Chapter 11
Disaster Mental Health: Strategic Planning

The newly accepted truism is that in the wake of disaster the people in psychological crisis (sometimes referred to psychological casualties) will outnumber the physical casualties associated with the same disaster. According to former Assistant Surgeon General Brian Flynn, "In situation after situation across the globe, the psychological footprint of large-scale disasters…has far exceeded the medical footprint" (Flynn, 2007, p. 285). This surge in demand for acute mental health services must be addressed. In the previous chapter, we discussed psychological crisis intervention as a *tactical* means of providing psychological assistance to those experiencing acute stress reactions regardless of the cause of their distress. In this chapter, we expand that discussion to review the *strategic* response. More specifically, we shall review the process of strategic planning to best meet the greatest surge in demand for acute mental health services, disasters. While strategic planning is useful in emergency settings, it is essential in the wake of disasters.

Disaster Defined

From community and public health perspectives, disruptive events may be categorized in three different ways: emergencies, disasters, and catastrophes. Emergencies are disruptive critical incidents that can be responded to using local response resources. We speak of "emergency services" such as law enforcement, fire suppression, and emergency medical services in such a context. Disasters, on the other hand, are disruptive critical incidents that exceed local response capabilities and thus require assistance from agencies outside of local jurisdictions. More specifically, disasters are incidents that profoundly disrupt the functioning of a community, society, or nation and which causes human, economic, physical, and/or environmental losses that exceed the community's or society's ability to cope using its own resources. Thus, assistance must be recruited from other towns, cities, states, federal government, or even international resources. Finally, catastrophes are

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critical incidents that exceed all response capabilities, at least for some period of time, before they devolve into a disaster or they simply cease. The focus of this chapter is upon the strategic mental health response to disasters.

Emergence of the Field of Disaster Mental Health

The field of disaster mental health, although never formally founded, can largely trace its roots to the organizational mandate of the American Red Cross and to some degree the pre-existing and expanding crisis response networks of the International Critical Incident Stress Foundation (ICISF). In 1992, Red Cross chapters in each state were encouraged to develop their own disaster mental health teams. These teams consisted of volunteer licensed mental health clinicians who received training in how to provide psychological crisis intervention to Red Cross personnel (and subsequently to local victims of disasters) within the overarching American Red Cross disaster response initiative. A pioneering group of volunteers were chosen from numerous states throughout the USA and trained in how to organize, administrate, and train volunteers in their respective states in disaster mental health response. The training document used in the initial training retreat held in Forsythe, Georgia was the Red Cross 3050 M. The senior author of this current textbook (GSE) was a member of that original group trained in the spring of 1992.

The pioneering Red Cross teams did not have to wait long for their first disaster mobilization and deployment. It came in response to Hurricane Andrew. Andrew was a Category 5 Atlantic hurricane that struck the Bahamas, South Florida, and Louisiana in August 1992. The Saffir–Simpson hurricane scale classifies hurricanes into five categories according to their respective wind speeds. To be classified as a Category 1 hurricane, a storm must have maximum sustained winds of at least 74 mph. Category 5 is the highest classification in the scale and consists of hurricanes with sustained winds exceeding 156 mph. At the time, Andrew was the most destructive hurricane to ever hit the state of Florida reaching sustained winds of 165 mph and gusts over 200 mph. It was the costliest hurricane anywhere in the USA and would not be surpassed in destructive expense until Hurricane Katrina struck in 2005. The city of Homestead in southeast Florida sustained a direct hit from Andrew. In its wake, Andrew left more than 63,500 houses destroyed and more than 124,000 others affected. Andrew caused more than $27.3 billion in damage, while killing 65 people. As one might imagine, Hurricane Andrew represented a remarkable challenge to the first group of mental health responders and represented a “birth by fire” for this emerging field.

After the seminal deployment of formally organized disaster mental teams in response to Hurricane Andrew, subsequent deployments became rather routine emanating not only from the American Red Cross network, but from emergent teams that would subsequently be developed in towns and cities all over North America and sponsored by a wide variety of nongovernmental organizations, as well as state and local governmental agencies. Listed below is a partial list of

noteworthy disasters that uniquely challenged the provision of mental health services in North America.

- March 28, 1979, nuclear reactor number 2 at the Three Mile Island Nuclear Generating Station in Pennsylvania experienced a partial meltdown of its uranium fuel rods. Fortunately, the containment vessel was not compromised. Nevertheless, as a result of this meltdown, radioactive gases were released into the atmosphere. Elevated adrenalin levels were seen in residents for years.
- 1982—Air Florida 90 air disaster in Washington DC prompts re-examination of psychological support for emergency response personnel; first mass disaster use of the group crisis intervention critical incident stress debriefing (CISD) which as originally formulated in 1974 by Mitchell (1983).
- Summer 1992, Hurricane Andrew. First Red Cross disaster mental health call-out.
- 1993—Social Development Office (Amiri Diwan) and Kuwait University implement a nationwide crisis intervention system for postwar Kuwait;
- April 19, 1995—Domestic terrorist bombing of the Federal Building in Oklahoma City left 168 people dead and more than 680 others injured;
- July 17, 1996—TWA flight 800 crashed off the coast of Long Island killing all passengers and crew;
- April 20, 1999—15 students including two shooters were killed and 21 students injured at Columbine High School in Littleton, Colorado;
- September 11, 2001—Terrorist attacks at the Pentagon outside Washington, DC and the World Trade Center in NYC killed thousands. A "new normal" of heightened security and counter-terrorism movements arose. The Department of Homeland Security was created. Wars in Afghanistan and Iraq were spawned.
- August 2005—Hurricane Katrina became one of the deadliest and the most costly natural disasters in American history;
- February 5–6, 2008—Super Tuesday tornado outbreak in the Ohio Valley killed a total of 57 people across four states and injured hundreds of people;
- April 2011—The Mississippi River floods killed 20 and cost billions of dollars.
- Late October 2011—Hurricane Sandy affected 24 states, including the entire Eastern seaboard. Damage was estimated to be in excess of $65 billion.
- August 9–August 25, 2014—Ferguson, MO civil disturbance. 10 civilians arrested, 6 police officers injured, 321 arrested.
- April 28–May 3, 2015—Baltimore civil disturbance. 486 arrested, 113 police officers injured, 350+ businesses and homes damaged.
- August 11–August 12, 2017—Charlottesville, Virginia, civil disturbance. 11 arrested, 38 injured, 3 deaths (1 civilian in car ramming, 2 police officers).
- August–September 2017—Hurricanes Harvey, Irma, and Maria struck the Caribbean and southeastern United States causing damage estimated to be in excess of $250 billion.

  In Houston, the associated flooding represented the third "500-year flood" in three years according to the National Weather Service statistics.

- February 14, 2018—A shooting at Marjory Stoneman Douglas High School in Parkland, Florida where seventeen people were killed and seventeen more were wounded. While seemingly limited in scope, this event rose to the level of a disaster in that the demand exceeded local mental health capacity.
- May 8, 2018—A school shooting at Santa Fe High School in Santa Fe, Texas, wherein ten people were fatally shot and thirteen others were wounded.

It should be noted, however, that as the recognition of the need for, and acceptance of, disaster mental health services grew, the greatest challenge facing the new field of disaster mental health was no longer tactical intervention methods, that is, how to best tactically intervene with those in acute distress. Those have been reviewed in the previous chapter and more comprehensively analyzed by Everly & Mitchell (2017). Rather, the emergent challenge was the strategic coordination and planning of disaster mental health services. In recognition of this need, in 2007, the United Nations adopted an integrated multicomponent strategic planning model to serve as the overarching framework for the intervention system for the delivery of psychosocial support services for its own United Nations field personnel (United Nations Department of Safety and Security CISMU Staff, 2007a, 2007b, 2007c). The model adopted by the United Nations was based largely upon and the seminal integrated multicomponent continuum of care Critical Incident Stress Management (CISM; Everly & Mitchell, 1997).

Strategic Planning

The great Chinese military strategist Sun Tzu (c. 544–496 BC) wrote the classic text *The Art of War*. In that text, he boldly asserted, "Strategy without tactics is the slowest route to victory. Tactics without strategy is the noise before defeat." But what do these terms really mean? Let's take a closer look.

Carville and Begala (2000) explained that there are three essential elements in planning: objectives, strategies, tactics. The strategy is often confused with the objective and the tactic. So let us begin by clarifying all three terms.

Objective

The term *objective* is derived from the Medieval Latin word *objectivus* which means something which is sought after a goal. Think of this as an overarching goal or the overall desired outcome. In order to achieve one's objective, one must have a strategy and set of tactics.

Strategy

The term *strategy* refers to the plan or schema to achieve the objective. It is derived from the Greek word *strategos* and the English *stratagem*. The strategy is the goal-path. So formulating a strategy yields goal-path clarity.

Tactic

From the Greek word *tactica*, *tactic* refers to the specific actions or behaviors that will be taken within the strategy to achieve the objective. Think of tactics as the specific actions, or tools, of the strategic plan.

Strategic Planning

So as you can see, the term strategic plan is actually a redundancy since a strategy is actually a plan. That having been said, we will use the term loosely as it has been used recently albeit imprecisely. So, think of strategic planning as the sum total of all planning processes in support of the objective or goal.

The field of disaster mental health has been plagued by the vigorous pursuit of tactics (psychological crisis intervention, psychological first aid, psychological debriefing), while often ignoring the importance of having a strategic formulation, or framework, within which the tactics may reside. Indeed, the perfectly performed tactical intervention implemented at the wrong time can be as complete a failure as the tactical intervention performed poorly. Thus, while tactical proficiency (how to intervene) is essential, so is the strategic understanding of when and where to implement the chosen interventions so as to maximize outcome and best achieve the objective. According to Flynn (2003), "There seems to be a consensus that the process of planning is nearly as important as the content of the plans" (p. 6).

The University of Miami psychologist and later Harvard psychiatry professor Theodore Millon brilliantly formulated a schema for the creation of a clinical science (see Chap. 7). Although his framework was designed to be used in the field of psychotherapy, it has direct application to and offers a guiding light for psychological crisis intervention and disaster mental health. According to Millon, Grossman, Meagher, Millon, and Everly (1999), "The palette of methods and techniques … must be commensurate with the idiographic heterogeneity for whom the methods and techniques are intended" (p. 145).

A Six-Step Planning Heuristic

A heuristic is nothing more than a model or framework designed to aid understanding, organization, and/or and application. The disaster mental health heuristic below consists of six elements designed to assist the strategic planning process. They are likely to be more effective if they are integrated into a resilience-focused multicomponent continuum of care (Everly & Mitchell, 2017; Kaminsky, McCabe, Langlieb, & Everly, 2007; Nucifora, Langlieb, Siegal, Everly, & Kaminsky, 2007; Richards, 2001). The actual process of planning would, therefore, consist of answering the following questions.

***Step 1*—Threat—What is the nature of the disaster?** The focus in this step of the planning heuristic is identification of the nature of the specific nature of the disaster. Is it school violence, flooding, a radioactive event, a storm, a riot, an infectious disease, etc.? Each disaster carries with it somewhat different psychological stressors and may require modifications to the response based upon unique incident response characteristics. The more advanced the planning process can be, the more likely unique incident characteristics will be effectively addressed. Ideally, planning comes before the event actually occurs. In some cases, incident-specific planning may not occur because of the unanticipated nature of the incident itself.

***Step 2*—Targeting Recipient Populations. Who will receive psychological crisis intervention services?** Determine which individuals or groups might benefit from psychological support or assistance in preparation for, during, or in the wake of, trauma and disaster. Who needs help? Who does not? Are they individuals or groups? How many individuals? If it is a group(s), what is the nature of the group (s)? Is the group a homogeneous group or a heterogeneous group? Homogeneity typically refers to similar exposure to the event. Are there cultural factors that would affect intervention? One simple visual planning aid may be used to show how target populations may be identified according to exposure. See Fig. 11.1 which depicts the "circles of impact" planning aid.

In Fig. 11.1, the variable of the intensity of personal exposure (impact) to potentially traumatizing experiences such as disasters is the criterion variable used to select and homogenize groups of survivors, or responders. This may be the most commonly used homogenizing variable for most disasters.

Another aid for planning is that of the metaphor of a funnel. The funnel is a representation of how the size of a recipient group may be used to identify target populations. The funnel refers to the notion that mental health interventions can be planned according to the size of the target groups to be addressed per intervention. Using a funnel denotes that interventions are planned to target large groups, then moderate size groups, then small groups, and finally individuals.

***Step 3*—Type. What types of psychological crisis interventions should be used?** Determine which types of interventions are going to be most appropriate for this particular incident with its unique constituent populations. In other words, "what" types of psychological crisis interventions will be used to help others? Will the services be individual "psychological first aid" or some form of group support

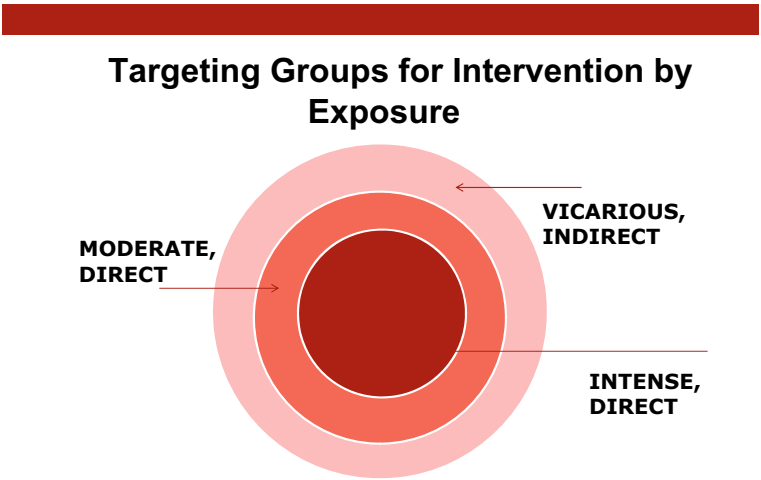

Fig. 11.1 Circles of impact

or both? Are families or organizations involved and do they need information or more supportive intervention? Is there a plan for the necessary follow-up and referral services?

Specific psychological crisis interventions that can be utilized would be such things as psychological first aid for individuals (Everly & Lating, 2017), informative town hall meetings/briefings for large groups of disaster survivors and/or their families or even the media (Everly, 2000), and small interactive group "debriefings" for groups of disaster survivors and/or family members (Everly & Mitchell, 2017; Mitchell & Everly, 1993, 2001).

***Step 4*—Timing. When are the crisis interventions best applied?** Timing answers the question of "when" to apply specific interventions or support services. When interventions are not carefully planned, they will be seen as interfering, intrusive, or unnecessary. If they are appropriately timed, they can make a very positive impact on the person or people involved in the experience.

***Step 5*—Themes. Are there are unique psychological themes that serve to make this disaster especially challenging?** Themes are factors that influence decision making or the choice of interventions. They must be considered throughout the crisis intervention process. Is the incident, for example, an act of terrorism? Are there child-related injuries or deaths? Was the incident preventable? We believe for example that child-related incidents are more stressful than are adult-related incidents. Human-made disasters are more stressful than natural disasters. Intentional acts of destruction are more stressful than are those which are accidental. Disasters that are chronic in nature (such as floods) are more stressful than are acute disasters (such as tornadoes). Radiologic and infectious disease-related disasters are more stressful because of their ambiguity.

***Step 6*—Team (Resources). What human resources can be mobilized to most effectively respond to the disaster?** This last consideration addresses specifically what human and logistical resources will be deployed. What human and logistical support is needed to articulate the most effective response? What medical, safety, legal, shelter, transportation, and nutritional issues are relevant for the intervention team? What are the plans for assessing and assisting interventionists postdeployment?

A Case Study: School Shootings

Let's now take these concepts and apply them to an actual incident.

On February 14, 2018, a gunman shot 31 students at Marjory Stoneman Douglas High School in Parkland, Florida. Seventeen were killed and fourteen more were wounded. The "Valentine's Day Massacre," as it is now being called, became the world's deadliest school shooting.

In the wake of the shooting in Parkland, once again, the all too familiar declaration echoed, "Grief counselors were dispatched". While it is certainly wise to recruit external support services to assist in such overwhelming incidents, simply putting out a call for well-meaning volunteers is insufficient. The impromptu "open door" approach is risky at best. Let's take a look at a more deliberate approach to responding to such an incident. We will integrate the strategic planning material in this chapter with the tactical interventions reviewed in the crisis intervention chapter so as to create a prescriptive response to a school shooting disaster such as the one in Parkland. We shall break the plan down into pre-incident recommendations, active incident recommendations, and postincident recommendations keeping in mind these recommendations focus on stress-related issues, not safety and survival issues. Safety and survival recommendations for an incident such as a school shooting are beyond the scope of this book and fall under the domain of "active shooter" training.

Pre-incident Recommendations

(1) Every school must have a disaster mental health/psychological crisis intervention plan. It should utilize two sets of resources: *internal school resources* and *external community resources*.
(2) Internal school resources should consist of two further elements: *resources at any given potential target school* and *resources within the school district*.
(3) Once these resources are identified, formal crisis intervention teams should be created. They should consist of school counselors, teachers, staff, and school leadership. All team members should be specifically trained in psychological

first aid (Everly & Lating, 2017) regardless of their specific professional backgrounds. It's important that all team members follow the same protocols. Standardized training increases the reliability of interventions. Cogent and consistent intervention platforms and messaging are essential.

(4) Ongoing training and rehearsal are essential to retain response capability.
(5) Regarding external community resources, ideally these resources would come from the community that is familiar with the school and the community at large. Police agencies, fire departments, hospitals, local Red Cross, and local critical incident stress management teams typically have pre-existing well-trained psychological crisis intervention teams that may be of assistance. Local mental health societies may have pro bono interventionists willing to participate as well. It is important that "mutual aid" agreements be created between the school and such agencies prior to any incident. These agreements serve as operating guidelines when an incident occurs.
(6) The school has an obligation to review the credentials of external agencies to increase the likelihood they too will be following the same intervention protocols. Licensure in a mental health discipline does not ensure adequate training in psychological first aid.

Active Incident Recommendations

(1) Maintaining active and accurate communications during an incident is essential to managing fear and stress in those outside of the immediate field of action. Staff, friends, family, and community members will be eager to learn of events. Communications will keep them informed while also insuring they do not put themselves at risk or complicate the emergency services interventions.
(2) In a school shooting, the actual event is typically brief in duration. In fact, it is often less than ten minutes. But other incidents may be protracted and can last an hour or more.
(3) Text messaging and the Internet can be efficient and effective communication tools. In the case of a school, shooting messaging should be a joint effort from school leadership and emergency services incident command.
(4) In the final analysis, during and immediately after any incident, school authorities should utilize appropriate social media platforms to inform all appropriate parties as to the status of the incident. There is no such thing as an information vacuum. If the school's authorities are not communicating, someone else is. And thus the rumor mill gains control of messaging.

Postincident Recommendations

(1) After the incident (*timing*) and relatively close to the scene, "safe" venues for acute psychological crisis intervention should be established to *target* those immediately affected. They should be staffed (*team*) with security personnel and only those interventionists who have been vetted to have received adequate training in psychological first aid. This is an opportunity to provide individual crisis intervention (*type of intervention*), as needed. This is not "therapy". Nor is this the time for therapy. Crisis intervention has been shown to be superior to therapy in the acute phase of incidents such as violence (Boscarino, Adams, & Figley, 2011). That said arrangements for follow-up counseling should be arranged in advance of an incident. States typically have pro bono counseling projects through state psychological, psychiatric, and social work societies. Think of this as an opportunity for establishing safety, psychological decompression, fostering rest, and providing information for the target groups of survivors and family members.

(2) Upon return to school, incident-specific assemblies (*type of intervention*) should be held which *targets* students, staff, and faculty. These assemblies should be conducted by school personnel with contributions from law enforcement and mental health experts (*team*). Here is a formula for specific topics to be addressed (Everly, 2000). Discuss (*themes*): What happened. What/who caused it. Current and anticipated effects (it's especially important to discuss depression, grief, survivor guilt, and posttraumatic stress); actions currently being taken relevant to the incident; actions being taken to prevent similar incidents in the future. A similar assembly/town hall meeting (*type*) can be held which targets families and friends. The *themed* topics would include helping children in times of crisis and vicarious trauma. These assemblies and town hall meetings (large group crisis interventions) typically last 30–90 min depending upon size of audience and the complexity of the incident.

(3) Following the assembly (*time*), students (*target*) should return to homerooms (or the equivalent) to have small group discussions (*type*) of the topics addressed in the assembly. These small group crisis interventions give students a chance to ventilate and discuss salient topics (*themes*). They should be conducted by those who have received special training in small group crisis intervention and can be co-facilitated by the homeroom teachers (*team*).

(4) Individual crisis intervention services (*type*) should be available for all students (*target*) at all times school is in session and immediately after school for about a month or as long as needed. Such services are only provided by those who have received specialized training in psychological crisis intervention (*team*).

(5) Memorial services (*type*) should be provided, as appropriate.

(6) A one-year anniversary service (*type*) should be considered.

The "open door" "catch-as catch-can" response to school violence is no longer acceptable. The science of psychological crisis intervention has progressed such that standard of care practices are emerging to the benefit of all. In the scenario described above, we have integrated material contained in this chapter on strategic planning and the previous chapter on psychological crisis intervention. The target-type-timing-team planning formula discussed in this chapter was integrated with specific tactical interventions reviewed in the crisis intervention chapter.

Case Study: A Community Volunteer Fire Service

The East Coldenham Elementary School disaster occurred on November 16, 1989 in Newburgh, New York, population about 20,000. A tornado-like wind blew down a free-standing school cafeteria wall, killing nine students. The volunteer fire company encountered nine dead or dying children with many others injured. Operational challenges appeared to delay extrication of the injured children. This operational issue served to vehemently divide the volunteer department and the entire community. The volunteer fire service, fraught with strife, lost over 50% of its membership putting at risk the entire community. A request from the Governor of the State of New York prompted a unique disaster mental health intervention three and one-half years after the disaster (Mitchell, Schiller, Eyler, & Everly, 1999).

The disaster mental health intervention was initiated with the dispatching of a surveillance and assessment team to Coldenham. Interviews conducted in the spring of 1993 with community leaders, volunteer firefighters, and spouses confirmed that not only was the volunteer fire service still in distress, the entire community was in mourning. The crisis themes of death and injury to children, operational errors, interpersonal anger, and grieving were noted as the most salient. The goal of the intervention would be to facilitate the mourning process and foster some sense of psychological closure concerning this tragedy. This was not unlike the challenge faced by Erich Lindemann and his colleagues as they sought to assist the survivors and family members in the wake of the 1942 Coconut Grove mass casualty fire in Boston.

An intervention team consisting of three mental health clinicians and five professional firefighters from New York arrived in Coldenham on June 16, 1993. They remained though June 20, 1993.

The targets of the intervention were identified as (1) fire service command staff, (2) firefighters, (3) spouses of firefighters, (4) school personnel, and (5) community members affected by the disaster.

Using a strategic planning funnel approach, the intervention began with a radio program broadcast to the Coldenham area wherein the disaster and the planned interventions were discussed. Town hall meetings were then held with large groups as well as homogenized smaller subgroups. Salient issues for each of the groups were discussed.

Small interactive group debriefings/discussions were offered to each of the targeted subgroups. Members of each of the targeted groups were offered the opportunity for individual crisis intervention sessions at any point over the five-day intervention period.

Follow-up visits to Coldenham were made by members of the crisis intervention team over the next four months, weekly at first then biweekly. Individual counseling sessions were offered for anyone interested.

The entire intervention process and the research supporting its effectiveness is published elsewhere (Mitchell, Schiller, Eyler, & Everly, 1999).

Summary

(1) In the previous chapter, we discussed psychological crisis intervention from a tactical perspective. In this chapter, we expanded the discussion of the provision of stress-oriented acute psychological intervention to disasters and the importance of strategic planning. Once again echoing Sun Tzu, "Strategy without tactics is the slowest route to victory. Tactics without strategy are the noise before defeat".
(2) We must take care to match even acute interventions to the needs of those in crisis as described by Millon et al. (1999), "The palette of methods and techniques … must be commensurate with the idiographic heterogeneity for whom the methods and techniques are intended" (p. 145).
(3) The Six-T alliterative mnemonic of threat (the nature of the disaster), target (the populations targeted for intervention), type (the types of acute crisis interventions to be utilized) timing (the timing and order of the intervention to be applied), theme (the recognition of unique psychological dynamics that may affect intervention), and team (the human resources that will be mobilized in response) may be used as a planning framework.
(4) Lastly, two cases were reviewed wherein the planning formulas were exemplified.

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