



# CATHOLIC CHARITIES, BATON ROUGE Teams Take Their Expertise On the Road

By DAVID C. AGUILLARD, M.H.A., M.P.A., M.A.

In the wake of Hurricane Katrina, Shannon Cerise, a licensed clinical social worker with Catholic Charities of the Diocese of Baton Rouge, set up office in an assemblage of joined-together trailers at Renaissance Village, the largest concentration of temporary trailers for evacuees in Louisiana. Meanwhile, for Stephanie Sterling, LCSW, department director of the agency's maternity, adoption and behavioral health services, a grocery store became her clinic.

Unfortunately in the recent past, we at Catholic Charities in Baton Rouge have had to become adept at altering our organization and service delivery to fit the landscape of a community in chaos. In 2005, Baton Rouge was a safe island between two storms that devastated southeast and southwest Louisiana — hurricanes Katrina and Rita — and we were the lead agency for two of the major recovery programs. Three years later, while the areas were still recovering from those hurricanes, two more hit — Gustav and Ike — and we helped pilot a then-new coordinated federal response effort. In 2012, Hurricane Isaac flooded large swaths of low-lying south Louisiana, and we are today delivering disaster case management services for a federal recovery program covering 14 civil parishes.

Between the hurricanes, this area has been challenged by calamities ranging from tornadoes to the 2010 BP Oil Spill. Each has introduced varying degrees of stress and trauma into the community. All challenged the agency

to learn how to remake itself, practically overnight, from a general human services agency into a disaster response and recovery organization as it distributed relief supplies and assisted people who otherwise would never show up at its doors.

Because of our experience, we often deploy personnel from Baton Rouge to other Catholic Charities agencies throughout the U.S. to help with disaster case management; that is, helping affected families develop and complete their recovery plans.

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The case manager serves as a single point of contact, helping families identify and obtain resources needed for recovery. In doing this work, we have seen that mental health needs of both dis-

aster victims and staff can be easily overlooked because of the understandable emphasis placed on immediate physical relief. Indeed, after Katrina, a survey by the Centers for Disease Control and Prevention indicated that about 50 percent of respondents showed signs of mental health stress, with 30 percent needing services, yet less than 2 percent received help.

As a mission-driven Catholic organization, serving a community after a disaster is an integral part of Catholic Charities of Baton Rouge's Gospel calling. Our role is not only to provide relief supplies, but also to attend to each individual's complete personhood; to see the face of Christ in our neighbors in the midst of traumatic and life-changing catastrophe; to offer affirmation that helps individuals tap their confidence and dignity; to uncover their inner strength, ultimately the most powerful source of full recovery from the physical, emotional and spiritual trauma of a disaster.

"As an LCSW, I can't say to a cli-



ent, ‘Hey, let’s pray,’” said Cerise. “All I can do is meet them where they are.” Through kindness, patience and acceptance, “you can bring hope into the midst of a crisis.”

For behavioral health professionals and their organizations, responding to a man-made or natural disaster radically affects four aspects of their work:

- Organizational decision-making capacity
- Service delivery location
- Clinical objectives and process
- The necessity for staff self-care

## THE INCIDENT COMMAND SYSTEM

### Q. Why is ICS needed?

**A:** When an incident requires response from multiple local emergency management and response agencies, effective cross-jurisdictional coordination using common processes and systems is critical. The Incident Command System (ICS) provides a flexible, yet standardized core mechanism for coordinated and collaborative incident management, whether for incidents where additional resources are required or are provided from different organizations within a single jurisdiction or outside the jurisdiction or for complex incidents with national implications.

### Q. What is ICS designed to do?

**A:** The ICS is a widely applicable management system designed to enable effective, efficient incident management by integrating a combination of facilities, equipment, personnel, procedures and communications operating within a common organizational structure. ICS is a fundamental form of management established in a standard format, with the purpose of enabling incident managers to identify the key concerns associated with the incident — often under urgent conditions — without sacrificing attention to any component of the command system. It represents organizational “best practices” and ... has become the standard for emergency management across the country. Designers of the system recognized early that ICS must be interdisciplinary and organizationally flexible to meet the following management challenges:

- Meet the needs of incidents of any kind or size.
- Allow personnel from a variety of agencies to meld rapidly into a common management structure.
- Provide logistical and administrative support to operational staff.
- Be cost effective by avoiding duplication of efforts.

ICS consists of procedures for controlling personnel, facilities, equipment and communications. It is a system designed to be used or applied from the time an incident occurs until the requirement for management and operations no longer exists.

— From the FEMA website: [www.fema.gov/incident-command-system](http://www.fema.gov/incident-command-system)

## ORGANIZATIONAL DECISION-MAKING

As part of disaster response, Catholic Charities of Baton Rouge reorganizes into an “Incident Command System” that incorporates the ICS protocol used by federal, state and local government entities, hospitals and the private sector. The system works anywhere and makes it possible to communicate, plan, coordinate, respond and manage large-scale community events. (See sidebar.)

Through our Incident Command System, we shift management responsibilities to focus on serving the needs of a disaster-stricken community rather than our regular agency programs. For example, the director of employment services may become the logistics coordinator, responsible for locating and arranging transportation of relief supplies. Executives may assess the needs of families in a shelter.

We have found that after a disaster strikes, businesses, medical facilities, neighborhoods and government agencies are often in turmoil, and models of mental health intervention need to adapt. Clients not only are subject to the trauma of the single event, but they can be re-traumatized at every step as they re-enter shattered areas. The familiar routines of normalcy that help anyone cope with tragedy can be nonexistent. Friends and family may be scattered, their whereabouts unknown. Familiar places that root and tie us to our community may have been obliterated — churches, schools, grocery stores, banks and gas stations. Familiar neighborhoods look like alien landscapes. Even one’s own home may be unrecognizable.

The effects on people tend to snowball. New mental health needs crop up in the community, and existing mental health issues tend to escalate. Secondary trauma is commonplace as people deal with their own disaster and that of neighbors and friends. Families may be living in shelters, surrounded by strangers sleeping on cots or crowded into a friend or family member’s house with a dozen other people — and their pets — in a home possibly without electricity or air. Phone calls won’t go through. Food is in short supply.

The community’s mental health professionals may be unavailable because they have evacuated, or they simply may be dealing with the same post-disaster issues as those needing help — their orga-



Photos courtesy of David Aguillard

Aftermath of the 2012 Waldo Canyon fire in a Colorado Springs, Colo., neighborhood.

nizations and clinics may be damaged or without electricity and full management staff.

Disaster planning is necessary, of course, but it can't fully prepare first-timers for the physical and emotional devastation they will experience themselves and witness in others. Experience has shown us that after a disaster, we should expect and be prepared for disarray, even among ourselves.

People impacted by a disaster are in a mental state of shock. Just as physiological changes take place, so do mental changes. Most fundamentally, people resort to "fight or flight" thinking, often not approaching the reality of their situation through a more rational mindset. This response applies not only to the victims, but also to the organizations and workers offering help. When assisting other organizations, we have seen staff so overwhelmed that basic managerial problem-solving skills can be organizationally compromised.

In her book *Five Days at Memorial: Life and Death in a Storm-Ravaged Hospital*, Pulitzer

Prize-winning journalist Sheri Fink, MD, illustrated the life — and sometimes death — consequences that followed myopic decision-making in a New Orleans hospital after Katrina. Katrina and its aftermath presented an extreme example, but Fink states that despite planning, preparation and drills, the same phenomena recur regularly in the confusion and chaos of a disaster. "There's this blindness that comes in, in a disaster," she said during an NPR "Morning Edition" radio interview. "[T]he real key for people who are seasoned disaster responders, they know. It's just like the

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military, like you have a plan but then you have to be prepared to change that plan. So it's preparation, but it's also flexibility. And that's so hard to do, but that's why — I mean, my hope is that we

can all think about these things in advance.”<sup>1</sup>

### THERAPY LOCATION AND OBJECTIVES

“Disaster blindness” is a typical mental response to trauma, said Paula Davis, LCSW, Catholic Charities of Baton Rouge’s clinical director of maternity, adoption and behavioral health services and a teacher at the Louisiana State University School of Social Work.

“People get tunnel vision and have vague glimpses of their surroundings. They shut down and intensely focus on the immediate. They have to do it in order to survive,” Davis said.

## **There, before me, were homes untouched while, a few feet away, all that remained of others was twisted metal and a layer of ashes.**

This is why external help from other communities is absolutely essential in the aftermath of a disaster, and also why the guidance of a therapist can be necessary for individuals who otherwise have never had that need before. And so in the aftermath of a disaster, therapists adapt traditional methods of talk therapy to become crisis intervention counselors.

“I become much more directive,” Davis said.

Her first priority is to make sure the clients are taking care of their basic needs — food, shelter and family. After that, therapists can begin to help clients deal with the trauma in adaptive ways.

Davis asks clients to identify methods that have helped them manage stress in the past, and then she helps them mold these methods to their current situation through specific, concrete means. For example, maybe a client has leaned on a brother for support, but now the brother is unreachable. “I’ll suggest they write a letter to the brother, even if they can’t mail it or get it to him,” she said.

Added Sterling, “Our first goal is to help them take care of their basic needs at a time when they may be embarrassed to ask for help. Some people might not even know what they need or understand what happened.” When venturing out, therapists may find themselves responding like paramedics to urgent situations at any moment, in any location. Therapists can find themselves working in shelters without privacy, or maybe from vehicles on the side of a street strewn with rubble, or

at emergency distribution sites.

At any time or place in a disaster-impacted area, therapists may see extreme responses to seemingly insignificant situations. For example, Sterling tells of walking past empty freezers in a grocery shortly after Hurricane Katrina brought tens of thousands of evacuees from New Orleans into Baton Rouge. Sterling overheard a shopper complaining because the store had no ice cream, which touched a nerve in another shopper standing next to Sterling.

“She lost her composure,” Sterling recalled. “Ice cream? You’re worried about ice cream, and I don’t know if my sister is safe! I want my family to be safe!”

The distraught woman was a Katrina evacuee whose home had been destroyed, and she was staying in an overcrowded house in Baton Rouge. Her sister was still stranded in New Orleans, working in a hospital without electricity. Last she had heard from her sister, food had run out.

Such overwhelming stress fueled an eruption, sparked by the complaint about the lack of ice cream. Sterling stepped in with what the National Center for Post Traumatic Stress Disorder calls “psychological first-aid.”<sup>2</sup> She asked the evacuee direct questions about her immediate concerns and suggested a plan of action.

“She needed to get out of there,” Sterling said. “She went home and worked on contacting her sister through other channels she had not yet tried.”

“Psychological first-aid is based on quickly building rapport with clients,” said Cerise, who worked with evacuees living in trailer parks after Katrina. “We aren’t there to pathologize or label,” she said. “We want to help people assess their situation. They might not even know where they are or why they are there. We help them make a plan, and provide them information.”

“I might not ever see them again,” she added. So her first priority is getting people to take care of themselves, reminding them they need sleep and food. Physical safety and comfort is the first goal. If they are in a shelter, “we may give practical advice,” she said. “If a family feels unsafe, they can sleep in shifts.”

The next step is connecting people with resources, helping them to locate family members and to identify support networks. Throughout this process, it is essential for the therapist to remain calm and to focus on meeting needs; it’s not yet time to ask about the details of their disas-



ter experience, as this may re-traumatize them.

Helping them cope may or may not follow. In a disaster area or shelter, therapists should be on the lookout for people showing signs of confusion and disorientation, “that flat stare,” as Toni Bankston, LCSW, calls it. If the opportunity to help arrives, she said, “we focus on their resilience, their strength and meet them where they are.” The therapist helps such clients identify methods of coping that have worked for them in the past. “The emphasis is on healing yourself, not being ‘fixed’ in a clinical setting,” she said.

Bankston is a former staff member with Catholic Charities of Baton Rouge and is now with the Mind-Body Medicine Center of Louisiana in Baton Rouge. She has provided mental health services in the wake of man-made and natural disasters all over the globe. She tells the story of a teacher who had “that flat stare” after an earthquake in Haiti. The teacher had lost her son, and her husband had been injured trying to rescue their child. Bankston helped the teacher work through guilt and forgiveness by identifying from within new images to replace “visions of mass death ... She saw her child in the arms of an angel, and was able to smile, saying, ‘I feel like I’m smiling from the inside out.’”

At this point, Bankston said, the teacher once again “was in charge of her life.”

### COLORADO FIRES

Even for those whose families and homes remained safe during a disaster, the emotional impact of seeing the randomness of destruction is both overwhelming and bewildering. While working with our team in Colorado Springs after the 2012 Waldo Canyon fire, I had these reactions myself. There, before me, were homes untouched while, a few feet away, all that remained of others was twisted metal and a layer of ashes.

A few days after the fire, I sat talking with Jim Ball in his home. He was on the couch, the TV was on, the air conditioning was humming. Outside, the houses on either side were gone.

In these situations, the same “psychological first aid” principles apply: helping survivors discover within themselves meaning and purpose. Ball described the night the fire raced through his neighborhood as he watched from a ridge, miles away, with a feeling of complete helplessness. He said he knew his home was being destroyed. But

a day later, on the cover of the newspaper, he saw a picture of his house standing amid ashen ruins.

“I was stupefied,” he told me, as he struggled to understand an event he described as “evil.” As we talked, he pointed out the irony that after Katrina, Colorado Springs took in New Orleans evacuees, and there I was, in his home, a New Orleans native helping in Colorado Springs. As he reflected on the two events, he commented about the Gospel command to love our neighbor. He described a growing insight about the necessity of kindness and neighbor-helping-neighbor, even when those neighbors are half-way across a continent.

He was nearing retirement, but Ball sensed his life might be changing in other ways. “I have to give back,” he told me.

Here was a person, creating his own path back to normalcy — through service.

### EFFECTS ON THE HELPERS

Just as survivors will feel alienated, lost and traumatized, so, too, will mental health workers. Therapists are confronted with problems that have no resolution. A man can’t locate his wife, and “you can’t say, ‘I’m sure you’ll find her.’ You don’t know that,” Sterling said.

“Staff will experience secondary trauma,” she said. “They may never know if they were able to help and will feel helpless themselves.”

Therapists also can find that a disaster area can trigger unexpected reactions, as I have experienced myself. As I walked into a Colorado Springs neighborhood that had been obliterated by wild-

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fires, the sight brought up images of the devastation to my family’s home in New Orleans after Katrina. Grief and anger from years ago resurfaced. I returned to my car sobbing.

Bankston pointed out that recognizing and combating her own stress is a regular part of her post-disaster work. She has found she must practice the same methods she encourages in her clients, such as stress-relief techniques of breathing and imaging.

“I have to take care of myself. I focus on inner strength and past ability to cope, to make it through a new reality,” she said.

Administrators and managers need to know that in the midst of dealing with post-disaster chaos and stress, a simple, sincere, “How are you?” to a staff member can represent an important moment of acknowledgment.

A few days after Katrina, I helped a paramedic unload a patient at a clinic in Baton Rouge. Returning to the ambulance, I asked her, “How are you holding up?” She turned and started crying. After a few minutes, she explained that she had lost count of the days she had been working without a break; that she had been in and out of New Orleans repeatedly, witnessing not only destruction from the storm, but personal tragedies. During the past few days, she said, “No one has asked about me.” She smiled, said “Thank you,” and climbed back into the driver’s seat.

Her response is normal, observed Davis.

With such staff stress in mind, Catholic Charities of Baton Rouge names a morale officer as part of the post-disaster Incident Command System. On the surface, the morale officer is in charge of lightening the mood around the office, bringing in snacks and meals. If we’re on emergency power, the morale officer may run an extension cord to a TV and bring in some DVDs for entertainment.

But more importantly, the morale officer’s role is similar to that of a therapist entering an emergency shelter — to be on the lookout for telltale signs of stress: short tempers, disengagement, overreactions. We retained a licensed clinical social worker from another practice, solely for the benefit of staff after Katrina. Administrators have to establish such safe forums and allow time for staff to process their own experiences. “Emotions come up, and you have to have a forum to talk about it,” said Sterling.

In our post-disaster work, caring for the caregiver as well as the client is where we meet our Catholic mission at its core and at its first principle — affirming the dignity and created personhood of each individual.

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#### NOTE

1. Interview with author Sheri Fink, “Morning Edition,” NPR, Sept. 10, 2013. <http://kutnews.org/post/during-katrina-memorial-doctors-chose-who-lived-who-died>.
2. [www.ptsd.va.gov/professional/manuals/psych-first-aid.asp](http://www.ptsd.va.gov/professional/manuals/psych-first-aid.asp).



Teams from Catholic Charities of the Diocese of Baton Rouge, La., help communities in chaos.

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# HEALTH PROGRESS®

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