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DISASTER NURSING (N 110)
STUDY GUIDE

DISASTER RESPONSE

Mental Health and Psychosocial Support

Introduction

Hello students!

> **In hours after the disaster at least 25% of the population maybe stunned and dazed apathetic wandering suffering from the disaster syndrome especially if impact has been sudden and totally devastating at that point psychologically first aid and triage are necessary -** *Beverly Raphael (1934 – 2018)*
> *A psychiatrist who held chairs at the Australian and the Universities of Queensland, Western Sydney and Newcastle*

Prehospital care is provided by emergency medical services (EMS) responders, who are the initial health care providers at the scene of disaster. EMS personnel often are the first to recognize the nature of a disaster and can immediately evaluate the situation and determine the need for resources, including medical resources (Committee on Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations; Institute of Medicine, 2012). Nurses' involvement in pre-hospital emergency care is increasing. In several countries, including the Philippines, nurses receive additional training to become a certified EMS responder who are attached to a specific hospital and can be called upon in emergency and disaster events.

A study on nurses' roles in pre-hospital emergency care showed that the primary function of the pre-hospital nurse emerged as that of providing emergency care to patients with serious illness or injury. Competencies were mainly related to immediate medical care and scene management techniques, together with specific attributes which are required to function in this setting (Abela Fiorentino, 2019).

This study guide focuses on nurses' roles and competencies in Disaster Response. The topic on Disaster Response has four interrelated sessions: pre-hospital care, priority public health interventions, mental health and psychosocial support, and disaster risk communication and collaboration. The learning resources and activities include online materials, virtual simulations and video summaries. Lab sessions will include online synchronous interactive activities, and discussion forums for deepening and sharing of knowledge and experiences.

Learning Outcomes

At the end of the module on mental health and psychosocial support, you should be able to:

1. Describe the basic concepts, principles and strategies in mental health and psychosocial support in disaster response.
2. Identify issues and needs of patients in relation to mental health and psychosocial support.
3. Describe the basic principles and application of psychological first aid.
4. Apply psychological first aid principles and strategies in table-top exercises.

Concept Outline

According to the WHO, emergency situations such as armed conflicts, natural disasters and other humanitarian crises exacerbate the risk of mental health conditions. Nearly all people affected by these emergencies will experience psychological distress, with one in five likely to have a mental disorder such as depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia. Some people may easily recover, while others may find themselves with heightened levels of depression if not addressed. These risks are increased in older people and marginalized groups. Stressful events such as violence and loss, as well as poverty, discrimination, overcrowding, and food and resource insecurity, are common in emergencies and can increase the risk of developing mental health conditions. This vulnerability is also found in people with existing severe mental disorders prior to the emergency or disaster event.

Impact of emergencies and disaster on mental health

Some key facts from the WHO Mental Health in Emergencies:

- *Almost all people affected by emergencies will experience psychological distress, which for most people will improve over time.*
- *Among people who have experienced war or other conflict in the previous 10 years, one in 11 (9%) will have a moderate or severe mental disorder.*
- *One person in five (22%) living in an area affected by conflict is estimated to have depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia.*
- *Depression tends to be more common among women than men.*
- *Depression and anxiety become more common as people get older.*
- *People with severe mental disorders are especially vulnerable during emergencies and need access to mental health care and other basic needs.*
- *International guidelines recommend services at a number of levels–from basic services to clinical care–and indicate that mental health care needs to be made available immediately for specific, urgent mental health problems as part of the health response.*

- *Despite their tragic nature and adverse effects on mental health, emergencies have shown to be opportunities to build sustainable mental health systems for all people in need.*

Mental Health and Psychosocial Services

The Inter-Agency Standing Committee (IASC) was established in 1992 in response to General Assembly Resolution 46/182, which called for strengthened coordination of humanitarian assistance. IASC is the primary mechanism for facilitating inter-agency decision-making in response to complex emergencies and natural disasters. One of several guidelines published by the committee involves the establishment and coordination of multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergency. The guidelines focused on implementing minimum responses, which are essential, high-priority responses that should be implemented as soon as possible in an emergency.

***Minimum responses**: first things that ought to be done; the essential first steps that lay the foundation for the more comprehensive efforts that may be needed (including during the stabilized phase and early reconstruction).*

The term **"psychosocial"** denotes the inter-connection between psychological and social processes and the fact that each continually interacts with and influences the other. The composite term **mental health and psychosocial support (MHPSS)** is used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder.

Problems in Emergencies and Disasters

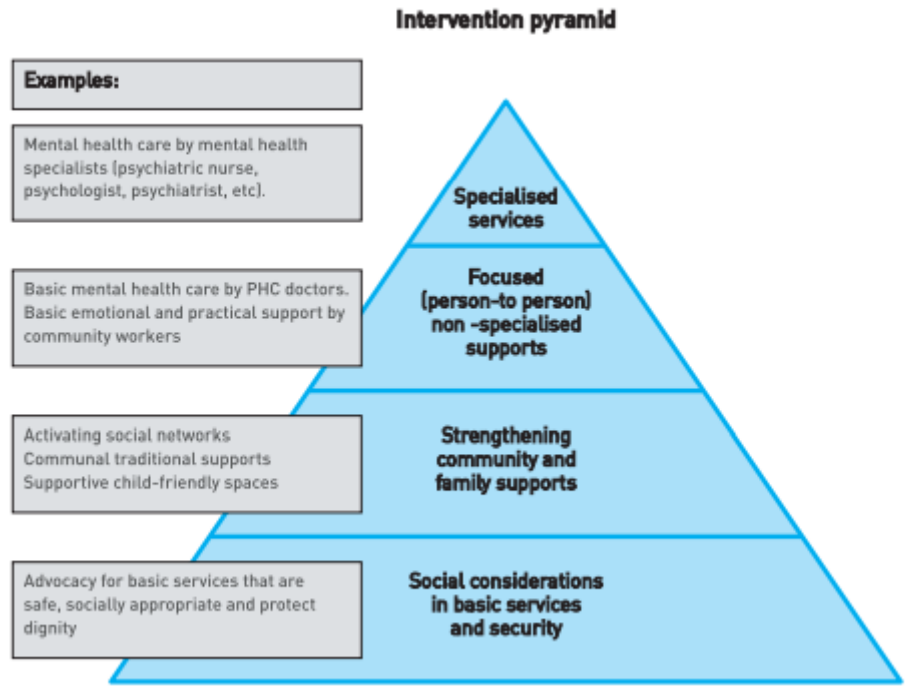
Predominantly Social Nature:

1. Pre-existing (pre-emergency) social problems (e.g., extreme poverty; belonging to a group that is discriminated against or marginalized; political oppression);
2. Emergency-induced social problems (e.g., family separation; disruption of social networks; destruction of community structures, resources and trust; increased gender-based violence); and
3. Humanitarian aid-induced social problems (e.g., undermining of community structures or traditional support mechanisms).

Predominantly Psychological Nature:

1. Pre-existing problems (e.g., severe mental disorder; alcohol abuse);
2. Emergency-induced problems (e.g., grief, non-pathological distress; depression and anxiety disorders, including post-traumatic stress disorder (PTSD)); and
3. Humanitarian aid-related problems (e.g., anxiety due to a lack of information about food distribution).

In emergencies, people are affected in different ways and require different kinds of supports. One of the key principles is ensuring the availability of complementary supports. MHPSS systems require a layered system of complementary supports that meet the needs of different groups (see figure below). All layers of the pyramid are important and should ideally be implemented concurrently



Source: Mental Health in Emergencies: What humanitarian actors should know
mhGAP Humanitarian Intervention Guide (mhGAP-HIG) training of health-care providers

The **Intervention Pyramid** involves four areas: basic services and security, strengthening community and family supports, focused non-specialized supports, specialized services.

Effective Emergency Response

WHO-endorsed inter-agency mental health and psychosocial support guidelines for an effective response to emergencies recommend services at a number of levels – from basic services to clinical care.

1. **Community self-help and social support** should be strengthened, for example by creating or re-establishing community groups in which members solve problems collaboratively and engage in activities such as emergency relief or learning new skills, while ensuring the involvement of people who are vulnerable and marginalized, including people with mental disorders.

2. **Psychological first aid** offers first-line emotional and practical support to people experiencing acute distress due to a recent event and should be made available by field workers, including health staff, teachers or trained volunteers.

3. **Basic clinical mental health** care covering priority conditions (e.g., depression, psychotic disorders, epilepsy, alcohol and substance abuse) should be provided at every health-care facility by trained and supervised general health staff.

4. **Psychological interventions** (e.g., problem-solving interventions, group interpersonal therapy, interventions based on the principles of cognitive-behavioral therapy). This is specific for people impaired by prolonged distress which should be offered by specialists or by trained and supervised community workers in the health and social sector.

5. **Protecting and promoting the rights** of people with severe mental health conditions and psychosocial disabilities is especially critical in humanitarian emergencies. This includes visiting, monitoring and supporting people at psychiatric facilities and residential homes.

6. **Links and referral mechanisms** need to be established between mental health specialists, general health-care providers, community-based support and other services (e.g., schools, social services and emergency relief services such as those providing food, water and housing/shelter).

Preparation and training for these services, including coordination among professional healthcare providers form part of the preparedness phase in the disaster continuum, so that these can be effectively carried out or implemented during the response phase. These services remain in place even through the recovery and rehabilitation phase in order to ensure safe transition into community and family life beyond the emergency or disaster event.

As a generalist nurse (i.e., without specialized training in psychiatric and mental health nursing, what roles would you be able to play? What activities and interventions will you be able to initiate or collaborate with other healthcare providers?

The IASC release of the guidelines for minimum responses in the midst of emergencies provided the MHPSS matrix. These aim to facilitate the implementation of the minimum responses during emergencies.

Deepening Your Understanding

Read about the **General Principles of Care for People with Mental, Neurological and Substance (MNS) Conditions in Humanitarian Settings.** This topic is part of the guide that contains first-line management recommendations for MNS conditions for non-specialist health-care providers in humanitarian emergencies where access to specialists and treatment options is limited. The extracts can be found **here**. *You can download and read the original document in the link below.*

mhGAP Humanitarian Intervention Guide (mhGAP-HIG). (2015). Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies. Geneva. **p.5 - 11**

Psychological First Aid

According to Sphere (2011) and IASC (2007), psychological first aid (PFA) *describes a humane, supportive response to a fellow human being who is suffering and who may need support*.

PFA is an alternative to “psychological debriefing” which has been found to be ineffective. In contrast, PFA involves factors that seem to be most helpful to people’s long-term recovery (according to various studies and the consensus of many crisis helpers).

These include:

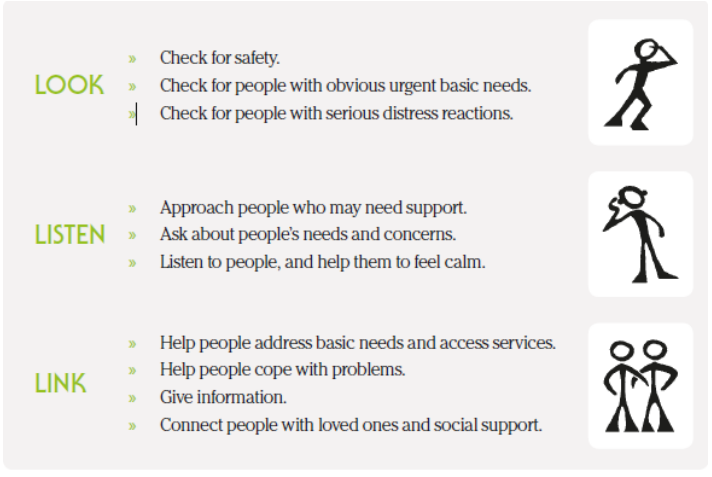
- » feeling safe, connected to others, calm and hopeful;
- » having access to social, physical and emotional support; and
- » feeling able to help themselves, as individuals and communities.

What PFA is	**What PFA is *not***
• Providing practical care and support, which does not intrude; • Assessing needs and concerns; • Helping people to address basic needs (for example, food and water, information); • Listening to people, but not pressuring them to talk; • Comforting people and helping them to feel calm; • Helping people connect to information, services and social supports; • Protecting people from further harm.	• It is not something that only professionals can do. • It is not professional counselling. • It is not “psychological debriefing” in that PFA does not necessarily involve a • Detailed discussion of the event that caused the distress. • It is not asking someone to analyze what happened to them or to put time and events in order. • Although PFA involves being available to listen to people’s stories, it is not about • Pressuring people to tell you their feelings and reactions to an event.

WHO (2010) and Sphere (2011) describe psychological debriefing as promoting ventilation by asking a person to briefly but systematically recount their perceptions, thoughts and emotional reactions during a recent stressful event. This intervention is not recommended. This is distinct from routine operational debriefing of aid workers used by some organizations at the end of a mission or work task.

Providing PFA

There are several guiding principles that are basic in providing PFA that is safe, effective, and relevant. The nurse should, in addition to the PFA training, consider these principles even before entering the disaster or crisis site, must have a good level of self-awareness, and knowledge of the resources available for connecting or linking people needing services beyond PFA. The three basic action principles of PFA are ***look, listen and link.***



Source: Psychological first aid: Guide for field workers (2011), p.18

Basic Ethical Guidelines in PFA

DO's	DON'TS
• Be honest and trustworthy • Respect a person's right to make their own decisions • Be aware of and set aside your own biases and prejudices • Make it clear to people that even if they refuse help now, they can still access help in the future • Respect privacy and keep the person's story confidential, as appropriate • Behave appropriately according to the person's culture, age and gender	• Don't exploit your relationship as a helper • Don't ask the person for any money or favor for helping them • Don't make false promises or give false information • Don't exaggerate your skills • Don't force help on people, and don't be intrusive or pushy • Don't pressure people to tell you their story • Don't share the person's story with others • Don't judge the person for their actions or feelings

Providing Care and Support for Self and Team Members

In the session on *Caring for Carers*, we noted that attention and provision of the needs of healthcare providers is part of the responsibility of the supervisor or team leader. This goes for their mental well-being as well. Here are some reminders.

N110 Skills Lab: Group Work

Application of the Principles of Psychological First Aid

You should have studied the content of this study guide and read through the materials or references given for you to be able to work on the skills lab activitiy.

Read further the instructions in the N110 course site on this particular activity.

References

Abela Fiorentino, T. (2019, August). *Nursing and pre-hospital emergency care: an exploratory study of roles and competencies - a Maltese perspective.* Retrieved from Coventry University: https://pureportal.coventry.ac.uk/en/studentTheses/nursing-and-pre-hospital-emergency-care

Committee on Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations; Institute of Medicine. (2012). Prehospital Care Emergency Medical Services (EMS). In *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response.* Washington (DC): National Academies Press (US). Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK201058/

IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. (2010). Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know? Geneva

World Health Organization, War Trauma Foundation and World Vision International (2011). Psychological first aid: Guide for field workers. WHO: Geneva.

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Level 1: Basic Services and Security

(Re)establishment of security, adequate governance and services that address basic physical needs (food, shelter, water, basic health care, control of communicable diseases).

These basic services should be established in participatory, safe and socially appropriate ways that protect local people's dignity, strengthen local social supports and mobilise community networks.

Level 2: Community and Family Supports

Useful responses in this layer include family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women's groups and youth clubs.

Level 3: Focused, Non-specialised Supports

Supports necessary for the smaller number of people who additionally require more focused individual, family or group interventions by trained and supervised workers (but who may not have had years of training in specialised care).

For example, survivors of gender-based violence might need a mixture of emotional and livelihood support from community workers.

This layer also includes **psychological first aid (PFA)** and basic mental health care by primary health care workers.

Level 4: Specialised Services

Include psychological or psychiatric supports for people with severe mental disorders whenever their needs exceed the capacities of existing primary/general health services.

Such problems require either

- (a) referral to specialised services if they exist, or
- (b) initiation of longer-term training and supervision of primary/general health care providers.

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Starting and ending with care for ourselves

Remember what you wrote…

- How do I take care of myself?
- How does my team take care of each other?

Be responsible to yourself and others by paying attention to self-care on a daily basis

Practice self and team care

- Before:
  - Are you ready to help?
- During:
  - How can you stay physically and emotionally healthy?
  - How can you support colleagues and they support you?
- After:
  - How can you take time to rest, recover and reflect?

Seek help when you…

- Have upsetting thoughts or memories about the crisis event
- Feel very nervous or extremely sad
- Have trouble sleeping
- Drink a lot of alcohol or take drugs to cope with your experience

Consult a professional if these difficulties persist more than one month

Team support

- It is best for helpers to be connected with an agency or group to ensure safety and good coordination.

- Tips for peer support or "buddies":
  - Use good listening skills
  - Show concern and empathy
  - Be respectful
  - Don't blame or judge
  - Have clear boundaries
  - Be available when needed
  - Help your colleague regain control and help themselves
  - Maintain confidentiality
  - Appreciate each other

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