Progress Made and Challenges Left: Perspective From Mississippi

Geographic circumstances: Although it was weakening, Hurricane Katrina impacted Jackson, Mississippi, 150 miles north of the initial landfall. I have made frequent trips to the Mississippi Gulf Coast to aid in short- and long-term recovery.

About the author: I am a developmental and behavioral pediatrician at the University of Mississippi Medical Center (the only medical school in the state), where I have been for the last 25 years. Since Katrina, my location has remained the same, but I have traveled more than ever to the Gulf Coast to help where needed in both a service and teaching capacity. For the American Academy of Pediatrics, I am a member of the Committee on Development, which helps to raise money for disaster relief along with other child issues, and a member of the National Convention Planning Committee, our large national continuing education meeting, which has dedicated several hours of education time to disaster preparedness.

Here we are 5 years later; numerous meetings, conference calls, plans, and formal talks have passed on the topic of disaster preparedness—time many people spent hoping to make better the damage that occurred to our land and our people and to help our nation better prepare for a disaster. However, are we really better able to handle a disaster of the seismic proportions that Hurricane Katrina brought to our Gulf Coast? Are we really where we need to be to handle children and their families who are affected by a major disaster in an efficient, seamless manner? Is there a clear protocol of what needs to be done in preparation for an impending disaster to adequately address children’s needs? Where are we now in the realm of mental and behavioral health for the families who were so affected by the wrath of the storm?

Perhaps the best way to explain where we are and how far we have to go is to recap what happened in my area 5 years ago. Before Katrina, Blair Batson Children’s Hospital had just recently revamped its disaster plan. An often-overlooked child mental health piece took form. We identified 3 major areas that needed attention: coverage of the emergency department to help children and their families with anxiety, grief, and separation issues; accommodations for children who do not require hospitalization and have missing or injured caretakers; and management of children who require intensive psychological services.

During the early aftermath of the hurricane, we found that several problems emerged. First of all, we had no plan in place for the hospital staff and faculty who had children at home. Our area, 200 miles from the coast, received hurricane-force winds. Much of the metropolitan area was without electricity, and gasoline was in short supply. Homes were damaged, and many roads were blocked by downed trees and other debris. Schools and child care centers were closed because of damage and/or lack of staff. Those who staffed Blair Batson Children’s
Hospital had no one to care for their own children at home so they could leave them and staff the hospital. The focus quickly shifted to setting up child care for essential personnel at the hospital. The real mental health piece fell by the wayside in an effort to just keep the hospital open. We did it; the quickly set up child care worked. We were able to keep our hospital staffed, but an unexpected thing happened. We did not have the number of patients come in that we had expected.

As it turned out, we hardly needed the “emergency” mental health piece at all. We had the hospital covered and beds open to take patients, but no one came. Communication between the recovery effort on the Gulf Coast and our hospital was so poor that no one seemed to know that our hospital had beds available.

What we needed, but had not planned for, was help with the long-term mental effects that occur when a disaster as devastating as Katrina occurs. The American Academy of Pediatrics came to the rescue by using Friends of Children money to set up meetings on the Gulf Coast with the major players including the Mississippi and Louisiana state chapters to determine the needs of the children and their families. The American Academy of Pediatrics also helped to secure a grant from the Doris Duke Foundation that allowed implementation of a plan to help with the child behavioral and mental health issues that occurred. Over the next 2 years, behavioral health specialists helped identify and treat those children who had significant issues. The grant monies helped to pay for the therapy fees and additional meetings for parents and professionals. Initially, teams from other areas of the state traveled to the coast to screen for children with mental or behavioral health issues. As local resources improved, we found that there were providers who lived on the coast and were ready to take over so the children were sent to the local services. Having the children served by local providers served a twofold purpose: the providers were able to make some income, and the children were being served by providers who understood all that the children and their families were going through. In the future, accessing the local providers who are available is something that should be done even earlier than it was done in this case.

As I began to write this article, I found that many people believe that recovery has been slow. Although the coastal areas are cleaned up and look much improved, there are many continuing ramifications left in the wake. Then the oil spill happened—a different kind of disaster, but nonetheless, it was a major disaster. Someone equated the spill as a one-two punch that had occurred to those who had been so affected by the hurricane. This time the mental health of the entire Gulf Coast area was affected. More jobs were lost, more incomes were dropped, and there was more anxiety and depression; another leap backward had happened.

The more questions that I asked, the more I found that, although we have made great progress in disaster planning, there is much left to do. In the question of recovery, I decided that one of the best places to go to find out how much we have really recovered in the area of child mental health and how ready we might be for the next disaster, was to start with the parent of one of my patients, a teacher in the Biloxi, Mississippi, Gulf Coast school system. She noted that although things look better and many have begun to rebuild, still many residents have not returned. This decrease in the population has had a ripple effect. The schools, which are generally excellent, have had to lay off teachers because of the diminished number of students. A nationally recognized school in the area recently closed. The income of so many families has decreased so much that families’ lifestyles have changed. Resources that help make family life better are still limited. Parks, theaters, restaurants, and child care centers are in short supply. She also noted that the children in the schools seem better adjusted, but some still have fears and anxieties that resurface, even with minor storms. Because many parents continue to suffer from depression and/or anxiety about their financial situations, there has been an increase in the rate of mental and behavioral health problems, substance abuse, child abuse, and family disruption. Then the oil spill happened to further knock down the strong people who live in this area. The people along the Gulf Coast are a largely tough and resilient lot, but recovery is certainly not complete.

Whether the disaster is the result of a bombing, a plane crash, an earthquake, or a storm, the recovery does not happen at the end of the cleanup of the environment and the patching of the physical wounds and the burial of the dead. There is much left to do to help repair the mental and emotional well-being of those affected.

We must also remember those who are the providers of the postdisaster mental health services. During one of the early trips to the coast after Katrina, we were meeting with some of the providers who had been through the storm and were serving patients on the coast. We were listing our plans, what we were going to do, and whom we were going to send to help. During lunch, we asked one of the mental health providers at the table a simple question: “How are you?” She burst into tears and choked out that we were the first to ask about how she was. She had spent weeks helping others, but...
no one had thought to see what she needed. As it turned out, she had lost her home, her possessions—everything—but was continuing to help others.

So are we ready for another disaster? There has been ongoing work on disaster planning in the American Academy of Pediatrics. Excellent resources are now available for families on disaster readiness. The dissemination of the materials in Mississippi has continued, and there is no doubt that families will be better prepared with the next occurrence. Our hospital and state-wide disaster planning group have worked with other groups in the surrounding states. However, when a question was asked recently about who would be the one person to call in each state about patient transport from the disaster to a hospital, the answer was not as definitive as I had hoped. I am not aware of a published contact list for who is responsible for what. We must be sure that we have not stopped short of developing the clearly delineated triage system that will ensure the best possible efficiency when another disaster happens, and one will. We need not just a list to triage patients but also a list of who to call when specific services are needed. I, and my colleagues, need easy access to a list that would include a designated person in each state to help coordinate mental and behavioral help for children. The list needs to have depth so that when the first and second persons are unable to respond there are other options. A support structure should also be present for the providers of the services.

A disaster drill that is a coordinated effort should occur to determine how far we have really come in the planning efforts and if we are ready to handle another man-made or natural disaster. Much energy was contributed to disaster planning in the first couple of years after the great storm; however, we must not settle back before the plan is complete. Intact communication within each state, between states, and nationally will allow families to stay together and hospitals to communicate with rescue personnel so that the closest available tertiary center is used. Once it is set up, a test of the system needs to occur to ensure that the communication lines really work.

We cannot afford to stop now; there is too much at stake.
Progress Made and Challenges Left: Perspective From Mississippi
Susan Buttross
Pediatrics 2011;128;S28
DOI: 10.1542/peds.2010-3724L

Updated Information & Services
including high resolution figures, can be found at:
/content/128/Supplement_1/S28.full.html

Subspecialty Collections
This article, along with others on similar topics, appears in the following collection(s):
Emergency Medicine
/cgi/collection/emergency_medicine_sub
Disaster Preparedness
/cgi/collection/disaster_prep_sub

Permissions & Licensing
Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:
/site/misc/Permissions.xhtml

Reprints
Information about ordering reprints can be found online:
/site/misc/reprints.xhtml
Progress Made and Challenges Left: Perspective From Mississippi
Susan Buttross
Pediatrics 2011;128;S28
DOI: 10.1542/peds.2010-3724L

The online version of this article, along with updated information and services, is located on the World Wide Web at:
/content/128/Supplement_1/S28.full.html