for us.

I will give you one simple example of how that manifests itself for Tulane University. For fall '06, we had 21,000 applications for 1,400 entering spots. For those of you who know higher education, you know that is a phenomenal ratio: 21,000 applications for 1,400. We accepted a little over 7,000 students, about a third of the students who applied. Based on our historical methods, we would have easily gotten a class of

1,400. We got 962. We surveyed all those parents and students who were accepted yet did not come and asked them, "Why did you not come to Tulane University?" Eighty percent of them said, "We did not come because we are concerned about the future of New Orleans." There was not one single significant factor that they mentioned about Tulane University.

The problems have been well-documented in the media, and I will not go into much detail here, except to point out a few of the most obvious challenges. Each of these challenges has an impact on people's mental well-being, whether they are in the city trying to rebuild or away from their homes and trying to find their way back.

First is the lack of housing. Lack of housing is the city's single biggest roadblock to recovery today. As I said, an estimated 60 percent of the city's population remains displaced, and there is no available affordable housing. As a matter of fact, in many parts of the city, rental costs alone have risen 40 percent in the past year. The Louisiana Recovery Authority has developed a program called "Road Home." Eventually, the program will compensate people for the loss of their homes. Unfortunately, 16 months later that money has yet to flow to the individuals whose homes were lost and destroyed. I have a feeling that many of those people in Atlanta and Houston are experiencing a better way of life, and I do not know that they will ever come back to the state of Louisiana, much less to New Orleans itself.

Next is city planning, and the question we are asked is, "Should you rebuild every part of the city again?" The city has, thus far, been unable to present a unified rebuilding plan based on sound planning principles. The result has been rebuilt haphazardly by individuals, often with one rebuilt home surrounded by blocks of destroyed and abandoned properties. We hope, though, that we have turned the corner on this challenge with the emergence of a unified planning process and the creation of a parishwide redevelopment authority to oversee the rebuilding effort. But to this date, we do not know what areas will be rebuilt or how they will be rebuilt.

There was hope immediately after Katrina that New Orleans' notoriously out-of-control crime problems had dissipated, but unfortunately, they

have returned and are exacerbated by a decimated court system that has been slow to rebound but is rebounding. The New Orleans Police Department is another group of heroes in New Orleans. What they suffered and went through was unbelievable. Those officers stayed in that city after the storm for weeks and months on end, without their families and with the

hardships. Unfortunately, you read about the few who did not do that, and all were tainted by it. I am hopeful – because I know the New Orleans Police Department and how courageous they are, and I know that our court system is beginning to reopen – that these issues will dissipate over time. Of course, when an incident does happen in New Orleans, it gets blown out of proportion

because people want to focus on the negative rather than the positive. But we are on our way. Assistance from the federal and state governments has been and will continue to be helpful.

And, of course, there are the levees. No discussion of the city's future could leave out concerns over the levee system that proved so inadequate during Katrina. We refer to it as a natural disaster. Others would say it is the worst man-made disaster. What shape is the levee system really in now? What strength of storm will the levees be able to withstand? How long will it take to build them to withstand stronger hurricanes? To be honest with you, we do not have the answers to those questions. I thank God we did not have a hurricane this year, because speaking of mental illness, you should see how people's spirits have been uplifted by the fact that we have not had another hurricane. I believe those levees, especially those that were breached, are being repaired and will be stronger than ever, but I do not know about the rest of the levee system that was never tested by this particular storm.

Last, but certainly not least, is health care. There are about 50 percent fewer hospital beds in Orleans Parish today than there were before the storm. I am pleased to say that Tulane University Hospital was the second hospital to open up in the area, and it played a major role in addressing indigent care issues and the reinvention of



Jocelyn Augustino/FEMA

the state's antiquated health care system. Still, there is an acute shortage of emergency, specialty, and, especially, mental health practitioners in the city.

After all of this, what have I learned from my experience of Katrina? Lesson number one: Never underestimate the resilience of the human spirit. I remember sitting on the helicopter making my escape from New Orleans and heading to Houston a few days after Katrina, and I thought there was no hope. I could not understand how we, Tulane University, could possibly put it back together, much less New Orleans. But along with a strong group of people in Houston, we all took a deep breath, regrouped, and began to look for ways to survive. It dawned on me three days after I was in Houston that Tulane University had been open 172 years, and I would not let it close on my watch. I saw that kind of resilience in so many people.

Lesson two is closely related, and it is this: Leadership can be found in unexpected people and places. People never know how they will respond in a crisis until the moment actually comes. Some of the people needed to take charge in the aftermath of Katrina simply could not do it. In other cases, leadership was manifested by the most unlikely of individuals at the most unlikely of times. Strength of character makes itself known, and the best you can do is throw out your organizational chart, recognize the talent around you, and give them authority. My favorite story is about our Cajuns. It turned out that our physical facilities department was all populated by Cajuns. I had been at that university nine years, and I did not know that. Those Cajuns were on campus with me after that storm, and whenever we needed anything, they found it. If we needed a boat, they found a boat. We were in 4 feet of water, and they found a boat – and not one boat but four boats. We needed food, and they found food. They taught me how to siphon gasoline out of cars. It was the spirit of these people, and hundreds of thousands of others like them, all showing leadership – one by one showing leadership – that helped us survive. I have learned that no matter where people are in the organization, if they demonstrate leadership, you give them the privilege of continuing to do it until they prove they cannot.

Lesson three is paradoxical. On the one hand, you need to be as self-reliant as possible. If Tulane had waited for the city, the state, the insurance companies, or FEMA to begin its recovery, we would still be looking at molded buildings in 4 feet of water. Because I can tell you, the insurance companies, FEMA, the city, and the state have done very little for Tulane University. What we have been able to accomplish, we have accomplished much on our own. Policy issues and political systems are well-intended, but they are not built to address urgent matters of significant magnitude when time limits and efficiency and tough decisions are demanded. At least that has been my experience in our state. So, some degree of self-sufficiency is needed. Paradoxically, you also have to know when to reach out and ask for help. In our particular case, we reached out to the higher education community. We were very selective, because when we asked for help, we wanted to get it, and it was that community that helped us.

Lesson four is a twist on the old saying “If life gives you lemons, make lemonade.” Out of every tragedy comes opportunity. I would never have wished a catastrophe like Katrina on Tulane University, but thanks to the leadership and strength of character of our board, we were able to step back, assess the situation, and make changes that, I believe, will make the university a stronger institution. I am delighted that I had a board that had the courage to make those decisions when others were not making decisions and were immobilized.

The fifth and final lesson is this: We must attend to the mental health needs of the people who have experienced these disasters. Most New Orleanians have survived Katrina and are moving on with their lives. However, they have been forever changed by this tragic event and are either consciously or unconsciously dealing with serious personal and mental issues. I see these signs even in my own behavior. It is difficult for me to speak or read about the immediate events in the aftermath of the storm. I have read no books or articles, seen no movies or news clips, and I have no desire to. I have a good case of denial, and that denial is serving me well. I have seen it in the behavior of my Tulane colleagues and in the results of a study conducted by Tulane researchers on mental health issues in our own

community. The results of that study are sad, but I am glad we did it, because now we can develop the interventions to deal with the issues that our people are facing. I see it on the faces of our young people who are coping, without much professional assistance, with what they have endured. I truly hope and pray that the work of your conference can help us and others who suffer in the future because, in the end, the power of one, and the power of the group, will ultimately determine how fast we recover and how that recovery takes shape. Our mental health will be key in our effectiveness, and everything you can do to assist us and others will be invaluable.

Because of Hurricane Katrina, New Orleans has an unprecedented opportunity to redefine

Because of Hurricane Katrina, New Orleans has an unprecedented opportunity to redefine itself for the 21st century.

itself for the 21st century. From the experience of Katrina and the struggles of the city of New Orleans to rebound, I realize there are at

least four things that define a great city. First is to have vibrant neighborhoods, with the quality of housing, schools, retail, and amenities that make an attraction for people to want to come back and to stay. Second, they need a great public education system, and that is mandatory for any city that wants to be a world-class city.

Unfortunately, prior to the storm, New Orleans had one of the worst school systems in the country. This storm has given us an unprecedented opportunity to remake that system, and I hope that it will turn around dramatically. If we cannot provide our young people with a solid education and appreciation for learning, we have no hope of breaking the cycles of poverty, crime, and hopelessness that prevail in so many of our inner cities.

Crime must be dealt with in a culture that does not tolerate or accept it. New Orleans had the unhappy distinction of leading the nation in homicides before Katrina, and I am sad to say, it has regained that distinction in the past few months. A city must have the leadership, willpower, and manpower to say, "We have zero tolerance toward crime" and to stand behind

those words. I am encouraged by what I am seeing in recent months on this particular front. I know at Tulane University, we are joining forces with the NOPD to help in any way we can. Fourth, a great city must have people willing to provide principled and courageous leadership. Despite the colorful but sometimes humorous history of Louisiana politics, the fact remains that, in the past, corruption existed at all levels. To stay in the past undeservedly taints the state and the city of New Orleans, because great strides have been made to undo this storied past.

As I travel the country, I have often been asked, "What will New Orleans be like five years from now?" I have no doubt in my mind that, five years from now, New Orleans will be a better and stronger city than it was pre-Katrina. My confidence is born out of several facts. All the things that made New Orleans such a great city – its culture, food, architecture, quirkiness, diversity, music – all of those things are still there in that great city in great abundance. Our history and traditions have defined who we are. Yet pre-Katrina, we had problems in New Orleans. I do not like to talk about them, but public education was a problem. The neighborhoods were a problem. Crime was a problem. And I have no doubt all of those issues are being attended to in a way, today, that they were not pre-Katrina. We will be better five years from now.

The question for me is not, "Will New Orleans be a better city five years from now?" It will be a better city. The question is, "Will it be the great city it has the potential to be in five years?" That is the question that needs to be answered, because out of this tragedy, there is that unprecedented opportunity. Will we, as a city, have the courage, boldness, and vision to make New Orleans a true 21st century city? Or will we go back to the old ways too quickly and miss those opportunities? I was not born and raised in New Orleans, but I am of New Orleans now. It is in my DNA, and I have one great hope for New Orleans. As long as I am at Tulane University, I will work on the hope that New Orleans continues to be one of the great cities, not only in the United States, but in the world. It deserves no less.



Rue Bourbon

Bourbon

Questions & Answers

Q Where would you say you got your strength of conviction and resolve?

A In my naïve way, I think life is made up of a series of critical incidents, events that define and shape who you are. For me, there are three things. One is that, as a youngster, I suffered from terrible learning disabilities and physical disabilities and was not able to read until I was nine years old. Therefore, all my life I had to fight to overcome those disabilities. I am the classic overachiever, who felt like if I gave up, people would run over me. The second is that I served as an Army infantry officer in the 1960s during a different war. At 22 years old, I learned what it was like to be responsible for people's lives and to grow up quickly. It was an awesome responsibility. You learn seriousness of purpose, you learn how to set objectives, and you know how to get things accomplished. Third is my faith. I happen to be Jewish, and my Jewish faith has beliefs about giving back, doing what you can for others, and education. I would say all those came to the fore when I needed them and have served me well. I have been surrounded by an extraordinary group of people as well.

Q Where did you find the money?

A Actually, our losses are \$500 million, and we have recovered \$150 million to date. So we are out of pocket \$350 million. We are in losses with all of our insurance companies because, technically, we have enough insurance to cover all of this. When it is all said and done, we will probably recover \$100 to \$150 million from FEMA. Sixteen months after the storm, we have recovered \$350,000, and that is almost criminal. We borrowed \$150 million of debt. We went into our lines of credit for about \$70 million, and then we stretched

payables for everybody else. One of the biggest challenges we have now is to make sure we get the insurance recoveries, the FEMA recoveries, but my guess is it will take two to four years to get those recoveries.

Q I am from New Orleans, and we are struggling to find education [models]. Can you set up a model for [education]?

A First let me explain a bit about New Orleans public education that could be a lesson for Atlanta. Prior to the storm, we had about 120 public schools in Orleans Parish, with 65,000 students. Today, we have 52 schools with 22,000 students, so about a third of the students are back. Of the 52 schools, 33 are charter schools. That is the largest proportion of



Questions & Answers

charter schools in a school system in America. For those charter schools that are networked and have a good charter partner, that is good news, but many independent charters are struggling. In addition, 20 schools are run either by the parish or the state. Our remounting of the school system has not been beautiful, but at least it has happened. The key will be what happens in the next year or two. At Tulane, we are trying to chronicle what is and is not working in public education. Most importantly, we try to bring in expertise from around the country to guide New Orleans and chronicle our experience so there can be lessons learned for others around the country.

This is a wholesale experiment in rebuilding a public education system. Even though we studied best practices around the United States in making our plan, nobody has tried to do what we have done. We are going to learn a lot as we rebuild our school system. We are going to make midcourse corrections and make sure we take a researcher's eye about what has and has not worked. It would be a shame for us to have done this and not used it as some type of laboratory for greater learning.

Q What was your most difficult decision?

A The most difficult decisions were around the renewal plan that, ultimately, led to about 700 people being separated from the university. That was extraordinarily painful. Some of those people were tenured faculty. We had made a decision that as we began to downsize the institution, we had one of two choices: One was to make cuts across the board, in which everybody would take a 20 percent cut, or we could be strategic and focused. We decided to take the latter approach. That really had an impact on a few of our schools. Given that everybody was going through personal trauma, all faculty who lost their jobs were given an equivalent of one year's severance or were allowed to do a teach-out at the university for a year. We tried to have as liberal a severance as we could, even though we did not have any money for the staff. The most difficult thing was to separate faculty and staff. We did not have a choice, but that was what we had to do.

PANEL I I: SCIENCE TO PRACTICE

Jane Hansen

Staff Writer, *The Atlanta Journal-Constitution*

I have been asked to speak about the 22-day series I wrote for *The Atlanta Journal-Constitution* called “Through Hell and High Water.” It is the tale of two hospitals located across the street from each other in downtown New Orleans: one public, Charity Hospital, and one private, Tulane Hospital. It is about what happened to the people who were stuck inside the week following Katrina and about the amazing helicopter rescue that was launched from the rooftop of one of Tulane’s parking garages.

What unfolded at Charity and Tulane, in my view, was a metaphor for what happened to the city of New Orleans. Those people with resources were able to get out. Those who were poor and had no resources were left behind and stranded. It is also a tale about individual heroism and transformation, not just a story of what went wrong in New Orleans but of all that went right.

What inspired me to do this story was a report I heard on CNN the week following the hurricane. That week, I suspect many of you, like me, were intensely following the incredible news coverage coming out of New Orleans and towns along the coast. But it was one report, in particular, that struck me. It was the middle of the week, two days after Katrina had made landfall, and a nurse from Charity Hospital had called in to CNN. She said her hospital had lost all its power. The generators were dead. Many of the medical procedures they needed to do, they could no longer perform. The respirators that breathed for people no longer worked. They were having to manually hand-bag ventilator-dependent patients. I am married to a doctor. I’ve been around hospitals for decades, and I thought to myself, “I do not know that this has ever happened before in our country in modern times, that a hospital has lost all its power and there are very sick people stranded inside.” Hearing that nurse pleading for help made me realize how big a catastrophe this truly was, that this was like none other.

My newspaper had never done a 22-day series. That was a first for us. But the editors felt this was such an important story that it was worth it. Even before we published the first story in our paper and on the Web, we ran a trailer to preview the series, like they do to preview a movie. Some of the voices are from interviews I taped; the two mothers and their sons, for instance, are main characters who are woven throughout the series. The frantic doctor you will [see] toward the end, shouting at the cameraman on the Tulane rooftop, is Dr. Ben DuBoisblanc, also a main character.

The Atlanta Journal-Constitution Trailer

“It was very intense. I did not know whether I was gonna live or I was gonna die. People was just fighting. This is what I kept on seeing, the Lord have mercy. Lord have mercy.”

“We do not have electricity. We do not have water. You know, we cannot run labs. We cannot take X-rays. I mean, we are basically back to primitive medicine.”

“We have no showers or toilets at all. We are just asking, begging for help.”

“We’d been waiting there for hours trying to get them out. We have been crying for help from anybody who will listen. We have a need. Two of them have already died here on this ramp waiting to get out, in this very spot.”

I am not a psychologist, and, unlike most of you, I do not work in the mental health field, but as a journalist, I had the privilege of being a sounding board for many people whose lives were transformed by Katrina. I learned that several weeks after a catastrophe such as this may be the ideal time to interview people. Most of the more than 50 people I interviewed still had incredible recall of details. Yet it was far enough out that they wanted to talk. Many told me it was cathartic for them to tell me, a stranger, everything they had gone through and felt.

One of the themes of this story was that those who survived Katrina were forever changed by their experience. Here is how Dr. Ban, director of Charity's medical intensive care unit, explained to me how he had been affected by what happened to him and his patients while they were stranded in the hospital. We are going to play one of the audio clips that we ran on our Web site as we published the daily chapters. Just to give you the context, his wife of 20-odd years also had left him recently.

Audio Clip of Dr. Ban

“Except for the dissolution of my marriage, which we briefly discussed, this is probably singularly the most, most phenomenal experience I’ve had as an individual, as a human being. So you, it is not something you could compartmentalize and tuck away very easily. I do not have post-traumatic stress disorder. I feel I’ve never felt more alive. I feel like it has awakened something inside of me. I have post-traumatic elation disorder. I am just elated by this awakening. And I think you can tell that I still feel very emotional about this experience, but it is not bad. It is incredibly humbling. It was so easy for me

as a techno-geek who works in a very technologically driven environment to be enamored with the technology, and the patients become diagnoses. When we lost the technology, all of a sudden, it was as though the patient emerged, the human being.”

As it did to others trapped in New Orleans, Hurricane Katrina took its toll on those who labored to save lives. Both hospitals had exhaustive emergency preparedness plans, but it was never in either of their plans to evacuate an entire hospital. It was only when the levees broke and they lost their backup emergency power that evacuation became a necessity. I think the public falsely assumes that something like this does not affect doctors and nurses the way it does others. After all, they deal daily with life-and-death situations. Yet, even for them, Katrina was so much more. For their sake and the sake of other medical professionals, rescuers, and first responders, I hope that you who are the experts will develop plans to safeguard their mental health as well as that of all other victims.



Michael Rieger/FEMA

David Satcher, M.D.

Director of the Center of Excellence for Health Disparities; Poussaint/Satcher/Cosby Chair in Mental Health, Morehouse School of Medicine

About a year ago, the Morehouse School of Medicine received funding from the Department of Health and Human Services to develop a regional coordinating center for rebuilding the health infrastructure in the post-Katrina area. Even though I am the principal investigator of that project, most of the leading work has been done by Drs. Dominic Mack and Tom Kim, especially in the area of telepsychiatry.

Let me back up a bit. As former surgeon general and the person who had the opportunity to release the first Surgeon General's Report on Mental Health, I find much of what is happening now quite interesting as well as challenging. In that first report, we defined mental health as "the successful performance of mental functions, such that one could be productive in his or her day-to-day activities and could develop and maintain positive relationships with other people." We also said that mental health was "the ability to adapt to change in one's environment and to deal with adversity." I was in office, of course, during the time of the Oklahoma City Federal Building bombing and worked closely with the fire

Our commitment was to build in such a way that the system was replicable and scaleable and could be modeled in other communities.

department and police officers for a year after that. In Oklahoma City, the firefighters had gone through a training program before the bombing of the federal building and were much better prepared than the police. We saw dramatic differences in the following year in terms of how firefighters were able to cope with their experiences, compared with police officers. So the idea of training to prepare for disasters is very important.

I also was involved when our embassies were bombed in Kenya. President Clinton asked me to lead a group of physicians to Nairobi and Tanzania to see if we could be helpful following the bombing. We were not able to offer much help because in Nairobi, many of the people died suddenly. What was clear was that there was no emergency preparedness system. With the help of

the Centers for Disease Control, we were able to develop one over a period of time. On Sept. 11, 2001, my last year in office, there was the experience of New York City and the role of the commission core in dealing with that and with what happened to some of the workers afterward – those who were digging for body parts, for example. In terms of their mental health, they were having difficulty even admitting they had problems and coming to the clinics complaining of everything but depression and anxiety.

There is a pattern here. There are mental health consequences of natural and man-made disasters, whether those disasters are related to a) worsening social problems and what we are seeing on violent streets such as Chicago, b) the civil unrest taking place in many places throughout the world, and c) refugee populations, whether in an earthquake, such as the tsunami and the resulting issues, or Katrina. We are seeing growing challenges for mental health, and aging is part of the challenge we are facing.

We proposed that we would do several things in the process of helping to rebuild the public health infrastructure in the post-Katrina area. Focusing on lower Alabama, Mississippi, and Louisiana – with the main focus in New Orleans – we had six aims.

The first aim was to establish a communication network among expert centers, which are centers of excellence on health disparities throughout the southeast and south central United States, to connect those to front-line community health centers and primary care practices. Part of the reason we were funded to do this was that we were a center of excellence on health disparities and the only one that had reached out reasonably. We had developed a network of community health centers throughout the Southeast, and we had even carried out some projects like the asthma projects that we published. We were given the responsibility of coordinating the efforts of all of these centers of excellence – University of Alabama, Medical

University of South Carolina, University of Mississippi, and others – in response to the aftermath of the Katrina impact.

The second specific aim was to identify health needs by utilizing advanced community-based screening and ongoing surveillance systems. You know the bedrock of public health is surveillance. That is how we answer the question, “What is the problem?” We were committed to working to develop surveillance systems. Some of those surveillance systems consist of screening programs that take place in various communities – and we have been involved with those in New Orleans as well as throughout the Southeast – but also there are other surveillance systems that are just as important. The Kaiser Family Foundation has been monitoring the plight of the evacuees. I serve on the board of the Kaiser Family Foundation, and it has been interesting to monitor the health and experiences of evacuees by following the reports developed by our team.

Our third specific aim was to work toward the development of a balanced community health system. By that, we meant a system that included health promotion, disease prevention, early detection, and universal access to care. The public health infrastructure in these areas was very inadequate prior to Katrina, so we were not talking about rebuilding the health infrastructure as it was. We were talking about building it as we thought it should be. We defined that as a balanced community health system. We know that Louisiana had one of the highest rates of uninsured of any state in the union, 21 percent of the population, compared to 16 percent for the nation as a whole. We know that among the evacuees, 52 percent were uninsured. We know about the inadequacies of the system in lower Alabama or lower Mississippi, for example, with no readily available mental health professionals. Our commitment was not only to rebuild but to build in

such a way that the system was replicable and scaleable and could be modeled in other communities.

The fourth component was to develop a state-wide export center for the state of Louisiana. Louisiana has some outstanding academic health centers, but it is one of the few states in the country that did not have a center of excellence on health disparities, despite all of the disparities in health in Louisiana among the different populations, such as African-Americans having a tremendously increased risk of diabetes, hypertension, and other problems.

Another commitment was to develop an electronic health records system among primary care practices and community health centers. Unfortunately, medicine tends to be far behind other areas when it comes to use of technology. I know it has something to do with the way we value our relationships with patients, but I think it is becoming increasingly clear – and seeing recently the Institute of Medicine report – that there are so many ways we can improve quality of care by using better technology. Trying to implement an electronic health records system in these areas was so critical, because so many of the patients who experienced Hurricane Katrina,



Win Henderson/FEMA

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,

We have been able to establish electronic health record systems in several areas.

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

Post-trauma, people may not want to talk about what happened. People want concrete services.



Robert Kaufmann/FEMA

significant increase in verbal arguments, which is somewhat expected post-trauma, as well as physical fights, disruptive behavior, and a great deal of parental conflict. Also, in the trailer parks, we have been seeing substance abuse and domestic violence, which are much expected post-trauma, especially given the conditions under which these people are living.

The perceived needs of the school-based health center staff also were interesting. They talked about how important it would be for them to have more mental health professionals, and we talked to them about why that was. They said they were tired and overwhelmed and wondered how it is that you are supposed to help other people when you were so impacted yourself. People wanted to take off a week or two, and they would say to me, "Come do my work. Just come help me out for a couple weeks, and then I will be back on my feet."

School-based health centers can be important – I say they are essential – in meeting the needs of students post-trauma. An important part of recovery is to establish a sense of normalcy. That is how we foster resiliency. It is what we need to do, especially with children who need structure and safety and need to know that those who are in charge of their well-being are OK and can take care of them. I would advocate for school-based health centers as an essential aspect of preparedness in terms of handling students' difficulties post-trauma. Staff require sufficient resources and support in addition to training.

I wanted to share the specifics of our school-based health center training. We have trained about 300 providers since we formally began in September 2006. We have about 250 people signed up for training in six different cities in Louisiana, including not only school-based health center staff but also clinicians from the Office of Mental Health. These professionals will be able to network and to connect with one another, which can be so meaningful post-trauma.

I also want to focus on the needs of kids. It is essential to understand the pre-trauma issues, conditions, and needs and target those right away. We need to be mindful of the fact that those who have a history of trauma will be more likely to develop PTSD or some type of mental disorder or to be more vulnerable for additional

stress. Prior to any type of trauma, it is important to build resiliency as an essential aspect of preparedness.

We can do much to prepare. We need to take logistics such as food and water into account. However, if we do not increase and encourage resiliency, we will have people who will suffer the mental health consequences of trauma. Care for the caregivers, providers as well as parents, is important, including taking care of their basic needs, such as medical needs, but also helping them with housing, jobs, etc.

I believe there needs to be more research on how is it that we can actually encourage post-traumatic growth, because it does happen to people. In fact, it is one of the last stages of trauma treatment, integration of the trauma into one's traumatic memory or traumatic narrative. There are ways in which people can feel as though what happened to them was unfortunate, but they were able to learn some lessons and have decided to make significant changes in their lives. Of course, this requires empowerment, so we need to work on how to help people feel empowered.

Have lessons been learned? I am not sure about that. I think many of us spent a lot of time post-9/11 talking about what needed to happen and what was important to take care of children and families. But not a lot had been learned, so I believe we need to be active in implementing some of the plans that we talk about.

Going back to the idea of the mental health infrastructure, I believe it is important to provide incentives for mental health professionals of diverse backgrounds to do the kind of work that needs to happen. I believe that there is a lot many of us can do; however, an understanding of the culture and community is essential. It is impossible for a person to learn it within two or three months working in one specific community, so we need to rely on locals to help us do our work.

Further, keep compassion fatigue in mind. It does happen. Many people do get burned out, and we need to care for them. We need laws that protect people and allow for services for those who care for others. That is an essential part of disaster preparedness and recovery.

Dennis Derr, Ed.D.

Senior Professional in Human Resources; Partner, Signature Resources

We have been talking a good deal about aspects of community and children's health, but I am going to talk about the employer side. The U.S. Postal Service has had an employee assistance program (EAP) since 1993, one of the oldest existing EAPs in the country. It also happens to be one of the largest, because it serves more than 800,000 employees in every town, city, borough, and village you can think of in this country.

To give you some context about that program, I am not an employee of the U.S. Postal Service. Instead, I work for an organization called Federal Occupational Health as the project officer. I am a contracted executive, and we oversee and manage the program. Clinical services are provided through Magellan Behavioral Health under contract to Federal Occupational Health.

Most EAPs now are being provided through contracts with behavioral health organizations, and they vary in scope and size and use different models. This program is unique in that it has embedded more than 130 Magellan EAP professionals into postal facilities. That is where those professionals go to work every day, including in call centers, so people become one with the organization.

I also want to talk about what is important to succeed with the U.S. Postal Service. They tell us you only need to remember three items if you are going to be successful – operations, operations, operations. That is important when you are dealing with how an employer looks at mental health and looks at the impact of a disaster. For the Postal Service, operations are critical because you want your mail. Think about

The Culture

"Neither rain, snow, sleet or hail nor the dark of night will keep us from our appointed rounds."

Delivery of mail is considered a sign of normalcy in disrupted communities.



those days that the mail does not come. How many times do you go out to that mailbox and check? It is an important part of our lives. So the Postal Service also is focused on what it needs to operate. That is no different from the focus of any organization that has employees.

We all know the Postal Service motto that “neither rain, snow, sleet, hail, or dark of night

Delivery of mail is considered a sign of normalcy in disrupted communities.

will keep us from our appointed rounds.” This is part of the postal culture and is a mission. When I joined this program in 2000, I

had no concept of what went on in the Postal Service. The employees really believe and live by this mission, to deliver that mail to you. I know there are days it does not come to you, but when you are handling a billion pieces of mail a day – actually more than that at times – a 1 percent failure rate is a big number. Not many of us can

operate at 99 percent efficiency on a regular basis. Delivery of mail is considered a part of normalcy – that return to normalcy we all talk about – that is an important sign of community mental health. In disrupted communities, mail delivery is a sign that everything is going to be OK, that normalcy is returning.

Due to our government’s policies, the only way many people can get their Social Security check is through the mail. We have heard stories about people who would stand at their mailbox, their houses destroyed, because they knew the letter carrier would come and deliver that mail. So mail delivery is part of our own culture, not just the culture of the employees of the Postal Service.

When Hurricane Katrina hit, the Postal Service had more than 7,000 employees who evacuated with their families to as far away as Maine. Seven thousand employees were gone. And because Katrina and Rita were almost back



to back, the Postal Service had employees who evacuated and felt safe in Houston, only to evacuate again. This was a major disruption for an employer who is committed to operations.

More than 800 postal facilities in the Gulf Coast were damaged, some beyond repair. I have not heard a final cost, but I have heard numbers of \$200 million to \$2 billion.

Within 48 hours, post-storm mail delivery returned in a limited fashion. Some facilities were set up in parking lots and shopping malls by people who evacuated, came back, and were living in damaged facilities. But they had a job and a commitment to the mission. We talked about self-efficacy as a part of the importance of recovery, and having a job is critical. Having a job that serves a mission for the community and coming back to that job are critical. We saw people delivering mail in the midst of chaos. In fact, often FEMA, particularly in the Louisiana and some of the rural Gulf Coast areas, relied on letter carriers to drive the routes, because they would know who was there and who was not. We had letter carriers who identified people trapped in their homes.

What was our EAP response? It is important to understand that the U.S. Postal Service, at least during my tenure, has had the unfortunate experience of dealing with two major disasters prior to this hurricane. On 9/11, the Church Street postal station in New York City was destroyed when the towers fell, so the Postal Service had employees who were impacted by that. And then when you think what happened in October of that same year with anthrax, the Postal Service was the only organization to lose two employees to death as a result of a bioterrorism attack. So we in the EAP have learned from and have had experience dealing with major disasters.

Unfortunately, we have had to apply those lessons to once-in-a-lifetime hurricanes. Within 48 hours, the EAP had dispersed critical response staff to the impacted sites in the Gulf region. We followed the weather. I almost feel like I should have a degree in meteorology because we would track these storms and think, "Who can we deploy? What can we get out there? How can we have them working?" We deployed people, using a construct of psychological first aid response, because the focus is on operations. You cannot

pull people aside and do a traditional Mitchell model critical incident debriefing such as, "Let's talk about what you saw, what you heard, and try and normalize it." We have to say, "Are they safe? What do they need to be safe? What does the organization need to be safe?"

We also did on-site organizational coaching. Our professional mental health staff went out to a facility that had been operating in a parking lot where people had been in the same clothes for two or three days. They wandered and they coached because everybody was under stress. The customers were complaining, "Why don't you have my mail? Why is it being held in Houston? I am here in Mississippi!" They worked that issue to keep all of it safe and calm, to support, to tell people to take a break. It is not about pathologizing or diagnosing. It is about supporting operations. You do get clinical interventions because people [feel] that the counselor is OK, and say, "I need to talk to you." The staff provided some short-term, brief intervention counseling, which is what EAPs are supposed to do, to help that person reframe or return to a level of productivity that is important.

With 7,000 employees scattered to the wind, the Postal Service set up an 800 number for employees to identify themselves and to call in with their evacuated location. In many cases, the Postal Service had no idea where people were, what their work capacity was, or whether they were willing to work. We linked that number into the Magellan Service Center that was dedicated to the Postal Service in St. Louis, because the Postal Service needed to hear from these people and know where they were. Also, they might have needed services where they were. The EAP also created employee resource centers in the main evacuation spots of Houston, Baton Rouge, and Mobile, Ala., to service the evacuees. We had our staff set up there where they could gather information from FEMA, Red Cross, other agencies, and shelters to be able to be a resource center to employees. They came back to work with stories such as, "I do not know where my grandmother is. She was evacuated. I do not know what shelter. Where do I get the forms?" These employees were working and could not take off time to stand in a long Red Cross line. The Postal Service in Mississippi actually got managers trained in the FEMA forms and in

Red Cross [forms] and had the managers come to the facilities and help people fill out the forms. That was part of that normalcy, getting that done while working to have money and benefits.

As the human resources staff in some of the large evacuation cities started calling employees and asking if they were ready to come back to work or knew what they would like to do, the

Psychological first aid, combined with organizational coaching, is key to helping organizations return to a level of productivity, and that is key to the community.

employees started telling their stories. It became a burden on the HR people to continue to hear these stories, so the EAP staff took over the responsibility of making those calls. It provided a wonderful intervention opportunity. Mental health professionals were listening to the stories, and that was helpful for the employees. We could, in a sense, do an EAP assessment over the phone and determine what was needed – not just for the person we were talking with, because sometimes it was the spouse rather than the employee – and help them identify and connect to resources. We also could provide feedback that said where people were and what their needs were. My role, sitting in Washington, D.C., was to work with postal executives and the unions and let them know what we had learned. As a result, the unions and the Postal Service agreed under a memorandum of understanding to allow postal employees to work wherever they were. All an employee had to do was go to the nearest postal facility and identify themselves as a postal employee, and they could start work that day. That was important in terms of their personal mental health: I have a job, I have benefits, and I can go forward.

We were able to both take in and share critical information and insight into employee struggles. That is a change from what a number of mental health professionals thought we should be doing, because we in the field get caught up unnecessarily in confidentiality. It is a beautiful wall to hide behind. My EAP staff could give me themes – not names, but themes and stories – and I could take those to headquarters and sit down with people like Jack Potter, the postmaster general, and say, “Jack, one on one, here is what you’ve got. Here is what you need to be looking

at.” I could sit down with leaders of the American Postal Workers Union and say, “This is what I told Jack. This is real. This is what is happening.”

They began to focus on their people, the people’s needs, and the mission to the community. We realized that the only way you can succeed in the mission of the community of mail and in helping people feel a sense of normalcy is to take care of your people. We had to push Magellan, had to push them that this was not a violation of the Health Insurance Portability and Accountability Act. It was important that we pushed that this was not a violation of confidentiality. We need to hear those themes and stories because that is what impacts the organization going forward.

We also embedded behavioral health experts from our team with the regional operations and emergency logistics staff, so that we had a behavioral health person and a mental health professional sitting with people and making decisions about operations and logistics. They would turn to them and say, “How do you think that is going to impact the psychological well-being of the employees?” We had to do a number of things. We had to encourage allowing times for grieving and for cultural differences. The Postal Service is a diverse organization. For example, some had Cajun traditions, and my staff were saying, “This is what you have to do.” Culture and relationships all play a role. I was embedded with some of my headquarters staff, providing feedback every day about how many facilities we had visited, how many people we touched, what we were hearing, what we were sensing, and what was happening.

In the end, more than 500 evacuees took postal positions away from the impact zone at least temporarily. Sometimes there was nothing to come back to. There are delivery routes that are completely gone and have disappeared. There are stations that are never going to reopen. There are areas that may not be populated for years. People had to do something, so the opportunity to have a place to work where they evacuated was important.

Now, we see higher utilization of the EAP by the evacuees who did not return home than by those who did. Part of that is the complexity of moving. Moving is stressful enough as it is.

Moving, losing everything you own, and having to start over in that situation are not easy, even when you are with family.

We also have EAP staff who act as key consultative experts with the Postal Emergency Planning Teams. As a result of what we have learned, unfortunately, between 9/11, anthrax, and the hurricanes, EAPs now have an active part in the emergency planning process. Even if there is a pandemic and you are in a quarantined area, it is likely your mail is going to be delivered. But what is the psychological impact of having areas cordoned off in a bioterrorism event and having postal employees go into that area to deliver mail? Psychologically, we ask what is it going to be like to go into a quarantined area and to be able to come back out? How are you going to be treated? Are you going to be seen as one who has been exposed?

We are seeing EAP utilization going up regarding life, stress, substance misuse, and family issues. We have created and are facilitating information groups in the impacted areas. People are seeking information, and they want to find out, "How did you get Allstate to give you your policy payment? What did they do?" It is an important part of mental health that, in the

workplace, people can gather and have facilitated discussions to find out what worked and what did not and to understand that they are not alone. When you get rejected by the insurance company, you feel alone. But when everybody else is rejected, too, you have a common bond. That can energize and support you going forward.

We have the ability to learn a number of lessons, but we do not always apply them, so we should focus on what can we apply. Psychological first aid, combined with organizational coaching, is key to helping organizations return to a level of productivity, and that is key to the community.

Another lesson learned is that although psychological symptoms exist in evacuees post-event, their first priority is creating some sense of normalcy in their lives. I have heard over and over again that they do not want to be diagnosed. They say, "Do not diagnose me. Yes, I am stressed, and I am more stressed than you, but this is my new normal."

Psychological and health resources continue to be depleted, and previous levels of care cannot be assumed. Even if you have benefits, you have no place to go with the benefits, so you do not have benefits. We have had to help the organization rethink that application.

Questions & Answers

Q Kim Tob reported in 2002 in the *Archives of Pediatrics and Adolescent Medicine*: A hurricane hit Kauai. He had four classroom sessions for the children in Kauai that focused on safety and happiness, loss, mobilization of competence, and issues of anger. He randomized control, incorporated all of the bells and whistles of good science, and none of those kids had any symptoms of stress or PTSD. Is anyone doing that for the children in New Orleans in a systemic way, since it is an evidence-based intervention?

A Paula Madrid: Post-9/11, I developed a cope and resiliency curriculum, which involved a 17-week module program that targets some of the issues that you brought up. It addresses emotional education, coping, safety, problem-solving, and some other topics. We have found it to be effective. However, I think things are tricky in that we have different levels of pre-existing trauma present in the children who we were able to apply this intervention to. It was mainly implemented in poor, underserved areas, such as East Harlem, Harlem, and Washington Heights. We are now in the process of doing the same work in Mississippi and Baton Rouge. Our hope is to do as much evaluation as we can, but I have to say that the priority is to implement the work right away. We cannot wait to set up a protocol at this point. We would like to begin the evaluation process and replicate it. We have had to adapt certain things because of the importance of the culture. Also we have involved parents a great deal, as well as teachers, when available.

A Dennis Derr: At the Postal Service, we have single-page talk sheets that are topic-specific, such as how to talk to your children about hurricanes or evacuation. We send those out to local postal facilities, and they distribute them to the employees. I do not have any data to say how well they are used, but I know they are expected. Sometimes even before my staff gets a chance to send out a sheet, we get calls saying, "Where are those talk sheets?" Anything you can do in preparation, as much as we can be prepared, is important.

A David Satcher: I do not think there has ever been an occasion when so many children were evacuated from their stable communities and homes and schools to other places. These children are now all over Atlanta, Houston, Baton Rouge, and so on. Whatever we can do to try to strengthen these children to function in their new location is important, because the children who are around them do not have the background to appreciate the needs of these children.

Q In the spirit of thinking through protective measures that we can put in place for future disasters, such as a severe pandemic influenza, in which we are likely to see overwhelmed hospitals, I wondered if the panelists could comment on the benefit of publicly vetted guidelines with scientific, ethical, and legal frameworks that can help support the difficult triage decisions that clinicians are going to have to make. In the context of pandemic flu, they will have to let some people in and discharge some people early to make room for people who are critically ill. Some Gulf Coast clinicians are facing murder charges and accusations of having euthanized patients, of not having an infrastructure to back them up, and of having to work in conditions of 100-degree weather with no food and water and with no sense of societal absolution or guidance regarding the disgraceful degradation of health care in extraordinary circumstances. Could the panelists comment on the benefits of having more public conversations about the difficult triage decisions that communities, not just clinicians but communities as a whole, will have to be making in a severe pandemic flu setting?

A David Satcher: It is critical that we have that kind of communication. There are very difficult decisions to make in a pandemic situation. Obviously, you have to make decisions about the people who are at the greatest risk – the elderly, children, the disabled – but also about the people who need to be available to be on the front line and why they should be prioritized in a certain intervention. Not only do we have so many people in our population who do not have access to the

Questions & Answers

system, but they do not trust the system. The more we can have public discussions about the strategy, the better, because this country is going to face a major problem with people who just do not trust a system that does not “include them.” It has been one of the real shames of our system that so many people are left out. So when we face epidemics, or any kind of tragedies, we are dealing with a large population of people who do not trust this system because they feel that they have not been included in stable times. Therefore, in times of difficulty, they are not going to trust decisions that leave them out. The more we can educate, the more we can communicate about preparing for epidemics and things like that, the better for everybody.

A Paula Madrid: That speaks to the Australian Defence Force Terror Management. What do we do when something happens, and how can we prepare to manage terror, extreme panic, and fear? A big part of it is trust, so how can we get people to trust the public messages? Furthermore, what can

we truly do so that risk communication targets and reaches those who need it, which is a tremendous problem right now.

Q There remain 13,000 families in group trailer sites across the state of Louisiana and more than 300,000 people outside of the state (125,000 in Houston alone) who are dealing with all of the issues that the people who we speak of in New Orleans are dealing with. When we identify measures that have some effectiveness in meeting the needs of people, families, and children, how do you replicate or ensure some consistency in approaches when you are addressing such a diaspora of people?

A David Satcher: Some of your comments were probably more important than mine about how you deal with individuals and families and how you try to maintain a certain amount of stability and normalcy in people’s lives. There are lessons from the postal workers’ experience. But with



Marvin Nauman/FEMA

Questions & Answers

children, security and normalcy are so important, and the adults in their lives are so important when they experience this kind of catastrophe, especially when they are uprooted from their homes, communities, and schools. Somebody has got to try to see that we maintain as much normalcy in their lives as possible but also help prepare them for the fact that they have undergone such a tremendous transition from stability to instability.

A Dennis Derr: Within the Postal Service, through the EAP, we were trying to engage in those conversations, engage in those best practices, to talk about things. I live in the Washington, D.C., area, which I like to call the zone of denial. There is little desire to speak the truth about some of the things that keep us up at night, and it is important that we

have that dialogue in whatever way. We have a training program called “Be Prepared, Not Scared” that focuses on behaviors of preparation rather than behaviors of fear. As silly as it was when the Department of Homeland Security suggested we buy duct tape and plastic for our windows, there is something to be said about the importance of being prepared. And now we are talking about a pandemic. We have some brochures we are sending out about making sure you have water. Start thinking about what will not be available in a pandemic. It is the same with hurricanes. We are trying to put it all into that same context of being prepared. If you feel prepared, you are less likely to panic and to run out in fear. My sense is that until we, as a nation, can begin to have an open dialogue and stop operating from fear, we are in trouble, because right now, we are a culture of fear.

PANEL III: POLICY

Bill Lichtenstein, President

Lichtenstein Creative Media

The charge of this panel is to pull together what we have heard over the past two days about the personal stories – about the science and the practice of dealing with response to disaster – and to deliver, in a clear way, an understanding of the relevant policies that can help minimize the impact of future disasters on the mental health of those affected. It is the intention of the panel and its presenters to focus on specific policy approaches to disaster response, to focus on the essential elements of early intervention in the wake of disasters, to operationalize response from a mental health perspective, and to promote the kinds of policies that would facilitate long-term care and recovery.

It has seemed to me that throughout history, people have had to respond to various types of disasters and come up with various types of policy responses. More often than not, constructive change was the result. I searched the Web for the word “Titanic” and found that there was an official British inquiry into the oceanic disaster. It was called the Lord Mercy Report, and it made 24 recommendations with a view toward promoting the safety of vessels and people at sea. Among the most important were life boats for everybody. On the Titanic, there were 1,100 seats, and there were 2,200 passengers, so only 50 percent were covered by the lifeboats. The report recommended “proper staffing and training of boat crews and frequent drills and, perhaps most importantly, prudent navigation in the vicinity of ice.” It seems to have worked. There has not been another disaster as large on the open seas.

Following another major disaster in Boston in Coconut Grove – which was the largest and deadliest nightclub fire in 1942, killing 492 people and injuring hundreds of others – major changes were made to the fire codes and improvements in the treatment of burn victims, not only in Boston but across the nation.

These are examples of changes in the wake of disasters that have had a positive, lifesaving impact. Many of us have been hopeful that the

same kinds of targeted changes and policy implementations would happen in the area of mental health, starting in the wake of the Sept. 11 attacks. As a nation, even while dealing with the immediate trauma of the terrorist attacks, we were looking for changes to be made to protect Americans and to ensure that mental health would be at the table for the next disaster. It leads to the question, “Why now, five years later, has it been so difficult to implement and effectuate changes from a policy perspective?”

It may be that, unlike fire or ocean travel preparedness, every disaster is different, whether it is terrorist, man-made, or natural. Consider that 9/11 was like a car accident. It happened in a flash, in an instant. Then it resonated for months. Hurricane Katrina, on the other hand, was a disaster that played out for days on

television, making it, arguably, the first televised national disaster. It acquainted

Hurricane Katrina, on the other hand, was a disaster that played out for days on television, making it, arguably, the first televised national disaster.

Americans with the nature of catastrophic disaster in the same way that Vietnam, as the first televised war, brought the realities of combat into America’s living rooms. In 9/11 and Katrina, the environments and populations were very different, even though the mental health impacts had many similarities.

The nature of disasters – not knowing when, where, or what might hit next – makes writing a single policy playbook difficult. What is important is that in the immediate wake of a disaster, there is a response to the core needs dealing with safety, calm, connectedness, self-efficacy, and hope as well as with triage, volunteer first responders, and hotlines. Then, going forward, there are the policies for the ongoing care of those in need.

Anthony Speier, Ph.D.

Director, Disaster Mental Health, Louisiana Office of Mental Health

I want to provide you with four sets of information: an executive summary and then three portions of information. What is emergency response? What did we do in Louisiana? What have we done since? We have not been sitting around waiting for somebody to tell us how to fix it. We have been very proactive. What is the Crisis Counseling Program? What have we done with it? It is federally funded. Then, based on this body of experience, what are some things we as a nation need to think about as we prepare for another catastrophic event?

Now I would like to share with you a “thank you” to everybody in this country and internationally who have helped us in Louisiana. The help we have received from all of our colleagues and all of our fellow citizens has been dramatic and essential.

Secondly, the Uniformed Public Health Service never seems to get any thanks. They roll up their sleeves and go to work, and they were great clinical assistants to us throughout this storm.

Thirdly, this disaster is not over. It is not an event in our past that we have observed and from which we are recovering. It is real. It is live. It is today. Disaster events are local events and must be managed locally, not federally.

Let me take you through the emergency preparedness status. The Louisiana Department of Health and Hospitals is our umbrella agency, and the health agency and the state were tasked with the responsibility for Emergency Support Function 8 (ESF8) in the state. We have all 12,000 of our employees on a call-out registry. The Office of Mental Health works with special-needs shelters. We have trained more than 4,000 people in how to respond in various settings. In May [2005], we held a conference, building a cadre of 350 to 400 mental health professionals, both public and private, around how to respond to mass trauma. We had just finished Hurricane Pam, which was a massive drill on the evacuation of 350,000 people from New Orleans the week of the storm. We also planned to put in place SARBOs and T-MOSAs. Those are not new

drinks for Mardi Gras. SARBO is “search and rescue staging area.” It was, literally, the middle of I-10 and the causeway where people were being dropped off by helicopter or by ambulances. T-MOSAs were sites at the sports arena, Louisiana State University, and the airport in New Orleans that were turned into massive field hospitals.

The weekend before Katrina hit, Aug. 25-28, we were taking the storm seriously. We knew it was going to be bad, but it was not catastrophic at that point, and we ran our normal operations. As you put a policy in place, as you mobilize resources, you have to put behavioral health staff in the operations center, mobilize staff to be able to evacuate hospitals, and staff special needs shelters. We knew from past experience to get our two hospitals out of the area by evacuating 48 hours before the event. The whole time frame of disaster response has changed. We try to work through the denial and move time frames back farther and farther so you can get people to safety. The state runs special needs shelters for people who cannot exist in a general shelter because they need a caregiver because of a health condition.

The storm happened, and we were asked to mobilize staff to the state health command center, SARBO, etc. People in all kinds of medical need were being dropped off by the thousands. We had all kinds of things that have been documented in the press going on there, but that kind of location will emerge in any city following a mass evacuation event. In those early days, it was the state of Louisiana’s resources, rather than federal resources, that were there. In the evacuation of Charity Hospital, helicopter pilots would not take people with a mental illness. All those evacuation plans were for everybody else. We had to use boats and school buses for people with mental illnesses, so you always have to have a second plan in place.

Another thing we had to keep in mind was continuity of operations. You have got to keep regular businesses and services going with a limited work force.

Since the storm, in this current disaster season, we have had to put emergency preparedness coordinators in each of our regions and facilities that are not “other duties as assigned.” Those in government know about that designation. This has to be a real position with at least 20-hour, preferably 40-hour, a week responsibilities.

We now are moving all the planning down to the clinic levels and out into our housing locations, and the idea here is to make plans real by practicing them constantly. We have done mock drills for major hurricane evacuation sheltering as well as lower-level storms, and now we are going to work on moving staff and clients from other acute units in other hospitals into our facilities.

People have talked about staying at the table, about working with the Louisiana Hospital Association and private hospitals so that all kinds of new options become available. We were struggling with how to open another 20 beds for a medical-level shelter. If we added one or two beds at 10 or 20 other hospitals, we could get the same bed capacity. We cannot make that kind of flexible plan if we are not working collectively with the public and private sectors.

One last point is the importance of a national incident management system and having a behavioral health function established – not a mental health function, but a behavioral health function that relates directly to the help desk.

Our crisis counseling program is a federally funded program. We call it Louisiana Spirit. We use the term “spirit,” dubbing on the concept of resilience.

We have spent about \$20 million on an immediate services program, which is a 60-day program that we experienced for a year due to part of the process of getting the additional grant. We now have approximately \$35 million for the regular services program, which will last nine months, and another \$4.3 million on top of that for the Rita experience.

Basically, we used six providers across the state, so using local providers and local communities allows you to have a much more culturally competent work force. It also helps you deal with issues of sustainability. A main thing is to have a

program that is local in design and reaches out to the whole community. Everyone was affected, and continues to be, by the storm.

The basic heuristic is a program in which you use lower-cost models of providing information to reach the greatest numbers of people for referral for treatment. This is not a treatment program, so the existing infrastructure, foundations, or other kinds of resources have to pick that up.

With schools, we have to integrate what we do and what mental health does with the existing infrastructure.

You cannot have too many decision-makers making the same decision over and over. My worn, but true, example is about the T-shirts that our outreach workers wear. The decision about whether we should have T-shirts and how many we should have has been made by the local provider, by the state, by FEMA locally, by FEMA in Washington, and by the Substance Abuse and Mental Health Services Administration (SAMHSA) in Washington. Then we had to appeal it because [they] only wanted to give us 500 instead of 1,000, so everybody had to make that same decision again. Do you know how expensive these T-shirts have gotten?

One important thing policywise is the behavioral health mitigation funds. There is no such thing in FEMA right now for behavioral health preparedness. Next is preparing action request forms. That is something everybody can



do. Ninety-nine percent of our staff has received all four National Incident Management System trainings. I urge you to do that. Use your training as an all-hazards approach, not just for natural disasters, and establish and maintain a volunteer cadre. People have talked the importance of practicing and of having media shelf kits. These are all things you can do right now. You do not need any national policy change to do these things.

Rather than having such a redundant granting process, states could have federal disaster response plans or emergency response plans pre-certified with a basic plan, a basic structure of how they would respond. Those plans could be updated, once an incident occurred, every six

months. Those plans would focus on indicators of both individual and community recovery and would specify the recovery strategy.

I think we, as a nation, need to spend some time defining a disaster event vs. a catastrophic event. The basic difference for us is that there is no infrastructure, nothing to build upon.

These, then, are the four things a state really needs. We need transparency in the support we get. We need answers. Rather than maybes, we need “yes” or “no” responses. We need a macro level instead of a micro level of guidance and support. And, we need access to content-knowledge experts. Those four things can be applied in a number of ways.

Craig Fugate

Director, Florida Division of Emergency Management

How many people here have a disaster plan? How many people have a working flashlight next to your bed? Unfortunately, you are not representative of many Floridians, because we know about 60 percent of them can identify a behavior that suggests that they are prepared, that they have a plan. When we talk about dealing with hurricanes, the National Hurricane Center has just a few minutes to deliver a forecast. Regardless of the colored warning lights that Homeland Security uses, there is no real way to indicate when the next terrorist event will occur. Most disasters will not occur with warning. And at that point, you are in response. Most people look at response as a government function, a government solution in which everything is going to work. If that is the point where you first start thinking about how you are going to serve your citizens, you automatically can make this assumption – you are going to fail. The outcome is predetermined. If you did not have an effective system and team to deal with the challenges, you are done. It is now “make it up as you go,” but you are not going to have a good chance of changing outcomes.

We tend to focus on preparedness, for our communities, our citizens, and our systems. Response is where we put it to the test. Recovery

is what we are in now throughout the Gulf Coast. In emergency management, we look at disasters as cyclic; they have a natural progression. The term is “mitigation.” We cannot always prevent certain types of events, particularly naturally occurring events. Katrina was a naturally occurring event. Hurricanes happen. Earthquakes happen. These are natural phenomena. When we build in hazardous areas and make our populations, our citizens, our infrastructures vulnerable, and we do not take these steps of mitigating the hazard, the outcomes are predetermined. What happened in Katrina was well-known. In fact, if you pick up the May [2005] issue of *Popular Science*, it listed catastrophic disasters, and one of them was the great deluge in New Orleans when a hurricane would overtop the levees. There was no mystery about the outcome.

The best way to mitigate most health issues in a disaster is to have a good infrastructure to begin with. If your community does not have effective programs for your citizens – or the great experiment where we deinstitutionalize many people with mental illnesses only to turn them into the homeless with no support network to care for them – the outcome is pretty well predetermined. We did not mitigate one aspect by making sure that if we discharged people from

the institutions there was an effective network to provide for their continual care, to enable them to continue to function. We just put them out there, and the experiment was to get them out of institutions. We took away the intensive care they were in, and we are going to see what happens, because the infrastructure was not there to take care of them.

How do you mitigate? Most action steps are built around getting ready to deal with the impact of disaster. I do not know what the next disaster is that will strike my state, but I do know this: My best defense against pan-flu is a robust, healthy population. My best defense against a trauma of disaster, psychologically, is a population that has those needs met before disaster strikes and that has a robust infrastructure.

The public has an expectation that when disaster happens, somebody else is going to take care of them, and there are perceptions of what that should look like, often from the standpoint from where the person is sitting. Quite honestly, if you are still in line complaining about water and ice after a disaster, I have achieved my number-one goal. You are still alive. I look at disasters as if I were a paramedic. People talk about responding. I do not know what that means. I am not even sure I know what disaster and mental health responses are until somebody tells me what the outcome should be. How do I measure that I have changed the event?

Our team in the state emergency operation center is not from a single agency. We are a collaboration of state agencies, local governments and their associations, and volunteer groups, including faith-based groups. No matter what the disaster is, you may alleviate trauma either systemically or through a community where far fewer individuals are suffering. They are trying to re-establish communications with the area impacted. If I cannot talk to the local officials who are impacted, I am flying blind. I cannot adjust, and I am going to respond with everything I have got, but I may be missing critical pieces of information.



Bob McMillan/FEMA

Secondly, you need to secure the area. And that merely may be a presence. Do not wait until lawlessness or the perception of looting and other things the media has focused on. Our observation is there actually is not so much panic, as people are trying to deal with issues without any real outside help. We do not wait for the sky to turn blue to get in there. But if you can get a presence in there and give people a sense that help is coming, they do not have to be toting guns. You would be surprised what a calming effect it is when you pull out of your yard and see a National Guard soldier in a Hum-V directing traffic at a busy intersection. They have not done anything for you, personally, but you see that help is coming. You have about a 12-hour window before things can get out of hand.

Our model is based upon how local governments are impacted. Many states go from local government to the state and then to the federal government. That works on paper, but in major events that are going to overwhelm the local ability to manage, you have to go into a “push” mode. If your house is on fire and I am at the fire station and can see it, I must sit there until you dial 911. That is how things are written. Until a governor asks the president to send in federal help, there is no legal basis to generate the response.

Thirdly, you have to search the area and reach the injured. You have about 24 hours. If you cannot complete your first primary search in the first 24 hours, you are not going to change the

outcome. If you are injured seriously, and your injuries are not immediately life-threatening, how many will survive after the first 24 hours? How many survive after the first 48 hours? What is your survival rate after 72 hours? If your system is built upon the fact that it takes three days to get resources on the ground to reach the injured, you did not change the outcome.

Again, it has to be a system that can rapidly take existing local resources, non-impacted regional resources, and state and federal resources

The best way to mitigate most health issues in a disaster is to have a good infrastructure to begin with.

and get in quickly, working as a team, reaching the injured, and getting them to definitive care, regardless of whether there are medical facilities in the area of impact that survived. You have 24 hours to impact an outcome. Everything else may impress the media, may impress citizens, but you did not save anybody.

Within that next 72 hours, you have stabilization. My observation is the poor are the most vulnerable, and the working poor are even more vulnerable, because they do not realize they are poor. But here is the challenge: Rich addicts will either buy their drugs or go somewhere where the drugs are. You are not going to have rich addicts going into withdrawal. Likewise, rich people with disabilities do not get left behind. The bottom line is poverty. Many people are in poverty and do not know it because they barely make it every day, until the support system is ripped out from underneath them. Then they find out they do not have the resources to cope in a disaster.

In that 72-hour period, you have to re-establish essential services to keep people alive. You are not necessarily going to make them comfortable, feel good, or cure or solve all of the pre-existing societal ills in the community. If a community had problems before disaster, they do not get better. So what do you need to do? You need to get basic medical care re-established. People who had mental illnesses, behavioral issues, or dependency issues prior to a disaster still have them after the disaster, and in many cases, they may have found themselves cut off from medications or acting out from stress, where normally, they were able to function.

You need to keep people functioning where they cannot harm themselves or others. I am not sure we can make them feel better. We are struggling to take care of basic trauma patients, and we are dealing with people displaying erratic, somewhat violent, somewhat damaging behaviors. Our only goal may be to keep them from hurting themselves and others.

In the New Orleans area, there are about a million people, including the surrounding parishes. In greater Miami and Dade County, there are 2.3 million, and in the south Florida counties, there are 6 million. You get a big enough event, and you are going to overwhelm what we consider normal and what we are going to have to do to meet those basic needs. So, you have to figure out what it is going to take to establish enough medical capability to keep from losing anybody else. Then you have to get some infrastructure, such as water, shelter, food, diapers, baby formula, adult formulas, medications – and ice is nice.

If you can get these resources moving in and get them in the hands of victims, not staged in some big pile outside of the disaster area or en route but in the hands of victims in about 72 hours, people will start coping better. They get a sense that things are not going great, but the loss is stopped. It is not getting any worse.

Quite honestly, from where I am sitting, we cannot deal with the individual. We have to deal communitywide and try to save and stabilize as many people as possible. In turn, we will start looking at reducing individual trauma.

What are the next steps? I work for an interesting governor, one who is big on education and reading. Early on in Hurricane Charley, Charlotte County lost seven schools. That was half of their school system. The governor called me about day three of the event. We were still trying to figure out up from down, and he said, “When are the schools going to open?” I said, “Sir, are you sure we should be talking about schools right now? We are still trying to figure out if we have accounted for everybody.” He said, “Yes, we need to get schools open.” And I said, “OK!” The school board was still assessing at that time. They had teachers and students scattered and did not know what was going on. And we said, “All right, we have gotten through that point of stabilization. We are now working on

getting the infrastructure, water, and power back up. Getting schools open? That makes sense. Let's make that the priority and put the whole team on it." What we found was that by getting schools open early into an event, we started giving kids a first sign of normalcy. We were not trying to get schools fully operational. We just wanted to get students back into something that was normal or, at least, near normal. It also gave our school district and the state board of education an opportunity to move counselors in and to get children out of the constant images of the disaster around them.

As we have come back out of these disasters, we have come back to our "standing orders": Get communications up, secure it, search it, get the basic essential services back up. You have 72 hours to get your infrastructure back up, get schools and businesses open, and start on your recovery. Some will say that in a big, catastrophic disaster, this is not impossible, but it is actually a matter of scale. Does anyone want to tell me that there are not enough resources in the United States to have had assets on the ground in an effective deployment if we had worked as one

team instead of as federal, state, and local levels? Different disciplines have their own plans and speak to their own groups and their own conferences and never cross-pollinate. Could we not have met the challenges more effectively? And if you take that approach, why are we meeting? Our approach should be to work as a team and solve problems more effectively. We have the resources. We have the knowledge. Let's respond better next time. Let's change the outcome.

Finally, I want to emphasize poverty again. Whether I am talking to people who represent groups of disability or whether I am dealing with housing issues, it comes back to this: Poverty is the single, biggest impediment to recovering successfully in a disaster. Whether people were poor before or became poor because of the disaster, we must recognize that poverty is the elephant in the tent in disaster recovery. With all of our programs and all our rules – and if you do not like FEMA's rules, remember that FEMA is an agent of Congress – we have to solve poverty. Otherwise, we will continue to face the same challenges.

Brian Flynn, Ed.D.

Associate Director, Center for the Study of Traumatic Stress; Adjunct Professor of Psychiatry, Uniformed Services University

I am not a fan of presentations that are long on identifying problems and issues and short on solutions, but I am afraid I am going to be presenting one of those today, because some of the issues that I am going to talk about are, frankly, just too big for me to get my brain around. The only thing that makes me feel good about giving this kind of a presentation in this group is this group has those brains. This group has the resources. This group represents the leadership in this country for disaster behavioral health. If any group can begin to address these issues adequately, it is this group.

As we look to the future, we are tied to where we have been. We are one of the few nations that has a legislated disaster mental health program. To the best of my knowledge, Israel is the only other country that has that. That program has been going for a long time. I think

there are some issues and questions about the goodness of the fit with that program, as we get into events like Katrina, but it is important to know that this nation has recognized the importance of behavioral health in disasters for a number of years.

I have been in this field for almost 30 years now, and I have begun to see more appreciation for the importance of behavioral health issues in disasters. It never seems enough, but taking that long view, it is better now. I also see advancements and enhancements at every governmental level, where there is better integration among emergency management, public health, and behavioral health.

As I look back at what we have provided in terms of services over that period of time, I believe that most of what we are doing is being based more on practice and experience than it is

on data and research. We are doing better about becoming more evidence-based, but I believe we have a long way to go.

That having been said, I think we have a gathering storm of problems and concerns. If we are not careful, it is going to grow into a perfect storm when we hit catastrophic events in the

We no longer have population-based, comprehensive community mental health programs in this country. We have systems oriented toward high-need populations.

future, so let me share with you some of those building kinds of issues.

I think we have a double-edged sword here. With

increased awareness of the value and centrality of behavioral health comes some increased expectations. I am not sure that, either in terms of our knowledge base or our numbers or our plans, we are as prepared as we should be to meet those expectations.

There are obvious changes in the public mental health system. I am not being critical of those changes. I just want to observe them. We no longer have population-based, comprehensive community mental health programs in this country. We have systems oriented toward high-need populations. Virtually all of these systems are under severe public or financial pressure. Every state mental health authority in this country is having severe financial problems. The challenge is that we have a public mental health system that is not prepared for, or currently designed for, the current population-based challenges we face in disasters.

We have research challenges. We have made great progress in research, but there has been too little intervention research. In terms of interventions, I am not sure we know much more now than we knew many years ago. And if that is a tough situation, we are in even worse shape when it comes to looking at models of organizing delivery of interventions, particularly in long-term, large-scale disasters.

I think we have decreasing confidence in government to manage disasters. As [David] Satcher said, when people do not trust the system, whether it is the health care system or the governments that are supposed to serve them, we hit a crisis in which anxiety and distress go up, and we face a dangerous combination of factors.

We have new kinds of events that challenge us – pandemic, terrorism, weapons of mass destruction, and national and transnational kinds of disasters. Many of the models we have were built for disasters other than the emerging challenges we face.

We have a cultural challenge that we need to work hard to resist. We want easy-fix, one-size-fits-all, everybody-can-do-it, cheap approaches to complicated problems. So it is seductive when somebody comes up with the answer to these complicated problems. These are extraordinarily complicated problems, and we seek quick and easy answers. This leaves us with a number of unaddressed challenges, and when they converge, they have the potential of providing a tragic perfect storm for us in the health and behavioral health fields.

Our traditional, typical kinds of disasters are locally oriented and fairly limited in time. That is not to say that they are not horrific to individuals, families, and communities, but they are based, typically, on one-time, limited events in restricted geographic areas.

In Katrina, we saw something different. We saw a catastrophic disaster in one locality, with the victims and survivors sent to virtually every other part of this country. We had a centrifugal disaster. People who had experienced trauma in one place were placed in new communities that now had to care for them, treat them, support them with a lot of unknowns. That is different from the typical disaster. With Katrina, we have had a taste of something that begins to approximate a national disaster.

When we look at things like pandemics, we are talking about extraordinarily different kinds of events that strike the whole country and require very different models than we have developed so far. To bring the elephant into the living room from my perspective, we lack the models and are not adequately prepared to deal with national and transnational kinds of disasters that have large behavioral and other kinds of consequences.

I have some serious questions about who owns these situations and who has responsibility for preparing for and responding to these new and larger kinds of events.

Who owns these kinds of events legislatively? Do we have legislation in place that allows us to address multistate, regional, or multinational

kinds of disasters? Do we have similar kinds of legislation at all governmental levels? Are we clear who can make what kinds of decisions under what kinds of circumstances? We certainly saw that break down massively in Katrina.

We do not have much talk about finances in meetings like this, but finances, as we heard in the last discussion about poverty, influence behavioral health kinds of issues. If we have a catastrophic disaster or a pandemic, there certainly is the potential for long-term, significant, and even catastrophic financial consequences. So there are many questions about who is going to pay for what in these situations. How long are they going to pay for it? What are they going to pay for? From the behavioral health perspective, that question is being played out in Louisiana with all the Katrina victims. Think about the magnitude of that question in a pandemic that touches every community in this country.

Who owns this strategically? Where are we going to get the resources? In this day of just-in-time delivery and global economy, where we get things and how we get them from place to place are huge strategic issues. Where are we going to get the people to do the kind of work that needs to be done in something like a pandemic? Will they come? How long will they stay? Are we going to take care of their families? In our more traditional disaster situations, we have been reassured that the cavalry can come in – maybe not as much or as quickly as we want – but will that happen when we have a pandemic or a weapon of mass destruction or a large-scale radiological type of event? Who is going to make decisions about this, and what is the role of behavioral health and social sciences in that dialogue?

[Robert] Ursano said that terrorism strikes along the fault lines of society. That could not be more true, and I do not believe it is limited to terrorism. It is true in all kinds of disasters. Are we prepared for the level of societal disruption that may come when we begin to close borders, when we begin to deny people care? What about consideration of the ostracism of people who have been exposed to some kind of disease? We



know one of the things that the research tells us clearly is the importance of social support systems. What happens when people are denied those social supports because they cannot be close to each other, their communities, their churches, and their schools? Our decisions reflect our value system. Who gets treatment? Who gets it first? I have been involved in many of those tough discussions, and they need to be wide-ranging discussions, because we all think we are the most important. We talk about the importance of protecting, immunizing, and treating health care professionals, police officers, and first responders, but are there not truck drivers who deliver food and people who fill the ATM machines sitting in those discussions? In my view, these are important people if we are to limit control or avoid societal social disruption. Again, who makes these decisions? How are they going to get made? And what's the role of behavioral health?

One of the most difficult and challenging issues is who owns these kinds of new challenges existentially? Who are we? Are we a nation of rugged individuals? Are we really our brother's keeper? What about *e pluribus unum*? Who are we individually and as a nation, and what responsibilities do we have? Who are we as we plan for this? What are success and failure in these kinds of situations? This is an extraordinarily difficult discussion to have, because there certainly are situations where many thousands, perhaps millions, of people might die. There are scenarios when you can pick any one of those

numbers, and under what circumstance does that number represent a success or a failure? These are difficult discussions to have, but I think we need to prepare this nation for events in which there may be large-scale death and suffering and how we are going to deal with that. What does that mean to us, individually and to our families, communities, organizations, and nation? When it is over, how are we going to be judged? How do we want to be judged? Are we going to look back and be proud of what we were able to accomplish, or are we going to come to meetings and be ashamed we did not do more or do it better? Who is going to be involved in those kinds of discussions? What is the role of behavioral health?

I believe we have to start this dialogue now, and that discussion has to include people beyond the kinds of folks at this symposium. It needs to go beyond behavioral health and involve other kinds of disciplines, other expertise. Journalism, for example, is extraordinarily important.

We need to plan with people rather than for them. That notion was reinforced in the Redefining Readiness study, and we in mental health know the bad things that can happen when we do not plan. We know the wonderful things that can happen when we plan with people and not for them.

This is a difficult discussion to have, and it calls on leadership characteristics that are difficult to find, certainly in one person and even in a number of people. The people who lead

these kinds of discussions have to have unquestioned content credibility. We have got to know that they know what they are talking about. They have to be true, honest brokers in this situation, nonpartisan, wise, trusted – and probably at the end of their careers – because when you talk about making choices about who gets services, who gets denied services, and who gets services first, you probably want somebody not worried about job security leading that discussion.

We need to make sure that every citizen and every professional has a role, that the role fits into a coordinated system, and that everybody who works in that system knows what the other parts are all about.

The cost of failure is high if we do not do this quickly and well. If we neglect this, if we do not take care of these issues and address them adequately, we can increase fear, distress, and loss in the populations that we care about and the people we got into this business to serve. We can see the potential for social and economic collapse. We run the risk of increasing the distrust and lack of credibility in government if we do not do the job well. It could be almost as serious as shifting geopolitical power, if we have transnational kinds of disasters and we do not do this well.

One of the cruelest ironies is that if we do not do what needs to be done, and we wind up with a situation in which people in disasters make behavioral choices based on fear and distress

rather than good information and good data, we have the ironic situation that a behavioral health consequence could kill more people than the event itself. If you look at the long-term effects of poverty, economic collapse, failure, and collapse of the health care system, the irony is that a behavioral health consequence could do more damage, cause more illness, and cause more death.

If we do this well, many positive outcomes could be derived from these efforts. We could reduce suffering, loss, and

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Suggestions:

- We must begin now to address these issues.
- The discussion must include voices from well beyond the behavioral health community (law, economics, faith, sociology, anthropology, risk/crisis communication, political science, business)
- Prepare with people, not for them
- Leadership must have unquestioned content credibility, be true "honest brokers," nonpartisan, wise, trusted, and at the end of their careers

Center for the Study of Traumatic Stress

death. We could reduce the adverse socioeconomic conflict. We could promote economic growth. We could foster the development of stronger individuals in more solid communities and restore confidence in leadership that seems to be so lacking. What may be most important is we can promote the idea that people make proactive and positive behavioral adaptations in the face of horrendous situations and, by doing so, enhance the public's health.

When Jeff Wellborn talked about leading people safely out of New Orleans, he said, "We are the guys who are supposed to know what to do, and we did not know what to do." When it comes to behavioral health and disasters, and public health and disasters, we are the people who are supposed to know what to do. I would challenge every one of us individually and in our organizations to think about what Jeff [Wellborn] said. In the planning phase, we are the people they turn to. Do we really know what we are doing, and can we give

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New Ideas?

"Without a great deal of forethought, prolonged training, and the development of systematic performances, drills, and tests of all participants, no community can prepare itself to provide those additional health services that will be essential for civilians subject to disasters. When the average community prepares itself for disasters, the effort of each citizen and every profession must be fitted into a coordinated system. Whoever guides each part of the whole must have a clear concept of the working of all the other parts."

Source: William Wilson (Col. MC, USA)
U.S. Armed Forces Medical J., Vol 1, No.4
April 1950

Center for the Study of Traumatic Stress

them the kind of help that they need? When an event happens and people turn to us for what to do, are we as well-prepared as we need to be to answer that question positively rather than say we do not know what to do? When we look back on the next pandemic and say that people looked to us for answers and guidance, it is going to be important to be able to say that we knew what we were doing and we did help, rather than having to say that we did not know what to do.

Questions & Answers

Q A number of issues were brought up that have come to the forefront in the 14-15 months since Katrina struck. One of them was the issue of getting a school started. What we have seen in some of the heavily devastated parishes around the New Orleans metropolitan area is that the schools drive the rebuilding of the community. Also, schools can drive the rebuilding of the community through self-efficacy, the feeling that “if we can come back, our children can be in school.” Sometimes schools have been the only normal place in the parish. For example, Saint Bernard Parish was 96 percent destroyed, and school started on Nov. 14. It is still the only normal place in that parish, and they just had their first grocery store open a month ago. Sometimes we think about reorganizing schools and about how they are going to come back, but we do not think of the force that the schools can have in the community for families and for the community.

Another point brought up in the last presentation had to do with the issue of the subsequent loss following a disaster. My colleagues in Florida told me, “Keep an eye on the obituary pages after the disaster,” and our obituary pages in New Orleans, usually about two pages, have been six-eight pages, and they are still three-four pages. It is not just the people in the New Orleans area but displaced people all over the country, including elderly people that had to evacuate. We do not talk enough about the fallout, and some of that perhaps could have been prevented if the response were better. These are some things that need to be out there related to disaster planning, besides all the structural things, in making a difference in the future for communities.

A Craig Fugate: We found that getting schools up gave local officials a goal, but it took more than just the single school board. It took the whole community to get a school open, and it gave the community a sense of purpose other than dealing with disaster. Then when the schools opened, that became something the community had achieved. The faster we can get to that, the faster we can get people to ask, “What’s next? We have got to get housing back in here. We have got to get jobs going. We have got to get businesses opened.”

You start shooting for milestones that a community can embrace vs. individuals who are not seeing progress.

Q The existential issues that were raised suggest that you [Brian Flynn] are calling for a new political movement. It seems that we are calling for an end to a politics of social exclusion, of isolating and pretending as though we were not connected, and calling for a politics that recognizes that we all share this country and the globe with lots of other people. I was taught that the reason that Pittsburgh existed was because New Orleans was there, meaning that it was the river that came down and allowed us access to the rest of the world that created the whole Ohio River Valley. I would love to see someday some way to visualize all of us along that chain of rivers so people could actually see that we are, in fact, connected. But my question is, “How do you create a movement that is against social exclusion, that builds this country as a whole, and that does not play politics on the fault lines?” In some ways, that is its own form of terrorism on the people who lived in New Orleans long before this flood ever happened and are living in other parts of this country at this present time. How are we going to get ready when the oil runs out?

A Brian Flynn: Those are our challenges, and my reflex reaction is it all starts personally. We need to examine our own existential role and how we communicate that with our families and our communities and the workplaces in which we work. It is also a responsibility that we speak with credibility within our knowledge base. I am reluctant to get into discussions that go too much outside behavioral health and public health, because I would then lose credibility and not help that dialogue. What has struck me is the urgency of that dialogue, the importance of preparing people to think about the tragic consequences of something like a pandemic that will, no matter how well-prepared we are, be extraordinarily destructive and painful to every community in this country.

Questions & Answers

A Anthony Speier: I do not have an answer, but I have an observation. There is a museum in New Orleans called the D-Day Museum. At that museum, there is room after room about preparedness, thinking about how we, as a country, pulled together in so many ways to provide the resources that were needed at the time. In the work we are doing in Louisiana right now, I am seeing the notion of preparedness and the simple skill sets with which everybody can succeed at being prepared. That is a unifying feature, and it is paying benefits.

Q Some people might remember that we used to do these civil defense drills in the 1950s and prepared to evacuate everyone from cities in anticipation of nuclear attack. Do we know anything about how effective those kinds of civil defense preparedness exercises were, and why did we stop doing things like that, in terms of overall civil preparedness?

Also, I lived in Tampa for 11 years, and Florida newspapers routinely put out supplements prior to the hurricane season with long lists of things you should do in terms of preparedness. We have a tax holiday in Florida on which you can go buy generators and plywood and the things that people need to prepare themselves. There are proactive plans to inoculate the public, if you will, and it gives people an opportunity to feel as though they have some agency in the matter and suggests that they could and should. Have you [Craig Fugate] evaluated the success of any of those programs, in terms of moving the needle on preparedness?

A Craig Fugate: Yes, we did a behavioral analysis. We did a survey about preparedness, and, rather than just asking if people were prepared, we asked for specific actions. That has been our baseline. We were waiting to see if we had a storm this year before we ran it again. We are going to wait now until after hurricane season and rerun it. Then several other studies came back, and, generally, Florida will score higher in responses on

preparedness, particularly when you ask specific questions. We know we have had some effect, but it is not where we need to go. My concern is you are the “able body.” If you do not have a plan and are not prepared, you are going to take resources away from the most vulnerable citizens. It is my goal to get people who should and could have out of my hair, because they did what they were supposed to do. Then we can focus on our most vulnerable citizens. There are too many people who are not doing that, and there are not enough resources.

Going back to historical stuff about civil defense, population relocation planning continued through the 1990s. Most people do not realize that. The reason it was still going was because it was gradually funded. It was seen as a national threat, so it was federally funded, while natural disasters and other things are seen as a local threat. As the mood of the country shifted away from the idea that we could survive a nuclear attack, and that, in some ways, preparing for it actually increased the risk of it occurring, Congress began backing away from the funding of those programs. I found Gene Hackman in a civil defense training film talking about doing shelter assessment, shelter surveys, developing a plan to harden and build shelters for populations. They were talking nuclear talk, but it is no different than what we are talking about now about shelters for evacuees from hurricanes. Some of the things previously recommended are not going to be that different from other disasters. Have a plan. Be prepared. Have supplies.

Q I run a volunteer center in Biloxi, Miss. We have about 160 volunteers who go out every day, building houses and those kinds of things, which are still critical needs. The concern that we have on the ground is that we are doing these things, but we also are trying to help create this normalcy that everyone talks about. From a policy standpoint, we are trying to create things that did not exist before the storm. We are trying to attack social problems, such as education or health, which were already problems. How do we balance creating new systems but also helping people who are receiving these new systems accept them?

Questions & Answers

A Brian Flynn: In the wake of disaster, there is a tendency for people to say, “We can build it back, and we can build it better,” which fights the immediate needs that Craig [Fugate] talked about.

A Craig Fugate: When you talk about political change or will or leadership, this is one area that you have to address. FEMA merely administers the Congress’ intent. The Stafford Act programs were never designed to fix the underlying issues of the community, even though we know that in disasters, the issues are exposed and there are opportunities. The Stafford Act is structured so as not to supplant local responsibility or pay for things that did not exist prior to disaster. Also, it is more interested in infrastructure than people. As a nation, we have to make a decision. Should we enable, through disaster declarations, additional flexibility to address these ills? Secondly, how many people were appalled at all the fraud and waste that occurred in these disasters? Well, it was not a big number. Percentage wise, it was small, but because of the national perception that we must control waste and fraud, most of the programs are so restrictive about preventing waste and fraud that we penalize victims. I have had congressional staff wanting to know about waste and fraud and supporting people in disasters. It turns out that the FEMA error rate for individual registration – where they said all the fraud occurred in Florida for 2004 – was 1 percent. I challenge you to

find a federal program that, on a daily basis, has a 1 percent error rate. Yet, because that totaled over \$37 million in fraudulent claims, Congress came back and restricted how those programs can be administered. We need to unshackle the disaster response program, not merely to deal with the infrastructure but to deal with the people, and understand that underlying issues are expanded. Also, you have to make a decision about how much fraud you want to prevent at the expense of helping people. You can be fiscally correct and take so many people out of eligibility. Also, one issue we have in Florida is this: When is a victim in the United States not a disaster victim? The answer is “when they are undocumented.”

A Anthony Speier: I have a different kind of answer for you on that. There will never be enough money or political policy to satisfy the issue of “I want it better than it was before.” The real question people are asking is about moving forward. They are starting to use resources and thinking in a creative way, to speculate about a future, and that has strength. That is what we build on – not the instrumental pieces, but where they lead a group of people collectively. We have not spoken much about mass casualties, and we have not spoken about a national model for how a community responds to a mass casualty event. New York did it one way. We did it another way. They were different situations, and we did not know what we were doing. We did not do poorly, but as a country, we need some national blueprints for addressing that issue.

GENERAL DISCUSSION

Thomas Bornemann, Ed.D.

Director, The Carter Center Mental Health Program

Lei Ellingson, M.P.P.

Assistant Director, The Carter Center Mental Health Program

Hurricane Katrina was a massive disaster, not only because of the extent of physical damage but also because of the exposure of weaknesses in the public infrastructure, which was completely destroyed. Never before have we seen such a wide-scale national evacuation of such a large population. Never before have so many Americans suffered such prolonged exposure to a life-threatening natural disaster. Mental health professionals and policy-makers are now presented with an opportunity and, moreover, a responsibility, to change disaster readiness and response strategies, providing continuous mental health services when the public most needs them.

The working groups are a vital part of every symposium. They provide the mechanism for actualizing the symposium topic into programmatic initiatives and activities. Recently, we have begun asking participants to make a commitment either of themselves or their organizations to carry out an activity related to the symposium topic. The working groups provide an opportunity to brainstorm about potential activities and how to implement them. Participants then come together for a general discussion to share their experiences with each other. The Mental Health Program then follows up with an online survey after the symposium to see where participants are in their commitments.

At this year's symposium, participants were divided into six working groups and given the following charge:

In the aftermath of Hurricane Katrina, it has become clear that improvement is needed in the infrastructure of the disaster response system in order to ensure the delivery of mental health services to men, women, and children during and after emergencies and disasters. Given what we have learned about the state of the science for disaster

mental health, the most current services and treatments available, and the policy issues facing disaster mental health:

Determine at least two priorities for disaster mental health response, including planning and preparedness. For each priority, develop at least one strategy for accomplishing or implementing that strategy.

Working groups reported the results of their meetings during a general discussion facilitated by A. Kathryn Power, M.Ed., director of the Center for Mental Health Services. Panelists and participants at the symposium agreed that the successful implementation of any disaster relief plan demands the integration of federal, state, and local entities. Working separately, these entities cannot be as effective as the three levels working together.

Priority areas for disaster mental health response identified by the working groups included:

Coordination of Services

- Remove red tape
 - including developing uniform licensure agreements and documentation across states
 - uniformity in training, response to affected areas, and immediate post-response follow-up services to those responders
- Clarify that mental health is the responsibility of all short- and long-term disaster planning and response
- Assign responsibility for identifying experts to the professional associations
- Develop communications strategies
- Secure funding

Development of the Evidence Base

- Identify evidence-based interventions

- Develop models that are culturally relevant
- Tie research on positive mental health outcomes to early safety interventions
- Conduct continuous community mental health surveillance with standardized measures
- Develop a repository of best practices in disaster mental health

Leadership

- Develop a transparent, unified leadership plan establishing a chain of command for mental health, possibly through SAMHSA
- Create blueprints to maximize healthy adaptive behaviors and well-being while minimizing dysfunction
 - Plans must reach local levels and be actively evaluated and updated based on experience from drills and events

Strategies created for implementation by the working groups included:

Infrastructure

- Improve technology infrastructure
- Base model development upon a central repository of lessons learned
- Create a common surveillance tool used nationally to build a database to collect and utilize data, test interventions, and evaluate outcomes
- Develop visible national leader(s)
- Create a national blueprint for how we manage mental and behavioral health problems related to disasters, creating additional blueprints to maximize healthy adaptive behaviors and well-being while minimizing dysfunction and caring for those distressed and ill
- Learn more from the past to develop a more thorough understanding that enables better public policy, which generates new research on a continuum
- Develop a statement on prevention and response to disasters
- Make available mitigation monies and commit to funding



Deborah Hakes

- Designate a national lead person specific to Mental Health Disaster Response
- Draft and publish a national white paper on disaster mental health priorities for new national leadership that clarifies the role of mental health and establishes a scope of services

Training

- Promote psychological first aid
- Introduce mental health module into training for disaster mental health response
- Include print mental health documents and preparedness documents in initial response
- Teach/implement crisis counseling. Early safety nets equal more positive mental health outcomes
- Include consumers and community members in disaster mental health planning and collaborate across systems

Education

- Initiate mental health surveillance and preparedness education through school systems
- Share best practices
- Learn the right language to move the disaster mental health policy forward, focusing on the consistency of messaging
- Develop innovative ways to educate the public – for example, online preparation kits
- Increase education and awareness of self-efficacy and resiliency

Implementation

- Establish an incident command structure for mental health response, coordinate services, and develop an evidence base
- Build a grassroots movement including focus on peers. Utilize Gulf Coast experiences as a lever, developing and using incremental metrics for each priority to measure and track progress

Sometimes making little steps forward can make a huge difference. These pledges represent a wealth of initial steps toward changing the world. As Kathryn Power stated,

“The depth and the breadth of human emotional range of response and adaptation and resiliency and rehabilitation and recovery are quite powerful, are quite elastic, and are quite profound. We are constantly learning about the expression of the human emotional range. I believe that the learning that we had in hurricanes Katrina, Rita, and Wilma was different than the learning we had in 9/11, particularly around that human emotional range. And our awareness of that in terms of the depth and the breadth of that range of response should continuously inform our learning and should continuously feed our planning. Throughout the day, I have heard the importance of very proactive and very comprehensive mental health and substance abuse response capability as one of the most vital and one of the most directed life-saving activities that significantly aids all aspects of disaster recovery.”

CLOSING REMARKS

Rosalynn Carter

Chair, The Carter Center Mental Health Task Force

It is so important that we move forward on this issue and not just come here and talk about what needs to be done, and then return to our jobs and not do anything. We have had some really good suggestions and recommendations. We can all work through our organizations or our positions to disseminate the information that we have learned here. There are many things we can do. There was a lot of emphasis on leadership, but what kind and who will rise to the occasion? Some concrete examples of activities were suggested. For instance, the coastal states working on changing licensing laws would seem to be a good thing for them to do.

We also need to think long term about the effects of disasters. We have learned from other traumatic incidents like the Oklahoma bombing and 9/11 that there will be major mental health consequences for a long time to come. Research indicates that natural disasters do not have the same impact on mental health as disasters resulting from terrorism and man-made disasters. But, the increased loss of life, disproportionate allocation of resources, the total breakdown of natural supports, and prolonged exposure to risk during Hurricane Katrina will have more adverse effects than seen in other natural disasters.

We also can train our political leaders. All of us have access to political leaders. We need to let them know the urgency of this issue and the planning and preparation that needs to be done for future disasters.

We have to take these lessons learned and act on them. We need to be prepared so that nothing like this will ever happen again. I hope we never again face anything of the magnitude of Hurricane Katrina, but there are so many other potential disasters. The mental health and substance use community must insist on being an integral part of all planning and preparedness activities.

Rosalynn Carter



Biographies



James Cooper

James Cooper is the office coordinator at The Extra Mile. Established in 1991, The Extra Mile began as the official volunteer recruitment organization for the Louisiana Department of Health and Hospitals. The Extra Mile served as a catalyst between community and state agencies to meet the special needs of people affected by mental illnesses, developmental disabilities, or substance abuse. It provides public education, fund raising, and client care through volunteerism to state agencies.



Scott S. Cowen, D.B.A.

Scott S. Cowen, D.B.A., is Tulane University's 14th president. He also holds joint appointments as the Seymour S. Goodman Memorial Professor of Business in Tulane's A.B. Freeman School of Business and professor of economics in its School of Liberal Arts. From his arrival at Tulane in 1998 until 2005, the university more than doubled its undergraduate applications, experienced all-time highs in student enrollment and quality, doubled the level of total private giving, and received a record level of research awards. Despite incurring more than \$400 million in damage from Hurricane Katrina, Tulane was repaired, and 88 percent of its students returned for classes. Cowen is a member of the board of directors of Newell Rubbermaid Inc., American Greetings Corp., Jo-Ann Stores Inc., and Forest City Enterprises Inc.



W. Dennis Derr, Ed.D.

W. Dennis Derr, Ed.D., SPHR, has more than 30 years' experience in workplace mental health, behavior, and management. He is the former global director of Employee Assistance and Custom Programs for Mobil Corp. and Michigan Bell. As a senior consultant with Signature Resources, he provides consultation to government agencies, universities, and private industry worldwide. He is the project officer for the U.S. Postal Service EAP. The author of numerous professional articles and book chapters, he is a frequent speaker at conferences on the relationship between leadership, workplace behavior, and mental health.



Brian Flynn, Ed.D.

Brian Flynn, Ed.D., is a consultant, writer, trainer, and speaker specializing in preparation for, response to, and recovery from the psychosocial aspects of large-scale emergencies and disasters. He has served numerous national and international organizations, states, and academic institutions. Flynn currently serves as an associate director of the Center for the Study of Traumatic Stress and adjunct professor of psychiatry, department of psychiatry, Uniformed Services University of Health Sciences in Bethesda, Md. He received his B.A. from North Carolina Wesleyan College, his M.A. in clinical psychology from East Carolina University, and his Ed.D. in mental health administration from the University of Massachusetts at Amherst.



W. Craig Fugate

W. Craig Fugate is the director of the Florida Division of Emergency Management, which coordinates disaster response, recovery, preparedness, and mitigation efforts with each of the state's 67 counties and local governments. In 2003, the program became the first state emergency management program in the nation to receive full accreditation from the Emergency Management Accreditation Program. His role as the chief of the State Emergency Response Team saw extensive action in 1998 when Florida experienced the impacts of floods, tornadoes, wildfires, and Hurricane George. In 2001, Gov. Jeb Bush appointed Mr. Fugate to serve as director of the Florida Division of Emergency Management, the role he continues in the governor's second term.



Jane Hansen

Jane Hansen is an award-winning writer for *The Atlanta Journal-Constitution*. Among other awards, Hansen has won a National Headline Award for the nation's top local interest column, a Society of Professional Journalists Green Eyeshade Award for investigative reporting, and a Selden Ring Award for investigative reporting. She has twice been a finalist for the Pulitzer Prize – for a series about the resegregation of the nation's schools and a series about the failures of Georgia's child welfare system. Hansen received her undergraduate degree from the University of Pittsburgh and her master's in journalism degree from Columbia University and worked on the White House staff under President Jimmy Carter.



Verlyn "Vee" Lewis-Boyd

Verlyn "Vee" Lewis-Boyd is the executive director of the Louisiana Federation of Families for Children's Mental Health, where she has volunteered and worked for 15 years. Boyd represents the parent voice on the advisory board to the Governor's Children's Cabinet, the Mental Health Reform Coalition, the Public Mental Health Review Commission, the state Mental Health Planning Council, the regional advisory board for Capital Area Human Service District, the advisory group to the Early Childhood Comprehensive System for the Office of Mental Health, and the Louisiana Youth Enhanced Services Consortium.



Bill Lichtenstein

Bill Lichtenstein founded Lichtenstein Creative Media in 1990 to produce high-quality film, television, and radio productions and educational outreach efforts focusing on mental health, human rights, and social justice issues. His work includes the national weekly public radio series "The Infinite Mind" and the award-winning documentary film "West 47th Street." Lichtenstein and Lichtenstein Creative Media are the recipients of more than 60 honors for their work, including the 2006 Media Award from the American College of Neuropsychopharmacology, Guggenheim Fellowship, Peabody Award, U. N. Media Award, and honors from a variety of mental health organizations including IMH, APA, MHA and NARSAD.



Paula Madrid, Psy.D.

Paula Madrid, Psy.D., is a New York State-licensed clinical psychologist and the director of the Resiliency Program of Columbia University's Mailman School of Public Health's National Center for Disaster Preparedness. The Resiliency Program has been dedicated to serving the mental health and psychosocial issues of children and families affected by 9/11 for almost five years. Madrid also serves as director of mental health services of Operation Assist, a joint initiative by the Children's Health Fund and the National Center for Disaster Preparedness to assist victims of hurricanes Katrina and Rita on the Gulf Coast.



Greg Miller

Greg Miller is a staff writer at *Science* magazine, where he writes about neuroscience, mental health, and other topics. He was a 2004-2005 Rosalynn Carter Mental Health Journalism fellow. For his fellowship project, Miller traveled to Sri Lanka, India, and Hong Kong and wrote a series of articles for *Science* on the challenges of addressing mental health in developing countries. One article in the series examined the international effort to provide mental health care for survivors of the December 2004 Asian tsunami. Miller earned a Ph.D. in neuroscience from Stanford University and completed a science writing program at the University of California, Santa Cruz.



Joy D. Osofsky, Ph.D.

Joy D. Osofsky, Ph.D., is a psychologist and psychoanalyst and professor of pediatrics and psychiatry at Louisiana State University Health Sciences Center. She also is an adjunct professor of psychology at the University of New Orleans. Osofsky is director of the Violence Intervention Program for Children and Families and the Harris Center for Infant Mental Health at Louisiana State University Health Sciences Center. She is president of Zero to Three: National Center for Infants, Toddlers, and Families. Osofsky was asked to oversee child and adolescent initiatives for displaced children and families in the state of Louisiana for the Office of Mental Health for Louisiana Spirit and the Department of Education.



Norman Robinson

Norman Robinson is the main anchor for the 6:00 p.m. and 10:00 p.m. newscasts and "6 on Your Side LIVE" for WDSU-TV, the NBC network affiliate in New Orleans. Robinson has worked for broadcast outlets in Southern California, Mobile, New Orleans, New York, and Washington, D.C., where he was a member of the White House press corps as a correspondent for CBS News. He has degrees and recognition from the U.S. Naval School of Music, the Columbia School of Journalism, and Harvard University. He also is the recipient of an honorary doctorate of humane letters from Our Lady of Holy Cross College.



David Satcher, M.D., Ph.D.

David Satcher, M.D., Ph.D., completed his term as the 16th surgeon general of the United States in 2002 and was only the second person in history to have held both positions of surgeon general and assistant secretary for health simultaneously. Satcher spearheaded the development of Healthy People 2010, which included the elimination of racial and ethnic disparities in health as one of its two goals. He also released 14 surgeon general's reports on topics that included tobacco and health; mental health; suicide prevention; oral health; sexual health; youth violence prevention; and overweight and obesity. Satcher now occupies the Poussaint-Satcher-Cosby

Chair in Mental Health at the Morehouse School of Medicine. He is a Morehouse College graduate and received his M.D. and Ph.D. from Case Western Reserve University. He is a member of the Carter Center Mental Health Task Force.



Monica Schoch-Spana, Ph.D.

Monica Schoch-Spana, Ph.D., is a medical anthropologist, senior associate with the Center for Biosecurity of the University of Pittsburgh Medical Center, and assistant professor in the School of Medicine Division of Infectious Diseases. She has led research, education, and advocacy efforts to encourage greater consideration by authorities of the general public's capacity to confront bioattacks and large-scale epidemics constructively. She currently chairs the Working Group on Citizen Engagement in Health Emergency Planning and was the principal organizer for the 2006 U.S.-Canada summit on Disease, Disaster, and Democracy – The Public's Stake in Health Emergency Planning.



Anthony Speier, Ph.D.

Anthony Speier, Ph.D., is a licensed psychologist and currently holds the position of director of Disaster Mental Health Operations for the Louisiana Office of Mental Health. Since hurricanes Katrina and Rita, Speier has been the principal lead for the Office of Mental Health in the development and implementation of federal crisis counseling programs in Louisiana. In 2001, Speier collaborated with 50 disaster mental health scientists, researchers, and practitioners from various nations in the framing of a consensus statement regarding best practices of early psychological intervention for victims/survivors of mass violence. He recently contributed a chapter to the 2006 publication, "Interventions Following Mass Violence and Disasters."



Sally Sullivan

Sally Sullivan currently serves as a crisis counselor with Project Recovery to assist Katrina victims with rebuilding their lives. She previously served as program director for an elderly in-patient clinic and as counselor for teens through the local Mental Health Center. Sullivan is certified for critical incident stress management and served at Ground Zero after 9/11. She earned an undergraduate degree and a master's degree in community counseling from Delta State University. Sullivan and her husband lost everything in Hurricane Katrina.



Robert Ursano, M.D.

Robert Ursano, M.D., is professor of psychiatry and neuroscience and chairman of the department of psychiatry at the Uniformed Services University of Health and Sciences in Bethesda, Md. He also is director of the Center for the Study of Traumatic Stress. He has served as the Department of Defense representative to the National Advisory Mental Health Council of the National Institute of Mental Health and is the editor of *Psychiatry*. Ursano is widely published in the field of PTSD and the psychological effects of terrorism, bioterrorism, traumatic events and disasters, and combat. Ursano received his M.D. from Yale University.



Jeffry Wellborn

Jeffry Wellborn is the assistant commander of the New Orleans Police Department Crisis Transportation Service, serving since 1998. He also is a guest instructor at the NOPD Training Academy on law enforcement and mental illness. He was awarded the Katrina Badge of Honor for heroic and outstanding service to the NOPD and the city of New Orleans. Wellborn also is the president of Crisis One, an emergency disaster planning and response company and the nonprofit organization Friends of CTS. He graduated from Baylor University and holds a master's degree from New Orleans Baptist Theological Seminary.

Planning Committee

Yakima K. Black

Executive Director
Mental Health Association in Louisiana

Daniel Dodgen, Ph.D.

Emergency Management Coordinator
Substance Abuse and Mental Health Services
Administration
U.S. Department of Health and Human Services

Brian Flynn, Ed.D.

Associate Director
Center for the Study of Traumatic Stress
Uniformed Services University

Ellen Gerrity, Ph.D.

Associate Director and Senior Policy Adviser
Duke University-UCLA National Center for
Child Traumatic Stress

Susan E. Hamilton, Ph.D.

Senior Associate, Disaster Mental Health
American Red Cross

Nadine Kaslow, Ph.D.

Professor and Chief Psychologist
Emory Dept. of Psychiatry and Behavioral Sciences
Grady Health System
President, American Board of Clinical Psychology
President-Elect, Family Process Institute
APPIC Former Chair and Board Member Emeritus
Member, The Carter Center
Mental Health Task Force

Dori B. Reissman, M.D., M.P.H.

Senior Adviser for Disaster, Terrorism,
and Mental Health
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Anthony H. Speier, Ph.D.

Director, Disaster Mental Health Operations
Louisiana Office of Mental Health

Terri Tanielian

Senior Social Research Analyst
RAND Corporation

Farris Tuma, Sc.D.

Traumatic Stress Disorders Research Program
National Institute of Mental Health

Cynthia Wainscott

Acting Director
Mental Health America

Participants List

Katherine L. Acuff, J.D., Ph.D.
Health Policy Consultant
Adjunct Associate Professor
Emory University

Renato D. Alarcon, M.D.
Chair, Division of Inpatient
Psychiatry and Psychology
Psychiatry and Psychology
Treatment Center
Mayo Clinic
Member, The Carter Center
Mental Health Task Force

Bernard S. Arons, M.D.
Executive Director and Chief
Executive Officer
National Development and
Research Institutes

William R. Beardslee, M.D.
Psychiatrist-in-Chief
Gardner Monks Professor of
Child Psychiatry
Harvard Medical School
Member, The Carter Center
Mental Health Task Force

Carl C. Bell, M.D.
Chief Executive Officer
Community Mental Health
Council Inc.
Member, The Carter Center
Mental Health Task Force

David Bergman
Director of Legal and
Governmental Affairs
American Association for Marriage
and Family Therapy

Richard C. Birkel, Ph.D.
Executive Director
Rosalynn Carter Institute
Georgia Southwestern
State University
Member, The Carter Center
Mental Health Task Force

Marsha S. Block, CAE, CFRE
Chief Executive Officer
American Group
Psychotherapy Association

Krista Bogertman
Deputy Director
Consumer Satisfaction Services

Thomas H. Bornemann, Ed.D.
Director
The Carter Center
Mental Health Program

Douglas Bowes
General Manager
Magellan Health Care

Andrea Bradford, M.D., MMM
Medical Director, Division of
Mental Health, Developmental
Disabilities, and Addictive
Diseases, Georgia Department of
Human Resources

Catherine B. Brenneman, LCSW
Clinical Supervisor
Western Regional
Altacare of Montana

Kathryn Brohl
Innovation Team
Children's Home Society of Florida

Shelly Brownsberger, M.S.
Global 2000 Assistant Director,
Ethiopia Public Health
Training Initiative
The Carter Center

Thomas E. Bryant, M.D., J.D.
President
National Foundation for
Mental Health
Member, The Carter Center
Mental Health Task Force

Melissa Brymer, Psy.D.
Director, Terrorism and
Disaster Programs
National Center for Child
Traumatic Stress

Peter F. Buckley, M.D.
Chairman, Department of
Psychiatry and Health Behavior
Medical College of Georgia

Kathryn E. Cade
Chair, Board of Directors
Judge Baker Children's Center
Member, The Carter Center
Mental Health Task Force

Monica E. Castillo
Katrina Aid Today
Program Coordinator
Catholic Charities USA

Christine Castles, R.N., M.P.H., CHES
Consumer/Educator
Post Traumatic Stress Center

Mary Cesare-Murphy, Ph.D.
Executive Director
Behavioral Health Care Program
Joint Commission on
Accreditation of
Healthcare Organizations

Elizabeth Chadwick, J.D.
Senior Vice President of
External Affairs
Devereux Foundation

Christopher M. Cherney
Social Worker
Mississippi Children's
Home Services

Larry Cimino
Manager, Neuroscience Global
Advocacy and
Professional Relations
Eli Lilly & Company

Julyette Clifton, ACSW, LGSW
Senior Chapter
Relations Associate
National Association of
Social Workers

Molly A. Colgan, B.S.N., R.N.
Community Health Coordinator
Hands-On Gulf Coast

Connie Concannon, M.S.W., CGP, FAGPA
President-Elect
American Group
Psychotherapy Association

James Cooper
Office Coordinator
The Extra Mile –
Southeast Louisiana

Scott S. Cowen, D.B.A.
President
Tulane University

Charles Curie, ACSW
President
The Curie Group

John Damon
Mississippi Children's
Home Services

Jeannette David
Georgia Department of
Human Resources

W. Dennis Derr, Ed.D, SPHR
Partner/Senior Consultant
Signature Resources

Marten deVries, M.D.
Professor, University of Maastricht
Center for Public Mental Health
Maastricht, The Netherlands

Daniel Dodgen, Ph.D.
Human Services
Policy Coordinator
Office of the Secretary for
Preparedness and Response
U.S. Department of Health and
Human Services

Benjamin Druss, M.D., M.P.H.
Rosalynn Carter Chair in Mental
Health Policy
Emory University Rollins School
of Public Health
Member, The Carter Center
Mental Health Task Force

Holly Echo-Hawk
Senior Mental Health Consultant
National Indian Child
Welfare Association

Lei Ellingson, M.P.P.
Assistant Director
The Carter Center Mental
Health Program

William Emmet
Interim Director
Campaign for Mental
Health Reform

Mary Jane England, M.D.
President
Regis College
Member, The Carter Center
Mental Health Task Force

Silke von Esenwein, Ph.D.
Associate Director of
Research Projects
Emory University Rollins School
of Public Health

Paul Jay Fink, M.D.
Consultant, Health and
Mental Health
American Psychiatric Association
Member, The Rosalynn Carter
Fellowships for Mental Health
Journalism Advisory Board

Cherry Finn
Director, Mental Health
Georgia Department of
Human Resources

Beth Finnerty, M.B.A., M.H.A.
Executive Director
Skyland Trail

Michael Fitzpatrick, M.S.W.
National Alliance on
Mental Illness

Brian W. Flynn, Ed.D.
Associate Director
Center for the Study of
Traumatic Stress, Uniformed
Services University of the
Health Sciences

Cynthia Folcarelli
President and Chief
Executive Officer
The Vanner Street Group

Mary C. Fox
Senior Vice President and Head of
Medical Related Products
Aetna Inc.

Jennifer C. Friday
President
The Friday Consulting
Group, LLC

W. Craig Fugate
Director
Florida Division of
Emergency Management

Lewis E. Gallant, Ph.D.
Executive Director
National Association of State
Alcohol/Drug Abuse Directors

Liz Gallaspy, L.M.S.W
Team Supervisor
Project Hope/Behavioral
Health Link

Betsy Gard
President
Georgia Psychologist Association

Bill Gardner
Georgia Mental Health Task Force

Candy Gardner
Georgia Mental Health Task Force

Preston J. Garrison
Secretary-General and Chief
Executive Officer
World Federation for
Mental Health

John J. Gates, Ph.D.
Former Director, The Carter
Center Mental Health Program

S. Nassir Ghaemi, M.D., M.P.H.
Director, Bipolar Disorder
Research Program
Emory University School
of Medicine

Frank A. Ghinassi, Ph.D.
Vice President, Quality and
Performance Improvement
University of Pittsburgh School of
Medicine/Western Psychiatric
Institute and Clinic

Robert W. Glover, Ph.D.
Executive Director
National Association of State
Mental Health Program Directors

Susan Golant
Freelance Writer

Sybil K. Goldman, M.S.W.
Senior Adviser
Georgetown University National
Technical Assistance Center for
Children's Mental Health

Maureen Goodman
Associate Director, Development
Health Programs
The Carter Center

Gregg D. Graham, M.A., M.B.A.
President and CEO
Behavioral Health Link

Pamela Greenberg, M.P.P.
Executive Director
American Managed Behavioral
Healthcare Association

Erin N. Greene
Director, D&A Services
Consumer Satisfaction Services

**Claire Griffin-Francell, M.S.N.,
CNS/PMH**
President
Southeast Nurse Council

Chuck Guerriero
Manager, National Neuroscience
Advocacy Relations
Eli Lilly & Co.

Alfonso V. Guida, Jr., J.D.
President
Guida Consulting Services Inc.

Paul Hackman
President and CEO
Ridgeview Institute

Margaret Halter, Ph.D., APRN
Associate Professor
University of Akron

Susan E. Hamilton, Ph.D.
Senior Associate, Disaster
Mental Health
American Red Cross

W. Rodney Hammond, Ph.D.
Director, Division of
Violence Prevention
Centers for Disease Control
and Prevention
Member, The Carter Center
Mental Health Task Force

Jane O. Hansen
Reporter
The Atlanta Journal-Constitution

Margaret Hansen
Senior Planner
Department of Health
Washington State

Robert Hartman
Vice President and Chief
Executive Officer
DePelchin Children's Center

Judith A. Hartner, M.D., M.P.H.
Director, Lee County
Health Department
Florida Department of Health

Larry Hayes, LCSW
Supervisor
Behavioral Health Link
Project Hope

Margaret Heldring, Ph.D.
President
Americas HealthTogether

Gary M. Henschen, M.D.
Medical Director
Magellan Health Services

John Herman, M.D.
Director of Clinical Services
Massachusetts General Hospital

Susan Hiers, M.P.H.
Crisis Outreach Worker
Project Hope

Jennie Hillman
Director, Project Recovery
Mississippi Department of
Mental Health

Ted W. Hirsch
Chief Operating Officer
Kalispell Regional Medical Center

Betsy Hoddinott
Psychologist
Georgia Psychological Association

Michael F. Hogan, Ph.D.
Director
Ohio Department of
Mental Health

E. Wayne Holden, Ph.D.
Executive Vice President
RTI International

Paula Hovater
President
Public Affairs
Atlanta, Georgia

Alan Hovestadt
President
American Association for Marriage
and Family Therapy

Larke N. Huang, Ph.D.
Senior Adviser
Substance Abuse, Mental Health
Services Administration

Andrew Hyman
Senior Program Officer
Robert Wood Johnson Foundation

**Ethleen Iron Cloud-Two Dogs,
M.S.**
Director, Office of Contracts
and Grants
Wakanyeja Pawicayapi Inc.
Member, The Carter Center
Mental Health Task Force

Ellyn Jeager
Interim Executive Director
National Mental Health
Association Georgia

Raymond A. Jetson
Chief Executive Officer
Louisiana Family Recovery Corps

Debra Johnson
Chair
National Association of Mental
Health Planning and
Advisory Councils

Yolonda M. Johnson
Program Secretary
The Carter Center Mental
Health Program

Celinda Jungheim
First Vice President,
Board of Directors
Recovery Inc.

Nadine Kaslow, Ph.D.
Professor and Chief Psychologist
Emory University School
of Medicine
Emory Department of Psychiatry
and Behavioral Sciences, Grady
Hospital
Member, The Carter Center
Mental Health Task Force

Glynda King
Division of Mental Health,
Developmental Disabilities
and Addictive Diseases
Project Specialist
Georgia Department of
Human Resources

**Matthew Klieman, M.S.W.,
LCSW**
Human Services Policy Analyst
Department of Health and
Human Services

Ray Kotwicki, M.D., M.P.H.
Assistant Professor
Emory University School
of Medicine

Courtney Lang, J.D.
U.S. Public Affairs Liaison
Eli Lilly & Company

Jerome Lawrence
Administrative Assistant
Georgia Mental Health
Consumer Network

William B. Lawson, M.D., Ph.D.

Michael Levier
Housing Coordinator
City of Opelousas

Verlyn O. Lewis-Boyd
Executive Director
Louisiana Federation of Families

Bill Lichenstein
President
Lichtenstein Creative Media

Christopher W. Loftis, Ph.D.
Policy Analyst
National Health Policy Forum

Beverly Long
Past President
World Federation for
Mental Health

Martha Long, CPRP
Executive Director
MHA Village

Paula A. Madrid, Psy.D
Director
The Resiliency Program

William Maloy
Pastoral Counselor
The Virginia Institute of
Pastoral Care

**Ronald Marks, Ph.D., M.S.W.,
M.P.H.**
Dean
Tulane University School of
Social Work

**Anthony J. Marsella, Ph.D.,
DHC**
Professor Emeritus
Department of Psychology,
University of Hawaii

Catherine Marshall
Founder and Board Member
Women's International
Leadership Institute

Mimi M. McFaul
Senior Research Associate
WICHE Mental Health Program

Martha McGlothlin, M.A.
Director, Community
Preparedness Section
Texas Department of State
Health Services

Gail Mears, Psy.D.
President, American Mental
Health Counselors Association

Allison Metcalf, M.S.W.
Director of Research
Children's Home Society of Florida
Anne Michaels
Director, Communication and
Public Affairs
National Foundation for
Mental Health

Greg Miller
Writer
Science Magazine
2004-2005 Rosalynn Carter
Journalism Fellow

Mark Mitchell, Ph.D.
President-Elect
National Association for Rural
Mental Health

Dawne Morgan
Director
Georgia Department of Human
Resources/Child and Adolescent

David G. Moriarty, BSEE
Team Leader
Health-Related Quality of Life
Surveillance Program
Centers for Disease Control
and Prevention

John A. Morris
Director, Human Services Practice
The Technical Assistance
Collaborative Inc.

Kay Gresham Morrison
Project Director
Southeast Addiction
Technology Transfer Center
Morehouse School of Medicine

Joyce Murray, Ed.D., R.N., FAAN
 Director, Ethiopia Public Health Training Initiative
 The Carter Center

Richard K. Nakamura, Ph.D.
 Deputy Director
 National Institute of Mental Health

James Nowicki
 Vice President
 Affiliated Computer Services

Jenn O'Connor
 Senior Policy Analyst
 Center for Best Practices
 National Governors Association

Joy D. Osofsky, Ph.D.
 Professor
 Louisiana State University
 Health Sciences Center

Rebecca Palpant, M.S.
 Senior Program Associate
 Rosalynn Carter Fellowships for Mental Health Journalism
 The Carter Center
 Mental Health Program

Jane Parker, M.P.H., L.C.S.W.
 Associate Dean
 Tulane School of Social Work

Kavita Patel, M.D., M.S.H.S.
 Associate Natural Scientist
 The RAND Corporation and University of California, Los Angeles, Semel Institute

June Peoples
 Executive Producer
 Lichtenstein Creative Media

Rick Peterson, Ph.D.
 President
 National Association for Rural Mental Health

Denise Pope, L.C.S.W.
 Project Hope Director
 Behavioral Health Link

David W. Proefrock, Ph.D.
 Chief Executive Officer
 Georgia Psychological Services

Erika Putinsky
 Director
 Hands-On Gulf Coast

Lynne Randolph
 Program Development Coordinator
 The Carter Center Mental Health Program

Charles G. Ray
 President
 CGR & Associates LLC

Darrel A. Regier, M.D., M.P.H.
 Executive Director, American Psychiatric Institute for Research and Education
 American Psychiatric Association

Dori Reissman, M.D., M.P.H.
 Senior Medical Adviser
 Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health

Barry Riesenber
 President
 American Aging Concern

Norman Robinson
 News Anchor
 WDSU-TV

Rhonda Robinson Beale, M.D.
 Chief Medical Officer
 United Behavioral Health and American Managed Behavior Healthcare Association

Yolanda Roman
 Director, Channel Strategy and Advocacy
 Ortho-McNeil Janssen Pharmaceutical Services

Douglas M. Ronsheim, D.Min.
 Executive Director
 American Association of Pastoral Counselors

George Rust, M.D., M.P.H.
 Interim Director
 Morehouse School of Medicine

Marc A. Safran, M.D., M.P.A., DFAPA, FACPM
 Chair, Mental Health Work Group
 Centers for Disease Control and Prevention

Eileen Salinsky, Ph.D.
 Policy Analyst
 National Health Policy Forum

Ruth Sanchez-Way, Ph.D.
 Vice President of Health Community Initiatives
 M.S.D. Inc.

Howard Savin, Ph.D.
 Board Member
 American College of Mental Health Administration

Carole Schauer, M.S., R.N.
 Senior Consumer Affairs Specialist
 Substance Abuse and Mental Health Services Administration

Monica Schoch-Spana, Ph.D.
 Senior Associate
 Center for Biosecurity of University of Pittsburgh
 Medical Center

James H. Scully, Jr., M.D.
 Medical Director and Chief Executive Officer
 American Psychiatric Association

Marion E. Sherman, M.D., M.B.A., DFAPA
 Chief Clinical Officer
 Twin Valley Behavioral Healthcare

David L. Shern, Ph.D.
 President and Chief Executive Officer
 National Mental Health Association

Ruth Shim, M.D.
 Community Psychiatry Fellow
 Emory University

James Shultz, M.S., Ph.D.
Director, DEEP Center
University of Miami Miller School
of Medicine

Joel Slack
President
Slack Consulting, LLC
Member, The Carter Center
Mental Health Task Force

Thurston S. Smith, AFC, NCAC
Case Manager
Court Services and Offender
Supervision Agency for the
District of Columbia

Nancy C. Speck, Ph.D.
Health Consultant
University of Texas
Medical Branch

Anthony H. Speier, Ph.D.
Director, Disaster Mental
Health Operations
Louisiana Office of Mental Health

Sandra A. Spencer
Executive Director
Federation of Families for
Children's Mental Health

Melissa Staats, M.A., M.S.W
President and Chief
Executive Officer
National Association of County
Behavioral Health and
Developmental Disability Directors

Judy Stange, Ph.D.
Executive Director
National Association of Mental
Health Planning and
Advisory Councils

Sandra Stockwell, B.S.N., R.N.
Nurse Case Manager
Emory University, Rollins School
of Public Health

Sally Sullivan
Project Recovery

Terri Tanielian
Senior Research Analyst
RAND Corporation

Theodore Taranto, Ed.D.
Director of Community Services
Massachusetts Department of
Mental Health

Kenneth S. Thompson, M.D.
Associate Professor of Psychiatry
and Public Health
University of Pittsburgh

Karen Travis, M.S.W.
Member, American Group
Psychotherapy Association

Henrie Treadwell
Director, Community Voices
Morehouse School of Medicine

**Sharon Jenkins Tucker,
M.A.**
Executive Director
Georgia Mental Health
Consumer Network

Farris Tuma, Sc.D., M.H.S.
Traumatic Stress Disorders
Research Program
National Institute of
Mental Health

Hyong Un, M.D.
National Medical Director
Behavioral Health Aetna

Cynthia Wainscott
Board Member
National Mental
Health Association

Sharon Weeks
President, Board
Mental Health Association
of Mississippi

Conni Wells
Consultant to the National
Federation of Families for
Children's Mental Health

Charles Willis
Project Director
Self Directed Recovery
Georgia Mental Health
Consumer Network

Wendy Wise
Project Manager
Northrop Grumman

Lynne Wright, L.C.S.W.
Director of Project Hope
Georgia Department of
Human Resources
Division of Mental Health,
Developmental Disabilities and
Addictive Diseases

Tingsen Xu, Ph.D.
Professor, Tai Chi Grand Master
Tai Chi Research and Health
Association and Emory University

Mental Health Task Force

The Carter Center Mental Health Task Force Members

Rosalynn Carter, Chair

Renato D. Alarcon, M.D., M.P.H., Consultant, Mayo Clinic; Professor of Psychiatry, Mayo Medical School; Medical Director, Adult Psychiatry Teaching Unit, Psychiatry and Psychology Treatment Center, Mayo Medical Center

William G. Baker Jr., M.D., President, Atlanta Regional Health Forum

William R. Beardslee, M.D., Psychiatrist-in-Chief, Gardner Monks Professor of Child Psychiatry, Harvard Medical School

Carl C. Bell, M.D., FAPA, FAC.Psych., President and CEO, Community Mental Health Council, University of Illinois

Richard Birkel, Ph.D., Executive Director, Rosalynn Carter Institute for Caregiving

Mary Jane England, M.D., President, Regis College

W. Rodney Hammond, Ph.D., Director Division of Violence Prevention, National Center for Injury Prevention and Control Centers for Disease Control and Prevention

Ethleen Iron Cloud-Two Dogs, M.S., Director, Office of Contracts and Grants, Wakanyeja Pawicayapi Inc.

Nadine J. Kaslow, Ph.D., Professor and Chief Psychologist, Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine

Sally Engelhard Pingree, Trustee, The Charles Engelhard Foundation; Member, The Carter Center Board of Trustees

David Satcher, M.D., Ph.D., Former Surgeon General of the United States and Assistant Secretary for Health and Human Services, Director of the Center of Excellence for Health Disparities, Poussaint/Satcher/Cosby Chair in Mental Health, Morehouse School of Medicine

Leslie Scallet, J.D., Washington, D.C.

Joel Slack, Executive Director, Respect International

Beverly Tatum, Ph.D., President, Spelman College

Cynthia Ann Telles, Ph.D., Assistant Clinical Professor, Department of Psychiatry and Biobehavioral Sciences, The University of California at Los Angeles School of Medicine

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Thomas Bryant, M.D., J.D., Chairman, President's Commission on Mental Health, 1977-78; President, National Foundation for Mental Health

Kathryn Cade, White House Projects Director for First Lady Rosalynn Carter, 1977-80; Judge Baker Children's Center Board Member

Benjamin G. Druss, M.D., M.P.H., Rosalynn Carter Endowed Chair for Mental Health Associate Professor of Health Policy and Management, Rollins School of Public Health, Emory University

FELLOWS

William Foege, M.D., Director, Centers for Disease Control, 1977-83; Health Policy Fellow, The Carter Center

Julius Richmond, M.D., Surgeon General of the United States and Assistant Secretary of Health and Human Services, 1977-81; John D. MacArthur Professor of Health Policy, Emeritus, Harvard University

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Leon Eisenberg, M.D., Pressley Professor of Social Medicine and Professor of Psychiatry, Emeritus, Harvard Medical School, Department of Social Medicine

Mental Health Task Force

Jeffrey Houpt, M.D., Former Dean and Vice Chancellor for Medical Affairs, School of Medicine, University of North Carolina, Chapel Hill

Antonia Novello, M.D., Commissioner of Health for New York State Department of Health; Surgeon General of the United States, 1990-93

Robert D. Ray, Governor of Iowa, 1969-83; President Emeritus, Drake University

Richard Surles, Ph.D., Commissioner, New York State Office of Mental Health, 1987-94; Head of Operations, Comprehensive NeuroScience Inc.

Joanne Woodward, Actress; Director

STAFF

John Hardman, M.D., President and Chief Executive Officer, The Carter Center

Thomas H. Bornemann, Ed.D., Director, The Carter Center Mental Health Program

Lei Ellingson, M.P.P., Assistant Director, The Carter Center Mental Health Program

Rebecca Palpant, M.S., Senior Program Associate, Rosalynn Carter Fellowships for Mental Health Journalism
The Carter Center Mental Health Program

Lynne Randolph, Program Development Coordinator, The Carter Center Mental Health Program

Yolonda M. Johnson, Program Secretary, The Carter Center Mental Health Program

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THE
CARTER CENTER



ONE COPENHILL
453 FREEDOM PARKWAY
ATLANTA, GA 30307
(404) 420-5100 • FAX (404) 420-5145

WWW.CARTERCENTER.ORG