From Short-term mental health and psychosocial support to client centered long-term recovery

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Introduction

The purpose of this commentary is to reflect on a recent study that investigated the impacts of disasters and described the most appropriate mental health and psychosocial interventions for enhancing resilience amongst the most affected population. This study has suggested that two week “in-and-out” missions by mental health personnel provide no value for the disaster-affected people. In contrast, a client centered response is more desirable and is best obtained through longer term mental health personnel assignments throughout the recovery period. This longer term presence of mental health personnel can facilitate the transformation of community attitudes towards the ability to bounce back and the use of schools and faith-based communities by changing educational practices and community messaging.

Resilience in the aftermath of Superstorm Sandy

The impacts of disasters are a product of the effects of the event itself, the government response, and the ability of the disaster-affected people to respond to the disaster. The focus of disaster-affected people transforms over time from a singular emphasis on safety and security to calmness. This transformation depends on a number of personal, societal, and contextual factors.

An example of the impacts of a major disaster and the response of disaster-affected people can be found in very recent history. Indeed, the states of New York and New Jersey were battered by a super storm at the end of October and beginning of November 2012, i.e., Hurricane Sandy. A recent report entitled “Resilience in the wake of Superstorm Sandy” (Tompson et al., 2013) provides some insights regarding survivor actions immediately after Hurricane Sandy and how secondary stressors appeared and were addressed by the population.

According to Tompson et al. (2013), Sandy generated extensive impacts beyond physical damage, including prolonged disruption to daily living and social relationships. First responders provided much support in the first 14 days of the response. Longer-term faith-based groups and relief organizations provided longstanding support. Six months later, the linguistically and culturally diverse communities continued the up-hill battle toward recovery, but the residents were not sure whether they would be ready for the next disaster despite the fact that most thought that another disaster would happen.

Tompson et al. (2013) report that altruistic behaviors occurred amongst neighbors in more stable communities (i.e., those that had many resources), which ultimately led to a more resilient community (p.6). Communities with culturally and linguistically diverse members, migrants, elderly residents, people with limited financial resources, and functionally disabled people with limited incomes reported encountering challenges with secondary stressors in recovery. This implies that this segment of the affected communities will face similar situations in time of future disasters. Some of the challenges faced by the latter groups included the following: (1) school and child care closings, (2) longer commutes, (3) missed time at work, and (4) the relocation of friends and neighbors. This cohort spent more time in shelters even though they turned to friends, family, and neighbors for assistance.

As infrastructure repairs were underway, reports of looting or stealing and hoarding of food and water increased. This is a natural response caused by insecurity and lack of information. Client centered tools can be used to identify what resilient behaviors helped survivors withstand secondary stressors.

Developing long term recovery programs that are client centered

Client centered recovery is “place based.” Tompson et al. (2013) suggested that the respondents in this study clearly stated that in the future, they would initially rely on first responders for safety and security and secondly on their family and friends within one mile of
their place, local schools, and relief organizations.

The disaster response community learned the following from this disaster: in order to foster responsive resilience, a partnership must be quickly developed between the helpers (i.e., those from outside groups) and the community of disasters survivors. This partnership must also have the objective of developing a long-term action plan that addresses primary and secondary long-term stressors.

To achieve recovery from a psychosocial standpoint, the following steps should occur:

1. The two-week “in-and-out” mental health disaster model is not applicable in terms of assisting survivors with client centered long-term recovery. Instead, engaging volunteers or personnel that will be in situ for an extended period of time (i.e., from six months to a year) is more appropriate. These personnel can serve as catalytic agents to encourage disaster-affected people by empowering groups of survivors to develop their own strategies to re-establish their “place.” Moreover, they can assist in transforming educational practices into informal activities or simply assist in the formulation or modification of social messages that will serve the whole community.

2. Psychosocial recovery and resilience development begins in the shelters with evening community meetings serving as a tool to discuss successes and challenges and to celebrate yet another day. The interventions that are proposed and developed in this setting will provide the context for the recovery process.

Measures of impact

The interventions and responses to a disaster are based on the individual, cultural, and contextual interactions with the environment and the providers of assistance (i.e., those from outside the community) and the providers of assistance (i.e., those from outside the community) and the providers of assistance.

Patel, Russsell, Allden, Betancourt, et al. (2011) Ultimately, the psychosocial intervention focuses on mobilizing disaster-affected people to take pro-active steps in their own recovery. Following are three potential measures of impact:

1. Is the action culturally, linguistically, and contextually relevant to the disaster-affected people in “place?”
2. Do the actions involve community resources and involve a road map toward resilience?
3. Are the actions accepted by the internal and external stakeholders?

Conclusion

Based on a recent study published in the literature and my own personal experiences, I have formulated a scenario pertaining to the importance of short-term mental health interventions and long-term psychosocial interventions in disasters. Based on the results of Tompson et al. (2013), disaster-affected people tend to rely on each other in their respective “places” for survival, and they develop long-term culturally and contextually appropriate actions that result in resilience. Disaster mental health and psychosocial support are two components of the continuum of recovery that must be developed among external disaster response organizations that serve disaster-affected people.

References

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