COMMUNITY PERSPECTIVES ON POST-KATRINA MENTAL HEALTH RECOVERY IN NEW ORLEANS

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Disaster-affected communities may face prolonged challenges to community-wide mental health recovery due to limitations in local resources, infrastructure, and leadership. REACH NOLA, an umbrella non-profit organization comprising academic institutions and community-based agencies, sought to promote community recovery, increase mental health service delivery capacity, and develop local leadership in post-Katrina New Orleans through its Mental Health Infrastructure and Training Project (MHIT). The project offered local health service providers training and follow-up support for implementing evidence-based and new approaches to mental health service delivery. This commentary shares the perspectives of three community leaders who co-directed MHIT. They describe the genesis of MHIT, the experience of each agency in adopting leadership roles in addressing post-disaster needs, challenges and growth opportunities, and then overarching lessons learned concerning leadership in a prolonged crisis. These lessons may be relevant to community agencies addressing hurricane recovery in other areas of the Gulf States as well as to inform long-term disaster recovery efforts elsewhere. (*Ethn Dis*. 2011;21[suppl 1]:S1-52–S1-57)

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Community leadership and capacity are essential for recovery from large-scale disasters such as Hurricanes Katrina and Rita. Six years after the 2005 storms, the New Orleans community still faces considerable challenges. Common disaster-related psychosocial problems such as depression and anxiety continue to affect individuals unable to access appropriate treatment.[1] Community-based organizations' attempts to serve clients' complex physical, emotional, and social needs may be hindered by lack of human and financial capital. Many communities still struggle to rebuild the physical infrastructure and social fabric of their neighborhoods. Individuals working within nonprofit, faith-based, health and social service agencies often experience these individual, organizational, and community-level stressors simultaneously, creating a substantial barrier to asserting leadership to advance disaster recovery.

Promising local capacity-development efforts include leveraging the resources of community-based organizations and academic institution through community-partnered projects.[2] Opportunities to develop community leadership in the areas of supporting mental wellness, resilience, and recovery since 2005 were afforded through the work of new organizations and expanded partnerships[3] among community-based agencies. REACH NOLA, a 501(c)3 nonprofit organization cofounded by community and academic partners to address unmet, locally-identified health concerns in post-disaster New Orleans, represents one clear example. The organization, recognized as an asset to disaster recovery efforts,[4] has since its inception employed community-participatory methods such as equitable sharing of power[2] to engage local agencies in designing and implementing health-focused programs, services, and research.

One of REACH NOLA's efforts, the Mental Health Infrastructure and Training Project (MHIT) is described in detail in this issue.[5] This 20-month community-wide effort to address post-disaster mental health, resilience and recovery involved more than 70 agencies and 400 providers and supported delivery of over 110,000 client services. Community-based organizations partnered with academic institutions to offer training and implementation support for evidence-based[6,7] and new[8] approaches to mental health service delivery. Descriptions of MHIT's collaborative care,[9] cognitive behavioral therapy,[10] and community health worker[8] training programs are detailed in this issue.

This commentary features perspectives of leaders from three community-based agencies that co-directed MHIT. They describe the genesis of MHIT, the experience of each agency in adopting leadership roles in addressing post-disaster needs, challenges and growth opportunities, and then overarching lessons learned concerning leadership in such a prolonged crisis. These lessons of overcoming obstacles, growth, and recovery may be relevant to community agencies addressing hurricane recovery in other areas of the Gulf States as well as to inform long-term disaster recovery efforts elsewhere.

BACKGROUND

New Orleans' health care infrastructure was largely destroyed by Hurricanes Katrina and Rita in 2005.

Community-based agencies responded by filling service gaps to the best of their abilities, drawing on their extensive knowledge of community assets and needs. In early 2006, several New Orleans-based social service agencies, health clinics, and faith-communities, as well as local and non-local academic institutions, began a collaborative effort to identify and build capacity to address community health concerns. Operating under the umbrella organization REACH NOLA, participating agencies agreed to abide by community-based participatory principles such as equitable sharing of power among organizations and community-academic co-leadership.[2]

REACH NOLA's first community health assessment revealed depression, stress, and anxiety as prominent and growing health concerns among New Orleanians.[3] While approximately one third of residents experienced symptoms of depression or PTSD,[11] people with fewer resources or more significant storm trauma were more likely to experience serious psychological impacts, and many people did not receive appropriate care.[12,13] The increase in mental health morbidity, coupled with the exodus of health providers and the shuttering of major service delivery facilities, underscored the need to develop mental health service delivery capacity in a way that drew on previously underutilized community strengths.[1]

With the generous support of the Robert Wood Johnson Foundation and the largest post-Katrina behavioral health grant issued by the American Red Cross, REACH NOLA partners began to address community stress and mental illness needs and started MHIT. The program was overseen by an executive council consisting of representatives from four academic/research institutions and four community-based organizations.[5] MHIT provided infrastructure support to six local services agencies to offer screening, referrals, education, outreach, and treatment for stress and depression. In addition, MHIT hosted training seminars, co-developed and presented by academic and community agencies, for health and social service professionals regarding evidence-based models of mental health care, quality improvement, community engagement, developing community networks of care, and other topics. More than 400 primary care providers, counselors, social workers, case managers, care managers, psychiatrists, psychologists, and community health workers (CHWs) from over 70 community agencies attended. All participants learned strategies for implementing collaborative models of care and team-based approaches to treatment, while specialized tracks were offered to develop skills specific to the various professions and paraprofessional groups. Community and academic partners developed a manualized mental health outreach training curriculum.[8] Post-seminar implementation support facilitated improvements in providers' and agencies' clinical practices and promoted project sustainability by fostering local leadership.[9,10]

CHARLES ALLEN, HOLY CROSS NEIGHBORHOOD ASSOCIATION

Developing Leadership

Shortly after Hurricane Katrina, the Holy Cross Neighborhood Association (HCNA), a trusted community-based organization in the Lower 9th Ward, resumed holding regular weekly meetings. Association president Charles Allen, along with other local leaders, aimed to provide a forum for returning residents to reconnect and discuss strategies for rebuilding the devastated community. In so doing, they also created a safe place for community members to express their emotions. Residents reported struggling to set priorities and follow through with tasks necessary for rebuilding, and they frequently had outbursts of anger and crying. Association leaders quickly realized that residents could not reconstruct the community without first addressing their primary recovery concern – mental health.

Mr. Allen's concern for human recovery prompted him to join other organizations in cofounding REACH NOLA, and later implementing MHIT, to engage in collective action to address unmet community health needs, particularly in the area of emotional recovery. Mr. Allen recognized that although HCNA leaders lacked capacity to provide clinical mental health services, the organization's trusted position in the community afforded it a unique opportunity to not only educate community members about depression and encourage residents to seek treatment when necessary, but to address stigma associated with mental disorders. MHIT provided HCNA infrastructure support for three CHWs to conduct mental health outreach under Mr. Allen's supervision.

The HCNA team served a central role implementing MHIT. Mr. Allen served on the project's executive council and contributed significantly to the development of a culturally relevant CHW training manual. Association CHWs delivered presentations during seven training seminars, offering insight and practical suggestions for engaging community members in discussions about depression and overcoming stigma. The association also led support meetings for CHWs where they shared referral resources with their peers from other agencies.

Benefits and Challenges of Participation

MHIT developed HCNA's capacity to colead and execute a community-based project focused on health,

increasing the potential for the agency to receive support for future health improvement efforts. Lower 9th Ward residents who became CHWs appreciated not only the economic benefits of employment, but also the opportunity to discover a career path that they found rewarding and empowering.

Networking with other agencies and sharing of ideas during training seminars and follow up meetings provided valuable opportunities for sharing best practices, resolving problems, learning about community resources, locating points of referral for clients, and establishing relationships. Most important, HCNA staff successfully facilitated entry into care for many residents in need of counseling and additional disaster recovery support. As a result, the community as a whole appears to be more receptive to discussing mental health and getting counseling for this critical issue.

Association leaders have faced some challenges in working on community-based mental health, particularly pervasive stigma. Residents have feared being labeled as crazy or that acknowledgement of stress or trauma might result in being committed to an institution. Engaging clients in follow-up for care also has proved difficult at times. Sustainability of the community engagement and outreach is a significant concern in light of the periodicity of philanthropic grant support. Though community members are still in need of support for emotional recovery, HCNA has not yet acquired funding to maintain outreach efforts.

Overall, the benefits of MHIT have been profound. From providing access to quality mental health care, reducing the stigma of mental illness, to providing worthwhile job opportunities to residents, the MHIT project has served well to help address the need for quality mental health care in the Lower 9th Ward and throughout New Orleans.

DONISHA DUNN, TULANE UNIVERSITY COMMUNITY HEALTH CENTER

Developing Leadership

Donisha Dunn, a dually trained internist and psychiatrist, returned to her native New Orleans in 2008 after completing residency in psychiatry and internal medicine. She joined the staff at Tulane University Community Health Center (TUCHC), a National Center for Quality Assurance-recognized patient-centered medical home[14] established in the aftermath of hurricane Katrina, and a REACH NOLA partner organization. Seeking to promote team-based approaches to care and integration of behavioral health services into primary care clinics, Dr. Dunn became the director of mental health programming at TUCHC and joined the MHIT executive council.

MHIT supported Dr. Dunn's leadership in implementing a quality improvement initiative for treating depression through a collaborative care approach.[6,7] At MHIT training seminars, TUCHC primary care providers, social workers, and care manager learned components of this approach to treating depression including screening, education, medication management, outcomes tracking, use of a patient registry, and psychotherapy. A collaborative care expert from the MHIT executive council provided TUCHC with weekly consultations to review steps for model implementation and to troubleshoot problems.

The project's executive council participation offered an important route for leadership development. As part of the council, Dr. Dunn contributed to planning and implementing the project. During CHW training seminars, she translated medical information about mental illness and medication into language accessible to trainees with no clinical background. She cofacilitated monthly CHW support meetings, soliciting feedback from previous training participants that led to modifications such as adding crisis management and serious mental illness content to later training seminars. As the only local psychiatrist on the executive council, Dr. Dunn served a vital role in developing and delivering the training curriculum for physicians. Her insight into local context and physician culture led to adaptations in training structure to better accommodate doctors' needs.

Benefits and Challenges of MHIT Participation

Through participation in MHIT, TUCHC developed an evidence-driven and quality-focused program to manage patients using mental health services, and a systematic approach to improving care for depressed patients. The health center's new mental health programming resulted in an increased number of patients receiving counseling services, and clinically significant improvement in the increased proportion of patients who had follow up monitoring.[15] Primary care providers in the clinic became increasingly comfortable managing depressed patients and psychotropic medications. The addition of care management for depression enhanced treatment follow-up and adherence. Integration of behavioral health into TUCHC's programming contributed to its recognition as a tier three patient-centered medical home by NCQA.[14]

Broadening TUCHC's practices presented challenges. New responsibilities were added to some staff members' previous duties. Stigma associated with mental health hindered engagement for some patients, as well as some staff members' willingness to participate in collaborative care implementation. The health center faced limited capacity to deliver services for serious mental illness and substance abuse, and there were few specialty clinics to which patients could be referred.

Participating in the executive council facilitated the sharing of ideas and insights between local and distant

leaders with various areas of knowledge such as psychotherapy or research, and from diverse settings such as neighborhood organizations, faith communities, and clinical organizations. These connections served as a reminder that TUCHC is part of a larger network of organizations working toward common goals, and they emphasized the need to enhance connections between health centers and community members.

Opportunities to share ideas during training conferences and follow-up meetings were instrumental in developing partnerships with other agencies. These collaborations provided a link to primary care for some patients, increased access to services and prevented unnecessary hospitalizations for mental health crises.

DIANA MEYERS, ST. ANNA'S MEDICAL MISSION

Developing Leadership

St. Anna Episcopal Church, largely undamaged by Katrina, assumed a leadership role in providing essential post-storm services to the working-class Tremé community. Church leaders discovered lack of access to basic health care services as a major concern among community members, and partnered with several non-local churches to establish St. Anna's Medical Mission, (SAMM) a mobile health outreach and screening program.

The mission began operating in 2006 under the direction of Diana Meyers, a parishioner and registered nurse. Although Ms. Meyers had significant background in providing clinical services, her limited experience in mental health made her apprehensive about directing a new program with limited staff. She found some support and gained leadership skills through her involvement in REACH NOLA and MHIT.

Ms. Meyers' participation in REACH NOLA's efforts to document health needs confirmed that SAMM patients were like many New Orleanians – they required clinical services for stress, depression, and trauma. She and other SAMM staff felt unprepared to help clients address mental health concerns, as they lacked formal training on the topic and resources for referral were limited. MHIT enabled SAMM to hire mental health staff including counselors, a part-time psychiatrist, and a care manager, and then provided previous and newly-hired team members with training in addressing depression, stress, anxiety, and PTSD. Upon gaining confidence in assisting clients in emotional distress, Ms. Meyers instituted changes to SAMM's clinical practice to include screening patients for depression during intake procedures and tracking patient progress. She also developed SAMM programming focused on promoting health and resilience, such as therapeutic drum circles, individual counseling, and stress management events.

Ms. Meyers' leadership in the MHIT executive council provided insight into community needs and practical suggestions for project implementation. With the support of fellow community-based and academic leaders, she undertook the significant task of developing a mental health outreach training curriculum for non-clinical providers such as CHWs and case managers with no prior mental health experience. Ms. Meyers co-facilitated some CHW training sessions. Her contributions, informed by personal experience of interacting with stressed and depressed SAMM patients with little training and no experience in how to do so, were invaluable in teaching others with neither medical nor mental health experience.

Benefits and Challenges of Participation

Participating in the MHIT project has been both challenging and rewarding. SAMM staff was initially concerned about working with non-local academic partners, fearing they would impose their ideas without considering community context, but all partners established trust and proved willing to listen and learn from one another. Academics were supportive when local community-based organizations suggested adaptations to training materials and curricula or pointed out when a proposed course of action would be inappropriate for the community. All participants demonstrated a true desire to make the project work for the people of New Orleans.

Misson staff sometimes felt conflicted and guilty about taking time away from clients to attend and facilitate MHIT training seminars. Participating in executive council meetings and preparing for and coleading training seminars required a significant investment of Ms. Meyers' time that would have been otherwise spent on other duties vital to SAMM's operations, but ultimately, the investment of staff time has increased SAMM's ability to provide quality services for clients.

Networking with over 70 other organizations participating in MHIT trainings connected SAMM staff to potential treatment resources and new mental health programming has enabled collaboration with other agencies. For example, social service organizations that lack on-site professional mental health care make referrals to SAMM, where patients receive screening and a care manager facilitates entry into treatment. Developing and maintaining collaborations with other organizations has been time intensive, as it requires ensuring that organizations meet one another's needs and that there is a manageable referral system. Staff still struggle to find adequate resources for the underserved and uninsured population.

Stigma associated with depression continues to be a significant barrier to accessing treatment, as does community members' tendency to prioritize basic survival needs over health. SAMM staff members are hopeful that community

education about mental health will foster discussion among members of social support networks.

The Mental Health Infrastructure and Training Project supported Ms. Meyers' efforts in sharing newly adopted practices at local, regional, and national conferences. She has applied leadership and consensus building skills honed through this project in her role as cochair of a consortium comprising New Orleans-based mobile health units.

DISCUSSION

Lessons learned from REACH NO-LA's efforts to promote leadership through MHIT may be relevant to other communities at risk of, or recovering from, disaster. Community-academic partnered public health efforts that intentionally work to advance community leadership and resources, while fostering implementation of scientifically-supported models of health services delivery, may develop enduring capacity to improve access to appropriate services, improve population health outcomes, and reduce outcomes disparities among vulnerable populations.

Early MHIT partners invested in developing an evidence-based mental health training program and altering their clinical practices because their participation in a community-academic needs assessment revealed that mental health was a significant problem. They experienced firsthand the need to treat depressed and traumatized patients. Community leaders provided input into the project design before program funding was requested, creating early buy-in and the opportunity to partner as equal decision-makers in implementation.

Leveraging existing personal and agency strengths was central to MHIT's success. The Holy Cross Neighborhood Association – adept at communicating with community members – took on an outreach role, while TUCHC expanded its strong clinical program to include mental health treatment. St. Anna's broadened clinical care management and services in partnership with other organizations. While these agencies' participation in MHIT expanded their ranges of services to some extent, the changes were complementary to their usual scope of work, and reflective of emerging community needs.

CONCLUSION

This article has attempted to explore how engagement in MHIT, a community-partnered participatory project, enabled local leaders and agencies to leverage their personal and institutional resources to drive recovery in post-disaster New Orleans. Community-partnered approaches are designed to enhance individual and institutional capacities through academic support. They develop interagency collaborative capacities toward a common response and recovery purpose, which in turn further support both community capacity and individual and agency leadership. Such community-academic co-led initiatives and models of implementing them, may be useful to consider as a catalyst for generating community-driven, and academic-supported, response capacities.

In learning from this effort, funders, academic partners, and community leaders interested in advancing post-disaster recovery should consider how to work with disaster-impacted community members to incorporate benchmarks and measurement into their efforts to build services capacity, promote community leadership, improve population health, and reduce health disparities. Communities at risk of recurrent seasonal disaster from hurricanes or other threats such as oil spills, as well as their partners in academia and granting agencies, must be encouraged to sustain the networks of leadership, support and information exchange that are developed post-disaster, and to improve agency and community resilience in the face of potential, subsequent threats. The gains in community leadership and capacity developed after a disaster should not represent quick fixes to a short term problem, but would be seen more appropriately as opportunities for long term community growth, population health, and change.

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