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Mending Our Nets:
Psychosocial Care in Post-Katrina New Orleans

Jane Parker[1]

During the writing of this article, my community and I experienced Tropical Storm Faye, Hurricane Gustav, and Hurricane Ike to varying degrees. In the instance of Hurricane Gustav, I complied with a mandatory evacuation that was instituted for New Orleans and surrounding parishes. Though constant threats and disruptions to our safety occurred, the storms and the evacuation allowed some of my colleagues and me to compare the state of psychosocial services and other disaster-related issues from post-Katrina to post-Gustav. In general, the evacuation of vulnerable groups had dramatically improved across the region. Nevertheless, the issues of race, class, and economic valence were again obvious in terms of who had the resources for transportation out of harm's way.

For people without a car or money to pay for transportation and temporary lodging, the decision to evacuate is more complex than for those in the middle- and upper- class with these resources. For example, a minimum-wage earner who does not have family or friends with whom to stay or who lacks the money to purchase accomodations must stay in a shelter. Food and gasoline costs add another burden to low-income households.

I am fortunate to have family members less than three hours away; however, I would be able to purchase motel accommodations had I not had family within driving distance. Therefore, my decision to comply with the evacuation order was fairly straightforward.

The evacuation for Gustav evoked both current and Katrina-related anxieties and imposed certain expenses on my colleagues, friends, and me. Sitting in contraflow traffic,[2] being displaced from home, and not knowing

the actual status of one's property and belongings add to the worry and exhaustion of even the "ideal" evacuation. We experienced what I have termed "evacuation fatigue." Frankly, I doubt that I would have evacuated a second time in one hurricane season, even though I know better.

Hurricane Katrina hit New Orleans and the Gulf Coast with a vengeance on August 29, 2005, leaving thirteen hundred known dead and millions of dollars in property loss and damage in its wake.[3] It has become known as the worst natural disaster in recent U.S. history. While the city and surrounding regions were battered by natural disaster, a technological disaster—the failure of an inadequate man-made levee system—flooded almost 80 percent of the city. The levees protecting the city could not withstand the powerful surge from Katrina, leaving many homes severely flooded and their owners unable to return home. Those who did not evacuate were at risk of drowning in their own homes; sadly, many did. The media were full of pictures of people wading in above-the-waist water, retreating to their roofs, and being forced to leave pets behind as Coast Guard helicopters airlifted them to safety.

It is not only the physical environment of the city that was affected, but also the psychological environment. The challenges of having quality mental health services available for existing and emerging mental health needs are being addressed, and, in some ways, services have improved. However, advocacy and program development are still needed due to remaining infrastructural inadequacies and concerns. The need for innovative mental health program development is crucial, especially for populations who may have fallen through the cracks, such as immigrants, new residents, the elderly, adolescents, and substance abusers.

This article discusses mental healthcare providers' efforts to serve communities recovering from Katrina and the continuing need for mental health care, especially in light of recent evacuations associated with Hurricanes Ike and Gustav in fall 2009. First, this article provides an

overview of a recovering city along five indices of community health: population recovery and shifts, economics, housing, public services, and mental health services. Next, this article asserts that even adequate crisis response systems will continue to struggle in a city still in need of economic, housing, educational, and criminal justice support. Additionally, ground-breaking programs and collaborations within a struggling community are discussed to inform and inspire the reader to follow the recovery efforts in the New Orleans and Gulf Coast region, with particular attention to psychosocial needs and vulnerable populations. Finally, with Tropical Storm Faye and Hurricanes Ike and Gustav pounding the city during the writing of this article, reflections on infrastructural improvements and continued needs of residents are offered.

I. A RECOVERING CITY

In discussing the psychosocial or mental health service system of post-Katrina New Orleans and the new demands on that system, it is first necessary to understand the broader environment of the city and its post-Katrina recovery efforts. The recovery of the city is described through the pattern of population return, the housing issues returning residents face, and the shifts in daily business services offered to the public. When discussing each of these areas, the shifts in the financial needs and economics of the region are also discussed.

A. Population Recovery and Shifts

To understand how the city is recovering and how the psychosocial systems are responding, one first needs to look to how the city is being reinhabited and the current needs of returning residents and newcomers. Three years after Katrina and the levee failures, 72 percent of the city's residents have returned.[4] In the greater region, 87 percent of the population has returned, 86 percent of jobs have been regained or newly gained,[5] and sales tax revenues are at almost 90 percent of pre-Katrina figures.[6]

Nevertheless, the rate of returning residents, jobs, students, and home rebuilding has, as expected, slowed during 2008.[7] Though the statistics on population demonstrate a city trying to rebuild and repopulate, the returning numbers significantly indicate that most residents have been through the evacuation process before and have memories of a pre-Katrina New Orleans.

Both returning and new residents are relocating to the least flooded parts of the city and region, with 50 percent of active households in the drier neighborhoods.[8] An increasing number of Hispanic households are located in the metropolitan area, with many residents working in construction or other aspects of physical recovery.[9] By actively participating in physical recovery, this working population sees the continued and lasting devastation in the city.

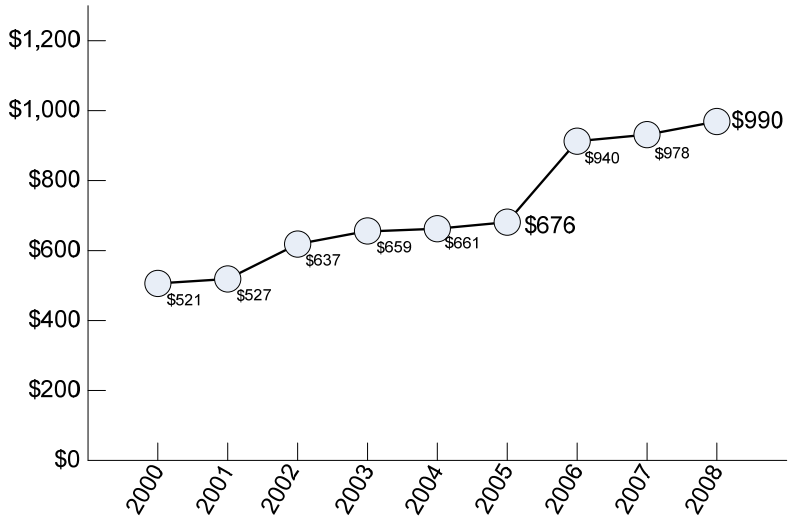
On the other hand, some groups of former residents seem to be choosing not to return in large numbers. School enrollment data indicates that families with children are less likely to return to the area.[10] Of pre-Katrina public and private school students, 76 percent have returned,[11] and enrollment in the city is less than 50 percent.[12] This data would indicate that while a majority of the New Orleans's population is approaching pre-Katrina figures, some of that population is comprised of new residents who came to the city largely for work opportunities in the construction and rebuilding industry.

B. Housing

Challenges of higher costs, especially for housing, greet newcomers and returning residents alike. Along with the devastation to the region, the returning population is affected by the recent financial crisis in this country, making it more challenging for people to pay for the basics of food, gasoline, and housing both in and beyond disaster-affected areas. With the landscape of supply and demand now skewed in New Orleans, fair-market rental costs in the region have risen by a staggering 46 percent.[13] Many

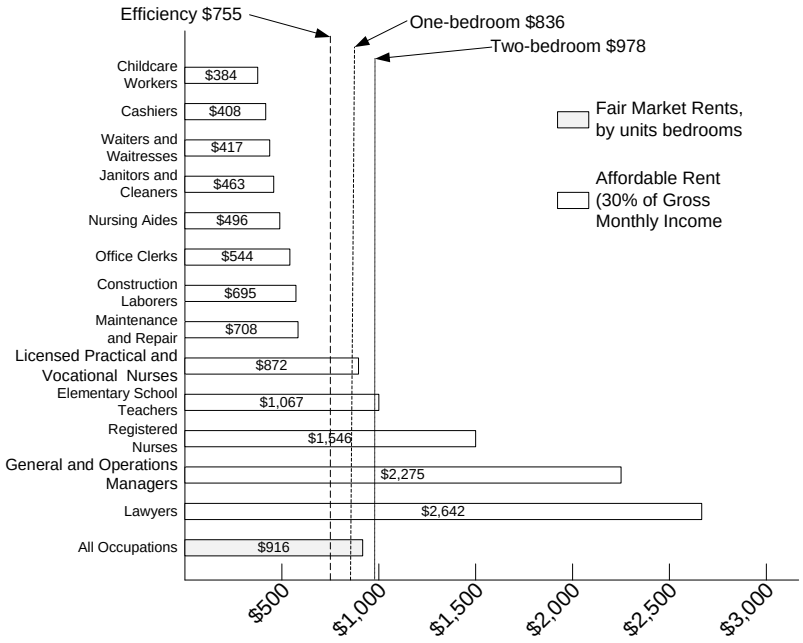
low-income and lower-middle-class residents, including essential service workers, cannot afford rent in the New Orleans area. For example, child care workers and maintenance/repair workers have to spend on average more than 30 percent of their income on rent.[14] A two-bedroom apartment now rents for an average of $990, as opposed to $676 in 2005.[15] To further burden working-class residents, disaster housing assistance vouchers will expire in March 2009, affecting fourteen thousand low-income families.[16]

Figure 1: Fair market rent for a two-bedroom apartment has increased 46 percent since 2005.



S O U R C E*: U.S. Department of Housing and Urban Development, Fair Market Rent History 2000 to 2005 and County Level Data File for 2006-2008.*

Figure 2: Affordable montly rent by occupation with 2007 fair market rents.



SOURCE: *Bureau of Labor Statistics Occupational Employment and Wage Estimates, May 2007, and U.S. Department of Housing and Urban Development, County Level Data File for 2006-2007.*

The above data demonstrates the difficulties that people in lower-middle- and low-income brackets face in affording housing. The result is that more families are living in cramped and unhealthy conditions, often in crime-ridden neighborhoods.

Though residents have continued to return and rebuild New Orleans, risks remain high for certain vulnerable populations, such as immigrants and the homeless. With an increase of Hispanic residents in the area, there are new

concerns about the affordability of housing and potential discriminatory targeting of this vulnerable group. There are anecdotal, yet widespread, reports of Hispanic construction workers being mugged, robbed, or extorted for their wages. The perpetrators seem to be taking advantage of these workers' reluctance to access protective law enforcement services due to fears of being deported.[17]

Regarding the homeless population, a 2008 article retrieved from *The Real Truth* claims that one in twenty-five residents in New Orleans is homeless.[18] According to the advocacy group Unity for the Homeless, the rise is due to a number of factors:[19] lack of affordable housing, cracks in the federal system designed to provide temporary housing after Katrina, insufficient financial resources,[20] and closing of Charity Hospital and other service centers for the seriously mentally ill and addicts.[21]

Additionally, the slow process of federal assistance is contributing to the risk of homelessness. Funds from the Federal Emergency Management Agency (FEMA) for the Orleans and St. Bernard parishes have not always reached those families in need of disaster aid.[22] While the Army Corps of Engineers works diligently to improve the city's flood protection to withstand the "1 percent storm" (a storm with a 1 percent chance of occurring per year), the Corps still identifies some neighborhoods that remain at risk of six to eight feet of flooding in another major storm.[23] The federal agencies' contributions to homelessness, resulting from a lack of secure housing and outright mistrust by many residents, add to the sense of anxiety and powerlessness among both the housed and the homeless.

C. Public Services

Along with shifts in population and housing, new needs are arising in the public services sector that need to be addressed, including education, public transportation, and child care. In both the city and metro areas, Hispanic students account for 5.9 percent of enrollments, compared to 3.9 percent prior to Katrina.[24] More students with limited English proficiency are now

enrolled in public schools.[25] Therefore, there is an increased need for both English language training for Hispanic students and Spanish language training for teachers and service providers is increasing.

Just as the city is struggling with issues of access to education because of the language demands of the new population, it is also struggling with its public transportation system. Not only has returning to New Orleans been difficult for many, but once they have returned, low-income residents lack mobility around the city due to the city's damaged public transportation system. There is a continuing rise in the need for and use of public transportation; however, the Regional Transit Authority is not yet operating at even 30 percent of its pre-Katrina capacity.[26] Prior to Katrina, public transit was underutilized in more affluent neighborhoods.[27] With a new population mix, as well as a drastic rise in gasoline prices, the current demand is different. The streetcar system has been restored during the past year, and I have observed that streetcars regularly tend to be full, especially during times when most people are traveling to and from work or school.

Similarly, the availability of child care services remain far below pre-Katrina levels, at 43 percent in Orleans Parish.[28] Since many families with children have not returned to New Orleans, the exact demand for child care is uncertain; yet a National Public Radio report indicates there are only one hundred institutionalized day care centers in a region that had approximately three hundred prior to the storm.[29] Finding staff for the child care centers is particularly challenging for those centers that want to reopen.[30] While wages for child care aides are in the same range as those for food service workers, workers in the food service industry can often earn better benefits with bigger hotels or food chains such as Burger King or Starbucks.[31]

The strain of seeking proper child care while trying to work or seek employment adds to parents' stress levels. Low-income women of color, who are the most disadvantaged minority in greater New Orleans and most large urban areas in the United States, are most affected by this struggle.[32]

These women are less likely to pursue mental health services for several reasons: lack of transportation, lack of child care providers, and fear of placing their children with unreliable caregivers.[33]

D. The Need for Mental Health Services

As a result of the psychological and social threats of the storm and flooding, returning residents, along with new immigrants coming to the city, need psychosocial care services at a higher rate than residents of the average American community. For returning residents, this need stems from the experience of evacuating, living in temporary housing, returning, and struggling to meet basic needs.

The population shift out of the more damaged neighborhoods, coupled with the slow delivery of assistance for homeowners to repair their property, contribute to the area's almost seventy-two thousand vacant or blighted homes.[34] These damaged, decaying properties and vacant, overgrown lots are a continual reminder of the devastation of three years ago. Such visual cues act as a physical, daily reminder of the devastation and loss suffered by many, and they contribute to the psychological trauma for many residents.[35]

Additionally, long displacements from home and the ongoing stressors of dealing with insurance, assistance agencies, contractors, and other entities have created a general sense of continuing disaster, with no recovery period for some residents.[36] Many residents report experiencing *Katrina brain*, a term indicating general malaise, mood swings, poor concentration, bad memory, and a low level of persistent sadness and anxiety.[37]

As a result, doctors, psychiatrists, and emergency room personnel report increased symptoms of hypertension, worsening of chronic illnesses, and a sharp rise in anxiety and depression.[38] Popular media and scientific reports since 2005 have identified the rise in anxiety in New Orleans, with the most recent year seeing a shift from anxiety to much harder-to-treat symptoms of major depression.[39]

The mental health system must not only deal with the long-term effects of Katrina, it must also address immediate mental health needs of the rescued and the rescuer. In the initial post-Katrina months, suicides tripled, according to the Orleans Parish coroner.[40] Twenty percent of police officers and firefighters—many of whom had lost their own homes—reported symptoms of post traumatic stress disorder (PTSD).[41] Surveys of people living in FEMA trailers showed that 66 percent of female caregivers reported symptoms of anxiety, depression, and other mental disorders;[42] half of the children in their care reportedly had mental health problems of their own.[43]

Such data sounds the alarm for greater integration of mental health considerations into all major emergency preparedness planning and response systems. To think that responders and ordinary citizens will experience the personal or collective destruction of a disaster the magnitude of Katrina without psychological fallout is at once naïve and dangerous. In New Orleans and nationally, those in the legal, social service, health care, education, and emergency planning professions have a particular obligation to advocate for psychosocial services for responders and residents.

After Katrina, the need for mental health services for both the chronically mentally ill and the general population increased at a time when many mental health providers were unable to operate.[44] A 2006 Center for Disease Control (CDC) report stated that half of those polled claimed to be suffering from mental health problems, yet only 2 percent of them were receiving services.[45] Simultaneously, many healthcare providers were unable to practice due to flooding of their offices. Because of evacuation or destruction of provider facilities, patients of both private and public mental health services were disconnected from their healthcare providers, thus disrupting their medication and/or psychotherapy regimens. The massive flooding and eventual closure of the Medical Center of Louisiana—known as "Big Charity" hospital—left thousands of physically and mentally ill indigent persons without a medical facility.[46] Prior to Katrina, the Big

Charity hospital was a Level 1 Trauma Center and the chief provider of indigent care in the city.[47]

In addition to having lost facilities and services, evacuees returned to a very different life in New Orleans. What many reports do not discuss is the difficulty of living in New Orleans with higher prices, higher insurance rates, and higher crime. These subtle and not-so-subtle pressures, along with the threat of future hurricanes, add ever-present tension to the air of routine life in the city. Ironically, at this writing, Hurricane Gustav's outer bands and the surge of the Gulf have affected areas southwest of the city near the community of Lafitte, Louisiana, flooding homes and businesses again. As before, local and state agencies, along with the American Red Cross and other social service agencies, responded to the crisis. Though the response is immediate, I and many local residents ask, how many more times can we go through this? The wearing effect of living under a hurricane threat for six months out of the year becomes more obvious in the days prior to an actual landfall, as the potential path of the hurricane shifts.

II. An Improving Mental Health System

Until 2008, the rate of returning or new psychosocial care services in the New Orleans's area lagged behind the rate of repopulation. Since then, innovative programming and collaborative planning have allowed increased improvements and access to mental health services. Many individual practitioners and agencies are concerned about the state of psychosocial care in New Orleans, and solutions will require coordination among providers. The Louisiana Public Health Institute has been a major leader in bringing together regional mental health providers and other stakeholders into a group called the Behavioral Health Action Network. Through live and online collaboration, the Network identified the city's critical mental health service needs, including psychiatric crisis response systems, including inpatient psychiatric treatment; provider workforce development,

recruitment and retention; and access to community-based psychiatric treatment and support services.[48]

As a result of collaborative efforts, the landscape of mental health services has brightened during 2008. New alternatives have been created to replace Big Charity Hospital, which prior to Katrina provided 96 percent of emergency psychiatric stabilization sources. Most recently, the situation has been improved by the addition of the following five programs:

1. Mental Health Emergency Room Extensions (M-HERE) in University Hospital and West Jefferson Medical Center;
2. Assertive Community Treatment (ACT) teams under contract with Metropolitan Human Services District (MHSD);
3. Jefferson Parish Human Services Authority (JPHSA);
4. Crisis Intervention Team (CIT) training for New Orleans police and Jefferson Parish sheriff deputies; and
5. Additional psychiatric beds in LSU's Calhoun Campus and New Orleans Adolescent Hospital (NOAH).

Additionally, Louisiana's governor, Bobby Jindal, and the state legislature have taken steps to improve services and New Orleans's access to them. Of particular significance was creation of the Primary Care Access and Stabilization Grant (PCASG) funding, which provides mental health services on a sliding fee scale.[49] Further, other federal and FEMA disaster relief money has finally reached service providers in recent months, allowing for the development of long-awaited programs. In total, the Department of Health and Human Services has spent almost 2.7 billion dollars for health care recovery for the entire Gulf Coast region.[50] While these program and funding additions are certainly progressive, there is still a need for more economic, housing, and other basic infrastructural support.

III. Recommendations from the Field

The restructuring and collaboration in mental health service provision has started a dialogue in the community about what is still needed. The recruitment of new service providers is an area of concern currently being addressed. New providers can offer economic and psychological support not only to the community, but also to existing providers who suffer from overwork and fatigue from the past three years.

A. Response to Needs of Service Providers

An ongoing concern is the mental health of the mental health workforce, specifically regarding recruitment, retention, and the health of the providers themselves.[51] The Louisiana Public Health Institute's 2008 mental health status update underscores this concern: mental health staff directly impacted by the hurricanes may still be attempting to rebuild their personal lives, individuals providing care experience similar symptoms as their clients, such as anxiety and PTSD, and civil service and nonprofit pay scales have yet to be adjusted to the new cost of living in the region.[52]

In an attempt to inform workforce leaders of worker needs, LPHI is currently conducting a workforce survey to identify environmental factors impacting staff in health care settings. Results are expected to be available in early October 2008.[53] Furthermore, LPHI is administering a Louisiana Workforce Commission grant for health workforce development in priority parishes, including funding for mental health professionals.[54]

Greater attention to individuals on the front lines of immediate disaster response and of ongoing recovery is vital for the continued health and job effectiveness of individuals and organizations. Few humans will ever endure the experience of dealing with the sights, sounds, and smells of a flooded city where debris and bodies of animals and people were discovered. Service people assist victims with their personal and collective traumas on a daily basis. To persistently hear the horror stories of others,

while often not being able to offer full services, brings a secondary trauma to providers. Building resilience enhancement programs into the organizational policy and practice systems of responder agencies may not only mitigate past disaster effects, but also inoculate workers, to a certain degree, against extreme psychosocial damage from future disasters.

B. Response to Needs of At-Risk Clients

In the wake of a major disaster, it is not surprising that individuals with the most serious illnesses are more likely to have episodes of exacerbated symptoms. In order to decrease the frequency of psychiatric emergencies and to improve management of their occurences, the Behavioral Health Action Network has come up with three recommendations.[55]

First, the Network recommends better outpatient care that closely follows the most serious, chronically mentally ill to prevent them from becoming a danger to themselves or others and to hospitalize them most frequently. Second, the Network recommends decriminalization of the chronically mentally ill. Jail is not the proper place for mentally ill or addicted persons who are acting out in public. Their symptoms need treatment through various combinations of psychiatric medications and appropriate level of care, whether inpatient, outpatient, day hospitalization, group home, or other. Third, the Network recommends integrating nonurgent primary and behavioral healthcare services. Logically, low-income residents who cannot afford transportation to distant specialized mental healthcare facilities will access decentralized and community-based facilities more frequently. Treating both physical and psychosocial issues in one location seems not only more efficient, but more holistic and normalizing after such traumatic events as hurricanes, deaths, property loss, and ongoing weather threats.

One example of holistically treating a person's needs within the community is an initiative of the Tulane University School of Medicine. The Tulane Community Based Health Center's program creates a "medical

home" for patients where their physical and behavioral health needs can be addressed.[56]

Additionally, recent legislation providing school loan forgiveness and other incentives to practice in underserved or disaster-affected areas have increased the number of healthcare providers and medical students coming into the region.[57] Funding such as the Primary Care Access Grant provides greater access to mental health services by allowing free and sliding-scale payments.[58]

Funding from the American Red Cross, door-to-door counseling programs like Louisiana Spirit, and the hundreds of volunteers still coming to the city further buttress the historically inadequate mental health system.[59] With no major weather event in three years—until Faye, Gustav, and Ike—many felt safe to come into the city. The number of college and graduate students interested in disaster recovery and mental health is increasing, resulting in curriculum changes and special programs like the Disaster Mental Health Certificate program of the Tulane School of Social Work.[60] Social work, public health, and medical students can take a new course, Psychosocial Aspects of Disaster. Students are required to work in interdisciplinary teams with a simulated disaster involving multiple layers of psychosocial and environmental needs. Students must address the exercise from the emergency planning phase through response and recovery, with particular attention paid to vulnerable populations. Related to this curriculum change, existing courses such as Crisis Intervention and Comparative Treatments of Anxiety and Depression have added more psychosocial case studies in disaster and recovery.

C. Response to Need for Basic Services

Along with development of and support for psychosocial services for providers and at-risk clients, New orleans is improving basic services in preparation for future evacuations. From his experiences with Katrina, Gustav, and other emergencies, Matt Kallmyer, deputy director of the

Office of Emergency Preparedness (OEP) for the City of New Orleans, offered the following information regarding transportation and sheltering after Hurricane Gustav:[61]

1. While the City-Assisted Evacuation Plan was successful in moving thousands of residents out of the city via trains and buses, there were still many people who waited too long before requesting Hurricane Gustav evacuation assistance, even though evacuation was meant to be more accessible as residents could call 311 or register online or in person with their parish OEP for services.

2. Government-subsidized assistance with personal fuel costs may promote greater willingness to evacuate, as would a moratorium on gas taxes during evacuation and repatriation.

3. The OEP would like to see a region-wide FEMA sheltering plan. A creative strategy would be to fund all hazard shelters with sleeping, feeding, showering, and toileting capacity beyond that of usual schools and sports arenas that could also be used as revenue-producing facilities for other venues in non-hazardous times.

4. Although only in a proposal stage, one idea is to use closed military bases for future sheltering.

Transportation was a precious commodity during Gustav, despite prior vendor agreements. One state bus vendor reportedly did not supply the promised buses, one of the three city vendors chose not to supply buses at all, and another supplied fewer buses than agreed upon. The supply of ambulances and animal transport units was reportedly inadequate for moving seriously ill persons or for moving animals to safe shelters. Though the city still is addressing logistical needs, the combination of an improved mental health care support system for both the population and service providers, along with infrastructural support around evacuation planning, will allow for a more holistic system of necessary services to the New Orleans population.

In conclusion, in addition to the recommendations of others captured earlier in the article, personal observations and study compel I want to reiterate certain points to address before, during, and after disasters regarding specific populations and programs.

1. Services to Vulnerable Populations

More psychosocial advocacy and program development are still needed, especially for immigrants and new resident workers who are often denied proper wages and basic safety on the job.[62] Additionally, there needs to be constant awareness that the elderly, the chronically mentally ill, poor women of color, and the homeless are especially vulnerable in a disaster its associated evacuation. Advocates for these groups must be part of the planning and policy formulation with the Office of Emergency Preparedness and the Department of Homeland Security. Otherwise, services to these vulnerable groups would be reactive rather than proactive.

From my interactions with local emergency planning and Homeland Security personnel, I know that these personnel are, in fact, concerned about mental health needs and vulnerable populations. They have been frank, however, in telling me that their priority is moving people out of harm's way. They do not have the training or full resources to meet mental health needs. However, they seem open to ideas on how to best address their needs through inclusion of social work and other mental health experts in the planning and execution of disaster response. It is noteworthy that the Office of Emergency Planning now accepts social work interns for their required one-year field placement.

In terms of services to the chronically mentally ill, New Orleans still needs more inpatient psychiatric beds, especially for adolescents and substance abusers. Thus, greater coordinated case management across service providers, including evacuation and repatriation planning with their most at risk clients, is recommended.

2. Safety Planning by Private Citizens

All citizens now must take increased responsibility in making a personal or family safety plan to activate in a disaster. A safety plan should include, at a minimum, basic ways to communicate with family members during a disaster. Phone numbers, an out-of-state contact, basic survival supplies for three days, and a first aid kit should be included in a family's organization for disaster. If there are elderly, disabled, or other persons with special needs in the household, early requests for assistance should be made for evacuation. Individuals and families need to decide early on whether to remain sheltered in place or to leave the region, realizing the consequences of defying a mandatory order to evacuate. Such defiance means the individuals cannot rely on normal services such as fire, police, ambulance, water, electricity, or public transportation during or immediately after a critical incident.

In the regions where multiple and sequential threats exist—as in the case of Faye, Gustav, and later, Ike—and where the possibility of mandatory evacuations continue, residents experience evacuation fatigue and may become less likely to evacuate when needed. Therefore, not only safety planning, but also community practice evacuation drills may increase citizen confidence in knowing what to do in emergencies.

One such simulation was held in early July 2008, in which a mock evacuation was held to test emergency response and transportation systems. At the Incident Command Center, I participated in making calls to a parish Office of Emergency Preparedness with various requests for assistance. The scripts for the calls were based on actual calls from previous disasters. Further, the evacuation transportation systems were tested using over two hundred actors representing evacuees with various special needs. Additionally, the actual evacuation for Hurricane Gustav was a real test of these systems and of the contraflow traffic plan out of the city. My personal experience of contraflow was challenging, exemplified by my nine-hour trip to a relative's home in central Missippi—typically a three-hour trip.

3. Continued Support for Service Providers

Finally, more attention and resources should be focused on psychosocial care for primary, secondary, and ongoing responders who provide services during times of crisis. First responders are those essential protective personnel who are first on the scene, like emergency medical services, fire fighters, and police. Secondary responders tend to be people such as clinicians, social workers, and physicians who are meeting the off-site needs of the disaster victims. There is overlap between secondary responders and ongoing responders who continue to work on disaster relief, such as nongovernmental organizations like Habitat for Humanity, volunteers, social workers, counselors, and case managers. As previously discussed, immediate exposure to disasters and ongoing efforts around disaster relief exert a mental toll on all levels of responders. In order to better serve a population in recovery efforts, continued vigilance and psychosocial support is needed for service providers and responders alike.

IV. CONCLUSION

Holistic community recovery in New Orleans will simultaneously bolster the recovery of the mental health system. Previously discussed initiatives by Louisiana's new governor, Bobby Jindal, and the Louisiana State Legislature will hopefully continue to support community recovery and to mend the nets of psychosocial care in New Orleans.[63] New collaborations have allowed innovative means of providing support and services to the community. However, there is still much to do for the community to completely recover and for the mental health system to provide all necessary services with proper support.

While television images of "business is back" in the Superdome and French Quarter are certainly applauded, the nation seems to have turned a blind eye, not only to the devastation of Katrina and the ongoing threats to the Gulf Coast regions, but also to the drastic social injustices they broadcasted as well. According to the Second Kaiser Post-Katrina Survey

focusing on Orleans Parish, many New Orleans residents see a lack of opportunity, are disappointed in the pace of recovery, and feel forgotten by the nation and its leaders.[64] The nation should not be oblivious or insensitive to New Orleans, not only because of the danger of a house divided, but also because it cuts off the exchange of knowledge for best practices in disaster recovery that can be useful in any part of the United States.

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[1] Jane Parker, MPH, LCSW, DCSW, is the director of the Institute for Psychosocial Health at Tulane University, which supports the Social Work Certificate Program in Disaster Mental Health. For more information, visit http://tulane.edu/socialwork/centers /institute-for-psychosocial-health.cfm.

[2] Contraflow traffic utilizes all interstate highway lanes for people to drive out of the city up to a certain geographical point, with exits and other access points to lanes normally used to drive into the city blocked off.

[3] Democracy Now!, *How Many Are Missing and Dead After Katrina? Three Months After the Hurricane, the Numbers are Still Unknown*, Dec. 9, 2005, *available at* http://www.democracynow.org/2005/12/9/how_many_are_missing_and_dead.

[4] AMY LIU & ALLISON PLYER, THE NEW ORLEANS INDEX, ANNIVERSARY EDITION: THREE YEARS AFTER KATRINA, (Brookings Inst. Metro. Policy Program & Greater New Orleans Cmty. Data Ctr. Aug. 2008) at 6, *available at* http://www.gnocdc.org/NOLAInde x/NOLAIndex.pdf.

[5] *Id.*

[6] *Id.* at 10.

[7] *Id.*

[8] *Id.* at 7, 8.

[9] *Id.* at 8.

[10] *Id.*

[11] *Id.*

[12] *Id.*

[13] *Id.* at 12.

[14] *Id.*

[15] *Id*.

[16] *Id.*

[17] *Id.*

[18] *Post-Katrina New Orleans*: *Homeless Rate Rise to 1 in 25*, REALTRUTH.ORG, Mar. 18, 2008, http://www.realtruth.org/news/080318-001-society.html.

[19] *Id.*

[20] After the initial job boom, many out-of-town workers who came to New Orleans lost their jobs as more homes were restored and residents exhausted their funds, any insurance, and assistance funds.

[21] The closing of these advocacy centers has resulted in displacement of the seriously mentally ill from their housing, overburdening missions and shelters.
[22] Sheila Crowley, *Where is Home? Housing for Low-Income People After the 2005 Hurricanes, in* THERE IS NO SUCH THING AS A NATURAL DISASTER: RACE, CLASS, AND HURRICANE KATRINA 129–37 (Chester Harman & Gregory D. Squires eds., 2006) (2005).
[23] LIU & PLYER, *supra* note 4, at 7.
[24] *Id.* at 8.
[25] *Id.*
[26] *Id.* at 14.
[27] *Id.*
[28] *Id.* The data does not indicate the actual ridership or child care needs in Orleans Parish.
[29] *All Things Considered: Family Affair: Childcare in Post-Katrina New Orleans* (National Public Radio broadcast Apr. 9, 2008), *available at* http://www.npr.org/templates/story/story.php?storyId=89502238.
[30] *Id.*
[31] *Id.*
[32] Avis A Jones-DeWeever & Heidi Hartmann, *Abandoned Before the Storms, in supra* note 4, at 85.
[33] *Id.*
[34] Liu & Plyer, *supra* note 4, at 14.
[35] Russell McCulley, *Is New Orleans Having a Mental Health Breakdown*?, TIME.COM, Aug. 1, 2006, http://www.time.com/time/nation/article/0,8599,1221982,00.html.
[36] *Id.*
[37] *Id.*
[38] *Id.*
[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] *See Health Care in New Orleans and the Gulf Coast Three Years After Katrina*, MEDICAL NEWS TODAY, (Aug. 2, 2008), http://www.medicalnewstoday.com/articles/117028.php.
[45] McCulley, *supra* note 35.
[46] First opening its doors in 1736, L'Hôpital des Pauvres de la Charité (Hospital for the Poor), Charity Hospital has been moved, reopened, and at the center of political maneuvering for over 250 years. In the United States, only one hospital is older than Charity: Bellevue Hospital in New York, which opened its doors just one month before Charity.
[47] Bill Quigley, *Trying to Make It Home: New Orleans One Year After Katrina*, COMMON DREAMS.ORG, Aug. 22, 2006,http://www.commondreams.org/views06/0822-31.htm.
[48] OVERVIEW, *supra* note 47.

[49] *See* U.S. Dep't of Health and Human Services, Estimates Show That More Than 40 Percent of Hurricane Evacuees Now Receiving HHS Benefits or Services, HHS.GOV, Sept. 29, 2005, http://www.hhs.gov/news/press/2005pres/20050929a.html.
[50] *See* http://www.hhs.gov/news
[51] OVERVIEW, *supra* note 47.
[52] *Id.*
[53] Unavailable at the time of this article's publication.
[54] *Id.*
[55] *Id.*
[56] *Id.*
[57] *Id.*; Peter Finney. Jr., *Door-to-Door Post-Katrina Counseling Critical to Recovery*, CATHOLIC NEWS SERVICE, Aug. 6, 2006, http://www.catholicnews.com/data/stories/cns/0604529.htm.
[58] OVERVIEW, *supra* note 47.
[59] *Id.*
[60] I coordinated this program and have taught many classes within it.
[61] Personal e-mail communication from Matt Kallmyer, Deputy Director, Office of Emergency Preparedness, New Orleans, LA, Sept. 22, 2008
[62] Puentes Presentation to the Diversity Committee, School of Social Work, Tulane University, New Orleans, LA (Oct. 21, 2008).
[63] OVERVIEW, *supra* note 47.
[64] THE KAISER FAMILY FOUND., NEW ORLEANS THREE YEARS AFTER THE STORM: THE SECOND KAISER POST-KATRINA SURVEY (2008), http://www.kff.org/kaiserpolls/upload/7789.pdf?msource=EDU34.