Katrina Survivors Strive to Reclaim Their Lives

Lynne Lamberg

TORONTO—Planning to rebuild, many evacuees have returned to New Orleans and other coastal areas affected by Hurricane Katrina, which struck on August 29, 2005, and Hurricane Rita, which followed 3 weeks later. Many of them knew someone who died in the storms. Many lost homes, property, and jobs. Some still are separated from families and friends.

"These individuals display enormous resilience," said Howard Osofsky, MD, PhD, chair of psychiatry at the Louisiana State University Health Sciences Center (LSUHSC) in New Orleans. "Yet many also report feeling demoralized by the slowness of recovery work and the enormity of mile after mile of devastation."

Osofsky and others recounted community mental health outreach activities that started days after Hurricane Katrina, along with efforts to assess and minister to ongoing needs of survivors, at the annual meeting of the American Psychiatric Association here in May. Speakers also discussed tactics that may improve delivery of care after future disasters, including a large federally funded initiative to document Katrina's long-term mental health impact and to monitor survivors' progress.

FLOOD OF CONCERNS

After such events as hurricanes, forest fires, and even the terrorist attacks of September 11, 2001, other areas in the United States have progressed from acute crisis to active recovery within a few months, Osofsky said. New Orleans, he maintained, "has transitioned only from acute crisis to chronic crisis."

Much of the health infrastructure has yet to be restored. New Orleans has 77 psychiatric inpatient beds today compared with 460 before Katrina, in all hospitals other than those run by the US Department of Veterans Affairs, the Louisiana Department of Health and Hospitals reports. In the New Orleans metropolitan area—Orleans, Chalmette, Jefferson, and St Bernard parishes—there were 289 psychiatric beds on July 5, 2006, compared with 668 pre-Katrina—a 57% reduction. Every month, police and emergency medical technicians (EMTs) pick up about 100 patients who need hospitalization for acute psychiatric illness; some must be transported 100 to150 miles away for hospital admission, Osofsky said.

Liz Roll/FEMA

A police officer pleads with a New Orleans woman to evacuate the city in response to Hurricane Katrina. Researchers are studying the disaster's effects on the mental health of first responders and city residents.

Early on, the Louisiana Department of Health and Hospitals' Office of Mental Health launched Louisiana Spirit, a crisis and recovery initiative, with funding from the Federal Emergency Management Agency (FEMA) and the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Osofsky became clinical director; his wife, Joy Osofsky, PhD, who directs LSUHSC's division of pediatric mental health, was asked to oversee child and adolescent programs.

Among the hardest hit were the area's first responders. In the week following Katrina, 2 police officers died by suicide. About 200 officers allegedly left their posts. Many police and fire stations were destroyed. Police and firefighters struggled to do their jobs without vehicles, food and water, a change of clothing, or a place to sleep. Some 80% of the city's first responders lost their own homes.

About 3 weeks post-Katrina, FEMA provided 4 stripped-down docked cruise ships as interim housing for area police, firefighters, and EMTs, most initially separated from their families. The Osofskys spent 2 nights a week on the ships; they and their teams also accompanied police on rounds in boats to provide help in the field. Important early tactics to restore a semblance of normality included bringing families to join workers on the ships—which eventually housed roughly 4000 people—and returning children to school.

The researchers surveyed 668 first responders—police, firefighters, and EMTs—at their job sites between February and May 2006, using standard questionnaires for posttraumatic stress disorder (PTSD Checklist-Civilian Version [PCL-C]) and depression (Center for Epidemiologic Studies Depression Scale-Short Form [CES-D-SF]) used by

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the Centers for Disease Control and Prevention, with additional questions on alcohol use and marital function. The self-administered surveys took about 20 minutes to complete, and drew a greater than 95% response rate, Osofsky said. Funding sources included SAMSHA, FEMA, and Louisiana Spirit.

Most respondents had witnessed deaths and injuries. Moreover, 1 in 20 reported the death of a family member, and 1 in 4, of a friend. About 1 in 10 described symptoms consistent with PTSD; 1 in 4, symptoms of depression; 1 in 5, increased alcohol consumption, and 2 in 5, increased marital conflict. Yet 2 in 5 also expressed a desire for counseling, a high proportion for this population, Osofsky said, and an indicator of the severity of their stress. First responders and their families are receiving clinical treatment with no out-of-pocket fees.

Children affected by Katrina also report high levels of stress, said Joy Osofsky. She reported preliminary findings from 1638 students in grades 4-12, among more than 5000 who completed the National Child Traumatic Stress Network (NCTSN) needs assessment and screening survey between December 2005 and May 2006. Nearly all students asked to participate did so, completing the surveys at school. About 1 in 3 said they had been separated from a parent or guardian, and 1 in 10 still were separated when they completed the survey. More than 1 in 5 had experienced the death or injury of a family member or friend. Nearly half had a parent who was unemployed.

On the positive side, she said, these children expressed pleasure in returning to school, being with other children, and resuming normal activities. Nonetheless, 54% met criteria for consideration for mental health referral, with symptoms of PTSD or depression. More than 14% requested counseling.

The same researchers also surveyed 619 children in preschool and grades 1 to 3, using an NCTSN questionnaire keyed to developmental age, filled out by 95% of parents asked to participate when they brought their children to school. This survey found that 31% met the criteria for mental health referral, manifesting symptoms such as irritability, headaches, and sleep problems, including nightmares. About 40% of parents sought services for their children. A variety of summer programs being offered to children of different ages aim to build coping skills, using curricula from the Louisiana Rural Trauma Services Center, developed by the NCTSN (http://www.nctsn.org).

EVACUEES IN DALLAS

After often harrowing experiences in the New Orleans Superdome and convention center, about 50 000 city residents were evacuated to Dallas and housed in that city's convention center and Reunion Arena. Dallas rallied mental health professionals to volunteer services for evacuees, setting up a crisis clinic in the medical triage unit at the convention center, said Carol North, MD, professor of psychiatry and Nancy and Ray L. Hunt Chair in Crisis Psychiatry at the University of Texas Southwestern Medical School in Dallas.

North and colleagues performed a retrospective chart review of all mental health contacts in that clinic September 1-15, 2005. Some 138 clinicians, 71% of whom were psychiatrists, saw 419 individuals, around 90% of whom were adults, some more than once. Most of these people were from New Orleans or its environs. Slightly more than half were female; most were black.

Clinicians had given about 1 in 3 a trauma-related diagnosis, such as acute stress disorder or a new depressive or anxiety disorder. Preexisting major mental disorders exceeded acute post-Katrina problems, however, affecting nearly half of those evaluated. Such disorders included major depressive or bipolar disorder, schizophrenia, alcohol and drug abuse, developmental disorders, and mental retardation. Nearly 2 in 3 people reported they had been taking medications that included antipsychotics, mood stabilizers, antidepressants, opiates, and benzodiazepines. Planners had not anticipated seeing many evacuees with substance abuse withdrawal symptoms and needing a methadone clinic, North said.

These findings contrast with those of the Disaster Psychiatry Outreach group (http://disasterpsych.org) after the September 11 terrorist attacks, she noted. In the New York Family Assistance Center, September 15 through November 20, 2001, 268 volunteer psychiatrists saw 848 people who received mostly trauma-related psychiatric diagnoses. Few reported alcohol or drug abuse or severe or chronic mental illness. About half the medications dispensed in New York City were hypnotics or anxiolytics, said North.

A second Dallas study, by the City of Dallas and Mental Health Association of Greater Dallas (http://www.mhadallas.org), involved a needs assessment between November 2005 and February 2006 of both Katrina and Rita evacuees, most of whom were housed in city apartments paid for by FEMA. Mental health professionals, including many volunteer social workers who had been displaced themselves, used structured interviews to ask all adult heads of households they could locate—about 500 individuals—about hurricane-related exposures and posttraumatic symptoms.

While data are still being analyzed, North said, many evacuees reported such distressing experiences as being rescued from a roof or bridge, losing family members or friends, or seeing bodies in the water. Going to a shelter added another layer of hardship, with separation from family members, physical discomfort, and worries about the future.

Moving into apartments brought little peace of mind, given uncertainties about how long FEMA support would continue. About 1 in 10 overall reported a constellation of symptoms suggestive of PTSD. Many more reported individual symptoms of traumatic stress.

After some disasters, the experience of being under duress is short, North observed. For hurricane evacuees, it was prolonged.

COLLECTING SURVIVORS' STORIES

A federally funded longitudinal research project aims to assess mental health needs of Katrina survivors, patterns of

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service use, and barriers to getting care, in hopes of improving preparedness for future disasters. Project Director Ronald Kessler, PhD, professor of health care policy at Harvard Medical School, Boston, Mass, and colleagues plan to interview about 3000 people, a representative sample of the 6.5 million adults affected by Katrina, every 6 months over the next 2 years. The researchers identified these individuals via random digit dialing of more than 100 000 residences nationwide, using lists from relief agencies, hotels, shelters, and other sources. Participants in the Hurricane Katrina Community Advisory Group include residents of the New Orleans metropolitan area and hurricane-affected areas of Alabama, Louisiana, and Mississippi.

Researchers conducted baseline interviews between January and March 2006, asking the same questions used in the Third National Comorbidity Survey Replication (NCS-R), a face-to-face household survey conducted between 2001 and 2003, also directed by Kessler. Availability of NCS-R data collected from 800 people in the same areas in 2003 allows comparisons of the same population before and after the hurricane, Kessler said. Results from the first wave of interviews are scheduled to be released in August in the *Bulletin of the World Health Organization* (http://www.who.int/bulletin/en/).

Researchers digitally recorded individuals' hurricane stories and will gather updates on how their lives progress as the study continues. More than 1000 oral histories are available at http://www.hurricanekatrina.med.harvard.edu. □

Experts Work to Prevent College Suicides

Lynne Lamberg

TORONTO—Feeling depressed after a friend's suicide, a college student voluntarily admitted himself to his university hospital's psychiatric unit. Within 2 days, the university barred him from campus and suspended him from school.

The student is now suing the institution, George Washington University in Washington, DC, claiming his suspension violated the Americans with Disabilities Act. The case received extensive press coverage, often critical of the university. In a March 13 editorial, the *Washington Post* said, "If the university wants to encourage ill students to seek timely treatment, this is a strange way to go about it."

Mandatory withdrawal policies for students deemed suicide risks appear to be on the rise at the nation's universities, said Paul Appelbaum, MD, a past president of the American Psychiatric Association (APA), at a symposium on campus suicides he chaired at APA's annual meeting here in May. College administrators worry about legal liability and adverse publicity that may follow a student suicide on campus, noted Appelbaum, professor of psychiatry and director of the division of psychiatry, law, and ethics at the Columbia University College of Physicians and Surgeons in New York City. Administrators also seek to avoid exposing other students to the disruption and stress that follow a campus suicide, and to minimize the likelihood of copycat suicides.

Yet mandatory leave takes students away from their friends, often their main support system, and may intensify feelings of failure, Appelbaum said. Some students may not find refuge at home; indeed, dysfunctional family relationships may contribute to distress. A mandatory leave policy also may discourage troubled students from seeking help (Appelbaum P. *Psychiatr Serv*. 2006;57:914-916).

Appelbaum and others discussed both practical tactics and ethical dilemmas in assessment and treatment of potentially suicidal college students. Speakers described a novel Web-based outreach program and a comprehensive mental health system now in place at one of the nation's premier universities.

A TRAGIC TOLL

An estimated 1100 suicides and 24 000 suicide attempts occur annually among US college students aged 18 to 24 years. About 10 million such students were enrolled in US colleges and universities in 2003—about one third of individuals in that age group living in the United States. The suicide rate on campus, estimated to be about 7.5 per 100 000 students, is about half that in nonstudents the same ages. Suicide is the third leading cause of death after unintentional injuries and homicides in persons aged 15 to 24 years in the United States, according to the Centers for Disease Control and Prevention. Because homicides occur less frequently in college students than in

Caitlin Cahill/iStockphoto.com

An estimated 1100 suicides and 24 000 suicide attempts occur annually among US college students aged 18 to 24 years. Colleges are grappling with how best to prevent suicides in this population.

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