EDITORIALS AND COMMENTARIES

Disaster Response: One Size Does Not Fit All

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The September 11, 2001 terrorist attacks, the anthrax attacks just 1 week later, and, more recently, Hurricane Katrina have all sensitized our nation to some acute security vulnerabilities. Both September 11 and the anthrax attacks exposed Americans to the realities of terrorism on US soil. The federal response to these events was to reorganize and reprioritize government agencies leading to the passage of the Patriot Act and the establishment of the Department of Homeland Security. However, Hurricane Katrina reminded us that in the absence of terrorists and enemies, natural disasters can also result in mass casualties and threaten health, safety, and security.

Unfortunately, Katrina also grimly pointed out that despite significant planning and advance notice, protecting health in large impoverished urban communities presents unique challenges that, if unrecognized, will only serve to complicate intervention efforts. Although there are some things that authorities handled appropriately in the aftermath of Katrina, there were also several unidentified barriers that had a significant impact on the ability of authorities to intervene effectively. Had these issues been understood appropriately, they could have been more adequately addressed both before and after the Hurricane.

In Homeland Security Presidential Directive (HSPD)-5, President Bush articulated his vision for a new National Response Plan (NRP) to align federal coordination structures, capabilities, and resources into a unified, all discipline, and all-hazards approach to domestic incident management.¹ Briefly, this vision is based on the following assumptions: (1) Incidents should be managed at the lowest possible organizational and jurisdictional level. (2) Incident management activities will be modeled after the National Incident Management System. (3) Government, the private sector, and nongovernmental organizations will be required to prevent, prepare for, respond to, and recover from incidents of national significance. (4) The Secretary of Homeland Security will coordinate operations for incidents that may occur at any time; require significant information sharing; involve single or multiple geo-graphic areas; have significant international impact; span the spectrum of incident management to prevention, preparedness, response, and recovery; involve multiple

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hazards or threats; result in numerous casualties, fatalities, displaced people, property loss; disrupt normal life support systems, essential public services, and basic infrastructure; cause significant damage to the environment; impact critical infrastructures; overwhelm capabilities of state, local, and tribal governments and private-sector infrastructure owners/operators; and require prolonged, sustained incident management operations and support activities. Top priorities for incident management are to: (1) save lives and protect the health and safety, (2) ensure security of the homeland, (3) prevent an imminent incident, including acts of terrorism, from occurring, (4) protect and restore critical infrastructure and key resources, (5) conduct law enforcement investigations, (6) protect property and mitigate damages, and (7) facilitate recovery of individuals, families, businesses, governments, and the environment.¹

On the surface, this appears to be a sound and logical approach; however, in the retrospective lens of Katrina, several significant omissions are evident. First, this one-size-fits-all approach may have merit with regard to potential hazard control, but it is ill conceived in terms of population management. It fails to recognize the fact that significant differences exist across major US subpopulations (minorities, immigrants, poor) in their perceptions of problems or willingness to believe and thus respond to authorities. For a variety of reasons, many minority and immigrant populations simply cannot be assumed to respond the way nonminority populations would respond.

The reasons may be varied, but as was seen in New Orleans, the response (or lack of response) was fairly widespread and in some ways predictable. For example, various newscasts reported that roughly 150,000 people were not able to evacuate New Orleans² and many more just chose not to. Authorities are apparently at a loss to explain this phenomenon, yet it is known that many residents of New Orleans lack cars. A 2000 census revealed that 27% of New Orleans households, amounting to approximately 120,000 people, were without privately owned transportation.³ Additionally, New Orleans has one of the highest poverty rates (28%) in the United States.³ A *Washington Post*, Kaiser Family Foundation, Harvard School of Public Health survey of evacuees in Houston shelters reports that 61% of survey participants indicated they did not evacuate before the storm. Of these, 38% said they were either physically unable to leave or had to care for someone who was physically unable to leave.⁴ This constellation of factors prevented many people from being able to evacuate on their own. Consequently, most of those stranded in the city were the poor, elderly, sick, and those caring for the sick.²

In addition, it has been variably reported that approximately 20,000 active substance abuser live in New Orleans. In some cases only after several hours and in most cases after a few days of not being able to get their drugs, these individuals would undoubtedly contribute to crowd management, looting, and violent crime activity. Indeed, anecdotal reports cite vandalized pharmacies sitting adjacent to near intact grocery stores. Finally, it is widely known that many members of immigrant and minority communities maintain a baseline mistrust of police, the health-care system, and the federal government. At the same time, these communities are typically more family and community oriented than other populations. Ironically, some of the same reasons for the New Orleans tragedy may also be significant contributing factors to racial and ethnic disparities in a more general sense. These realities may help explain why so many residents simply chose to ignore "outsider" information and recommendations, despite the consequences. Unfortunately, these realities are typical of large urban centers and could have been addressed in the

massive post-9/11 response planning efforts had they been recognized as potentially significant.

The implications of these issues are potentially significant in terms of health, safety, and perhaps even national security, especially as the issues are not unique to New Orleans. Given a like scenario in another city of similar demographics, the same results could occur again, even with a more vigorous governmental response to the incident. On the other hand, lack of appreciation, informed planning, and implementation of interventions to addresses these sociocultural realities will only increase pre- and post-incident problems. Based on the New Orleans experience, it should be apparent that one size does not fit all, and attention should be directed to understanding how low income communities can best be prepared in the future for both natural and manmade disasters. Indeed, unless a greater national commitment to understanding and embracing sociocultural differences—often concentrated in large urban centers—emerges, history will once again likely repeat itself.

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