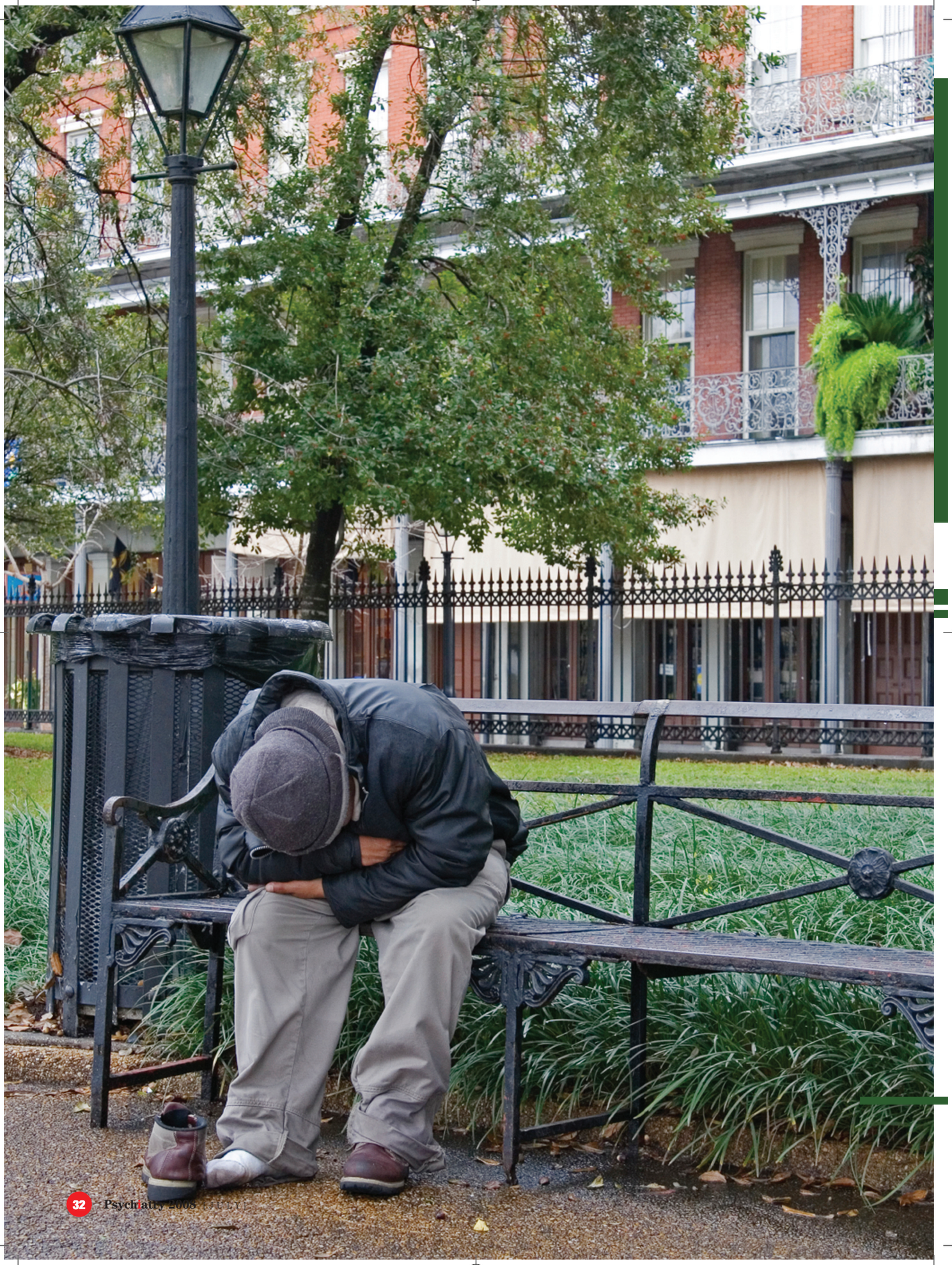

[REVIEW]

The Struggle for Mental Healthcare in New Orleans—One Case at a Time

by MORDECAI N. POTASH, MD
Associate Professor of Clinical Psychiatry, Tulane University Department of Psychiatry and Neurology, New Orleans, Louisiana

ABSTRACT

Using cases publicized in the media, this article demonstrates key issues that have led to the crisis in mental healthcare in New Orleans. These cases demonstrate the plight of chronically mentally ill individuals returning to New Orleans, the emotional stresses faced by New Orleans residents rebuilding their lives, and the consequences of shunting mental health services from a healthcare setting to law enforcement. This article also describes preexisting deficits in Louisiana's mental health system that contributed to this crisis as well as factors that have hampered the rebuilding of the mental health infrastructure in New Orleans. Finally, this article suggests future changes for needed mental health services after a large-scale disaster.

INTRODUCTION

Since Hurricane Katrina's landfall on August 29, 2005, New Orleans's healthcare infrastructure has been struggling to recover its pre-storm resources in order to meet the needs of returning residents and the influx of people assisting in the recovery effort.

In no other area of healthcare has this struggle been as evident as it has been in mental health services. The on-going lack of mental health services has been so pronounced that it has been repeatedly termed a "crisis" by the media,[1] political leaders,[2] and mental health organizations[3] alike.

This article discusses several of the key issues that have led to this crisis. In particular, we focus on the lack of services available to chronically mentally ill residents with preexisting psychiatric disorders and the problems that have resulted due to the shortage of services, the development of new and severe mental health symptoms stemming from overwhelming post-Katrina stressors, and the shunting of mental treatment from healthcare settings to treatment after arrest and incarceration in correctional settings.

Although this article uses actual cases, the information in these case examples is all garnered from public sources, such as print and televised media. Information about these cases does not come from treatment records or interviews with healthcare providers, and no privacy-protected health information is disclosed. These cases do mirror many of the clinic situations that mental healthcare providers have found themselves treating in New Orleans since Hurricane Katrina.

ADDRESS CORRESPONDENCE TO: Mordecai N. Potash, MD, Associate Professor of Clinical Psychiatry, Tulane University Department of Psychiatry and Neurology, TB-48, 1440 Canal Street, 10th Floor, New Orleans, LA 70112; Phone: (504) 988-5405; E-mail: mpotash@tulane.edu

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The issues raised in this article are ones faced by other municipalities in the United States. Hurricane Katrina has certainly exacerbated these issues, but other municipalities are facing similar problems. It is my hope that by discussing these issues we can help build stronger mental health services for all whom we serve.

CASE 1—THE PLIGHT OF THE RETURNING MENTALLY ILL

Much of the published literature about psychiatric issues from Hurricane Katrina has focused on the development of acute or posttraumatic stress symptoms in evacuees who witnessed traumatic events in their homes and evacuation centers. However, some of these studies have also demonstrated the barriers faced by the chronically mentally ill evacuees who left New Orleans like most others.

Gavagan and colleagues[4] found a high number of evacuees at the Houston Astrodome with preexisting psychiatric diagnoses that would lead to serious problems if left untreated. Russell-Rodriguez and colleagues[5] found that 14 percent of evacuees treated at an evacuation center in Oklahoma had preexisting mental illness that required medications pre-hurricane that also pre-disposed them to experience posttraumatic stress disorder (PTSD). North and colleagues[6] found high rates of pre-evacuation diagnosis of bipolar mood disorder (7.2%) and schizophrenia (16.3%)—along with urgent requests to refill medications used to treat these diagnoses—in several hundred adults surveyed at the Dallas Convention Center. Other published reports[7] also found frequent mental health complaints among evacuees, but these reports did not differentiate preexisting symptoms from those that developed due to the trauma of the storm.

As residents began to return to New Orleans in the late fall and winter of 2005, mental health services did not follow their return. One often-cited report by Weisler[8] found that 22 psychiatrists remained in New Orleans from a pre-storm total of 196. The State of Louisiana Department of Health and Hospitals found only 42 of 208 psychiatrists practicing in the greater New Orleans area.[9] The same state report found that mental health beds had dropped from 487 beds pre-storm to 190 beds—with many of those beds already filled by institutionalized mentally ill patients. By one accounting, there were only 17 mental health beds in New Orleans for acute mental health issues a year after Katrina's landfall.[10]

It was in this setting that Willie Lewis and his family returned to New Orleans. On March 31, 2007, Mr. Lewis was brought to a hospital in New Orleans by police officers. The police had been called to transport Lewis, who had a long-standing diagnosis of paranoid schizophrenia, because he had been refusing to take his psychiatric medications and had been threatening his mother.[11] According to police reports, Mr. Lewis declined treatment at the hospital and left—reportedly without a physician evaluation. Less then 10 minutes after arriving back at home, Mr. Lewis repeatedly stabbed his 77-year-old mother in the driveway of their home in the Uptown section of New Orleans. Mr. Lewis was then arrested and is now being held in Orleans Parish Prison on charges of attempted second degree murder.[12]

This incident prompted widespread publicity about violence being committed by the chronically mentally ill in New Orleans. Mayor C. Ray Nagin released a letter that he urgently sent to then Governor Kathleen Blanco demanding that at least 100 mental health beds be opened in New Orleans.[13] Police also complained that they were spending enormous amounts of time "baby-sitting" the chronically mentally ill and were transporting 185 to 200 mental health patients every month to hospitals—a sharp increase from pre-Katrina levels. It was also publicized that hospitals were trying to curtail police from bringing the mentally ill to their emergency rooms (ERs) for evaluation and treatment. Police reported being berated by nurses at hospitals, who were urging them to take psychiatric patients elsewhere. One reported example claimed that police were met by hospital staffers on the ER ramp hoping to turn away patients before they set foot inside the hospital's grounds and become that hospital's responsibility.[9]

Supporting law enforcement's accusation was the fact that many area hospitals had closed their psychiatric wards after the storm. Therefore, the mentally ill needing hospitalization often had to be transported to psychiatric facilities in Baton Rouge, Alexandria, and Shreveport, Louisiana.[14] With the addition of these mentally ill patients "parked" in their ERs, uncompensated care at New Orleans area hospitals sky-rocketed after Hurricane Katrina. One hospital reported that uncompensated care increased by more than 140 percent—from $17 million prior to Katrina to $41 million after Katrina, with 90 percent of the uncompensated care coming from its ER.[15] Five hospitals reported an aggregate loss of $135 million in uncompensated care after Katrina.

A major issue that prevented area hospitals from reopening their psychiatric wards was that there was no solution in sight for funding uncompensated inpatient mental healthcare. Reopening psychiatric beds would likely have increased area hospitals' problems with uncompensated care, even though it would have alleviated the situation in their ERs. In fact, it is only relatively recently that the state of Louisiana has proposed financing mechanisms of reducing the burden of uncompensated care for hospitals in New Orleans that are caring for the mentally ill.[16]

Because of the lack of mental health facilities in which to place the chronically mentally ill, Orleans Parish Prison has become the largest psychiatric center in New Orleans.[17] It is at that facility where Willie Lewis remains and is presumably finally receiving psychiatric care.

CASE 2—THE MENTAL HEALTH CHALLENGES OF MANY RETURNING NEW ORLEANS RESIDENTS

"If we weren't already the screwiest crowd in America, we sure are now."

Times-Picayune columnist James Gill wrote the quote above in describing the plight of many New Orleans residents as they returned to their homes in late 2005 and 2006.[18] His sentiments have since been borne out by a number of studies examining the mental and emotional health of returning New Orleans residents—most without significant pre-existing psychiatric issues. These studies include the on-going door-to-door survey of over 1500 residents performed by the Kaiser Family Foundation that found 18 percent of returning residents facing serious mental health challenges.[18] In another study—this time a telephone survey done in early 2006 of over 1,000 displaced residents of the Gulf Coast—Wang and colleagues[19] found evidence of mood or anxiety disorders in 31 percent of those surveyed. Most distressing about Wang's study results is that just a fraction of those with symptoms, whether serious or not, were receiving any form of treatment. It was in this environment in New Orleans that the plight of *Times-Picayune* photographer John McCusker occurred.

On August 6, 2006, Mr. McCusker was seen driving erratically in New Orleans and was pulled over to a street corner by police.[20] When officers approached his car, McCusker rolled his window down and repeatedly said, "Just kill me, get it over with, kill me!" When the police did not shoot him, McCusker put his car in reverse and pinned one of the officers between the rear bumper of his car and his police cruiser.

Although lethal force was indicated, the responding officers instead shot at McCusker's back tires. McCusker then drove off and sped down St. Charles Avenue, purposely knocking down a few of the ubiquitous roadside construction signs that appeared after Katrina. Police eventually pulled him over at another intersection several blocks away. McCusker then had to be pulled out of his car and subdued by a Taser device as McCusker continued to resist police and beg the police to kill him.

When media outlets became aware that Mr. McCusker was a *Times-Picayune* photographer—and part of its 2006 Pulitzer Prize winning staff[21]—his arrest became widely reported.[13,22,23] Even the manufacturer of the Taser, at that time under its own public assault by the American Civil Liberties Union for scores of deaths associated with its device,[13] put out a press release that gave the Taser great credit in being able to subdue and arrest McCusker, rather than killing him.[22]

McCusker was very distraught at the scene, which alerted police to his mental health issues. Furthermore, McCusker was known to several police officers through his work as a photographer for the *Times-Picayune*. In fact, he had taken many of the highly publicized photographs of Katrina's impact on New Orleans.[23] McCusker was arrested and charged with battery of a police officer and aggravated flight from an officer.[24] He also underwent psychiatric care through Orleans Parish Prison.

In the days that followed his arrest, many of the stressors that McCusker had been experiencing became generally known. In an eerie coincidence, the current issue of the *American Journalism Review* featured McCusker and other *Times-Picayune* staffers in a tribute to their continuing efforts to cover Katrina's effects on New Orleans.[25] The article discussed that McCusker had wanted to be a photographer for the *Times-Picayune* for decades and could trace his own New Orleanian lineage back to the days of colonial Spain. McCusker had helped the *Times-Picayune* to document New Orleans's darkest moments after Katrina and described his experience this way: "You have to understand the depth of the horror that the city was… Tens of thousands of people on the freeways stranded. The children begging for food and water. The looting at the Wal-Mart. It was of biblical proportions."[26]

In the months after Katrina, McCusker had become increasingly depressed and irritable, and frequently broke into crying fits. He sought psychotherapy, eventually going three times a week. He also took a leave of absence from the newspaper to help him emotionally recover. Although his leave certainly helped him, McCusker had also just learned that his insurance was not going to pay to rebuild his destroyed home.[27] Furthermore, McCusker reportedly had an adverse reaction to psychotropic medication he had been put on to help him deal with his stress during his absence from work.[28]

Following his arrest, there were declarations of support from people representing a wide swath of New Orleans. Mr. McCusker had no prior arrests and his family was well respected in the city. Furthermore, nearly all New Orleanians could easily identify with McCusker's frustration with his insurance company and his symptoms of posttraumatic stress, now formally diagnosed by mental health experts assigned to evaluate him in prison. As Lt. Governor Mitch Landrieu told 8,000 members of the American Psychological Association gathering at that time in New Orleans for a convention, "You don't need an expert—a psychologist or psychiatrist—to see that the people of Louisiana are hurting."[25] *Boston Herald* editorial columnist Rachelle Cohen best captured the zeitgeist of New Orleans by writing, "Everybody has a story, and many are weary of the daily battle just to exist."[29]

In December, 2007, more than a year after the initial incident, McCusker reached an agreement with prosecutors that allowed him to receive probation and the possibility of charges being dismissed in the months to come. McCusker also sincerely apologized in court to the police officer who McCusker had pinned with his car. The presiding judge summarized the view of many when she stated at the end of the hearing, "I think it was a bad

situation, on many parts. It's a good thing no one was seriously injured or we would be in a far different position than we are today."[29]

CASE 3—WHEN LAW ENFORCEMENT BECOMES THE PROVIDER OF MENTAL HEALTHCARE

"When the police department is forced to do the job of the mental health system, it's a lose-lose situation for everyone."[30]

The quote above is from Jeffrey C. Rouse, MD, Chief Deputy Coroner for Orleans Parish. Dr. Rouse is responsible for mental health commitments in New Orleans. Although the quote is his alone, it reflects a sentiment often heard and shared by police officers, emergency room providers, and mental health professionals in New Orleans. As touched upon previously, the police have found themselves the *de facto* provider of front-line mental health care in New Orleans. It is not a job that they desired.

Soon after Katrina's landfall, the police encountered frequent problems dealing with the mentally ill. The day after Christmas, 2005, the police confronted Anthony Hayes, a 38-year-old man who had been diagnosed with schizophrenia.[31] Hayes came to the attention of the police after he confronted a Walgreen's store manager. Hayes was chased by police for several blocks and was shot and killed as he backpedaled down St. Charles Avenue with a knife in his hand.[34] Part of this incident was filmed by a local videographer and was shown widely on national media.

In early May, 2006, Ronald Goodman was killed after a standoff with his police outside his Algiers home. Mr. Goodman also had a long history of mental illness and began shooting at police officers after refusing to be taken into protective custody for psychiatric evaluation.[32] Police tried several times to coax Mr. Goodman out of his house but shot and killed him after a round from Goodman's rifle came within inches of hitting the head of an officer.[33]

Late in the following month, police had to subdue Percy Matthews, a 43-year-old man who was threatening people in the Riverbend section of New Orleans. The police also brought another man into protective custody on the day of Matthews's arrest after he was found to be walking naked along the interstate.[34]

The case that has had the largest impact—and is still being acutely felt—involves slain police officer Nicola Cotton and her accused assailant Bernel Johnson. On Monday morning, January 28, 2008, New Orleans Police Officer Nicola Cotton approached a man sitting down in a small strip mall in the Central City section of New Orleans who matched the description of a rape suspect. Surveillance footage from one of the store's security cameras showed that she motioned for the man to come toward her. The man then attacked Officer Cotton and they struggled in the parking lot for seven minutes. Eventually, the man took Officer Cotton's gun and shot her 15 times, killing her. The man then sat down in the parking lot and waited as other police responded to Cotton's radio calls for help. He then surrendered without incident. The man, Bernel Johnson, was charged with first-degree murder of a police officer.[35]

Within 24 hours after the shooting, local media revealed that Mr. Johnson was not the sought-after rape suspect, but had a similar name. Mr. Johnson did have a history of chronic paranoid schizophrenia with many past psychiatric hospitalizations in the New Orleans area before and after Hurricane Katrina.[36] Johnson's family also described that his repeated abuse of drugs and nonadherence with psychiatric care contributed to Mr. Johnson being homeless, an exploding population of New Orleans. It is presently estimated that four percent, or 1-in-25, of the city's residents are homeless, one of the highest rates recorded in the United States since the 1980s.[35]

Cotton's death opened an outpouring of anger and grief. She had graduated from the first New Orleans Police Academy class after the storm.[37] Police officers recounted that Cotton had even camped out in a FEMA trailer so that she could return to New Orleans to continue her training. Adding to their grief was the fact that Cotton was the second female NOPD officer to be killed in the line of duty. The first female officer had also been fatally shot by another mentally ill man she was trying to take into protective custody.[38] Tempers were only heightened when autopsy results revealed that Cotton was eight weeks pregnant.[39] These strong emotions caused Crisis Unit Commander James Arey to lash out at Louisiana's broken mental health system, saying, "The State of Louisiana had ample time to figure out this guy. And because they weren't doing their job, this officer, my friend, is dead."[40]

The issues brought up in Nicola Cotton's killing—the lack of inpatient psychiatric beds and outpatient services after discharge and difficulty in protecting patients and the public from violence associated with psychiatric illness, substance abuse, and homelessness—has prompted action. The Louisiana Secretary for Health and Hospitals has announced a four-point plan to improve outpatient mental healthcare, including a "Nicola's Law" provision similar to New York State's well-known "Kendra's Law."[41] This plan has already been introduced as a bill before the state legislature with $26 million in funding to achieve its goals.[42] Louisiana Governor Bobby Jindal has also championed these plans and other improvements in the mental health system totaling $89 million, even though it was a topic he had previously rarely discussed in his recent successful political campaign.[43]

At the present time, Mr. Johnson remains in Orleans Parish Prison. He is being held in the part of the prison that houses mentally ill inmates. In fact, he was seen recently by reporters who were being given a tour of this dilapidated and crumbling wing of the prison.[44] He has recently undergone examinations by forensic psychiatrists to determine if he is competent to proceed to trial on a capital murder charge.[45]

DISCUSSION

The cases presented in this article raise several important issues regarding mental healthcare in New Orleans after Hurricane Katrina. The statistics cited in the case of Willie Lewis demonstrate that many emergency receiving sites did not anticipate the high level of pre-existing psychiatric disorders that they found in evacuees. Whether it was the neighboring state of Texas or states farther away, such as Oklahoma and West Virginia, preexisting psychopathology was a common feature in evacuees who sought help immediately following Katrina.

The fact that Louisiana's evacuees had a high level of symptomatic psychiatric illness has been suggested to reflect deficits in mental healthcare existing long before Hurricane Katrina. A series of studies done by the Substance Abuse and Mental Health Services Administration in the year before hurricanes Katrina and Rita showed that Louisiana was in the group of states with the highest rate of serious mental illness[50] and illicit drug use.[51] Louisiana has also consistently received low ratings for its mental health services from the National Alliance on Mental Illness (NAMI), garnering grades such as 'D' on state report cards.[52] Per NAMI's report, these low grades reflect Louisiana's lack of mental health infrastructure, lack of patient information access and portability, and low per capita mental health expenditure of $51.34.

Compounding Louisiana's challenges in mental healthcare is its high poverty rate at 19.6 percent, well above the United State's average of 12.4 percent.[53] Most studies of mental illness and poverty strongly correlate poverty as a risk factor for negative outcomes among the mentally ill.[51] Further problems that Louisiana faced before the devastation of hurricanes Katrina and Rita also included its patchwork system of community mental health care centers and group homes that had been criticized as being riddled with incompetence and fraud.[54–56] The state's Office of Mental Health had also endured deep budget cuts in preceding years, resulting in reductions in residential treatment, substance abuse treatment, and inpatient mental healthcare.[57] In his testimony before the US Senate Governmental Affairs Subcommittee on Disaster Recovery, Louisiana's Disaster Mental Health Operations Director Anthony Speier, testified that the rebuilding of Louisiana's mental health system must correct inequities that existed prior to Hurricanes Katrina and Rita, as well as address pressing issues that have arisen since the storms.[60] These preexisting mental health issues in Louisiana are summarized in Table 1.

TABLE 1. Mental healthcare problems in Louisiana prior to 2005 hurricanes

Low per-capita spending on mental healthcare
Little utilization of health information technologies/electronic medical records in mental healthcare
High rates of illicit substance use in adults
High rates of serious mental illness in adults
High rate of household poverty
Findings of widespread incompetence and fraud in community mental health system
Recurrent monetary reductions in state's mental health budget

Another issue has frequently arisen in the discussion of the treatment of the seriously mentally ill after Katrina. Many mental health professionals found it impossible to receive funding for services through the main federal funding mechanism for mental health services after a disaster, the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act). Indeed, a recent report from the General Accounting Office has confirmed and documented the inflexibility of the Stafford Act.[55] The Stafford Act restricts funding to short-term crisis counseling efforts designed to provide emotional support and mitigate additional stress after a disaster. The Stafford Act has no provision that allows it to fund services, such as psychiatric treatment or prescription drugs, should these services not be available after a disaster.[56] Furthermore, funded crisis services rely on "paraprofessionals" who often have not had any formal training in mental healthcare, disaster management, or crisis counseling.

Certainly, these crisis counseling services do have value. Louisiana's program (Louisiana Spirit) has conducted over 2,500,000 contacts with hurricane survivors, reaching almost 250,000 people in the state.[48] However, many other types of services for populations who were known to be vulnerable to stress due to their preexisting psychiatric issues were not funded because the services were determined to be a continuation of preestablished care and not simply "crisis counseling."

Other smaller federal funding sources are not under the same restriction as the Stafford Act. In the immediate aftermath of the storms, the Administrator of SAMHSA announced that part of its two-fold response plan was to "ensure that people impacted by the hurricanes who have serious mental illnesses and addictive disorders…continue to receive ongoing treatment for their chronic problems."[57] Indeed, SAMHSA even took steps to provide

TABLE 2. Mental healthcare issues in New Orleans after 2005 hurricanes

Destruction of hospital infrastructure that provided inpatient mental healthcare
Lack of reimbursement for high proportion of uninsured patients needing psychiatric hospitalization
Mental health clinicians relocating or recruited out of greater New Orleans area leading to severe shortages in qualified mental health professionals
Loss of group homes and residential settings due to property destruction, staffing shortages, and inability to reimbursement programs for services
High rate of psychiatric symptoms in returning New Orleans residents leading to increased rates of anxiety, depression, substance abuse, and marital/family strife
Exploding homelessness in New Orleans due to damaged housing and lack of affordable rental units
Shunting of acute psychiatric patients from healthcare settings to correctional facilities and unfamiliarity of police officers in dealing with seriously mentally ill suspects

medications to treat chronic pain and prevent opiate withdrawal in evacuees with chronic pain conditions who were dependent on opiates for pain relief.[58] Looking at the whole federal response to Katrina and Rita, the GAO Report recommends more flexibility in the Stafford Act so it can respond to the specific mental health needs of areas impacted by disasters in the future.[49]

Even for those evacuees without preexisting psychiatric issues, the chronic stressors from Katrina greatly affected emotional wellbeing and important relationships. The Kaiser Family Foundation study found that 23 percent surveyed affirmed that Katrina's aftermath had endangered important relationships—with 3 to 5 percent filing for divorce. Not surprisingly, there has been a sharp rise in divorce filings in New Orleans.[59] Overall, 18 percent in the survey stated they are facing serious mental health challenges.

An important study by DeSalvo and colleagues complement many of the Kaiser Family Foundation findings. DeSalvo surveyed more than 1,500 employees of Tulane Hospital and Clinic in early 2006. The surveyed employees had, on average, high levels of education, household income, and property insurance. Despite these seemingly protective factors, nearly 20 percent of those surveyed met criteria for PTSD.[60] Less than a third of those with symptoms of PTSD had talked to a health professional about Hurricane Katrina—despite universal health coverage and an employee assistance program available to them. The mental health issues that confronted New Orleans, and all of Louisiana, after hurricanes Katrina and Rita are summarized in Table 2.

This article has illustrated that exploding mental health problems in New Orleans, combined with scarce mental health resources, has pushed mental health encounters from healthcare settings to police and correctional settings. This scenario is not new in the United States and not unique to New Orleans. E. Fuller Torrey's describes this process occurring when deinstitutionalized former patients of Marlboro State Hospital streamed into Ocean Grove, New Jersey.[61] Pete Earley recounts Miami becoming inundated with the mentally ill when Fidel Castro encouraged Cuban asylum patients to flee to Miami.[58] Perhaps Katrina has accelerated this process in New Orleans, but the situation itself is far from without precedent in the United States.

However, there have been recent developments suggesting that these trends are reversing in New Orleans and that the next 1 to 2 years may yield great improvements in access to mental health services in New Orleans. The Greater New Orleans Health Service Corps—modeled on the National Health Service Corp—continues to recruit and retain psychiatrists in New Orleans with attractive financial incentives and flexible terms of service within the New Orleans area.[62] Several public hospitals in New Orleans have reopened psychiatric units and are continuing to add more inpatient psychiatric beds as there are staff and renovated facilities to do so.[63] The American Red Cross has continued its program, Access To Care, which provides up to $2,000 in reimbursement for mental health and medication expenses, among other services offered.[64] The provisions for mental health crisis intervention and case management specified in Nicola's Law have sailed through committee in Louisiana's legislature and seem well on the way to being enacted and funded.[65] Even the research by the Hurricane Katrina Community Advisory Group, while quantifying the mental health issues some New Orleanians face, show that many of us affected by Katrina have also found new sources of inner strength and abilities to rebuild our lives that have helped to mitigate some of Katrina's impact.[66]

SUGGESTIONS TO IMPROVE MENTAL HEALTH SERVICES AFTER A DISASTER

This article has illustrated a part of Hurricane Katrina's impact on the system of mental healthcare in New Orleans. This system, generously described as an "at risk" collection of mental health services before the storm, has fractured even further since Katrina's landfall. This fractured care has lead to grave issues developing in New Orleans since the storm. These issues include further deterioration and marginalization of the chronically mentally ill, the emergence of untreated serious psychiatric symptoms in residents without mental health issues before Katrina, and the shunting of mental health encounters from healthcare

settings to legal and correctional settings.

These issues have been illustrated by real case examples in this article. The purpose of using these cases is to show the complexity of the issues and how they combine to create a crisis in mental healthcare for an entire community struggling to recover, not just those directly affected. But, by rigorously studying Katrina's impact on mental health services, we can suggest improvements for the future. I would suggest changes in the funding of mental health services and professionals after a disaster.

One suggestion is that the Stafford Act can be amended so that it will allow for the funding and provision of mental health services after a disaster beyond the narrow confinements of "crisis counseling." It can further be amended to provide funds for indirect costs of mental healthcare, such as facility costs and administrative costs. We now know that these types of indirect costs—currently prohibited from reimbursement through the Stafford Act—are significant after a disaster destroys much of a healthcare system's infrastructure.

Another suggestion is to allow governmental agencies that typically reimburse hospitals for healthcare costs, such as the Center for Medicare and Medicaid Services (CMS), to allow for rapid estimated reimbursement of uncompensated costs after a federally declared disaster. Although CMS has offered waiver programs to reimburse hospitals and practitioners for some of the costs of services after Katrina,[67] many estimated costs remain unpaid. This has left many New Orleans area hospitals to come to federal legislators with hat-in-hand to ask for funding so that these hospitals can survive.

A final suggestion is that federal agencies charged with monitoring the availability of health professionals after a disaster, such as the Health Resources and Services Administration,[68] can more quickly provide incentive programs to help healthcare providers stay in their communities after a disaster. These agencies need to be more aggressive in assisting healthcare providers in rebuilding their own practices as the community they serve also rebuilds. To use an example in our rebuilding, the establishment of the Greater New Orleans Health Service Corps took years to develop. During that time, more healthcare providers in primary care and psychiatry left the New Orleans area, compounding the shortage in these specialties. Primary care and psychiatric providers were faced with the choice of rebuilding their practices, seemingly on their own, or being relocated and reestablished elsewhere in the country with significant financial assistance by private professional recruiting firms. These suggestions for improvements are summarized in Table 3.

TABLE 3. Improving mental healthcare delivery after major disasters

Amend Stafford Act and applicable federal legislation to allow for direct funding of licensed, professional mental health services and administrative costs associated with these services
Provide prompt reimbursement to hospitals for services provided in immediate aftermath of disaster and allow for estimation of services if patient care was not/could not be recorded
Provide software and technical support to psychiatric facilities and mental health providers to facilitate using electronic medical records with automated and off-site back-ups
Promptly offer financial support, in the form of retention grants, to local mental health providers so that these professionals can continue to practice in their affected communities
Create several mental health response teams that work with law enforcement to treat mental health issues in the community before symptom escalation

CONCLUSION

This article has demonstrated several important mental health issues that have confronted New Orleans since Hurricane Katrina. By using actual case examples, I have attempted to demonstrate the complexity of these problems in a community with serious deficiencies in mental healthcare prior to Katrina's landfall. I have also made suggestions to facilitate New Orleans's recovery of mental health services. It is my hope that these suggestions will also help municipalities deal with future disasters, whether natural or man-made.

By improving legislation now, we will be able to meet diverse mental health needs that are present immediately after a future disaster. We can also develop resources to help municipalities stop exploding homelessness and substance abuse in the short term after a disaster, while preventing an implosion in healthcare infrastructure through uncompensated healthcare. Finally, we can better prepare responding mental health professionals for the long arc of emotional issues encountered in those struggling to recover and move forward with their lives.

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