

STORM DAMAGE

According to medical student Kassandra Scales, the struggles of Hurricane Katrina survivors are little different than other refugees, be they displaced from Darfur, Sudan, or New Orleans.

By Kassandra Scales, MPH, MS1

Hurricane Katrina scattered as many as one million evacuees across the United States, the largest displacement of Americans in 150 years, if not ever. Many of the Katrina refugees settled permanently in other parts of the country; others still hope to return to New Orleans but have been unable to. Not surprisingly, the mental health needs of this population are much higher than normal. However the services available to them, at this juncture, are largely nonexistent.

As a master's student in public health at Columbia University, I focused my thesis project on the mental health needs of Katrina survivors. As the recipient of a grant from the



Left and below: The collage-making session allowed Hurricane Katrina survivors to meet each other and share their thoughts and feelings. Many of the survivors Scales talked to noted that it was really hard for people to relate to them and her project provided a setting where people actually could interact and share their experiences.



Above: New Orleans Biloxi Bridge in the wake of Hurricane Katrina, July 2006. Right: The Great Flood Commemoration, New Orleans, August 2006.



Scales making her presentation.

Arnold P. Gold Foundation, I put together an art therapy exhibit entitled *After the Rain: Celebrating Memories, Supporting Mental Health*. Through photographs of the Gulf Coast, submitted by people across the nation, *After the Rain* created an environment where survivors could commemorate their losses and celebrate their memories. Unlike many exhibitions, *After the Rain* invited individuals to contribute to a collage or writing narrative reflections of memories and new beginnings. This exhibit grew and evolved as it traveled on a three-month exhibition to New York, NY, Baton Rouge, LA and New Orleans, LA. This project established a virtual gallery with more than 100 photo submissions and engaged more than 200 people contributing.

As a result of that project, I had the unique experience of traveling to Cairo, Egypt, in January to present my work at the 11th Annual International Association for the Study of Forced Migration Conference.

A large number of attendees were academics: professors and doctoral students in fields such as anthropology, psychology and environmental safety. There were also a large number of practitioners working in agencies either in developing countries with internal displacement issues (Darfur, Iran, Afghanistan, Uganda) or in developed countries (primarily Europe, Canada, and the U.S.) that focused on policy regarding populations seeking asylum from countries currently in conflict.

It was interesting to hear each side tell its version of similar issues related to displacement, refugee rights, and forced migration, as

each had a slightly different perspective. I felt there wasn't enough emphasis on health in these populations with disasters. While issues such as safety and distribution of resources are important, the health of displaced populations is equally important. You can have people "safe" in the sense that they are contained in a secured area, however, if there are no resources to attend to their physical and mental health, their lives are still at risk.

There was a Medicine and Law session that focused on including medical reports as a part of the application process for asylum seeking refugees in the Netherlands. The intent of this recommendation was to obtain early identification of health problems, provide referral for treatment, and take into account medical barriers that would impede a refugee's ability to account his or her experience. This topic generated a lot of discussion around confidentiality, the doctor and patient relationship, cultural competency, documenting psychological trauma, and stigma that might prevent asylum approval. As I participated in this discussion, I reflected on how many of these topics were covered in our Practice of Medicine course here at Upstate.

Because my audience was primarily academics, I chose to present my project in terms of its theoretical basis of the psychology of *place* introduced by psychiatrist Mindy Fullilove, MD. The psychology of *place* describes the relationship between an individual and their interactions with their surroundings and the psychological consequences of disrupting this relationship. I emphasized the public health principles behind the project to show the translations between research and practice. For example, I illustrated the effectiveness of using social capital and post-disaster organizations in reaching displaced populations. Based on reports from sources including the National Substance Abuse and Mental Health Services, FEMA and the Louisiana Government, I presented statistics document-

ing an estimated 900,000 persons reported displaced from Hurricane Katrina, with more than 500,000 in possible need of mental health care. Due to the Stafford Act of 1974, the federal government is limited in providing mental health treatment in crisis management not long-term care. Despite the fact that Hurricane Katrina survivors remain in crisis; there are little to no long-term services available.

Not only was my presentation one of the few topics to address health, but perhaps the only one that focused on Americans being treated as "refugees" within their own country. At times I felt I had to defend the relevance of Hurricane Katrina as a part of the global struggle for justice in displaced populations. The general sentiment was that United States is the world's "super power" and Katrina can't be as bad as other places internationally. With the majority of presenters coming from war-torn nations with very limited resources, it was challenging to get my audience past the perception of the United States as a wealthy nation. Although we are a wealthy nation, I countered that our wealth is not evenly distributed and there are pockets of populations that are like Third-World nations.

This was my first academic presentation as a public health professional. Having others question my ideas and being forced to defend my work was a new experience. Although challenging, I learned how to accept differences in approach and ideology while maintaining my own integrity and beliefs.

The conference was a tremendous experience and I am thankful to the Medical Alumni Foundation and the Upstate Office of Student Affairs for their financial support.

More than anything, I realized that no matter where these situations arise, the same human values hold true. Everybody wants to be healthy. Everybody wants to feel safe. As a medical professional, I would love to be in a position to work toward those goals.