



Action Timeline, Training, and Support for Psychosocial/Disaster Mental Health Responders

IPRED Psychosocial Working Group

The Timeline depends in part on the type of disaster; moreover, the phases of a disaster are usually overlapping rather than discrete. Pandemic, drought, oil spill can be “slow moving” and might require response at all three phases (acute, mid-, long-term) operating simultaneously, depending on the individual or group. With a pandemic, for example, there are many unaffected yet in a state of uncertainty. Others may be recently impacted while still others are recovering. DMH personnel most often need to move forward and back across the timeline; (for example, after 71 cm of rain fell on Louisiana, a family returned to find their house ruined and their pet dead. Responders were well into the middle phases of this response but had to shift back to actions appropriate for an earlier phase for this particular family.)

DMH Responder Professional Education and Training

- Advanced educational training in social work, counseling or clinical psychology, public health epidemiology;
- Special courses in disaster preparedness, response, and long-term management;
- Training in leadership/coordination roles;
- Specialized training in suicide prevention, crisis response, stress and trauma management;
- Cultural sensitivity;
- Expertise in training community members (paraprofessionals) to carry out some of the group activities, coordination, information to the population, media;
- Skills in effective referral for long-term treatment of PTSD and/or complicated grief as well as comorbid disorders;
- Research foundation - research methods, statistics, empirically-based assessment of interventions;
- Continuing education.

Note: Different professional skills are needed within each phase and across different phases of a disaster

- Mid-phase psychosocial counseling interventions require a greater specialized level of expertise.

Pre-Event

Planning strategies for responding to and managing different types of disasters across the timeline:

- Natural disasters;
- Terrorism (bombs, rocket attacks, shootings);
- CBRNE events including toxic and nuclear accidents;
- Other human caused disasters (fires, plane and other mass transportation accidents; mass casualty shootings);
- Public health emergencies (pandemics);
- Civil strife and ensuing internally displaced and refugee populations.

Pre-event planning should include:

- Identification of which agency/established system is responsible for taking the lead in psychosocial planning, response, and recovery;
 - Designation of what this leadership role entails;
- The contribution of disaster mental health (DMH) helpers to the improvement of individual and family preparedness, such as developing a campaign to encourage residents to create family emergency plans;
- Identification of vulnerable populations in the community (nursing homes, child care centers, psychiatric hospitals, facilities for the disabled);
 - When disaster strikes, these populations can receive appropriate attention and resources;
- Identification of practitioners who can supply long-term evidence based best practice so they can be contacted when needed;
- Strengthening of the national capacity of health systems to provide DMH in emergencies;
- Strategies to identify, monitor, prevent and respond to protection threats and abuses through both social and legal protection systems.

Training in disaster mental health (DMH) for professionals, training in psychological first aid (PFA) for community responders:

- Application of a human rights framework through mental health and psychosocial support;
- Training in DMH principles, human rights standards, ethics and ethical decision making for professional and community responders;
- Identification and treatment of vicarious trauma, compassion fatigue, burnout;

- Support for special groups and vulnerable populations;
- Training in shelter operations;
- Improvement of cultural competence.

Self-Care and Support

Formal training in stress management skills through seminars, role playing workshops, etc.:

- Specific training for supervisors for effective implementation of self-care programs for staff;
- Screening, self-assessment;
- Attention to maximizing the effectiveness of self-care training.

Acute Phase

- On-site coordination – supervision, advocacy, consultation, inclusion in Incident Command meetings;
- Provision of PFA to responders and population;
 - Support, reassurance, food, sedative medications as needed, rest opportunities;
- Psychological triage;
 - Assessment and screening - appropriate referral for those identified as having extreme reactions;
- Ability to coordinate with incident commander, other responders;
- Involvement in information debriefing to first responders and other volunteers;
- Involvement in information debriefing to media;
- Rumor control;
- Cultural competence in assisting survivors;
- Identification and recruitment of staff and engagement of volunteers who understand the local culture;
- Instructions and aid to population for access to food, water, shelter;
- Psychosocial support to survivors with missing relatives and providing help to activate strategies to find those relatives;
- Attention to the psychosocial needs of groups who may experience additional vulnerability;
 - Women, children, elderly, those with functional disabilities, serious mental illness, physical injuries, bereaved;
- Point of contact in acute phase is often via phone. Helpers should be trained and prepared to offer assistance by phone;
- Map existing resources for formal and non-formal educational practices;

- Build capacities to provide quality care for young children and their caregivers.

Intervention and prevention efforts should promote:

- Sense of safety;
- Calm;
- Sense of efficacy in self and community;
- Connectedness;
- Hope;
- Psychoeducation.

Self-Care and Support

- Apply stress-management techniques including rest;
- Social support through interactions with teammates;
- Buddy system – end of shift check in/out and other methods to identify vicarious trauma and possible need for more intense intervention.

Mid-Term Phase

- On-site coordination – supervision, advocacy, consultation, inclusion in Incident Command meetings;
- Continue to provide PFA as needed;
- Organize Family Assistance and similar centers and conduct individual, family, and/or group counseling, and psychoeducation sessions as needed;
- Train paraprofessionals in the community in advanced PFA to assist with psychosocial activities;
- Work with community agencies to deal with practical issues and to provide a setting to promote coping and resilience
 - Organize group activities to promote social support, bonding, recreational activities;
- Group meetings for venting and discussion/help with problems such as housing, jobs, safety, medical care;
- “Anniversary” group meetings if mid-term phase is prolonged;
- Assist with and support other types of memorial activities;
- Focus on needs of vulnerable populations;
- Attention to cultural differences;
- Determine levels of education and vocational options for girls, boys, and adults who may have missed out on education in long-term conflict situations;

- Facilitate community-based reintegration of children recruited or used by armed forces or groups;
- Provide crisis counseling and early cognitive behavioral therapy as needed;
- Provide bereavement counseling if necessary;
- Continue to screen with reliable brief instruments and treat with evidence based practices if available;
- Systematically evaluate the effectiveness of interventions and adjust to meet the changing needs, cultural and other characteristics of those receiving services;
- Carry out systematic, empirical research to implement effective evidence-based interventions, tailored to the cultural and other characteristics of the people the DMH professional is treating.

Self-Care and Support

- Apply stress-management techniques;
- Social support through interactions with colleagues, family, other community members;
- Help from community agencies to deal with personal, family problems;
- Alertness to signs of compassion fatigue and burnout with comprehensive plan for mitigation.

Long-Term Interventions - Recovery Phase

- On-site coordination – supervision, advocacy, consultation;
- Continued building of community resilience;
- Continued “Anniversary” group meetings;
- Help in coordinating medical care, social services;
- Coordinate/supervise work of community paraprofessionals;
- Encourage long-term treatment for those in need with evidence informed best practices;
- Continue with empirical research evaluating “best practices”;
- Strengthen access to safe and supportive education.

Self-Care and Support

- Apply stress-management techniques as needed;
- Social support through interactions with colleagues, family, other community members;
- Help from community agencies to deal with personal, family problems.

Post-Event Evaluation

In addition to the ongoing evaluation of interventions and needs throughout the course of the disasters, a careful evaluation of the entire event should be conducted. Were the plans thorough and appropriate or did gaps become apparent? Can additional targets for mitigation be identified in hopes of preventing or reducing harm from a repeat event? Were the response and recovery efforts carried out as planned, or were there lapses in communication or other problems of implementation? Every aspect should be considered thoughtfully – and the conclusions should then be incorporated into updated plans. It would be regrettable if personal defensiveness were allowed to get in the way of maximizing preparedness, but many people are not comfortable having their actions closely examined. Mental health professionals can assist in this evaluation by reminding those involved that this is not a critical assessment of individual or agency performance (unless, of course, that's warranted by some actual failure), but an opportunity to improve and protect the community better in the future.

