Social Work in the Aftermath of Disaster: Reflections from a Special Needs Shelter on the LSU Campus

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This narrative describes a social worker's experience providing volunteer assistance in a special needs shelter on the campus of LSU following the Katrina and Rita disasters. The author reflects on how the experience has influenced her practice, teaching, and scholarship. The persons described exemplified strength of character and resiliency, yet long-term needs and responses have yet to be fully understood. This article includes illustrative stories of unforgettable survivors in a unique university shelter while illuminating the essential role of social work.

Background

As citizens of New Orleans were rescued from floodwaters and rooftops, those with serious injuries were taken by ambulance and helicopter to the Pete Maravich Assembly Center (PMAC), ordinarily home to LSU basketball, volleyball, and gymnastics. The PMAC would serve as a triage center. From there, the seriously ill and injured were transported to Baton Rouge Hospitals. But soon local hospitals were at capacity, and the PMAC and the Carl Maddox Field House combined became a field hospital with 800 beds. The field hospital was later identified as the largest acute-care hospital to date in U.S. history. As it became clear that the field hospital needed doctors, nurses and volunteers, the entire LSU community mobilized to find medical, personnel, clothing and supplies. The site would have nearly 3,000 LSU students, staff, and community members working as volunteers on various tasks during the first week after the storm. Many patients at the field hospital were in shock, disoriented, or hysterical. Some volunteers grew emotionally exhausted. (Bacher, Devlin, Calongne, Duplechain, & Pertuit, 2005, pp. 16 - 17)

The disaster relief efforts on the Louisiana State University campus were remarkable, yet a story that was not widely told. I have worked as an Assistant Professor in the LSU School of Social Work since the fall of 2001 after practicing in the field of long-term care and community social work for many years. My routine was pretty much straightforward. I studied nursing home care, taught a couple of classes each semester to approximately 60 graduate students in the MSW program, oversaw my field load, and served as the Associate Director of the University's Life Course and Aging Center. I went home to my dogs, planned the occasional dinner party, and wrote. As a Connecticut transplant, I've enjoyed the festive atmosphere of the South working within a daunting, but inspiring Research I institution with all of the challenges, trappings, and unknowns of an untenured faculty member. I never imagined the magnitude of Hurricanes Rita and Katrina making such an indelible impact on my teaching, service, research, and relationships and igniting a new passion for social work's role in disaster relief/response. Although much of our lives are "back to normal," nearly every

grant proposal we submit, and many discussions on social work and social problems in Louisiana, incorporate some level of disaster realities. If we hadn't been directly impacted by serious loss, someone close to us had. The disasters have impacted every facet of our School, and the memories of my brief work in the Special Needs Shelter (SNS) stands as a marker in my life to always remind me of the late summer of 2005. Like many areas of social work, human suffering realities do not make us run away; they can seal our testament to the reason we're here in the first place. I feel that I am a part of Louisiana and Louisiana is a part of me more than ever.

As we now are now well acquainted, August 29, 2005, altered the world as we knew it. Baton Rouge and the LSU campus were largely spared from the worst natural disaster in U.S. history, and I admit to breathing a sigh of relief that mine was not one of the hundreds of local homes pummeled by large, uprooted trees. Word quickly spread that citizens were being flown to Baton Rouge shelters and I knew I had to participate. I called a general number that identified the LSU Field House as needing social workers. On August 30, I passed through a matrix of sign-in tables and the jarring sounds of endless helicopters, trying to remain focused. The word used over and over was "surreal." It was as if a horrific movie scene dropped onto the campus and into all of our lives; but we were living the reality and witnessing the destruction head on. The experience is hard to describe due to so many complicated levels of destruction and human suffering while the reality was still sinking in.

The Pete Maravich Center (PMAC) is a spaceship-shaped sports arena within a stone's throw of Tiger Stadium. The PMAC turned into an emergency disaster hospital that treated some 6,000 patients and referred an additional 15,000 people to shelters and special needs facilities following the Katrina devastation. One such facility included the Carl Maddox Field House next door, which during the aftermath became an SNS. This is where I would report for the next several weeks. The SNS was a 400-bed medical "nursing home" arranged in partnership with LSU administration, the Department of Social Services, and the LA Health and Hospitals system only three days before Katrina hit. The shelter was to temporarily house persons in need of medical care – many thought it would be an emergency back up for nursing home residents before returning to their original facility. Nobody anticipated the widespread destruction that has lasted and will continue for years to come. Many of those who entered the SNS were transferred to nursing facilities. Most of those had never lived in an institutional setting prior to the catastrophes and many will never return home.

The PMAC closed on Thursday, September 8, yet the less known SNS remained open for an additional 40 days. The majority of the patients in the SNS were largely old, sick, and poor – without data, it would be inaccurate to report the actual racial and gender composition, but there were more men and more Caucasians than I expected. The cases were complicated with heightened realities of medical problems now combined with homelessness and separation from family, friends, and community. The SNS was never expected to run for the exhausting 50 days, yet another deadly storm, Rita, struck the Louisiana and Texas coasts within a month of Katrina and brought in several hundred more occupants who required placement or other assistance. The SNS was cleared out just in time for a large football game, and the haste of some of the transfers posed additional challenges to personnel working under diminished resources to follow through. Armed with 10 years of social work experience in the nursing home setting, but still not sure what to expect, I became one of the volunteers to assist in the SNS. It is a part of my life that will remain with me forever.

Social Workers and Disaster

Padgett (2002) noted that social workers, more than any other discipline, were the primary players following the World Trade Center disaster, and I echo that social workers were unparalleled in providing assessment and placement for Louisiana disaster victims. As the LSU Chancellor described, "Katrina was like watching 9/11 in slow motion." Other professions—emergency workers, physicians,

firefighters, and military personnel—were needed for short-term intervention, but the roles of social workers are there for the long run. Social workers have the unique role of requiring expertise and presence long after the debris is cleared and the shelters are turned back to their original use. Social workers are and will continue to be primary agents in helping to normalize persons who have experienced historic and unimaginable tragedy. Given the pivotal role, and the likelihood that social workers will interface with post-disaster realities at some point in their career, training is desperately needed (Zakour & Harrell, 2003).

Within the Shelter

I entered the gym to witness hundreds of people requiring care. Units were set up with makeshift cots and identified by signs crafted of colored construction paper. Although the destruction was everywhere on television, witnessing the survivors was entirely different. I checked in a few places and introduced myself to a couple of the units and saw medical personnel circling around. I'll admit to having a keen sense of who the sources of power are and who the workers are. I met a young, tireless woman who was put in charge of the discharge planning, and she shared some of the harder cases with me and told me horror stories about planning challenges. Although not a social worker, she was tuned-in to respectful care and moved quickly to get things done. Someone knew what they were doing when she was given her assignment, as her role was likely one of the most grueling; arranging transportation and keeping track of the myriad needs of the clients.

Sharing Stories

I was immediately moved by the stories and the sheer devastation of the citizens who lay on cots on the floor of the track/basketball stadium after having been brought from their houses, nursing facilities, flooded streets, or the chaotic Superdome. The fresh hell of the aftermath was demonstrated everywhere. Mothers walked in with their children, carloads of people drove in with sick family members desperate for care. Some were turned away; others admitted. Older people were lying on cots in pain and confusion; medical personnel walked purposefully and in a daze. The scene continued for days and would be revisited later, although with less intensity, within the same month. Despite some chaos and common evidence of individuals being overwhelmed, I was also touched at the attention to people's dignity that so many professionals and volunteers infused into care.

Social workers, by far, were the most frequently paged. The system consisted of a volunteer who spoke into a microphone responding to various requests from each unit that made the announcements. The noise was unsettling. Although material goods were stacked high inside and outside of the shelters, there was no phone for workers to access, no available computer, and no fax set up in the Field House for days. Cell phones often didn't work, particularly when we were trying to reach storm-impacted areas, but they were all we had to try to connect people, so we used our own when we could. There was one lone copy machine, way at the back of the shelter, and it was in high demand, often breaking down. Files were strewn about and impossible to locate until weeks into the shelter's operation. The people being served either had chronic health problems that were often exacerbated by the storms, or had medical and emotional complications directly brought on by storms and their aftermath.

The willingness of people to share their intimate, painful stories surprised me at first. Perhaps it was due to my limited exposure to disaster survivors or from propaganda tossed around that people might be re-traumatized if asked to discuss their story. Disaster scientists in the human services illuminate that a person who has experienced disaster will focus on his or her own perspective, and professionals should pay careful attention to the information shared during this raw and critical time and try to not be led by what *we* identify as the most pressing concern (Rosenfeld, Caye, Ayalon, & Lahad, 2005). Likewise, they stress, a family-centered vs. a professional-centered approach should be emphasized. As any social worker worth his or her salt knows, the client rather than the worker leads the helping

process. What is unique about disasters is that many people have never been on the receiving end of charity prior to the event, as noted by Shah in 1985.

The first of the evacuated citizens I met was a woman in her late eighties who immediately invited a visit. Her cot was placed next to a spirited, storm-weary man who proclaimed he was 90 years old. The neighbor plainly told me the woman beside him saved his life, telling him he must leave and take the ride from the helicopter and she would accompany him. She was his tenant. He explained his reluctance to leave, having been through many other hurricanes before. He noted the horror of watching the water rise within his home through the floor furnace vents, lifting furniture along with the current.

The woman described in detail that the image of the refrigerator falling over in the flooding apartment, as if it were made of cardboard, was what told her to get to higher ground. The two aided each other to the window on the second floor and were airlifted up onto a helicopter just before the floodwaters reached shoulder level. The man wanted to give up, but his tenant and the rescuers wouldn't allow it. The friends were then brought to the LSU campus, first to the PMAC, then to the SNS where I met them within the first hours of their arrival. The woman was unable to walk and required oxygen to breathe. They knew that they would not be able to return home and were accepting of nursing home treatment. They desired to remain together, and their modest request was upheld, although in separate rooms more than 80 miles away from their original residence. The most likely outcome for persons occupying placement in the shelters was nursing home placement. It presented a cruel paradox. Although there were minimal opportunities, many people were once living independently, successfully in their homes against the odds. Now they will remain dependent in a long-term care facility, for an indefinite period of time. Overnight, their lives changed.

Another woman seared in my memory is Thelma. I met her one afternoon in the Green unit. She was sitting upright on her cot, desperately trying to find her purse in her bedding. She asked me to sit down. She immediately began recounting her experience before knowing my name or what business I had at the shelter. Thelma acknowledged a mild level of confusion, but her memory of what brought her to LSU was striking. She recounted the events leading to placement in a sequential, logical, and fluid manner; she was even able to make light of the situation, noting that she initially thought the responders in their flat-bottom boat were soldiers taking her off to war. She explained to me that she told the military men who lifted her into the boat that she wouldn't be much help fighting the war in her nightclothes. I recently found out that she was in a nursing home 70 miles away from her home.

The helping process could be discouraging due to the immense wreckage of people's lives. I was a volunteer, pretty much coming and going as my schedule allowed, not nearly carrying the endless responsibility of those who worked the 12-hour shifts or the workers who flew in from all over the country and stayed in makeshift places in the gymnasium, some on the bleachers, sleeping when they could, which wasn't often. I put one psychologist on my office floor to sleep, as he hadn't slept in two days. Two nurses from the East Coast stayed in my home for a week, miscellaneous friends or their friends stayed over, and I cooked whenever I could for a house full of family, old friends, new friends, neighbors, and strangers who were strange no more. Despite enormous odds, however, people survived with the help of one another. As Webster (1999 in Puig & Glynn, 2003) reminds, true first responders are always the survivors aiding each other. While many had intimate knowledge of the evacuee they were assisting, many were connected through circumstance alone.

Providing pro bono services may be in the NASW charge for all social workers, but it went beyond a professional principle to a necessary response to do something in one of the worst times in history. Volunteering helped to make sense of what at times seemed an impossible situation. The work re-ignited my passion for frontline efforts in a time of crisis and reinforced that my research and past

experiences were necessary, not just anecdotal accounts to illuminate a point in the classroom. I consider myself a hybrid social worker. My nursing home and ombudsman experience prepared me to provide advocacy with a tenacious spirit. Although I had never been in a disaster shelter before, my nursing home practice with thousands of residents and their families as a member of an interdisciplinary team were essential in facilitating my comfort. Also, feeling an almost immediate rapport with the medical team made me realize that my background hasn't entirely left me, even as an ivory tower occupant. The shelter medical director called asking that I sign up to do responder debriefing for a week across town with medical and military personnel arriving from the storm scene needing support or referral. It was good to be needed. Teaching and research, for me, are not nearly as laden with the same degree of urgency and reward, yet the lessons we provide foster future participants and can, in time, be their own sweet rewards. If my reflection seems a little steeped in melancholy, it may be. I view the chance to have served in the SNS as a rare and honored opportunity, yet this is not to minimize the deep concern I carry for the people who moved through the shelters and some of my own survivor guilt that whatever we did was ever enough. It was, at the very least, something.

Among the most important skill in SNS case management was to maximize choice given the dreadful conditions and diminished choices available. Housing was almost impossible for the families with limited resources and disabled family members. The hardest cases were those who were there for weeks on end as there was nowhere for them to go, but they were threatened daily with having to vacate the facility. Social workers were constructive in stalling and pulling out any stops possible, straining for the most feasible and humanistic course in the face of so few options.

The impressive theme in the SNS shelter was the can-do spirit of the assigned workers and the many volunteers who moved mountains for people. The mantra in the PMAC and the SNS Field House was *make it happen* (Bacher et al., 2005). The volunteers were the champions in the response effort. We lecture to our students about the challenges of poverty and homelessness, about fighting injustices and advocating for those vulnerable, but riding in the car into impoverished sections of Baton Rouge in desperate search of housing for someone who days before lived in her own home providing full-time care for her disabled spouse while raising her two grandchildren was a lesson that went beyond the mere description of hypothetical values. The themes we discuss were literally on our doorstep and the reality of poverty and homelessness, lack of health care, need for direct services, and a slack policy response brought to unfortunate light became regular points of discussion over the next year, and I suspect will continue into the future.

Following the Katrina catastrophe, many students faced homelessness. Several attended classes while staying in shelters or with family members, friends, and strangers. Virtually everyone took someone in during the aftermath of the storm. A number of our faculty took in entire families, strangers who became part of their own family. I am not so sure that any other unit on the campus was engaged as fully as the School of Social Work.

Challenging Cases and Discharge Plans

Discharge planning can be challenging under the best circumstances – dueling needs and preferences stacked against medical realities. Add to it the worst disaster in history where you have to immediately paste together a place for people with medical conditions to stay. There were either people desperate to locate their loved ones or, in more unusual cases, people who didn't wish to be reunited with family even if we were able to contact them. These cases were more likely situations where the evacuee was from the devastated area and the family members were from elsewhere in the U.S. Certainly, several people did not desire to relocate so far away from their beloved home, even if safety and stability were present. However, even a seasoned social worker can temporarily table the reality of challenging dynamics in the family system.

Several people had fractured relationships with their families. One older couple from Calcesieu Parish forbade anyone to contact their family in Montana, explaining that they had taken money from them and were not welcome in their home, yet nurses pled – this is our only opportunity to keep them from entering a nursing home, they'd tell me. Yet the concerns of the couple were legitimate. They warned us not to let their family know that the house was empty, although severely devastated, that they would get in there and "put their hands on what doesn't belong to them." The husband said he would rather die than to be forced to live with his children. A social worker trained in integrity and preservation of people's rights would be unethical to do anything than uphold the choices of the couple. Still, several people tried to secure information to get the family out of the shelter. The couple were eventually afforded no other option than to enter a nursing facility. Again, the outcome as to how long is unknown. Knowing there was little I could do at times in these cases, I offered to take the soiled clothing home to be washed. The reluctant husband trusted only me to clean his clothing, which felt like a small, but significant thing, particularly as the clothing represented all that they had. Their pride interfered with taking any donations that were piled on makeshift tables in the florescent glare of the shelter.

Given that the citizens were left without homes and separated from family and community, the first response was to reunite families, especially when the citizens had relatives in places not devastated by the disaster. Anyone even remotely familiar with Louisiana knows the deep cultural connection of families and communities where they were raised, and multiple family members in case after case were displaced in different shelters. People who know Louisiana would never ask the starkly naïve question of why someone would live in a "soupbowl" if they knew how dangerous it is. The question to many was never why they lived there, but why they would live anywhere else. What is essential is sensitivity to cultures and norms among disaster workers (Puig & Glynn, 2003).

People were bused or flown to the SNS and certain cases allowed for one other person, such as a spouse, child, or caregiver, who could assist with the needs of the patient. Some exceptions were made, such as when a spouse of a disabled person was also caring for her young grandchildren, the family was admitted together, but this was rare. There was no ideal situation for the young children who had been immediately severed from their other peers, not to mention forced out of school for weeks on end. Given the medical nature of the SNS, designed largely for older persons with chronic medical needs, there were not many children in the shelter. However, the few who arrived with their parents or grandparents were visibly restless as they were in a difficult and scary situation with few options. The nature of the SNS was institutional and had little to offer the children, so the support of volunteers was key in providing meaningful activity. Families with multiple risks posed the biggest challenges: medical conditions made worse, poverty compounded by homelessness, immediate unemployment, schools closed and destroyed. What should we do?

The SNS was not a productive environment for the children, either. Clearly, separating children from their primary caregiver proved to be negative, but many caregivers in the SNS were older persons with medical challenges. Some were providing care for their grandchildren. Additionally, several professionals and volunteers were concerned about the double-edged sword of temporarily placing a child in a school system only to be plucked out days or weeks later to move elsewhere. Some may be wondering, where was the programmatic intervention? I can only express that persons were spread so thin that there were those who fell through the cracks and there was no organized services for these children. Many of the volunteers brought in toys and crayons and would walk the track with the children chatting about the day, while trying to ignore the reality of a child in a place dealing with a tragedy they shouldn't have to be handling.

Given that the shelter was a special needs shelter, those caregivers attending to the needs of a loved one, or a newly formed relationship

through devastation, were not afforded the same level of attention as the patients. In one case, I worked to find clean clothes for a daughter who came with her 71-year-old, medically unstable mother. Approaching the table stacked with t-shirts and sweat pants, with brightly emblazoned LSU decals, the person tending the table literally swiped the shirts from the caregiver's hand, insisting they were for patients only! Rules at times could be illogical and punitive, a concern when all of the people were facing hardship. Diminished resources can prove even harsher for those facing compounded loss.

The floods reunited some families who had been separated through geography and time. One man, who suffered bilateral knee injuries, told me that he had to climb off his roof and make his way uptown to Carrollton where his ex-girlfriend lived. Once he arrived, the door was locked. She wasn't there, but he knew where she kept the key to enter the second story apartment. Neighbors started yelling at him to leave and threatening him with violence. He calmed them down, but noted it was the only place he thought of to go. I was asked to help reunite the man with his sister who lived in California. He hadn't left New Orleans for 50 years and had never flown before. Someone indicated that there might be someone from an organization called Angel Flight to help, pilots who volunteered their own time and fuel to evacuate people to many destinations. This was a huge help, as at the time of placing people, the commercial airlines were not offering assistance despite volunteer workers reporting that they flew in on almost empty planes and were told that the planes were returning to their hub, nearly empty. The Angel Flight volunteer worked with me to reunite the patient with his sister, whom he hadn't seen in 35 years. When I finally reached the sister on my cellular phone, she said, "So this is what it takes to see my brother...!" Connecting with Paul's sister felt like an accomplishment, and I will never forget Buck, the pilot who worked long hours to coordinate flights. Buck walked with me to meet Paul, telling him he would be glad to fly him to Colorado for the first leg of the journey. He asked him if he would mind flying on a small plane. Paul explained in his thick New Orleans accent the story of walking uptown on a broken knee to get to safety and that a small plane would suit him just fine. However, many reunions were bittersweet due to the result of necessity over choice.

We intuitively know that people can experience a variety of emotions following a disaster, largely based on their pre-disaster behavior and influenced by several variables linked to the severity of devastation, to loss, and whether the disaster was man made or natural. The case of the levee neglect, for instance, and lack of response by government officials may be debated for years to come, but overall there is a consistent feeling that more could have been done: both to prevent the levee failure and to make more solidified arrangements in terms of evacuation of citizens (accounting for more death and devastation than the hurricane itself). More should have been done in terms of response. However, it is noteworthy to recall the number of people who were saved in the disaster's aftermath.

Social workers have an ethical duty to take reasonable steps to avoid abandoning clients who are still in need of services (NASW, 1996). This can create a challenge in times of crisis, but thus speaks to the necessity of sharing essential information. You might not know the status of a person once you leave and the next person to pick up the chart comes in. This interrupted case management in a multiple layered, necessity-driven manner proves challenging to the social worker. The unfortunate reality was that in the speed of trying to relocate people from the campus SNS, not only were some plans less thorough but many persons lacked information, and it was not unusual to respond to a distressed visitor looking for a loved one. Several records were left with quickly penned entries, such as "left with family," or "released to a nursing home," but the specifics of location were lost and in some cases, critical social histories were not maintained. Taking the time to investigate the family composition and history made a profound difference.

A case I stumbled upon was an 85-year-old woman whose brother was in Baton Rouge with a diagnosis of tuberculosis. The sister had

a diminished cognitive status and because of her trauma and lack of memory, she did not tell the discharge person – at this time, a military designee without any social/human service or medical background – that her brother was in Baton Rouge. It was only through the knowledge of a situational caregiver that another volunteer who was at the hospital across town earlier met the brother who was frantically searching for his sister. The volunteer raced to the SNS looking for the sister. The sister was about to be whisked onto a bus toward Alexandria, some 150 miles away. The volunteer approached me with my penned "social work" sticky badge affixed on my shirt, pleading that they not remove the woman from the shelter until a plan for the brother was formalized. The two were eventually reunited, but in a nursing home miles away from their now destroyed residence.

A Brief Interlude in Another Special Needs Shelter: Good and Not So Good Practices

I was asked to report to a short-lived special needs shelter in a vacant K-Mart across town that lacked proper plumbing and air conditioning. The bathrooms were literally stalls set up outside of the shelter. A psychiatrist was designated for the role as social work chief and decided it best if we sit behind a table and wait for the patients to approach the mental health desk. A few of us glanced at each other and went back to work knowing this would be the least effective approach to the clients. Some others crafted and affixed a sign with the Greek symbol for psychiatry above the table. I couldn't remain silent on this one, so I suggested that we remove the cryptic sign and replace it with "SOCIAL WORK" or "MENTAL HEALTH." Signs were not what was needed; direct presence was. Volunteers worried about role overlap with professionals. Any overlap, if you could call it that, was a welcomed discussion between two or more engaged professionals.

In fact, one of the first cases I was called to arrange the discharge for was a woman, exhausted, obese, and distressed, awaiting a transfer to a local church shelter. I asked about her condition, as it appeared that she was immobile and likely did not get much therapeutic support in her home. She told me she could not walk and spends most of her time in bed. Her daughter helps, but she did not know where her daughter was. On further investigation, it was found that she had a stage-four decubitus ulcer on her buttocks, a bedsore that had become so infected it went all the way to the bone, and the phase of treatment requires a labor-intensive effort of skilled nursing/medical professionals. The plan was to send her to a non-medical shelter without any support, which of course was inappropriate. I rearranged the plan with coordination of the nursing staff for added medical support in a rehabilitation center, found the daughter, and tracked the physician to secure his signature.

Social workers are often necessary agents in filling in essential gaps. Anyone who believes there is no power in social work has never addressed someone's pain and reversed a plan that would cause undue hardship to all involved. One of the skills social workers learn is to feign ignorance while working with the medical and, often legal, personnel. Playing dumb while soliciting the support of those who may ultimately sign the plan is a skill many successful social workers hold as their trump card. In emergency settings, there are often people who have not worked with the population that require assistance. While any help can be beneficial, blindly following orders without asking questions can be deadly for our clients. Of course, using well placed charm gets us further than acting as an enraged zealot. Fortunately, social workers are usually well acquainted in handling conflict because much of what we do is riddled with conflict.

Volunteerism

It seemed that there were several factors that initiated volunteerism. Some professionals came out of concern and curiosity but were paralyzed by fear of lacking experience or being overwhelmed by the situation. There were others who came for the disaster tourism/ anthropologic experience, and others who came to roll up their sleeves and do whatever they could to allay a very difficult situation. One social work volunteer reminded a group:

"We just need to help each person, one at a time." Specialization was less helpful than a generalist, ecological perspective. Various workers attempted to set up how-to manuals, but this seemed to waste precious time from the actual hands-on work that was needed. The turnover in staff was so swift that the opportunity to sit and read any kind of social work recipe simply wasn't feasible. The best system was to begin, communicate with the workers who were on top of things, take direction about what was needed, assess the situation with the clients, and share the status of the case with those who were involved or who would be picking up after you left. Most critical priorities were shelter, family, and social service and medical facility connections. Some objectives were easier to secure than others. Working with the key discharge planners who ultimately arranged transportation and secured nursing home beds was essential. It was important to protect vulnerable people from unnecessary prying or another layer of stressful interrogation. There were virtually thousands of stories where the goodness of strangers came through despite the disorganization and limited institutional support. However, there were less sterling attempts, some bordering on exploitative practices, particularly where the medical businesses were concerned. Among them, I would include some less-than-noble nursing homes that seemed to view the disasters as a means to fill beds.

One social work entrepreneur-type flew in from Atlanta and determined that we must ask all individuals if they were HIV positive and forward those who were positive to her agency for counseling, yet she indicated no follow-up plan. She handed cards out like candy. She had grand ideas to identify a very real problem, but often what we needed was social work at the core of simplicity: meet the person, establish a rapport, take common sense approaches to make the difficult situation as comfortable for the victim as possible – eye level, covered, warm, hydrated, fed. Let them tell you what is wrong; ask them if there is anything they need. Validate their feelings. Assess status – physical, cognitive, emotional, disabilities, addictions—work to secure a plan that is ideally acceptable and/or initiated by the client. If it is not accepted, work to compromise, or describe the limited options given the post-disaster reality. If at all possible, work to place clients in facilities close to family and friends. This is all common sense, but common sense can be lost in times of crisis. Furthermore, AIDS/HIV supportive services may be a crucial area of service, but if services are not requested by the people in need, it smacks of placing our agenda before our clients'. It also can add undue stress to an already trying situation.

Getting Back to Normal?

Within only about a week or so of Katrina, there was a message dispensed through various broadcast emails from top administration that it was time for LSU employees to get back to "normal." I pondered about what normal meant after the largest disaster in history. Was I supposed to remove myself without having the opportunity to reunite families and search for more appropriate, more secure housing and schooling for the children? It wasn't possible for me to get back to *normal* when nursing home research is my primary area and there was the largest nursing home in reach of my office. Although there were messages that volunteering was embraced and celebrated, there was a similar echo that the grants needed to be submitted, the classes taught, and the office hours occupied. Getting back to normal, for me, was to turn my learning experiences into teachable moments, empirically tested research, publications and presentations, but more importantly to ponder the meaning of it all. I was fortunate to have a full teaching release based on a pre-tenure reward system in our department. It was a blessing, yet difficult to be outside of the classroom, but it crystallized my responsibility to work within the shelters and has since given me the invaluable opportunity to reflect on what it all meant.

Invisibility of the Shelters

The SNS Field House was reminiscent of many social service agencies and nursing facilities – horrific on the inside, but nearly invisible, nondescript on the outside, particularly

after the much publicized PMAC stopped the emergency rescue and triage efforts. It wasn't unusual for people in offices less than 200 yards away to ask if the special needs shelter was still in operation just days and weeks after the storms. The 50 long days may sound brief, but during the epic aftermath, days dragged on as if they would never end. In retrospect, people did not realize how long they would be away from home. Many parishes (counties) were closed for extended periods of time. People lacked transportation, housing, and other necessary resources. Added vulnerabilities were undetermined separation from social networks, disorientation, increased disease, and lack of information on anything from contacts to prescriptions. The patience of many wore out, as the days and planning were long, tedious, and precarious.

Research and Teaching Implications

With Hurricanes Katrina and Rita striking within a one-month period, an excess need for social workers became another kind of crisis. Waiting for curriculum and post-disaster recapping is not as useful as working with social workers ahead of time. Ideally, we will incorporate a higher level of disaster training in our curriculum, and our research will speak to our teaching. LSU has endeavored to provide extensive continuing education for practitioners and students who will inevitably be influenced by past and future disasters, yet many of us had no idea how influential Katrina and Rita would be in changing our future course.

Never before has the intersection of age, race, and poverty become so evident and never before has it been so clear that our country is ill prepared to manage a severe disaster for those who are most vulnerable. Unfortunately, persons who were living successfully, albeit with hardship, have made a mass exodus into nursing homes when shelters were swollen and medical care was necessary. They presented a paradox: was it a blessing that Louisiana had so many open nursing home beds? Or did the beds serve as a lesser of evils, prematurely forcing people to be located in nursing homes due to the lack of support required to get them back to their own home, providing a structured place for many that had no home to return to? Louisiana already had a higher utilization of nursing home care rate than most states. Still, time will be the only indicator for how people are doing—if we are able to track them down.

Perhaps the hurricanes opened the nation's eyes to the risks of older and disabled persons in the face of a natural disaster, yet the images are all but faded. From the relocation of citizens crammed onto buses and stuck in traffic on poorly planned routes for several days, to the unparalleled tragedy of St. Rita's nursing home where 34 residents perished, arguably due to a failure to execute a proper evacuation plan despite having had the resources, the stories were reminders or warnings of what can go wrong.

Future Implications and Unanswered Questions

I often think about the people I met in the emergency shelters, facing acute needs with chronic realities. So many spoke a counterintuitive theme that "it could have been worse." The gratitude and hope of life seemed nothing short of remarkable, as was the faith that so many expressed. Where are they? Will they return? Are they receiving the services they need, and are they still optimistic? What do we do when our practitioners are pushed beyond their capacity? How will we, as a society, fess up to the deplorable manner in which we responded to our own act of natural terrorism with compounded human error implications? Perhaps over cited, but more relevant than ever, it is Margaret Meade - our profession's sociologist-cousin - who said that things which make sense pose the harshest riddles. We can't underestimate what a small group of invested individuals can do to change the world. Why is it always only a small group of invested individuals working to change the world? Why do some people walk around able to muffle the sounds of suffering while only a small segment participates for the long run? Social workers are often the participants. We do not turn out the lights and forget the faces and the needs when we return home. Our heroes through this national crisis, our unsung national guard, have been our social workers.

The catastrophes reminded me of who we are and, I believe, propelled the profession to a higher level of awareness and appreciation. Working through the disasters renewed my sincerity in conveying to our students what we stand for, beyond a self-serving clinical approach to the reality of helping people in pain and challenging those who are removed. We work to overcome unthinkable obstacles on a daily basis. This is what makes our profession beautiful – its perseverance in the face of resistance. The experience reminded me of the pioneers: Bertha Reynolds, who didn't give up even after being blacklisted and scathed as a feared Communist because of her then renegade views about helping people and fighting corruption; Mary Richmond, who worked to professionalize our field; and Jane Addams, who transcended practice from noblesse oblige to a multi-level advocacy and direct-line activism.

Perhaps the harshest reality of the storms was that older people disproportionately perished, and older people with added medical and financial hardships are now indefinitely residing in nursing homes. Social workers did what they could to provide support and humane treatment, yet the cruelest reality may be the long standing societal treatment of older persons who have few options, a reality that revealed that disaster unearths cruel disparities among those who are vulnerable. I hope that all of the stories will continue to serve as reminders that we can do better when disaster strikes again, and what we can do to improve every day practices.

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