
Community Mental Health Response to Crisis



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Mental health is seen as an important aspect in the community response to crisis and disaster. Research offers limited guidance to what interventions are likely to be effective in preventing postdisaster mental health problems. This article reviews recommended elements of mental health responses to community disasters. Different factors influencing response are illustrated by using 9/11 and Hurricane Katrina as examples. Clinical suggestions for community planning and actions of individual psychologists conclude the article. © 2006 Wiley Periodicals, Inc.* *J Clin Psychol*: In Session 62: 1029–1041, 2006.

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In the last 125 years, catastrophic events in the United States have led to extensive loss of life and property. These events include the 1889 Johnstown flood, the 1906 San Francisco earthquake, the Great Mississippi River flood, Hurricane Betsy, and the Galveston hurricane. Most recently, Hurricane Katrina has been the most devastating natural disaster experienced in this country. As of October 2005, the death toll stood at 1,122. The hurricane and the resulting floods displaced over 1 million people and caused estimated financial damage ranging from \$100 to \$200 billion.

Survivors of mass disasters and other traumatic events are vulnerable to lasting psychological sequelae associated with exposure to risk of death and injury, loss, and displacement (Norris, Friedman, Watson, Byrne, Diaz, & Kaniasty, 2002). Many survivors witness death and destruction and are injured themselves. They may be separated from

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loved ones and friends and may not know for hours, days, or in the case of Hurricane Katrina, weeks, whether people survived or perished. Survivors may have to wait for rescue and face uncertainty whether they will perish or will be rescued before they run out of food and water. After rescue, they must contend with the losses of home and treasured possessions collected over a lifetime and with basic life decisions to be made whether to return to the area or relocate. Survivors face many practical challenges in reestablishing their lives.

Mental health aspects of disaster are increasingly addressed at the disaster planning table. Mental health planners, in collaboration with first-response organizations, have been reworking disaster mental health response by using a variety of interventions. To date, research offers only limited guidance as to what interventions are likely to be effective in preventing posttraumatic stress disorder (PTSD) and other postdisaster mental health problems.

This article reviews two aspects of mental health response to community disasters: the need for clear organizational leadership at the disaster and the evolving perspectives on the types of mental health interventions provided during disaster. Psychological responses to the disasters are discussed in the context of two recent crises: the September 11, 2001, World Trade Center terrorist attacks and Hurricane Katrina. We offer recommendations about how individual practitioners can assist their communities and suggestions for mental health planning and response to communitywide disasters.

Organizational Contexts for Immediate Response

When a disaster occurs, there is initial confusion regarding responsibility for leading response in the crisis. This was abundantly clear during Hurricane Katrina with the lack of clarification of leadership, for example, determination of who would be in charge of providing transportation and safety and the insufficient coordination among city, state, and federal agencies. As well, there are generally confusion and conflict over mental health response without clear designation of the lead agency. When there is competition for leadership, more emotional stress is created for both workers and families.

In addition to city, county, state, and federal agencies that respond, nongovernmental agencies now provide crisis mental health services. A partial list of the organizations that have responded to the mental health needs of victims and workers include the National Organization of Victim Assistance, the International Critical Incident Stress Foundation, the International Association of Trauma Counselors, the Salvation Army, and the Red Cross.

Regrettably, there is little protocol for designation of a lead agency in community crises. In some cases, the state Mental Health Department may be the lead; in others, leadership may fall to the city. For example, in the Oklahoma City bombing, the governor appointed the state Department of Mental Health and Substance Abuse Services to act as lead agency (Pfefferbaum, 1996). There is one exception to the confusion of agency leadership: When a transportation accident occurs, the lead agency for mental health is, by federal mandate, the American Red Cross.

The American Red Cross (ARC) is a volunteer-driven nongovernmental agency recognized as a first-responding organization for disaster victims. Given its key role in disaster planning and response, the ARC has a seat at the Emergency Management Association meetings. Although it has a long history in response to disaster, only in recent years has it been involved in mental health response. In the early 1990s, after Hurricane Hugo, the ARC recognized that disasters left survivors with significant mental health issues. Trained ARC mental health workers could provide immediate mental health support to clients while they were in shelters and obtaining emergency financial assistance.

The organization also recognized that its volunteers and staff were experiencing significant job stress and they could also benefit from the support of mental health workers available on site.

In 1991, a statement of understanding between the American Psychological Association and the ARC was signed, and in 1992, the Disaster Response Network (DRN) was developed as a centennial “gift to the nation.” DRNs are state-organized groups of psychologists who are trained in ARC-approved interventions and can be called upon by the organization in the event of a disaster. Each Disaster Response Network is headed by a psychologist who is designated as the coordinator (APA Disaster Response Network, www.apa.org/practice/drnguide). Since 1991, the American Red Cross has also signed letters of understanding with other mental health disciplines regarding service provision. Mental health professionals can be mobilized to provide emergency mental health services to ARC clients, staff, and volunteers during the preparation, response, and recovery phases of a disaster.

It is imperative that mental health responders understand the structure of the relief efforts, including leadership and coordination of mental health programs. Mental health needs must be continually assessed because disaster environments are fluid and change quickly. To prevent duplication of effort and meet needs of survivors, organizations on site must synchronize their efforts and do so rapidly in a chaotic environment.

Mental Health Interventions in Disaster

In the 1980s, a number of interventions were developed to prevent burn out, PTSD, and vicarious traumatization in first responders to disasters. One of these interventions was a group procedure called Critical Incident Stress Debriefing (CISD; Mitchell, 1983), which was a strict protocol for leading survivors through a review of personal experiences of a traumatic event. Over time, this postdisaster intervention was applied not only to first responders but to victims of disasters.

Additional interventions included defusings and demobilizations. Defusings are shorter stress-relieving meetings used to explore a traumatic event, discuss signs and symptoms of stress, and develop coping mechanisms to address the stress. Demobilizations are designed to provide information about the incident and stress reactions and are offered when large numbers of personnel are being released from active duty. These interventions were adopted by many police and fire departments as well as employee assistance programs throughout the country.

Empirical studies of the effectiveness of stress debriefing have recently emerged. The well-conducted studies have focused on individual debriefing rather than group debriefing, but comprehensive reviews of the evidence have concluded that debriefing does not prevent development of posttraumatic stress disorder (e.g., Litz, Gray, Bryant, & Adler, 2002; McNally, Bryant, & Ehlers, 2003). In 2002, the National Institute of Mental Health (NIMH) collaborated with several other federal agencies in convening a consensus conference on interventions after mass disaster. This group made strong recommendations for no longer using CISD as an intervention for prevention of PTSD (National Institute of Mental Health, 2002). Mitchell (2003) rebutted the NIMH recommendation and recommended using a more comprehensive Critical Incident Stress Management (CISM) approach, rather than debriefing as a stand-alone intervention. He also stated that direct victims of disaster should not be given CISD.

Acknowledging the limitations to the Critical Intervention Stress Debriefing has led to increased efforts to rethink immediate intervention. In particular, psychological first aid (PFA) has been proposed as the primary service during the first hours and days after

a disaster. PFA has been manualized in order to speed its delivery and evaluation (National Child Traumatic Stress Network and National Center for PTSD, 2005; <http://www.ncptsd.va.gov/pfa/PFA.html>). PFA actions are designed to meet the immediate practical needs of survivors, not to offer extensive psychological treatment.

The eight core actions of PFA and their associated goals are summarized in Table 1. These core actions should be flexible and delivered on the basis of the needs of the person in situation. *PFA* is an umbrella term that includes some of the components described in more detail later, such as education and social support.

In addition to immediate needs assistance via PFA, it is widely recognized that selected survivors may benefit from brief interventions in the weeks and months after disaster exposure (Gibson et al., in press) and from referral to mental health treatment if symptoms do not remit with brief interventions. Because efforts to incorporate mental health services into disaster response are becoming more systematic and research is growing, conceptions of best practices in disaster mental health response will change in the coming years.

Recommended Elements of Mental Health Response

A comprehensive community mental health response incorporates a range of activities designed to contact, assess, educate, support, and intervene with community members. The relative emphasis on these activities changes with the phases of the event. The phases can be divided into the preimpact or preparatory phase, the impact phase, the response phase, and the recovery phase.

Outreach and Survivor Engagement

Because many disaster survivors will not use mental health services, it is important to make the affected community aware of available services and, if appropriate, engage them in using such services. Active use of mass communications media and face-to-face outreach to survivors help with this process, as can adaptation of services to the cultural contexts of affected groups. Often, outreach involves having staff knock on doors, engage

Table 1
Eight Core Actions and Goals of Psychological First Aid

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1. Contact and Engagement. Goal: Respond to contacts initiated by affected persons or initiate contacts in a nonintrusive, compassionate, and helpful manner.
 2. Safety and Comfort. Goal: Enhance immediate and ongoing safety and provide physical and emotional comfort.
 3. Stabilization (if necessary). Goal: To calm and orient emotionally overwhelmed/distraught survivors.
 4. Information Gathering: Current Needs and Concerns. Goal: Identify immediate needs and concerns, gather additional information, and tailor psychological first aid interventions.
 5. Practical Assistance. Goal: To offer practical help to the survivor in addressing immediate needs and concerns.
 6. Connection with Social Supports. Goal: To reduce distress by helping structure opportunities for contacts with primary support persons or other sources of support, including family members, friends, and community helping resources.
 7. Information on Coping Support. Goal: To provide the individual with information (including education about stress reactions and coping) that may help him or her deal with the event and its aftermath.
 8. Linkage with Collaborative Services. Goal: To link survivors with services and inform them about services that may be needed in the future.
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survivors on the street, and give presentations in disaster assistance centers, neighborhood stores, places of worship, schools, and other community gathering spaces.

Survivor Education

Survivor education is a core component of PFA. Psychoeducation is widely seen as a service that benefits all survivors, offering little risk of the stigmatization sometimes associated with seeking mental health care. It may be delivered via informal conversations or through structured formal presentations. Postdisaster education is designed to help survivors understand posttrauma responses, view posttrauma reactions as expectable and understandable (rather than as reactions to be feared or as signs of personal failure and weakness), recognize the circumstances under which they should seek further treatment, know how and where additional help can be found, use social supports, develop adaptive ways of coping, decrease use of problematic coping (e.g., alcohol consumption, social isolation), and increase the ability to help family members cope.

Social Support

Immediate postdisaster intervention involves ensuring, as part of PFA, that survivors are provided with instrumental and emotional support from family and friends. Broadly speaking, social support is an important predictor of postdisaster outcome and should be a focus of attention throughout all phases of disaster. In intervention, individuals who work with survivors should actively explore how survivors are able to access and use social support. PFA intervention directs the professional to talk to survivors about sources of social support, the well-being of significant others, and ways of asking for and giving social support.

Early mental health response includes provision of support during the processes of death notification and registration of affected families. Initiation of a centralized service for notification and family support is an early priority for federal and local agencies during the immediate aftermath of an event involving high death tolls.

Brief Crisis Therapy

As the weeks pass, emergency PFA services are supplemented by efforts to offer time-limited emotional “crisis” therapy services. In a few (e.g., one to three) sessions of contact, mental health clinicians offer survivors emotional support, education about reactions to disaster/normalization of responses, coping support and advice, problem solving, and direction to available resources.

Assessment and Follow-Up

A key aim during contacts should be to identify the central needs of the survivor and determine need for referral to more intensive care. Mental health interventions should routinely include assessment (including assessment of known risk factors) and discussion of further care options. However, it is not possible in the first days and weeks after a disaster to identify reliably those in need of more intensive help. Moreover, concern about risk of stigmatization and unwise use of scarce resources suggests that referrals for unneeded therapy are to be prevented. It is an important option to provide telephone follow-up at a later date for those considered at high risk. Such a practice may reduce the

likelihood of unneeded referral, maintain contact with vulnerable individuals, and offer later assessments, 2 to 3 months after the event, when the need for further psychotherapy interventions may be more reliably determined.

Referral for Mental Health Treatment

PFA and brief crisis therapy are likely to be inadequate for some of those who are more severely affected by the event. Referrals to more extensive treatments should be considered for individuals who are exhibiting extreme problems, such as inability to function, suicidality, and alcohol dependence, in the immediate aftermath of the crisis. In typical disaster situations, the majority of referrals for mental health treatment are made after several months have passed after brief crisis work.

Two Recent Communitywide Disasters

The 9/11 and Hurricane Katrina disasters illustrate the mental health activities undertaken in the preparation, impact, response, and recovery phases of major community events. In both, the country was overwhelmed by the magnitude of the mental health needs of those touched by the disasters. Both events challenged our collective sense of invulnerability and perceived capability to respond to disaster. Before 9/11, it was collectively believed that the United States was invulnerable to large-scale terrorism from abroad; afterward, we recognized our vulnerability to threat and danger. Before Hurricane Katrina, the country believed that in a severe crisis, the federal government would be able to rescue people and reduce the disaster's impact. After Hurricane Katrina, it became clear that city, state, and federal agencies could be just as overwhelmed as agencies in other countries that have faced catastrophic disaster.

Hurricane Katrina and 9/11 differed, however. For 9/11, there was a sense of "us," Americans, against "them," terrorists, which tended to unite Americans in a temporary heightened state of classless, raceless unity. Hurricane Katrina underscored awareness of the reality of the impact of poverty and race on access to comfort, services, and survival and intensified the differences in American society.

There were other similarities and differences between the mental health responses to 9/11 and Hurricane Katrina. For 9/11, there was little mental health response preparation for such a unique disaster. Existing mental health agencies with disaster plans were not on alert because there were few public indications of the likelihood of this kind of event. In contrast to 9/11, Hurricane Katrina allowed for significant warning, and relief agencies were on standby, waiting for the impact phase. Supplies had been moved, shelters set up, and mental health workers assigned to monitor the stress of evacuees before the hurricane. Some mental health workers were assigned to monitor stress levels at emergency operating centers where multidiscipline teams met to plan operations.

During the impact phase of the disaster, if there has been no warning, mental health professionals outside the impacted areas are obligated to call the agencies with which they have contracts or contacts as they become aware of the need for a disaster response. If mental health professionals are inside the zone of the affected disaster area, they become disaster victims themselves. They may, themselves, have suffered trauma-related losses and may not be in the best position to assess their own stress. Ideally, mental health professionals directly impacted by the disaster will not be asked to respond. However, in disasters, the initial responders are typically the members of the impacted community. After 9/11, many of the local mental health disaster volunteers were psychotherapists

whose offices were in the area of the World Trade Center. They went to the ARC to volunteer, initially shaken but eager to be of assistance. There are many anecdotes of New York City psychologists who realized, after working a few hours, that they needed time for themselves because their personal worries prevented them from providing professional availability to upset survivors.

After Hurricane Katrina, some psychotherapists wished to volunteer before they resolved their own living situations. The advisability of this practice can be debated, though the opportunity to help certainly can be a healing factor. However, the impact of disasters on the helper can be underestimated. Personal experience of a disaster may create symptoms of anxiety and posttraumatic stress that can undermine the ability of the helper to perform an emergency role.

The first 72 hours after the impact of the disaster in the response phase are critical and extraordinarily stressful. Rescue missions are occurring and the extent of the numbers of injured and dead is unclear. First responders are working without normal breaks, and there is a clear sense of life or death for those responding. At 9/11, first responders attempted to dig survivors from the rubble and many worked for 48 hours without respite. Mental health workers accompanied ARC emergency response vehicles that provided food, coffee, and water and encouraged responders to take breaks. After Hurricane Katrina, the ARC could not enter the affected area for many days and waited far away from the impacted area. In states such as Texas and Georgia, thousands of evacuees streamed into shelters, hotels, and ARC service centers, looking for food, assistance, and temporary housing.

In the response phase of the disaster, helpers provided psychological first aid to the responders, survivors, planners, and those in the community who were providing for the evacuees from the hurricane. A new manualized protocol for the conduct of Psychological First Aid (National Child Traumatic Stress Network and National Center for Post-Traumatic Stress Disorder, 2005) was widely distributed and applied. The scale of the disaster quickly demonstrated the inadequacy of existing lists of mental health responders. The American Red Cross, to meet the intense need for mental health workers, modified its existing selection/training requirements in order to recruit additional responders and provided on-site training.

At 9/11, there were drop-in respite centers that allowed first responders to receive refreshment and to socialize. There were circulating mental health professionals available for informal and undemanding conversation. Massage therapists and spiritual care professionals were also present to provide comfort and support. At the pier on 9/11, the first responders, on the front lines serving the families of victims, were offered services on an "as needed" basis as they showed signs of distress. When mental health staffing is insufficient in a disaster, such as during Hurricane Katrina, there is reduced ability to provide for the needs of first-responder groups. The mental health responder can only respond to the group or agency of assignment.

In the response phase, the range of activities in which mental health professionals are engaged is highly dependent upon their defined role. This role may be loosely or tightly defined. In 9/11, a tightly defined psychological role involved supporting families during the process of providing information and personal items, such as toothbrushes and hair samples, to aid investigators and police making DNA identifications of the remains of their loved ones. Later, they supported families who were taking boat rides to view the site of the remains of the buildings and their loved ones. At Hurricane Katrina, psychological assistance was tightly defined to support survivors who did not know whether their loved ones, from whom they had been separated, had survived the disaster. The process involved practical aid, making phone calls and searching Web sites. First responders were involved in helping

coordinate resources for family reunions. They were also called upon to help family members be patient with the inefficient service delivery process. Some psychologists assisted the families with the grief of learning of their loved ones' death.

In the recovery phase, the focus gradually shifts from immediate needs of reunification, sustenance, temporary shelter, and daily survival coping to the longer-term issues of assessing the losses and determining "what next" steps. The psychological response during this stage shifts from the emergency and disaster relief agencies to the affected community. The federal government, through the Substance Abuse and Mental Health Services Administration (SAMHSA), has a mechanism for states that have had a presidential declaration of disaster. The community can apply for immediate assistance grants to hire workers for mental health support for 60 days after the grant is awarded. States can also apply for longer-term grants, lasting for 9 months after the initial 2-month grant, which will effectively provide approximately 1 year of mental health services to affected communities. The 9/11 events produced a range of innovations in this phase, including experimentation with delivery of more intensive therapy options, use of a screening tool in SAMHSA crisis programs, training of community providers in evidence-based treatments, extensive use of a telephone hotline, and increased application of Web technology to provide information to survivors. For example, referral for "enhanced" services was offered in which individuals judged at risk could participate in a more formal (10- to 12-session) intervention based on cognitive therapy methods (Hamblen, Gibson, Mueser, Rosenberg, Jankowski, Watson, & Friedman, 2003). The treatment manual had not yet been empirically researched with disaster survivors, but the interventions were consistent with those supported in the empirical literature for a range of psychological problems (e.g., PTSD, anxiety, depression, guilt).

For Katrina, the immediate services grants are currently funded and workers are being trained. As this article is being written, mental health workers are beginning outreach to find survivors and evacuees. Katrina has presented unique challenges because many of the survivors have not returned to their original communities and are living in adjacent and distant states. Texas has an estimated 275,000 evacuees still living in the state and Georgia estimated its evacuee population at over 100,000 during the peak of the evacuation. Each state receiving large numbers of evacuees received immediate services grants. To help find the dispersed survivors, a \$66 million Federal Emergency Management Agency (FEMA) grant has been awarded to United Methodist Committee on Relief, the humanitarian relief and development arm of the United Methodist Church. This agency will select up to 12 other agencies with expertise in disaster response to assist vulnerable citizens in negotiating the process that will connect survivors with services and assist in making individual plans. In its lead role, UMCOR will represent a broad-based coalition known as NVOAD, the National Voluntary Organizations Active in Disaster. NVOAD members are secular and faith-based. FEMA will supervise the implementation of the grant.

In the recovery phase, several psychological associations have set up pro bono services. Psychologists will provide a certain number of free psychotherapy sessions to victims. In Georgia, the program is multidisciplinary. Through a central data bank, names of mental health practitioners willing to see clients or families and provide follow-up assessment or short-term interventions has been distributed throughout the community. In some states, psychology associations are providing training in evidenced-based therapies for posttraumatic stress disorder; others have applied for grants from the American Psychological Association and other organizations to provide the infrastructure for treatment to survivors in their community.

Katrina has challenged many agencies and providers because accurately determining need and access has been difficult. Hurricane survivors have mental health needs beyond

diagnosed or subthreshold PTSD. The research literature suggests an increase in substance use disorders, depression, anxiety, and domestic violence. Children often experience more school difficulties and/or acting-out behavior. There may be more somatic and physical symptoms (Meichenbaum, 1994). The evacuees are not clustered within a geographic area. Telephone hotlines are being used to help the survivors find services. Outreach to primary care providers and agencies is occurring. Recovery will require unique methods of support. Given that entire neighborhoods have been dispersed, it will be important to help survivors create new networks of support and find ways to integrate evacuees into their new communities. The disenfranchised are at more risk than those connecting through their children's schools, work, or a faith-based organization. Those at highest risk will often be the most difficult to engage in traditional services and require creative methods of engagement. In some communities, restaurants are offering New Orleans Creole meals and town meetings or free jazz concerts to reach newcomers.

How Individual Psychologists Can Help

Psychologists are ideally suited to lead the community response to crises if they enter the disaster with the appropriate tools and mindset. The psychologist best serves the community by joining an organization that operates in the community during the disaster. Psychologists can provide effective services in the preparatory, impact, response, and recovery phases of the disaster when they have formed relationships and alliances with the major disaster agencies that are mandated to respond, are knowledgeable about leadership, and know about interagency interactions. The greatest challenges occur in disasters such as Katrina when different agencies do not coordinate efforts.

The following are some suggestions for psychologists interested in responding to disasters:

- Join an agency recognized as central to disaster preparedness and response.
- Receive training in disaster concepts and response interventions. Education about incident command structures and training in psychological first aid will be helpful. A new American Red Cross disaster mental health course has been developed. Other ARC courses on weapons of mass destruction and response to disasters with mass casualties will be important for those hoping to work through the ARC.
- Understand the differences between working in an office and working in a disaster environment. Before working in a large traumatic disaster, volunteering for a smaller disaster by working on an ARC disaster action team that responds to house fires or working with a fire or ambulance department or a local emergency management association is strongly advised.
- Be prepared to clear regular schedules for at least several days and up to 2 weeks when they volunteering for disaster work.
- Benefit from being part of the state psychological associations as each state association has a structure for a disaster response network of psychologists. E-mail communication assists the coordinators in times of disaster in knowing more about what the different states are doing and what the American Psychological Association is doing to respond to the disaster.
- Understand that all the mental health disciplines are needed, and respect the ability of all licensed professionals to assist in the disaster.
- Find mentoring for experiences and have support networks available to talk about the stresses of the disaster. Other psychologists can often provide such mentoring via telephone consultation if there are no on-site mentors available.

- Know lines of supervision and to whom to report. Psychologists are often comfortable operating “solo” and are accustomed to making independent decisions. In disaster situations, collaboration, consultation, and communication are the “3 Cs” of effective decision making.
- Form relationships with the people in key positions who work in disasters. It is helpful to know the fire and police chiefs in the city, the local and state emergency managers, and the social workers at the emergency receiving hospital.
- Psychologists who are undergoing personal stresses or have personally experienced the disaster should not volunteer to work during the disaster. If they do, they need to do so with an understanding of the risks. They may later in the recovery phase provide pro bono services to survivors with less risk when their own lives are more in order.
- Offer to provide pro bono services to survivors in the recovery phase.

Suggestions for Disaster Mental Health Planning

In the following, we offer suggestions related to planning for disaster mental health response (New York State County Disaster Mental Health Planning and Response Guide, 2005; Neria, Suh, & Marshall, 2003; Norris, Hamblen, Watson, Ruzek, Gibson, Price, Stevens, Young, Friedman, & Pfefferbaum, 2006):

- Develop a consortium of mental health professionals to plan local disaster mental health response. This consortium must include a broad spectrum of professionals, agencies, and organizations. Be as inclusive as possible. Develop memoranda of understanding with community partners. Consider including the Veterinary Association and sheltering groups so populations can shelter their pets when they need to evacuate (see Young, Ruzek, Wong, Salzer, Naturale, & Wisher, 2006).
- Work with state mental health systems to explore plans for the chronically mentally ill and disabled in the event of a disaster: where shelter will be located, who will be with them, how their medication management will be addressed, and what transition plans are in place for return to predisaster placements.
- Find materials on resiliency that can be given to the media. Have available links to Web sites that the public can access for information.
- Develop a detailed plan with names, numbers, and mechanisms of how mental health functions and relationships will operate.
- Have tabletop exercises and disaster drills of different types of disasters. Ensure mental health is included in airport and public health drills on local, state, and federal levels. In Atlanta, the opportunity has been available to work with the airport and with participating airlines through a drill called “Big Bird,” in which mental health professionals role play injured victims, hysterical families, first responders, airline workers, and bystanders. Practice, practice, practice!
- After the disaster, clearly establish who is in charge and follow the incident command structure or the structure of the organization.
- Ensure that those psychologists who interact with the media are media savvy, ensuring confidentiality and operating with the permission of response leadership. Be available to provide mental health support to media professionals as they may experience vicarious trauma.
- Use different professional organizations to enlist local volunteers and provide advice to the volunteers about what is needed. Utilize a Web site to have volunteers enroll

online and indicate their interest and availability, especially if there is limited administrative assistance on site and hundreds of volunteers are trying to call a few numbers to get information. If possible, verify licensure of mental health professionals. If there are out of state mental health professionals entering the state to volunteer, be sure that state statutes allow them to practice for a limited time in the state for humanitarian purposes. Develop scripts to orient and provide on-site training for untrained volunteers.

- If there are multiple mental health agencies, suggest regular (daily) meetings with representatives to help coordinate efforts.
- Determine what groups need mental health assistance/oversight and assign mental health leads for each group who can address the specific needs of that group (Compton et al., 2005). These might include volunteer recruitment and training, supporting and processing of the volunteers' experiences, media and public relations, services for rescuers and first responders, services for wounded or ill or triaged victims, services for families dislocated by the disaster or with surviving members impacted, services for family members who have lost a family member, services for those in the existing mental health system, services for the community providers, and services to the public secondarily impacted by the disaster.
- Establish a mental health telephone hotline for the public.
- Prepare to offer services to primary care clinics, physicians, schools, faith-based organizations, Employee Assistance Programs, and community organizations to help them understand the impact of disaster and build resiliency.
- Establish liaisons with police, fire department, FEMA, the Federal Bureau of Investigation (if necessary), schools, clergy, EAPS, the attorney general's office, state agencies, the medical examiner's office, and universities.
- Establish a system to reach out to those who may not be able to go to the sites where service is being offered. Teams may need to go to where the clients are.

Conclusion

Our nation has experienced two overwhelming disasters in the past 4 years that have drained financial reserves and exhausted disaster planners. It is virtually impossible to plan for every kind of disaster and anticipate all the mental health issues that each disaster may involve. In truth, disasters inevitably involve chaos, fear, and destruction.

There are many questions raised by huge catastrophic disasters: Can we take steps to increase the resiliency of those affected? What social supports are most effective and can we create these for people who have few predisaster supports? What services are most effective for first responders, and when should they be offered? How should we identify those in need of more intensive help? The answers to these and other questions are not yet known with confidence, given that the field of early intervention and community response is relatively new. As we wait for more definitive answers, we have much to learn from our own bitter experiences. We can take many steps to improve our response capabilities and help ease suffering and speed healing through our collective efforts.

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