

# Editorial

## The Next Disaster: Are You Ready?

Disastrous events overwhelm us physically, mentally, emotionally, and financially and frequently require the assistance of the medical profession and in particular mental health professionals who can deal with both victims and volunteers. As advanced practice psychiatric nurses, we need to review what we have done in past disasters and ask what lessons we have learned that can better prepare us for future events. Hopefully, after reading the first-hand reports of volunteer nurses and physician during a disaster, you will be motivated to take disaster training and get involved with your communities' disaster plan. As Buck, Trainor, and Aguirre (2006) so succinctly state, "governments cannot guarantee protection against disaster and catastrophe. People are responsible for their own welfare" (p. 21). Getting involved at the grassroots level is one way to learn from past mistakes and to contribute to devising effective programs for disaster recovery in your community.

During my own experience as an active duty military mental health nurse (currently a retired Lt Col), there were continuous practices and real scenarios that prepared us for the specific role we would play during a disaster. The military has a well-developed protocol for disasters that clearly spells out the chain of command with disciplinary consequences for not following the plan. Unfortunately we do not have something in civilian life that replicates the success of military disaster planning. Although there is a designated National Response Plan in place, the continuous practice and communication of the chain of command is insufficient. Therefore, when medical personnel volunteer during a disaster, they frequently have no previous disaster experience or training for the role they are given. Needless to say, they do not know how the system works and often unwittingly make decisions that complicate and slow down recovery services.

My first real encounter with a disaster was in Honolulu, Hawaii, when a Navy boat in the Pacific had a huge fire with multiple burn victims. I remember standing on the lanai of Tripler Army Hospital straining to look out with anticipation and anxiety to see the boat coming into the harbor. In the 1970s, when

stationed at the USAF Hospital in Wiesbaden, Germany, the Bader Meinhoff gang and other terrorists were active. We were told never to wear our uniforms in public and to hide our identification cards while traveling. The day I was returning to the United States, a terrorist group bombed the Rhein Mein Officers Club just 1 hr after I had lunch there, resulting in 18 people injured. The Panama invasion, dubbed "Operation Just Cause," created casualties who were sent from Panama to Wilford Hall USAF Medical Center in San Antonio, Texas, where I was a Mental Health Clinical Nurse Specialist. I was part of a team that conducted debriefings with anguished ICU nurses soon after the rush of patients subsided. After the first Gulf War, I conducted Critical Incident Stress Debriefings of active and reserve duty nurses at two Air Force bases in the United States. Each time I participated in these, it evoked strong feelings in me. I was seeing how other nurses coped with working with disaster victims and the difficulty of incorporating these experiences into their everyday lives.

When I retired from the military and became a faculty member at the University of Texas Health Science Center at San Antonio School of Nursing, I joined a voluntary community group called the Mental Health Disaster Consortium (MHDC). At monthly meetings we discussed disaster planning, disaster training, and networking with the other agencies and organizations in the city to coordinate care and treatment during disasters. On September 2, 2005, I was called to the shelters at the former Kelly AFB in San Antonio as Hurricane Katrina victims from New Orleans began to arrive. Then, again on September 23, Hurricane Rita victims arrived to join the Hurricane Katrina victims. There were thousands of these people in the multiple shelters in San Antonio. San Antonio was ready to put its plans to the test. It was a huge undertaking and to be part of this and involved totally for over 3 months was an awesome and overwhelming experience.

No one ever could have been fully prepared for Hurricane Katrina. The complexity and magnitude of this disaster was something the United States had

never before experienced. Understanding the usual processes of how disasters are handled is important. First, the mayor, in San Antonio, activates the local response teams, the fire chief is the commander during a disaster, and then when the local resources are overwhelmed, the mayor requests help from state resources through the governor. The federal government (through FEMA) may not enter until the governor of the state requests help. Common issues seem to arise during all disaster experiences. Usually, there is confusion and chaos, and organizational, leadership, and role concerns. This detracts from or interrupts the delivery of services and care. I, myself, found that I had difficulty in how or where the MHDC fit in services provided in the shelters in San Antonio. I was clear as to my role with MHDC, but those in other groups and agencies had other ideas.

### Nurses' Participation in the Rescue Efforts

Yes, there were many problems and plenty of blame to go around. The media focused mostly on the dire situation and repeatedly showed images that were devastating. Meanwhile, there was also phenomenal help, rescues, and responses that were heartfelt and miraculous. The generosity of the U.S. citizens to help in this disaster was overwhelming. We can be proud that so many nurses and physicians left their comfortable homes and volunteered to go and provide medical and psychiatric services to those displaced. Our compassion as nurses spurred us to action and we are willing to put up with the confusion, long hours, lack of leadership, and heartbreaking stories to offer our help. By reflecting on our combined experiences, we can learn some lessons, gain some collective knowledge, and help each other to cope. Our stories need to be told and shared. As Ollie North says, "It is a story that deserves to be told."

This issue of *Perspectives in Psychiatric Care* is dedicated to the stories of the nurses and physicians who

were present during a disaster as a volunteer—during Katrina, Rita, the tsunami, and California wild fires. As you will see when reading their personal accounts of the experience, each volunteer offers some valuable insight for changes to be implemented into disaster planning. Lessons learned need to be acknowledged and acted upon in every agency—local, state, and federal level—that is involved with emergency care during a disaster. Only by learning from our experiences can we hope to provide a more timely response to the victims and provide the services that are critically needed during the time of chaos and upheaval.

A "failure of imagination" of the magnitude of Katrina can no longer be used as a reason as to why we are not prepared for a monstrous event. We had September 11, 2001, the earthquake and tsunami in December 2004, and Katrina and Rita in September 2005. Now we know. Now we need to heed the advice of the people who were there and begin immediate planning, training, and practice for the next disaster. Change needs to happen at every level. As Buck, Trainor, and Aguirre conclude: "The collective responsibility is to learn from the past and come up with new approaches using the best informed means and most appropriate resources available to the society. This is the larger vision that is needed for a new public administration of disasters" (2006, p. 22).

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