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 staffers Blair Batson Children’s
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state chapters to determine the needs
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Gulf Coast with the major players in-
dren money to set up meetings on the
American Academy of Pediatrics came
as devastating as Katrina occurs. The
Academy of Pediatrics came
to the rescue by using Friends of Chil-
dren money to set up meetings on the
Gulf Coast with the major players in-
cluding 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 Do-
ris Duke Foundation that allowed im-
plementation of a plan to help with the
child behavioral and mental health is-
issues that occurred. Over the next 2
years, behavioral health specialists
helped identify and treat those chil-
dren 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
taveled to the coast to screen for chil-
dren with mental or behavioral health
issues. As local resources improved,
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 chil-
dren served by local providers served
a twofold purpose: the providers were
able to make some income, and the
children were being served by provid-
ers who understood all that the chil-
dren 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 oc-
curred to those who had been so af-
fected 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 back-
ward had happened.
The more questions that I asked, the
more I found that, although we have
made great progress in disaster plan-
ing, 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 popula-
tion 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 sit-
uations, 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 re-
silient lot, but recovery is certainly not
complete.
Whether the disaster is the result of a
bombing, a plane crash, an earth-
quake, 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 statewide 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.
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